2018 GLOBAL PROGRESS REPORT

on Implementation of the WHO Framework Convention on Tobacco Control

FCTC

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

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FOREWORD

The 2018 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) is reflective of the level of activity and commitment of the Parties to the Convention as they move forward with implementation of the Convention. The WHO FCTC is the first international treaty negotiated under the auspices of WHO. It was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. It has since become one of the most rapidly and widely embraced treaties in United Nations history.

The advances that have taken place in the implementation of the Convention, which are reflected in this report, demonstrate the impact of the Convention – in the reduction in tobacco use among adults and young people in many Parties.

This report marks the first time since the Convention came into force that all Parties have formally submitted at least one report on the implementation of the treaty within their respective jurisdictions. As we are hopeful to have the Conference of the Parties (COP) adopt the Convention's first *Medium-term Strategic Framework*, this global analysis of WHO FCTC implementation status will provide the baseline dataset for measuring the impact of the Strategic Framework in the future.

The concerted effort of the Parties, the Convention Secretariat and other stakeholders have led to significant advances in implementation of various measures required under the Convention. The 2018 reporting cycle also detected mounting support for the Protocol to Eliminate Illicit Trade in Tobacco Products, which successfully gathered the 40 ratifications needed for its entry into force just after the closure of the reporting period.

The active engagement of the WHO FCTC Secretariat's knowledge hubs is making a significant contribution towards strengthening the implementation of the Convention and in the development of policy and legislative enhancements among the WHO FCTC Parties. New tools have been developed in the areas of smokeless tobacco and water-pipe tobacco use by some hubs, and other new tools are coming from the others. Technical assistance generated through South–South and triangular cooperation projects and through other partners of the Convention Secretariat also helps in building country capacity to improve the implementation of the Convention.

Reporting, while an obligatory function under the WHO FCTC, presents an opportunity for Parties to recount their stories on how tobacco control can remarkably improve the health of their populations. This process helps highlighting the Parties' own domestic successes, but also helps to paint a picture of the treaty's global impact. Sharing this valuable information on worthwhile practices can help all Parties improve the health of their own populations, strengthen their relations with one another and withstand the influence of the global tobacco industry.

Despite the broad acceptance of the WHO FCTC reporting instrument introduced in 2016, challenges remain as the reporting process is complex and could be perceived as burdensome. The Convention Secretariat is continuously looking for the most effective ways to improve the reporting process and make it more user-friendly.

The Convention Secretariat is happy to inform the Parties that for the first time in the preparation of the Global Progress Report a knowledge hub was involved in the analytical work. Specifically, the WHO FCTC Secretariat's

Knowledge Hub on Taxation has taken over the duty of analysing taxation and price data reported by the Parties. Our positive experience with the hub will help us extend the scope of such collaboration to other hubs. Additionally, it is also for the first time that a United Nations agency partner, which also happens to be a COP observer, the United Nations Industrial Development Organization, contributed to the Global Progess Report by summarizing the information they collect on tobacco manufacturing. As always, our main partner, the World Health Organization, contributed to the analysis of the prevalence data. All these contributions are warmly acknowledged.

The Convention Secretariat, when releasing this 2018 Global Progress Report, remains enthusiastic on the advances that we are making collectively in addressing the global tobacco epidemic. We remain committed to working with and supporting the Parties to the Convention in their efforts.

The Convention Secretariat

(Courtesy of the Secretariat of the WHO FCTC. Photo: A.Tardy)

EXECUTIVE SUMMARY

The 2018 reporting cycle for the WHO Framework Convention on Tobacco Control (WHO FCTC) was conducted in accordance with decision FCTC/COP4(16), using an Internet-based reporting instrument. Data collection for the 2018 reporting cycle was carried out from 1 January to 31 March 2018.

Of all 181 Parties to the Convention, 142 (78%) formally submitted their 2018 implementation reports, while most of the remaining Parties updated some of their information in the reporting database. For the first time since the Convention entered into force, all Parties have formally submitted at least one implementation report.

Reporting on their implementation of the WHO FCTC is not only an obligation for the Parties, it also is an opportunity for them to share information on their progress towards implementation, as well as challenges, needs and barriers. In addition, the reporting process contributes to the dissemination of experiences and best practices among the Parties to the WHO FCTC.

While the status of implementation has consistently improved since the Convention's entry into force in 2005, progress towards implementation of the various articles remains uneven, with implementation rates ranging from 13% to 88%. Time-bound measures under the Convention (Articles 8, 11 and 13) continue to be the most implemented, with the Article 13 measures lagging somewhat behind the other two time-bound articles.

As was the case in previous reporting cycles, Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products), Article 12 (Education, communication, training and public awareness) and Article 16 (Sales to and by minors) have been implemented most successfully. Meanwhile, Article 18 (Protection of the environment and the health of persons), Article 19 (Liability) and Article 17 (Provision of support of economically viable alternative activities) seem to be the least successfully implemented, with little or no progress in comparison to 2016. Some implementation details are highlighted below.

In 2018, an increasing number of Parties reported having put in place or developed comprehensive multisectoral national strategies and tobacco control action plans, with nearly two thirds reporting measures taken to prevent tobacco industry interference with tobacco control policies. Tobacco industry monitoring, in line with the recommendations of the Guidelines for implementation of Article 5.3 of the Convention, seems to receive more attention from the Parties, not least because of the emphasis put by the Convention Secretariat on the project establishing sentinel tobacco industry observatories in various regions.

Important advances were observed in implementation of measures relating to the reduction of demand for tobacco. More than 90% of the Parties indicated having implemented tax and/or price policies, and the same percentage declared having banned smoking in all public places. A considerable number of Parties also shared their experience in extending or planning to extend smoking bans to outdoor environments, as well as on the inclusion of novel products in their existing smoke-free legislation.

Health warnings are now required in almost 90% of Parties, with a growing number of Parties implementing or planning to implement plain or standardized packaging. Education, communication, training and public awareness campaigns have been carried out widely at the national and regional levels, often in conjunction with World No Tobacco Day. However, further efforts should be carried out by Parties to specifically address gender-specific risks when developing tobacco control strategies.

Furthermore, it is important to address the needs of indigenous peoples in order to reduce the high prevalence of tobacco use in such communities.

While most of the Parties have reported the existence of a comprehensive ban in their countries on all tobacco advertising, promotion and sponsorship, cross-border advertising remains less regulated and difficult to enforce.

Tobacco-dependence diagnosis, treatment and counselling services are included in national tobacco control programmes in more than two thirds of the Parties, which is significant progress compared to one half in 2016.

A key milestone for 2018 was the entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products, which was ratified by 46 Parties at the time of the writing of this report. Meanwhile, over two thirds of the Parties have also reported enacting or strengthening legislation aimed at tackling illicit trade on the national level.

Even though 85% of the Parties have prohibited sales of tobacco products to minors and a growing number of the Parties have increased the minimum age to purchase tobacco products, there is still room for improvement, especially in banning self-service shelves and vending machines.

National tobacco surveillance systems established by more than 70% of the Parties, advances in research, and the observation of patterns of tobacco consumption have contributed to the improved monitoring of progress towards both the implementation of the WHO FCTC, which is a target in the Sustainable Development Goals, and global targets for noncommunicable diseases.

Despite the significant progress and sustained effort in implementation of the Convention, the lack of human and financial resources remains the challenge cited most often by the Parties. Additionally, technical assistance is still very much needed in the fields of taxation, policy development, research and national cessation programmes. Finally, tobacco industry interference, combined with the emergence of new and novel tobacco products, continues to be considered the most serious barrier to progress.

The WHO FCTC Secretariat's knowledge hubs, South–South and triangular cooperation among the Parties, the dissemination of reports documenting best practices in countries, and the development of toolkits by the Convention Secretariat and its partners offer the Parties tailored support in areas in which implementation rates are lower and present greater challenges.

Overall, the progress described in this report indicates that the Convention is indeed having an impact through the momentum it creates, the intensification of international collaboration and creation of a network of supporting partners within and outside the UN system, all these taking place under the clear guidance of the Conference of the Parties (COP).

For the first time in the history of the Convention, the eighth session of the COP will consider a draft Medium-term Strategic Framework for scaling up implementation of the Convention. The data and findings from this reporting cycle present a solid body of information on which the new framework could be based, as they provide insight into the most successful and most challenging areas of work. That insight will help the COP and the Parties to the Convention prioritize their actions at the national, regional and international levels.

1. INTRODUCTION

The *2018 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* is the eighth global tobacco report since 2007. It has been prepared in accordance with decision FCTC/COP1(14) taken by the Conference of the Parties (COP) at its first session, which established reporting arrangements under the WHO Framework Convention on Tobacco Control (WHO FCTC), and decision FCTC/COP4(16) taken at its fourth session, harmonizing the reporting cycle under the Convention with the regular sessions of the COP. Furthermore, in the latter decision the COP requested the Convention Secretariat to submit global progress reports on implementation of the WHO FCTC for the consideration of the COP at each of its regular sessions, based on the reports submitted by the Parties in the respective reporting cycle.

The scope of this Global Progress Report is threefold. First, it provides an overview of the status of implementation of the Convention on the basis of the information submitted by the Parties in the 2018 reporting cycle. Second, it presents self-assessments by the Paries of measures and innovative practices they put in place while implementing the Convention. Finally, the report summarizes progress, opportunities and challenges related to the implementation of individual articles of the Convention and formulates conclusions for consideration by the COP when determining possible ways forward.

In the 2018 reporting cycle, two questionnaires were available for Parties' use: 1) the core questionnaire, adopted by the COP in 2010 and subsequently amended for the 2014 and 2016 reporting cycles; and 2) a set of "additional questions on the use of implementation guidelines adopted by the Conference of the Parties", available for Parties' use since 2014 and updated for the 2016 reporting cycle. Both questionnaires are in the public domain and can be viewed on the WHO FCTC website[1]. In 2016, the reporting was conducted for the first time with an online questionnaire, and in 2018 the online questionnaire was populated for the first time for each Party with the data from their latest available implementation report.

Of all 181 Parties to the Convention, 142 (78%) formally submitted their 2018 implementation reports via the online platform[2]. Several Parties also updated some of their data. The number of Parties submitting their implementation report increased since 2016, when 133 (74% of the 180 Parties in 2016) submitted their report in the given time frame. Since the publication of the 2016 Global Progress Report, an additional 18 Parties have submitted their 2016 report on the online platform. In this 2018 Global Progress Report, the full 2016 dataset (151 Parties) is used for the comparative analysis.

The results in this report were also compared to the total number of WHO FCTC Parties for the first time. Since 2007, implementation analyses in the previous reports have been conducted

[1] http://www.who.int/fctc/reporting/reporting_instrument/

[2] The 2018 reporting period ended on 31 March 2018, but upon request from the Parties the data extraction date was extended. For the analysis presented here, data including all submissions and updates in the reporting system by 17 April was utilized. The following Parties have formally submitted reports by this time: Afghanistan, Algeria, Angola, Australia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Cabo Verde, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Comoros, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Djibouti, Ecuador, Egypt, El Salvador, Equatorial Guinea, Estonia, European Union, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Grenada, Guatemala, Guinea-Bissau, Guyana, Honduras, Iceland, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Lao People's Democratic Republic, Latvia, Lebanon, Liberia, Libya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Mongolia, Montenegro, Mozambique, Myanmar, Nepal, Netherlands, New Zealand, Nicaragua, Nigeria, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Saint Lucia, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovenia, Solomon Islands, South Africa, Spain, Sudan, Suriname, Sweden, Syrian Arab Republic, Thailand, The Former Yugoslav Republic of Macedonia, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Ukraine, United Arab Emirates, United Kingdom, United Republic of Tanzania, Uruguay, Viet Nam, Yemen, Zambia and Zimbabwe.

among the responding Parties of the respective reporting cycle. As the number of Parties to the WHO FCTC has stabilized, the new analysis method provides better comparability between reporting cycles and indicates the needs and gaps in the implementation better among all Parties. In addition, three Parties[3] submitted information on their use of the implementation guidelines adopted by the COP by completing the additional questions, and this information is also utilized in the report.

The regularly updated status of submission of reports can be viewed on the WHO FCTC website[4]. The report follows as closely as possible the structure of the Convention and that of the reporting instrument.

In the reporting instrument, Parties have the opportunity to provide more detailed information of the progress in the implementation of the Convention through open-ended questions. This qualitative information was utilized for identifying examples of novel approaches or themes where several Parties tended to progress. In addition, examples of progress by individual Parties were searched from the updates and short news pieces collected in the WHO FCTC Implementation Database[5].

METHODOLOGICAL NOTES

In this Global Progress Report, implementation of the Convention is analysed on two levels: 1) as a percentage of the Parties implementing individual key measures; and 2) and as an average of implementation rates across substantive articles. The calculation of the average implementation rates is provided in the footnotes to Chapter 2, entitled "Overall progress in implementation of the Convention". The complete list of key indicators is available on the WHO FCTC website.[6] It should be noted that implementation of Article 17 (Provision of support for economically viable alternative activities) and Article 18 (Protection of the environment and the health of persons) is considered only among the tobacco-growing Parties.

This report also provides examples of how the Parties have progressed in their implementation of the Convention. These include examples of recent activities, legislative processes and other actions. The examples are based on reporting the Parties' answers to the open-ended questions concerning progress in the implementation of different articles in the core questionnaire, Parties' responses to the additional questions, or on the news and updates received from Parties in the period between the last two reporting cycles published in the WHO FCTC Implementation Database or on social media.

However, some limitations need to be noted. The Parties' implementation reports are not subject to systematic confirmation against laws, regulations and programmatic documents (such as national strategies or action plans), and do not always include enforcement and compliance aspects unless Parties provide this information in the open-ended questions (except in the Article 8 section of the core questionnaire, where Parties are required to provide information on their enforcement activities). This may lead to some discrepancies between the information reflected in the implementation reports in different reporting cycles and the experience on the ground.

Global progress reports provide a snapshot of the status of implementation in the latest reporting period among those Parties that provided their information by the deadline. This may not fully reflect the situation among all Parties. For this reason, the Convention Secretariat has established the WHO FCTC Implementation Database, which presents the information among all Parties to the Convention across all reporting cycles, with changes applied on a regular basis as additional reports are being received from the Parties, outside the designated reporting cycles.

[3] Japan, Panama and Turkey.

[4] http://www.who.int/fctc/reporting/en/

[5] http://untobaccocontrol.org/impldb/updates/

[6] http://www.who.int/fctc/reporting/party_reports/who-fctc-annex-1-indicators-current-status-implementation.pdf

2. OVERALL PROGRESS IN IMPLEMENTATION OF THE CONVENTION

CURRENT STATUS OF IMPLEMENTATION[7]

The status of implementation on the Convention was assessed on the basis of information contained in the Parties' 2018 implementation reports. A total of 152 key indicators were taken into account across 16 substantive articles[8] of the Convention.

Figure 1 presents the average implementation rate[9] of each substantive article as reported by the Parties in 2018. The figure shows that the implementation rates across the articles are very uneven, ranging from 13% to 88%.

The articles having the highest implementation rates, with an average implementation rate of 65% or more, across all Parties analysed are, in descending order:

- Article 8 (Protection from exposure to tobacco smoke);
- Article 11 (Packaging and labelling of tobacco products);
- Article 12 (Education, communication, training and public awareness);
- Article 16 (Sales to and by minors);
- Article 5 (General obligations); and
- Article 6 (Price and tax measures to reduce the demand for tobacco).

They are followed by a group of articles for which the implementation rates are in the middle range between 42% and 61%, namely, and again in descending order:

- Article 13 (Tobacco advertising, promotion and sponsorship);
- Article 15 (Illicit trade in tobacco products);
- Article 10 (Regulation of tobacco product disclosures);
- Article 14 (Demand reduction measures concerning tobacco dependence and cessation);
- Article 20 (Research, surveillance and exchange of information);
- Article 9 (Regulation of the contents of tobacco products); and
- Article 22 (Cooperation in the scientific, technical and legal fields and provision of related expertise).

The articles with the lowest implementation rates are:

- Article 18 (Protection of the environment and the health of persons);
- Article 19 (Liability); and
- Article 17 (Provision of support for economically viable alternative activities)[10].

When assessing the development in the overall implementation rates of the substantive articles among all Parties in the 2016 and 2018 reporting cycles,[11] notable improvement was observed for most articles (Fig. 1). The largest increase in the average implementation rate, over 10 percentage points, was observed for Article 11 (Packaging and labelling of tobacco products), Article 12 (Education, communication, training and public awareness), Article 15 (Illicit trade in tobacco products) and Article 16 (Sales to and by minors).

TIME-BOUND MEASURES

There are several indicators under Article 11 (concerning the size, rotation, content and legibility of health warnings, banning of misleading descriptors, etc.) and Article 13 (concerning adoption of a comprehensive ban and coverage

[7] The status of the implementation was assessed as of 17 April 2018.

[8] Due to the specific nature of quantitative data on tobacco taxation and pricing, the status of implementation of Article 6 is described in more detail in the section on that article.

[9] Implementation rates of each indicator were calculated as the percentage of all the Parties (181 in 2018) that have provided an affirmative answer with respect to implementation of the provision concerned.

[10] Average implementation rates for Articles 17 and 18 are calculated only among tobacco-growing Parties.

[11] The 2016 implementation rates were recalculated among all Parties (180 in 2016) to: 1) allow comparability with the 2018 calculation; and 2) include all 151 reports submitted in the 2016 reporting cycle, not only those 133 that were submitted by the end of the designated reporting cycle of 2016.

of cross-border advertising, promotion and sponsorship) to which timelines of three and five years after entry into force of the Convention for each Party, respectively, apply.

In addition, although there is no timeline imposed in the Convention itself, the guidelines for implementation of Article 8 recommend that comprehensive smoke-free policies be put in place within five years of entry into force of the Convention for that Party.

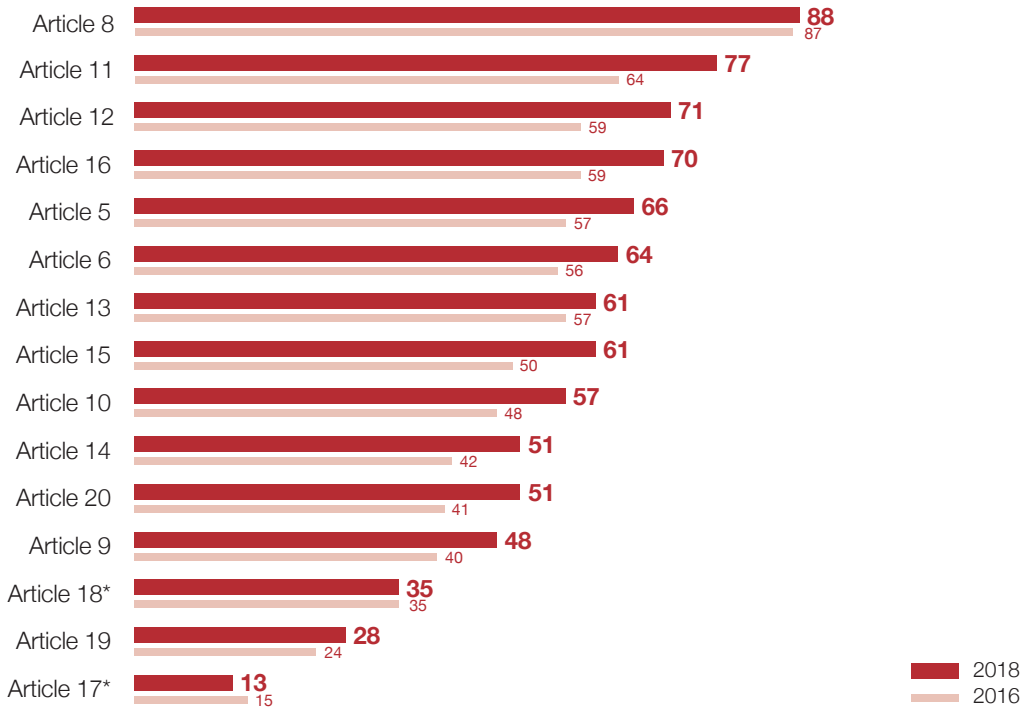
Two out of the three articles mentioned in the paragraph above (Articles 8 and 11) currently have the highest implementation rates, thus sustaining their places at the top of all articles since 2014 (Fig. 1). Specifically:

- nine out of 10 reporting Parties have now implemented measures to protect their citizens from exposure to tobacco smoke, which makes Article 8 the most-implemented of all WHO FCTC articles.
- implementation of Article 11 as a whole improved considerably since the previous reporting cycle, showing a notable increase of 13 percentage points in its average implementation rate. The greatest increase was observed in the proportion of Parties requiring pictorial warnings, and the need for health warnings to cover 50% or more of the main display area of the package.
- over two-thirds of all Parties have reported instituting a comprehensive ban on all tobacco advertising, promotion and sponsorship, but despite notable increase in implementation, Article 13 continues to show the lowest implementation rate of the three time-bound measures. Parties also progressed in broadening the scope of their tobacco advertising legislation to cover new and emerging tobacco and nicotine products.

As shown in Fig. 2, there are still many Parties that have not yet implemented the time-bound requirements of Articles 8, 11 and 13. It is therefore important for Parties that have not yet implemented them do so as early as possible.

Fig. 1

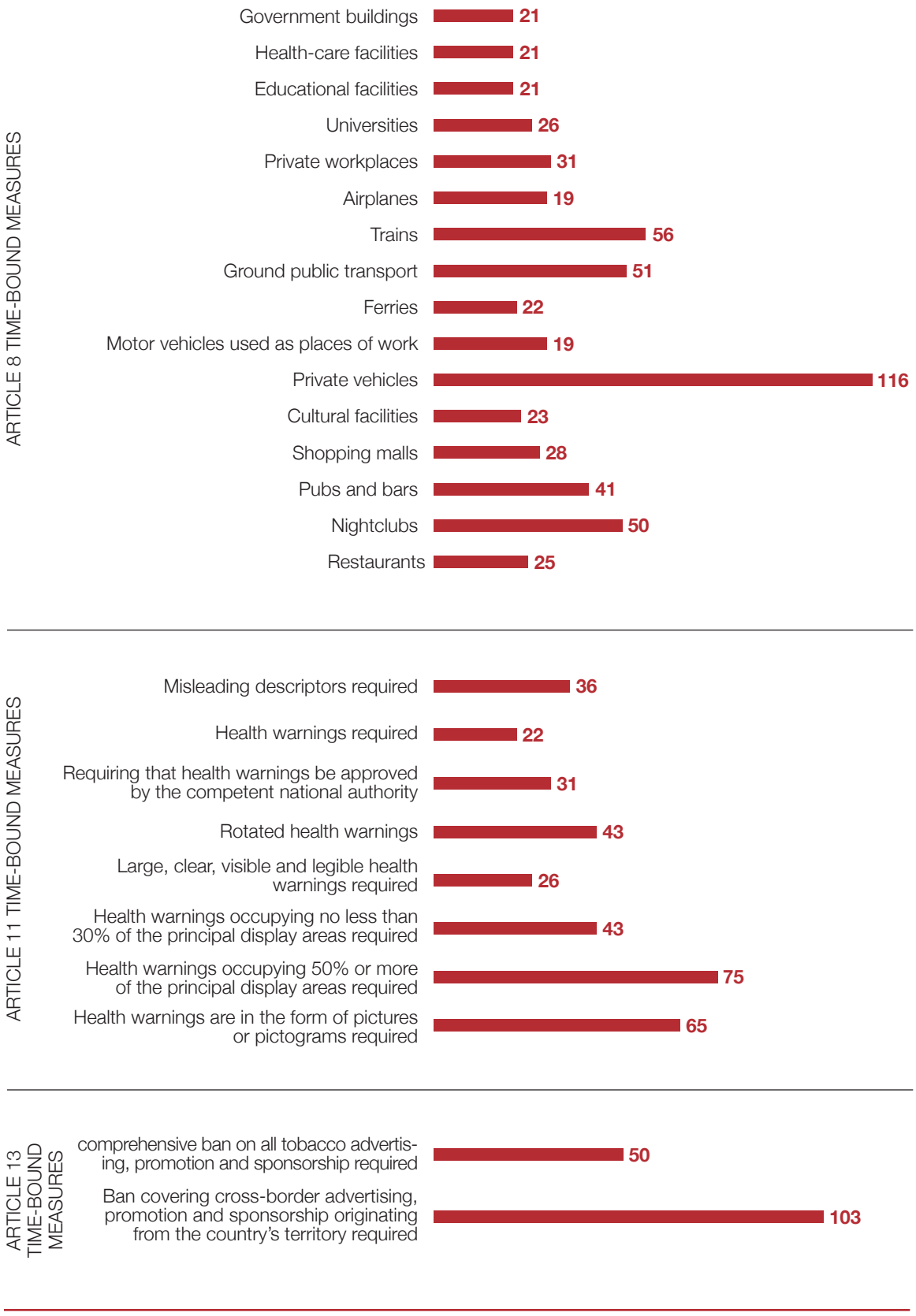
Average implementation rates (%) by Parties of substantive articles (n=180 in 2016; n=181 in 2018)



*The average implementation rates for Articles 17 and 18 are calculated only among Parties which report tobacco growing in their jurisdiction in the reporting instrument (n=33 in 2016; n=27 in 2018).

Fig. 2

Number of Parties, which have not currently implemented time-bound measures under Articles 8, 11 and 13 of the Convention.



3. IMPLEMENTATION OF THE CONVENTION BY PROVISIONS

KEY OBSERVATIONS

General obligations [Article 5]

- ***Parties have significantly progressed in establishing focal points, national coordinating mechanisms and units for tobacco control, advancing both the national and global infrastructure for tobacco control.***
- ***The implementation of Article 5.3 seems also to have increased, as over two thirds of all Parties have now adopted or implemented measures to prevent tobacco industry interference.***

Comprehensive, multisectoral tobacco control strategies, plans and programmes (Article 5.1). In 2018, some 67% (122) of all Parties had such strategies, plans and programmes in place. They are more prevalent today as compared to the situation in 2016 (61%).

Several Parties reported having developed and implemented new programmes or strategies since the previous reporting cycle. More than 20 Parties reported having developed new national tobacco control action plans, while some Parties integrated tobacco control in their health and development programmes.

For example, China adopted the *Healthy China 2030 Plan Outline*, which prioritizes a number of areas of WHO FCTC implementation. In Qatar, the *National Health Strategy 2018–2022* includes tobacco control. In India, the *National Health Policy 2017* identifies coordinated action on addressing tobacco, alcohol and substance abuse as one of the seven priority areas for improving health. Some Parties that are taking part in the FCTC 2030 project have considered developing action plans in line with this project.

Infrastructure for tobacco control (Article 5.2(a)). The infrastructure for tobacco control appears to have been strengthened significantly in 2016–2018 (Fig. 3). The majority, 84% (152), of all Parties now have reported designating a national focal point for tobacco control, and 64% (115) have established a tobacco control unit.

Most focal points are based in either a health ministry or public health agency, which is under the direction of a health ministry. In some cases, the health and social ministry are combined. A national coordinating mechanism for tobacco control was put in place by 74% (134) of all Parties. Seven Parties (Afghanistan, Cameroon, Georgia, Madagascar, Nigeria, Saint Lucia and Zambia) reported that they have established new national coordinating mechanisms.

In Guyana, in addition to passage of the tobacco control bill in 2017, a National Tobacco Control Council was created in order to advise and work with the Minister of Public Health. Established by law or by other measures (executive and administrative), these mechanisms often involve governmental departments, agencies and other key stakeholders, as appropriate.[12]

[12] http://untobaccocontrol.org/impldb/guyana-new-tobacco-control-bill-passed/

GEORGIA

Comprehensively addressing Article 5 of the Convention

On 30 May 2017, the Parliament of Georgia adopted amendments to the Law of Georgia On Tobacco Control (2010), in accordance with Article 5.2(b) of the Convention. The new law introduces a series of advanced measures, including, among others, plain packaging of tobacco products and a complete ban of tobacco advertising, promotion and sponsorship, and also makes all public places smoke free and bans tobacco-vending machines. The law also introduced measures to ensure full implementation of Article 5 of the Convention, as summarized below.

Article 5.1 – According to the amendments to the law, the Government of Georgia is now required to implement a long-term state strategy and an annual state tobacco control programme. Georgia is now one of the FCTC 2030 Parties, receiving support for the implementation of a various range of programmes. This includes a revision of the national action plan approved by Government decree in 2013 to put it in line with the new legislation.

Article 5.2(a) – The Health Promotion and Prevention Council was created soon after the adoption of the amendments of the tobacco control legislation. The leading force behind the Council is the Committee on Health-care and Social Matters of the Parliament of Georgia, and consists of tobacco control agencies, including enforcement agencies, and other stakeholders of this field. The Council assists with the implementation of tobacco control legislation, coordinates the work of different sectors and is also involved in proposing revisions of the law.

Article 5.3 – As a new principle in tobacco control, introduced in the new version of the law, the development and implementation of state policy on tobacco control shall be protected from interference by the tobacco industry, and any interactions shall be conducted in accordance with state publicity and transparency principles.

(Photo courtesy of Nino Maglakelidze, WHO FCTC focal point, Georgia)

Fig. 3

Percentage of reporting Parties with tobacco control infrastructure in 2016–2018 (n=180 in 2016; n=181 in 2018)

Adopting and implementing effective legislative, executive, administrative and/or other measures. (Article 5.2(b)) The reports of the Parties show that most progress in implementation of the Convention seem to be achieved through the adoption and implementation of new legislation or the strengthening of already existing tobacco control legislation.

New tobacco control acts or amendments of their previous tobacco acts were reported by 17 Parties, 11 of which are members of the European Union (EU). Four other Parties (Dominica, Grenada, Malaysia and South Africa) reported that they are considering, or in the process of developing, new legislation or amendments to their existing laws. Three Parties (Gabon, Niger and Seychelles) reported that they developed regulations to implement already adopted legislation.

Overall, 158 (87%) of the Parties have strengthened their existing or adopted new tobacco control legislation after ratifying the Convention.

In many jurisdictions, regulations or implement tion decrees are required to implement legislative and executive measures adopted by national parliaments. The experiences of the Parties indicate that the time lag between the adoption of legislation and the development of such regulations or decrees varies substantially and that the process may be delayed by internal factors (for example, the lack of technical/ financial capacity), changing priorities and volatile circumstances or challenges by the tobacco industry.

Protection of public health policies from commercial and other vested interests of the tobacco industry (Article 5.3). Global tobacco production continues to fall despite the sustained effort of the tobacco industry to interfere with policy development.

Overall, 71% (128) of all Parties had adopted or implemented at least one measure to prevent tobacco industry interference. This is a notable increase as compared to 2016 (Fig. 4). Providing public access to information on the activities of the tobacco industry became more common. However, it remains an underutilized measure, implemented only by 37% (67) of all Parties.

Several Parties have succeeded in their recent efforts to strengthen implementation of Article 5.3. For example, Georgia's new legislative changes only allow for strictly necessary interactions with the tobacco industry and call for transparency of such interactions; furthermore, it provides the grounds for criminal and civil liability actions against the industry.

In 2017, France adopted a government decree to ensure transparency of tobacco industry activities, with special regard to its expenditures, including spending on lobbying. Lithuania amended its tobacco legislation in 2016 by stating that in the process of setting and

implementing national tobacco control policies, the Government should be required to protect these policies from the commercial and other interests of the tobacco industry. The newly adopted tobacco legislation in 2017 by Benin limits the interactions between representatives of the tobacco industry and public officials.

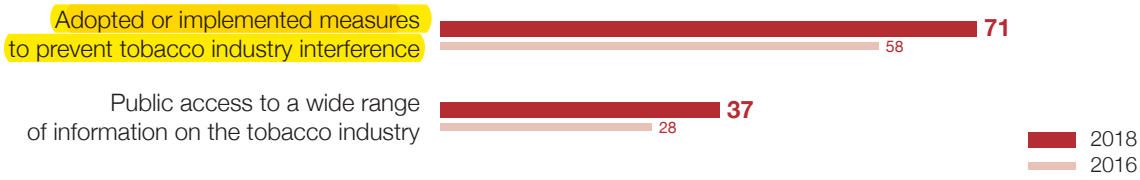
Finally, despite fierce attacks from the tobacco industry, which were dismissed by the Constitutional Court, the Ugandan Tobacco Control Act became fully operational on 19 May 2017. Among other public health provisions of the legislation, including the protection of current and future generation from the devastating health, economic and environmental effects of tobacco, the act also highlighted the duty of the Government to protect tobacco control policies from the tobacco industry interference and to ensure transparency of any interactions with it (Part VIII of Uganda's Tobacco Control Act, 2015).[13]

Other Parties reported having conducted national workshops, engaging in the development of codes of conduct or developing information materials to promote implementation of Article 5.3. Three Parties (Brazil, South Africa and Sri Lanka) established tobacco industry observatories to monitor the activities of the tobacco industry within their countries and beyond. The WHO FCTC Secretariat's Knowledge Hub for Article 5.3, hosted by the University of Thammasat in Bangkok, Thailand, was officially launched on 1 November 2017.

Furthermore, the needs assessment exercise, which is a review of a Party's implementation status jointly conducted by the Party and the Convention Secretariat and its partners, also covers Article 5.3. The resulting report addressing all areas of the Convention contains recommendations on how to further address the gaps in implementing article 5.3. Such gaps, if identified as urgent priority by the Party, are addressed in the post-needs assessment phase in the form of assistance projects.

Fig. 4

Implementation (%) of Article 5.3 reported by Parties in 2016–2018 (n=180 in 2016; n=181 in 2018)



[13] http://www.who.int/fctc/publications/fctc-article-5-3-best-practices.pdf

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL
SECRETARIAT • KNOWLEDGE HUB

New knowledge hub set to curb tobacco industry interference

In November 2017, the Convention Secretariat of the WHO FCTC launched a new Knowledge Hub to track and gather data on – and inform the public about – tobacco industry interference in public policy-making. Located in Bangkok at the Thammasat University's School of Global Studies, the Global Center for Good Governance in Tobacco Control (GGTC) has a specific mission related to Article 5.3 of the Convention.

The Knowledge Hub was created to counter tobacco industry interference and aims to assist WHO FCTC Parties in developing strategies to counter interference through various channels, including training and direct assistance. This Knowledge Hub is also expected to coordinate tobacco industry monitoring efforts of the Parties, including the establishment and operation of formal tobacco industry monitoring centres (observatories).

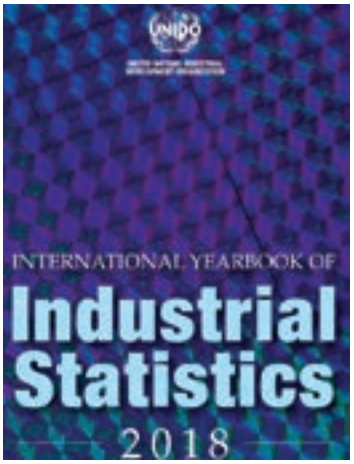
The primary objective of the WHO FCTC is to reduce tobacco use worldwide, an important public health goal. Since the adoption and entry into force of the WHO FCTC, governments increasingly recognize that policy-making involves a range of legal issues. Thus, the WHO FCTC should be applied as a policy in good governance when developing public health goals. Instruments such as codes of conduct for government officials, transparency measures and policies to protect against conflict of interest facilitate the workings of all governmental institutions. It is imperative that governments act now to implement good governance policies enshrined in the WHO FCTC and its guidelines.

The Thai Knowledge Hub joins a worldwide network of six other institutions from Australia, Finland, India, Lebanon, South Africa and Uruguay, mostly based in renowned universities and all working with the Convention Secretariat to assist Parties in specific areas of the Convention.

(Photo courtesy of WHO FCTC Secretariat's Knowledge Hub on Article 5.3, Thailand)

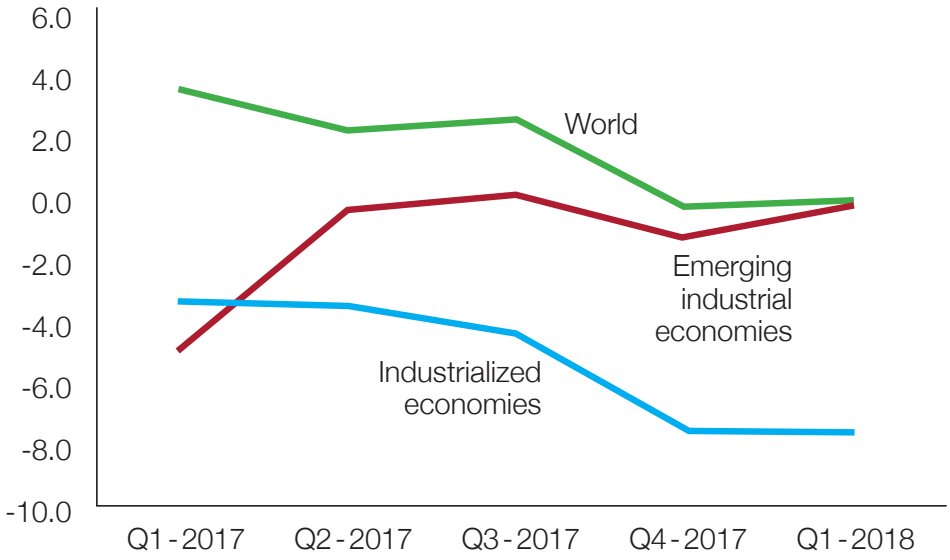
UNIDO

Recent trends of global tobacco production



In general, global tobacco production has been falling, especially since 2016, and the total output of tobacco manufacturing globally fell consistently throughout 2017. The global output of tobacco manufacturing in industrialized economies dropped by 7.6% in the first quarter of 2018 compared to the same period of the previous year. In the first quarter of 2018, global output of tobacco manufacturing dropped by 0.1%. In 2017, an overall negative growth was observed in production of tobacco also in emerging industrial economies. It is still to be seen how the future trend progresses.

Output growth of tobacco manufacturing (in percent compared to the same quarter of the previous year)



Source: United Nations Industrial Development Orgnaization Quarterly report

To summarize, the production of tobacco is falling worldwide, according to an analysis of production data. It would also be relevant to analyse export–import data to estimate consumption by country. As the production data suggest, a small number of economies has significant share in the global tobacco market.

REDUCTION OF DEMAND FOR TOBACCO

KEY OBSERVATIONS

Price and tax measures to reduce the demand for tobacco [Article 6]

- ***The proportion of Parties that levy some form of excise tax increased from 93% in 2016 to 96% in 2018. There have been substantial improvements in the structure of the excise system in a number of reporting Parties. Between 2016 and 2018 there has been a move towards mixed systems, away from purely ad valorem systems. The proportion of Parties that levy only a specific tax remained unchanged.***
- ***Several countries have announced large increases in the excise tax up to four years into the future, which makes the future tax level and prices more predictable. The aim is to make cigarettes increasingly unaffordable.***
- ***No change was observed in the proportion of Parties that earmarks tobacco taxes for public health or the number of Parties that prohibit or restrict imports of tax- and duty-free tobacco products by international travellers.***
- ***The reporting of data related to tobacco taxation and pricing, as required by the Convention (in Article 6.3), remains a challenge for Parties, especially in the case of tobacco products other than cigarettes. Data on cigarette prices were also not adequately reported on by the Parties, with only 24 out of 142 reporting Parties providing 2018 prices in the 2018 reporting cycle.***

Regular and rapid increases in tobacco taxation are an essential part of a comprehensive tobacco control strategy, which can contribute to the achievement some of the Sustainable Development Goals (SDGs). Raising the price of cigarettes and other tobacco products can be an effective measure in deterring people from starting to smoke and encouraging smokers to quit, particularly among lower socioeconomic groups. There is a sizable amount of literature that indicates that household expenditure on tobacco products crowds out expenditures on other basic necessities, such as education and food that often is consumed by children. Particularly among the poor, increasing tobacco tax can help to redirect income towards the consumption of other products, promoting good health and well-being. It can also help reduce poverty by redirecting income away from tobacco consumption and to other goods and services.

Taxation of tobacco products. 133 Parties provided sufficient information on tobacco taxes and prices to be included in the analysis. Most Parties only provided data on cigarettes. The global median total tax burden – that is, the sum of excise tax, value-added tax (VAT) and/or other sales taxes, and other duties and levies – on the most popular price category of tobacco product was 63%, compared to 58% in 2016. The African Region has the lowest median tax burden at 34%, and the European Region has the highest median tax burden at 78%.

129 out of 133 Parties in 2018 (96%) levied excise taxes in some form (Table 1). There has been a marked change in the type of excise tax levied since 2016. The proportion of Parties applying ad valorem excise alone decreased from 21% in 2016 to 14% in 2018 while those applying a mixed excise tax system (a combination of both specific and ad valorem

taxes) have increased from 43% in 2016 to 56% in 2018. The proportion of Parties that levy only a specific tax has increased marginally from 29% to 30%.

A combination of specific and ad valorem rates remains the most favoured excise regime in the European Region with a large proportion of Parties in that Region reporting its use. Countries that belong to the EU are obliged to implement such a mixed system under the EU Directive 2011/64/EU. Compared to the 2016 report, Parties in the Region of the Americas have reported a stronger preference for a mixed excise tax regime as well (from 29% to 65%). In the African Region, there has been a move away from an ad valorem regime to a mixed tax system. While in 2016, 31% of Parties in the African Region preferred a mixed regime, in 2018 that number stands at 46%. Parties in the Western Pacific Region continue to favour the use of specific tax only.

With regards to the reported progress in taxation policy, several member states of the Cooperation Council for the Arab States of the Gulf (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates) recently imposed, for the first time, excise taxes on tobacco products. This is applied in the form of a selectivity tax of 100% on the net-of-tax price and a 5% VAT), based on the sum of the net-of-tax price and the excise tax.

Price of tobacco products. Table 2 presents maximum and minimum cigarette prices in US dollars by WHO region, as well as the ratio of maximum to minimum prices within each region.[14]

TABLE 1 Cigarette excise regimes in 2018, by WHO region

WHO Region	TYPE OF EXCISE TAX						Total Excise	Import duty only	%	Total No. Reporting	Without tax answer
	Specific only	%	Ad valorem only	%	Both Specific and Ad valorem	%					
African	8	31%	6	23%	12	46%	26	0	0%	26	6
Eastern Mediterranean	5	31%	5	26%	6	32%	16	3	16%	19	0
European	3	8%	1	3%	34	89%	38	0	0%	38	1
Americas	5	22%	3	13%	15	65%	23	0	0%	23	0
South-East Asia	3	60%	1	17%	1	17%	5	1	17%	6	1
Western Pacific	15	71%	2	10%	4	19%	21	0	0%	21	1
Overall	**39**	**30%**	**18**	**14%**	**72**	**56%**	**129**	**4**	**3%**	**133**	**9**

[14] Data on cigarette prices presented in this table originate from the reports of the Parties submitted in 2018.

TABLE 2 Minimum and maximum prices for a pack of 20 cigarettes in US dollars by WHO region in 2016 and 2018

WHO Region	2016			Total reporting Parties in 2016	2018			Total reporting Parties in 2018
	Minimum (country)	Maximum (country)	Ratio		Minimum (country)	Maximum (country)	Ratio	
African	$ 0.49	$ 8.39	17.1	28	$ 0.07	$ 7.35	74.0	32
Americas	$ 0.97	$ 7.47	7.7	24	$ 1.14	$ 8.12	7.4	23
South-East Asia	$ 1.52	$ 2.93	1.9	6	$ 1.22	$ 4.55	3.8	7
European	$ 0.44	$ 15.43	35.1	40	$ 0.87	$ 14.79	16.4	39
Eastern Mediterranean	$ 0.58	$ 3.27	5.6	17	$ 0.42	$ 6.04	15.0	19
Western Pacific	$ 2.62	$ 15.18	5.8	17	$ 0.90	$ 16.54	18.3	22
Total				**132**				**142**

Illicit trade in tobacco products poses a threat to government revenue through tax evasion. Large price differences among countries in the same region increase incentives for illicit trade activities and potentially undermine government efforts to collect tax revenues from the sale of tobacco products. The European Region and the Region of the Americans display an increase of minimum prices and a reduction of the ratio of maximum to minimum prices between the two reporting periods. For the other four WHO regions, the reported minimum prices are lower than in 2016 and the ratio of maximum to minimum price has increased.

Changes in taxation across reporting cycles. Regular and rapid increases in tobacco taxation are an essential part of a comprehensive tobacco control strategy. An innovative initiative is Australia's policy to announce in advance large increases in the excise tax, over and above inflationary adjustments, for the coming four years. Since 2013, Australia has consistently increased the excise tax on cigarettes by 12.5% each year and intends to continue with this strategy until at least 2020, resulting in some of the highest cigarette prices in the world.

Fifteen countries reported that they have not implemented tobacco tax policy changes between the last two reporting periods, and 47 Parties did not provide any information on this issue (Table 3). The Eastern Mediterranean Region and the Region of the Americas reported the highest proportion of reporting Parties with no tax policy changes between 2016 and 2018, while the African and South-East Asian regions reported the largest proportion of Parties with no information on the change in tax policy.

Earmarking tobacco taxes for funding tobacco control. Thirty-four countries reported earmarking a proportion of their tobacco taxation income for funding national plans, tobacco control strategies or other activities, such as sport. Between 2016 and 2018 the number/proportion of countries that earmark some of tobacco tax revenues has remained largely the same. The majority of countries earmark tobacco taxes specifically for funding tobacco control activities, while a minority direct the resources to health promotion and health financing.

Costa Rica, for example, allocates tobacco taxes widely, towards the diagnosis, treatment and prevention of diseases associated with smoking (60%), Ministry of Health (20%), cessation and

TABLE 3 Regional distribution of "no change" and "no information provided" options on tax policy

WHO Region	No Changes	Percentage over reporting countries in the region (%)	No Information	Percentage over reporting countries in the region (%)	Percentage of countries with no change and no information	Number of reporting countries
African	2	6.3%	17	53.1%	59.4%	32
Eastern Mediterranean	4	21.1%	6	31.6%	52.6%	19
European	1	2.6%	6	15.4%	17.9%	39
Americas	5	21.7%	8	34.8%	56.5%	23
South-East Asia	0	0.0%	4	57.1%	57.1%	7
Western Pacific	3	13.6%	6	27.3%	40.9%	22
Total	**15**	**10.6%**	**47**	**33.1%**	**43.7%**	**142**

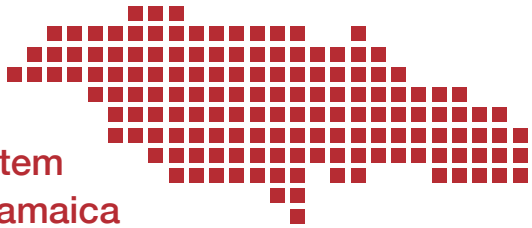
prevention education programmes (10%), and sports and recreation (10%). Bangladesh approved the *Health Development Surcharge Management Policy* in 2017, in which revenue collected from a surcharge on tobacco products is allocated among various tobacco control and health-promotion activities.

Tax and duty-free tobacco products. Ninety-one out of 142 (64%) Parties that submitted implementation reports in 2018 indicated that they prohibited or restricted imports of tax- and duty-free tobacco products by international travellers, reflecting a consistent trend compared with 2016, when more than 65% of Parties reported such a policy.

The WHO FCTC Secretariat's Knowledge Hub on Taxation is now fully operational at the University of Cape Town. The hub provides assistance to the Parties in designing their tax systems through training programmes and tailored assistance at country level.

The WHO FCTC Secretariat's Knowledge Hub on Taxation at the University of Cape Town (South Africa) hosted a workshop on the economics of tobacco control at the University of Cape Town, from 29 January to 1 February 2018. The workshop had 12 participants from Burkina Faso, Chad, Gabon, Kenya, Madagascar and Mauritania. This workshop aimed to provide policy makers with the essential tools to illustrate the benefits of tobacco taxation using taxation modelling. (Photo courtesy of WHO FCTC Secretariat's Knowledge Hub on taxation, South Africa)

JAMAICA



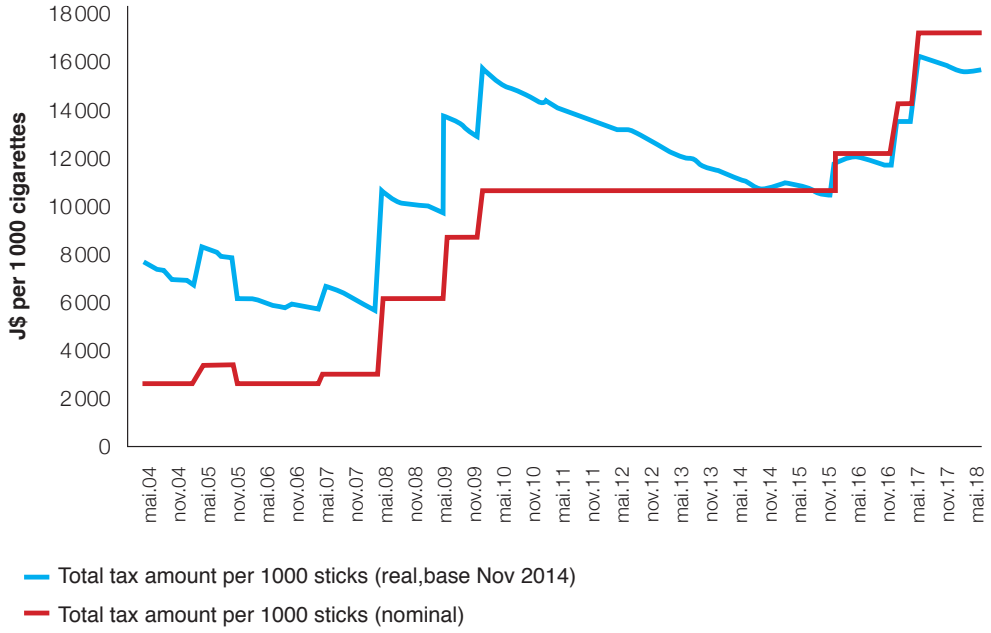
Why a simple tobacco tax system is important: the example of Jamaica

WHO FCTC Article 6 Guidelines encourage Parties to adopt simple tax structures. Uniform specific taxes, regularly adjusted to account for inflation and increases in per capita income, are generally recommended as the most appropriate, as they have desirable properties from both a public health and an administrative perspective (Article 6 Guidelines, 2014 and WHO, 2010). Jamaica provides an interesting example of a country that migrated from a highly complex, multi-layered tax system to a simple uniform tax. It also highlights the importance of adjusting the specific tax on a regular basis to avoid inflation eroding the real value of the tax.

Until 2008, the tobacco excise tax in Jamaica consisted of two components: (1) a specific tax; and (2) an ad valorem tax that came into effect if the price exceeded a specific threshold value. For many, and the media included, it was reported to be very complicated to determine the net effect of any tax change. The tobacco industry used this confusion to increase the retail price by more than the increase in the excise tax, allowing itself to increase its profits at the expense of smokers and government treasuries.

In 2005, the dominant tobacco company in Jamaica terminated all domestic production and imported all its cigarettes. Excise tax revenues and especially the levy (23% of the sum of the base price) imposed to fund the National Health Fund fell precipitously.

Nominal tax versus real tax on cigarettes in Jamaica (2004-2018)



[15] Van Walbeek, C. A review of excise taxes on cigarettes in Jamaica; 2015 (https://www.moh.gov.jm/wp-content/uploads/2016/07/ Jamaica-report-2015.-Van-Walbeek.pdf, accessed 14 August 2018)

The Government responded by abolishing the complex tax structure and implemented a uniform system. It then raised the excise tax, increasing the retail price and tax revenue, and decreasing consumption. However, for five years subsequently, the nominal excise tax remained unchanged, and the real value of the excise tax dropped by 32% eroded by inflation.[15] In that time, the tobacco industry increased the retail price of cigarettes to its own benefit. Since 2015, the Government has been consistently increasing excise taxes.

The Jamaican experience illustrates many important lessons for the designers of tax systems, including the need to keep the tax system simple. The tobacco industry will exploit a complex tax system for its own benefit A uniform specific tax system is good from an administrative and public health perspective, with regular adjustments to palliate the effects of inflation.

In 2017, Jamaica was recognized “for steady increases to tobacco taxes over several years to protect the health of all Jamaicans” at the 5th Latin American and Caribbean Conference on Tobacco or Health.

Sheryl Dennis-Wright from the Ministry of Health Jamaica was presented with an award by Beatriz Champagne from InterAmerican Heart Foundation. (Photo courtesy of Sheryl Dennis-Wright, WHO FCTC focal point, Jamaica)

REDUCTION OF DEMAND FOR TOBACCO

KEY OBSERVATIONS

Protection from exposure to tobacco smoke [Article 8]

- ***Nine out of 10 reporting Parties now have implemented measures to protect their citizens from exposure to tobacco smoke, which makes Article 8, the most-implemented of all WHO FCTC articles.***
- ***The trend of extending smoking bans from closed public places to outdoor areas continued, and several Parties also broadened the scope of their smoke-free legislation to cover new and emerging tobacco products. Several Parties have succeeded in advancing legislation to ban smoking in private cars when minors are present. Many Parties highlighted progress on smoke-free legislation or policies at regional or local level.***

Measures to protect from environmental tobacco smoke. In 2018, overall 91% (165) of all Parties had implemented measures to protect their citizens from exposure to tobacco smoke by applying a ban – either complete or partial – on tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. There was a significant increase as compared to 2016, when 79% of all Parties had banned smoking in public places. Most Parties (149) have national legislation providing for the ban, but 44 Parties reported operating with subnational legislation. Thirty-six Parties still have voluntary agreements providing for the ban.

As Fig. 5 shows, among the 165 Parties that have smoking bans, over 80% of these Parties enforce a complete ban in aeroplanes, educational facilities, public transport, health and cultural facilities, motorized vehicles for work, and government buildings. Partial bans tend to be common in private workplaces, restaurants, pubs and bars, and nightclubs. A positive trend was observed in banning smoking in private cars in the presence of children, enforced now as either a complete or partial ban by 40% of Parties that have smoking bans. Bans on smoking in cars when minors are present were recently enacted by Finland, France, Luxembourg, Malta, Qatar and Slovenia. The Republic of Korea also enacted a ban on smoking in multi-family housing.

Several Parties highlighted in their progress notes success in extending their smoking bans to outdoor areas, such as parks (Luxembourg, Malaysia and Singapore), outdoor dining areas (Australia and Sweden), tourist attraction and pilgrimage sites (Viet Nam), childcare facilities or playgrounds (Luxembourg, Republic of Korea and Sweden) and balconies in housing cooperatives (Finland).

Barbados, Croatia, Finland, Georgia, Luxembourg, Norway, Poland, Portugal and Slovenia reported amending their smoking bans to cover new and emerging tobacco products. For instance, in 2017 Luxembourg prohibited smoking and vaping in sports arenas where children below the age of 16 are performing sports, and the amendments also ban smoking and vaping in vehicles when children below the age of 12 are present. Vaping in play areas for children was also banned.

Benin, Guyana, Georgia and the Czech Republic succeeded in passing long-awaited comprehensive smoke-free bills. For instance,

the legislation passed in 2017 in Benin now prohibits smoking in enclosed public places, in some open areas, and within a range of 500 metres from any school, health institution, sports facilities, and cultural and administrative infrastructure.

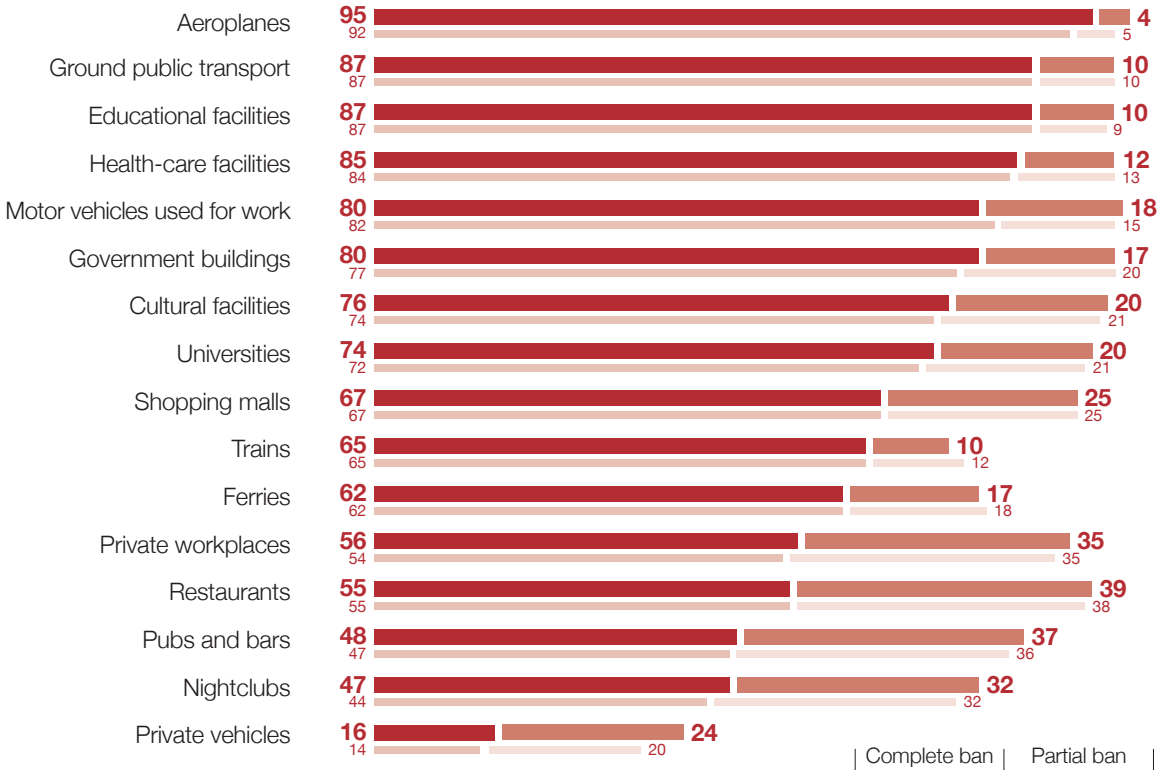
Regional or local progress was highlighted by Bosnia and Herzegovina, Canada, China, Malaysia, Pakistan and the Philippines. For example, new provincial legislation in Quebec (Canada) requires colleges, universities and hospitals to adopt a policy regarding smoking on their grounds.

Mechanisms/infrastructure for enforcement. A majority, 86% (142) of the 165 Parties that have enacted smoking bans had put in place a mechanism/infrastructure for the enforcement of smoke-free measures, which includes specific guidelines (Solomon Islands and Zambia) and strong collaboration with other governmental agencies (Jamaica and Pakistan). However, a few Parties have highlighted the need for meaningful penalties and a sufficient level of inspections to ensure compliance and limit violations of the law.

Smoke-free sign in Islamabad, Pakistan. (Photo from Dr Tibor Szilagyi's personal collection)

Fig. 5

Percentage of settings covered by Parties smoke-free bans in 2016–2018 (n=142 in 2016; n=165 in 2018)*



Note: the remaining percentage includes Parties with no ban or no data

*Calculated among Parties that have a smoking ban

MALAYSIA

All public parks go smoke-free

The guidelines for implementing WHO FCTC Article 8 reiterates the requirement for Parties to put in place protective measures not only in all "indoor" public places, but also in "other" outdoor or quasi-outdoor public places where they feel it is most "appropriate" to protect citizens from the hazards of second-hand smoke.

On 1 February 2017, and in line with the definition of "other" public places, the Government of Malaysia officially designated all public parks as non-smoking zones. This new regulation was put under the Control of Tobacco Regulations (CTPR 2004) of the Food Act of 1983.

Under the new regulation, smoking is banned in public parks, any open area for leisure and recreational purposes, such as pedestrian paths, playing fields, game courts and playgrounds.

The Government of Malaysia is fully committed to implementation of Article 8. In Malaysia, it is estimated that seven out of every 10 adults (8.6 million adults) who visit reastaurants are exposed to cigarette smoke in public places, while four out of every 10 adults, or 4.9 million, are exposed to it at home.

With 22.8% of the Malaysian population estimated to be smokers, this law aims to help reduce morbidity and mortality attributable to tobacco use in Malaysia and contribute to the strengthening of the implementation of the WHO FCTC.

(Photo courtesy of Dr Norliana Ismail, WHO FCTC focal point, Malaysia)

KEY OBSERVATIONS

Regulation of the contents of tobacco products [Article 9] and regulation of tobacco product disclosures [Article 10]

- ***Notable progress took place in Parties requiring the testing and measuring of the contents and emissions of tobacco products, but almost half of all Parties still lack such legislation or other regulatory measures.***
- ***Over two thirds of all Parties now require the disclosure of the information of the contents of tobacco products to government authorities. It remains less common to require the disclosure related to the emissions of these products, especially to the public.***

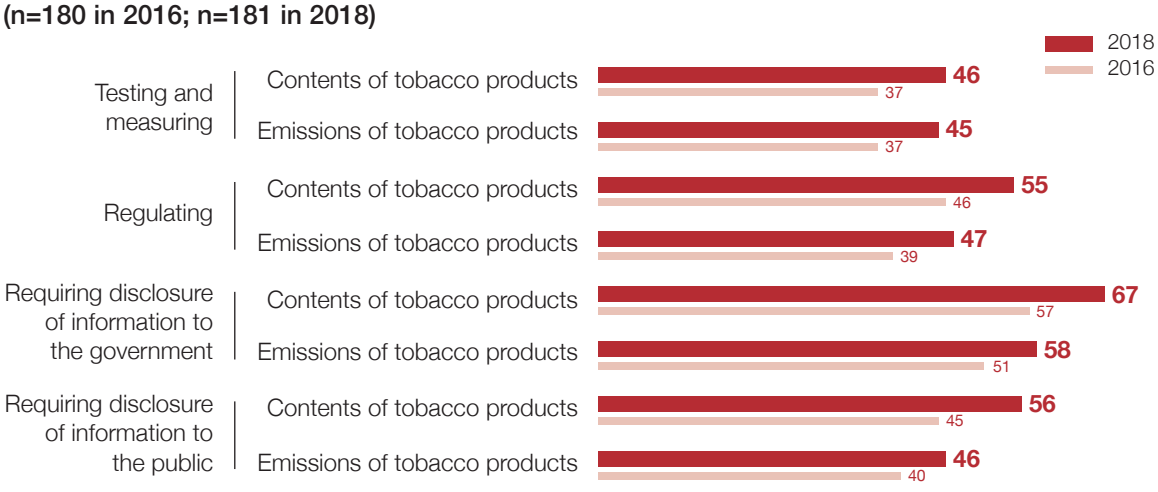
Regulating contents and emissions of tobacco products. For the 2018 reporting cycle, notable progress has been made by the Parties in implementation of requirements under Article 9 (Fig. 6). Over half (55%) of all Parties now regulate the contents of tobacco products, and almost half (47%) the emissions of tobacco products.

Progress has been noted by several European Parties that have transposed the 2014 EU Tobacco Products Directive into their national legislation (see text box). As a specific example, Austria, an EU Member State, amended its Tobacco Act in May 2016 to cover novel tobacco products including electronic nicotine delivery systems (ENDS) and to ban tobacco products with characterizing flavours. In 2017, Canada amended its legislation to prohibit menthol in cigarettes, blunt wraps and most cigars.

Additionally, Brazil banned all flavours in tobacco products in 2012 but was challenged by the National Confederation of Industries on

Fig. 6

Implementation rates (%) by Parties of provisions under Articles 9 and 10 in 2016–2018 (n=180 in 2016; n=181 in 2018)



the constitutional grounds. The Supreme Court has recently judged the case unconstitutional and has granted the mandate of Anvisa, the Brazilian health regulatory agency, to regulate tobacco products and the tobacco industry.

Testing and measuring of the contents and emissions of tobacco products. Of all Parties, almost half test and measure the contents (46%) and emissions (45%) of tobacco products (Fig. 6).

While many Parties still relied on the manufacturers and importers to report on the ingredients and emissions of tobacco products, a number of Parties carrying out tests within specific governmental divisions (Japan, the Republic of Korea, Trinidad and Tobago, and Turkmenistan). Others mentioned using the services of independent laboratories (Bulgaria, Kingdom of Bahrain and Luxembourg) or were in the process of setting one up (Honduras and the Islamic Republic of Iran).

Disclosure to government authorities and the public. In 2018, 67% of all Parties required manufacturers or importers of tobacco products to disclose information on the contents of the products, and 58% of the Parties required the release of emissions findings to government authorities. Around half of the Parties require such disclosures to be made available to the public. As compared to 2016, there was a clear positive trend in requiring the disclosure of the information (Fig. 6).

Of note, Italy developed a website to disclose available information to the public. In Canada, the numerical values of toxic emissions on tobacco packs have been replaced by four text-based statements that provide clear, concise and easy to understand information about the toxic substances found in tobacco smoke.

Inauguration of the testing laboratory at the National Institute for Cancer Prevention and Research, Noida, India. (Photo courtesy of the WHO FCTC Secretariat's Knowledge Hub on smokeness tobacco)

EUROPEAN UNION

A shared vision and direction

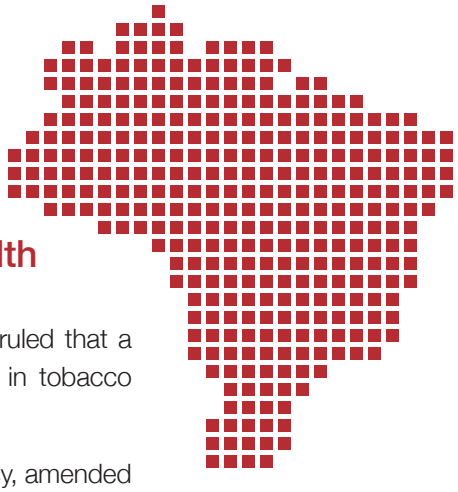
Article 9 provides a framework for Parties to test, measure and regulate the content of tobacco products. While progress has been made, only slightly over half of the Parties reported that they regulate the contents and emissions of tobacco products.

Following the introduction of the Tobacco Products Directive in 2014, EU Member State Parties have since 2016 accelerated their implementation of the requirements under the directive. The directive provides rules and a framework to govern the manufacturing, presentation and sale of tobacco and related products. It also requires the tobacco industry to report on the ingredients used in the production of tobacco products, including information on tobacco ingredients, additives, emissions and toxicological data. Working in partnership with EU Member States and industry stakeholders, the EU developed a Common Entry Gate (EU-CEG), designed to reduce the burdens for regulators and companies to report and to make it easier to compare data.

While they are in the process of implementing measures regulating contents and emissions of tobacco products within their domestic jurisdictions, many EU Member States are now participating in an effort called Joint Action on Tobacco Control (2017–2020), which focuses on supporting Member States in this endeavour.

While the directive has given support to EU Member States for the implementation of measures within their jurisdictions, a comprehensive website and supporting materials developed by the EU Commission provide a reference for other WHO FCTC parties to consider similar legislation. This may include implementation of measures such as the EU common reporting format as a means of providing comparability of data in the reporting on the content of tobacco products.

BRAZIL



Brazilian Supreme Court upholds the regulatory power to regulate the tobacco in favour of public health

Following a five-year wait, the Supreme Court has ruled that a regulatory agency has the power to ban additives in tobacco products, including flavours in cigarettes.

In 2012, Anvisa, the Brazilian health regulatory agency, amended the Collegiate Board Resolution prohibiting the use of additives that confers aroma and flavour to cigarettes. In 2012, the National Confederation of Industry (CNI) filed a lawsuit questioning Anvisa's competence to amend the resolution and questioned the law that creates the agency.

The injunction requested by CNI was granted, and the Anvisa Resolution was suspended in 2013. The judgement was challenged and the case reopened in November 2017. The Minister of Federal Attorney General´s Office argued that the discussion involved only the insertion of additives in the manufacture of cigarettes, not the prohibition of their sale. She presented numbers on the damage to public health from smoking and argued about the need of prohibiting the addition of flavours to the product due to its potential appeal to the young population, encouraging children and adolescents to initiate cigarette consumption.

She further argued that Anvisa acted within the regulatory limits assigned by the legislature, fulfilling its duty, in view of the recognized need to ban these additives, and in the spirit of agile response typical of regulatory agencies.

The Direct Action of Unconstitutionality (ADI) judgement concluded in February 2018. The Court favoured the constitutionality declaration of the law that creates Anvisa. The regulatory power of the agency was maintained, which is a great victory for Public Health.

However, regarding the specific aspect of the additives, there was a tie: The Supreme Court considered that the application of the resolution would have no binding effect throughout the national jurisdiction, which means that the rule prohibiting the use of additives in cigarettes may be challenged in lower court environments.

This ruling provides support for WHO FCTC Parties in passing measures supporting FCTC, including bans on tobacco flavours and additives.

KEY OBSERVATIONS

Packaging and labelling of tobacco products [Article 11]

- ***As compared to 2016, the greatest increase in the average implementation of the Articles was observed for Article 11.***
- ***There has been a domino effect as more Parties to the Convention adopt plain packaging legislation. Following Australia's lead, France, Ireland, Hungary, Norway, Slovenia and the United Kingdom of Great Britain and Northern Ireland have passed legislation on plain packaging.***
- ***Many Parties have increased the size of their pictorial warnings. Meanwhile as an important development concerning a regional block, EU Member States have started implementing the 2014 EU Directive and increased the size of their combined text and pictorial warnings to cover 65% of the package surface.***
- ***Pictorial health warnings and plain packaging continue to be under constant scrutiny and legal action by the tobacco industry at the national and international levels.***

Health warnings. Implementation rates for measures under Article 11 to which the three-year deadline applies are presented in Fig. 7. The reports show that 88% of all Parties now require health warnings. In the 2018 reporting cycle, the implementation of Article 11 as a whole improved considerably. The greatest increase was observed in the proportion of Parties requiring pictorial warnings, and the need for health warnings to cover 50% or more of the main display area of the package.

Use of pictorial warnings. In 2018, 64% of all Parties required health warnings in the form of pictures or pictograms on tobacco product packaging.

EU Member States began implementing the 2014 EU Directive and increased the size of their combined text and pictorial warnings to cover 65% of the package surface. Georgia has increased the required size of health warnings to 60% of the entire surface. In addition, India has increased pictorial health warnings to 85% of the principal display areas.

Plain packaging. Australia adopted the law requiring plain (standardized) packaging of tobacco products in 2012.

In the wake of Australia's action, there was a domino effect with Parties adopting plain packaging standards. Following Australia's lead, France, Ireland, Hungary, New Zealand, Norway, Slovenia and the United Kingdom of Great Britain and Northern Ireland have passed legislation on plain packaging, and some of them have already begun implementation.

Other Parties (Belgium, Georgia, Lithuania, Mauritius, the Russian Federation, South Africa, Sri Lanka and Uruguay) have expressed their interest to implement similar measures. Ecuador reported organizing a high-level forum, Towards Plain Packaging, with panellists from the National Assembly, the Pan American

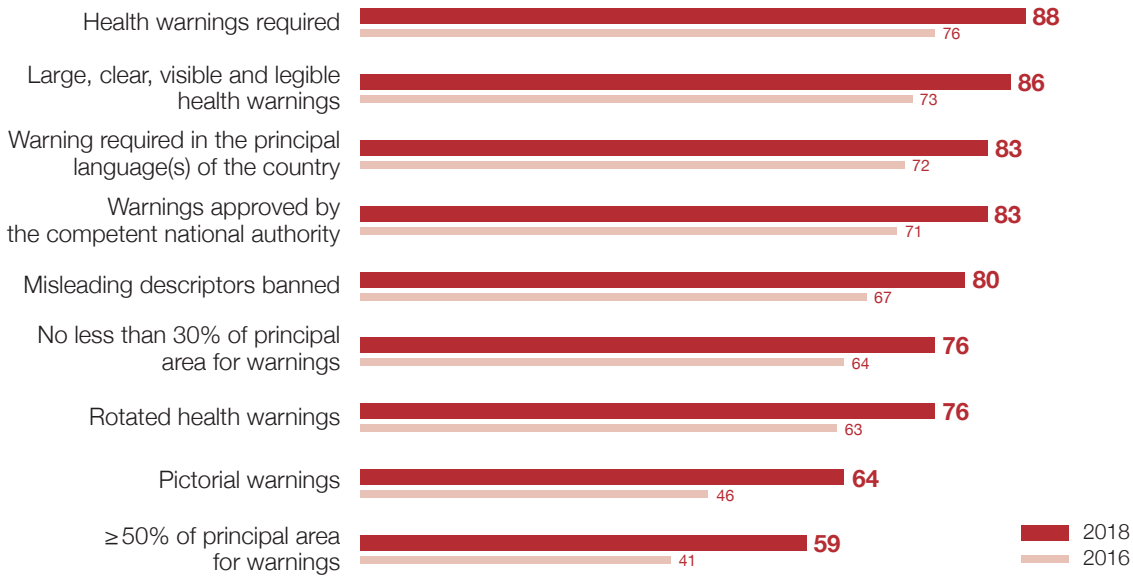
Health Organization and the Ministry of Public Health in 2016.

Plain packaging is a measure that is often challenged at international foums. In 2018 after years of litigation, a World Trade Organization (WTO) panel rejected a complaint brought by four countries (Cuba, Indonesia, Honduras and Dominican Republic) and confirmed that Australia's plain packaging policy for tobacco products was in line with global trade rules.[16]

Implementation challenges. The tobacco industry has aggressively and vehemently fought against the implementation of package warnings and plain packaging because tobacco packaging is a crucial aspect of its marketing strategy to target consumers, especially children and young people. With the use of litigation, its objective is to avoid, dilute or delay effective measures on tobacco product packaging, with the pretext that the packaging violates the industry's intellectual property rights or would facilitate an increase illicit trade. Numerous lawsuits to discourage countries from enacting or implementing life-saving tobacco control laws were launched and decisively rejected in Australia, Norway and the United Kingdom of Great Britain and Northern Ireland.

Fig. 7

Percentage of Parties implementing the time-bound provisions under Article 11 in 2016–2018 (n=180 in 2016; n=181 in 2018)



[16] http://untobaccocontrol.org/kh/legal-challenges/initial-overview-wto-panel-decision-australia-plain-packaging/

WORLD

The domino effect in effective pictorial messages

Plain packaging in Hungary (Photo courtesy of Tibor Demjen, WHO FCTC focal point, Hungary)

Health warning messages are an effective and cost-efficient means of communicating the health risk of smoking. Compared to 2016, the greatest increase in the average implementation of the FCTC was observed for pictorial warnings, with close to 90% of all Parties now requiring health warnings.

The efficiency and effectiveness of health warnings has led to a domino effect in developing measures as Parties moved forward to apply legalisation based on the successes and outcomes of other Parties. This was most evident in the portion of Parties now requiring pictorial warnings to cover 50% or more of the principal display area of the package, and as Member States of the EU move towards implementing the 2014 EU Directive requiring an increase combined text and pictorial messages to 65% of the principal display area.

The move towards plain packaging has emerged as the next leading milestone for Article 11, with a fast-growing number of Parties to the Convention developing legislation following Australia's lead in 2012. France, Ireland, Hungary, New Zealand, Norway, Slovenia and the United Kingdom of Great Britain and Northern Ireland have passed legislation on plain packaging, and some of them have already commenced implementation. Other Parties (Belgium, Georgia, Lithuania, Mauritius, the Russian Federation, South Africa, Sri Lanka and Uruguay) have expressed their interest to implement similar measures. In addition, Ecuador organized a high-level forum, Towards Plain Packaging, with panellists from the National Assembly, the Pan American Health Organization and the Ministry of Public Health in 2016.

This domino effect is a result of the collaborative and cooperative approaches among Parties in the sharing of information, best practices, and milestones in the development of national policies and legislation. This collaborative approach is not just reflected in the implementation on measures of pictorial warnings and health messages but also serves to further the effective and efficient implementation of the Convention.

REDUCTION OF DEMAND FOR TOBACCO

KEY OBSERVATIONS

Education, communications, training and public awareness [Article 12]

- ***Ninety per cent of all Parties reported having implemented educational and public awareness programmes. However, there is still a need to better reflect the socioeconomic, educational and cultural differences of the target population and the needs of ethnic groups in the implemented programmes.***
- ***Parties have broadened the reach of their training and awareness activities by targeting not only health workers and educators, but also other key stakeholders such as decision-makers and media professionals.***
- ***Involvement of public agencies, nongovernmental organizations (NGOs) and private organizations in the development of programmes and strategies, as well as using evidence-based research to guide the development of programmes, has clearly strengthened.***

Implementation of educational and public awareness programmes. Ninety per cent (162) of all Parties reported that they had implemented educational and public awareness programmes. The proportion was significantly larger than in 2016 (76%). Several Parties succeeded in continuing their previously established campaigns or activities.

For instance, Norway highlighted that as part of its five-year-strategy of mass media tobacco campaigns, including extra funding of approximately 19 million Norwegian krones annually (US$ 2.3 million), five campaigns have been carried out in 2016–2018. A wide range of topics such as health risks, addiction, snus (smokeless tobacco) use, smoking cessation and standardized tobacco packaging were covered.

In Qatar, the Ministry of Public Health was implementing a media campaign in four phases, focusing on health risks, tobacco control legislation, smoking prevention and smoking cessation. The United Kingdom of Great Britain and Northern Ireland continued to run “Stoptober”, a 28-day mass participation event to help smokers in the country quit via a public challenge to stop smoking for the duration of the month of October. Social media plays an integral part in this campaign, which was developed using behavioural economic principles. Participants were supported to quit, receiving a free Stoptober pack with information about the health and financial benefits of quitting smoking.

Altogether 80% of all parties implemented local events to promote cessation of tobacco use, and World No Tobacco Day (WNTD) was the single most often highlighted event by the Parties. Many Parties systematically build national activities around the date and/or the theme of WNTD. This highlights the importance of continuing the WHO WNTD campaigns in collaboration with the Convention Secretariat and other partners as appropriate, as a means of promoting implementation of the Convention by the Parties.

New campaign initiatives were reported for instance by Bulgaria (student competition), Chad (oral cancer), France (Mois Sans Tabac), Italy (women’s health) and the Kingdom of Tonga (first national quit smoking campaign).

TONGA

Hard-hitting two-phase campaign to curb smoking and noncommunicable diseases

On 1 June 2016, to celebrate World No Tobacco Day, the Tongan Ministry of Health launched a hard-hitting mass media and social media campaign highlighting the dangers of smoking around children. The Tuku Ifi Leva (Quit Smoking Now) messages was intended to motivate smokers to stop with the support and advice from a trained specialist through a newly established toll-free national Quitline.

In October 2017, the second-part of this campaign was launched. With strong graphic visuals showing tumours and damaged organs, the objective was to increase awareness among tobacco users on the deadly risks of tobacco use, including cancers and heart disease.

The Tonga Police, alongside the Ministry of Health's Tobacco Control Unit, has been using this campaign as an opportunity to deliver an enforcement blitz to reinforce the new tobacco legislation requiring most public places to be smoke-free.

Currently 46% of men and 13% of women are smokers, which makes Tongan prevalence among the highest in the world.

This campaign was implemented by the Tongan Ministry of Health as part of the *Tonga National Strategy for Prevention and Control Non-communicable Diseases 2015–2020*. The implementation of a sustained mass media campaign was recommended as part of the needs assessment exercise conducted jointly by the Convention Secretariat and the Government of Tonga.

(Photo courtesy of Dr Reynold 'Ofanoa, WHO FCTC focal point, Tonga)

Georgia, Nigeria and Vanuatu launched campaigns to support newly adopted smoke-free legislation. For instance, the Tobacco-Free Nigeria Advocacy Programme campaign, supported by the Campaign for Tobacco Free Kids, an Observer to the COP, aims to educate the population about the National Tobacco Control Act that was signed into law in 2015. It focuses on reaching young Nigerians through social media and the #ClearTheAir hashtag. It also called on support from influential leaders such as Nigerian music superstars Timi Dakolo and Oluwatosin Oluwole Ajibade, known as Mr Eazi, and Miss Saadatu Hamu Aliyu of the World Economic Forum's Abuja Global Shapers Hub. This public awareness campaign and stronger partnership with the civil society was recommended as part of the needs assessment exercise conducted jointly by the Convention Secretariar and the Government of Nigeria.

Azerbaijan, with the support of the International Union Against Tuberculosis and Lung Disease and the Bloomberg Philanthropies, carried out a project to advocate for stronger tobacco control legislation.

Target groups and messages of educational and public awareness programmes. Almost all Parties that have implemented these programmes targeted at children or young people, and adults or the general public. Several Parties reported progress in programmes and activities, especially in the school context.

For example, in Costa Rica, the Ministry of Health has initiated a project where two mobile exhibitions equipped with interactive electronic devices and information about the risks related to tobacco visit schools, including those in rural areas.

Around three quarters of all Parties that had implemented these programmes reported having run specific campaigns targeted at women, men and pregnant women. This remained on similar levels as in 2016.

Thirty percent of Parties also reported targeting their educational and public awareness programmes to ethnic groups. Australia continues to lead in this area with its Tackling Indigenous Smoking (TIS) programme. The programme aims to contribute to closing the gap in indigenous health outcomes by reducing tobacco smoking as the most significant risk factor for chronic disease among Aboriginal and Torres Strait Islander people.

Most of the Parties implementing educational and public awareness programmes consider age and gender differences (91% and 78%, respectively) among targeted population groups in their programmes. Fewer Parties reflected socioeconomic differences (51%), educational background (62%) and cultural differences (42%). The proportions considering the different background aspects in the targeted population groups remained similar in 2016 and 2018.

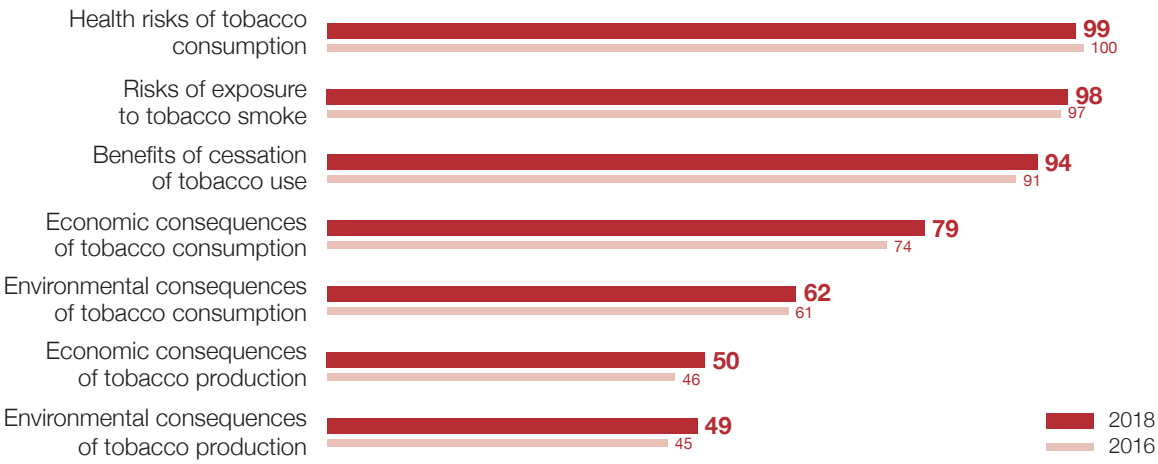
Almost all that reported implementing communications programmes covered the health risks of tobacco use, risks of exposure to tobacco smoke and benefits of cessation in their messages (Fig. 8). The largest increase was observed in covering the economic consequences of tobacco consumption, reported by 79% of Parties. The economic and environmental consequences of tobacco production remain least covered, but the proportions increased in 2018 as compared to 2016.

Targeted training or sensitization programmes on tobacco control. A majority of the reporting Parties had implemented targeted training or sensitization programmes to at least one specific group. Targeted training or programmes were most often addressed to health workers and educators, followed by decision-makers and community workers (Fig. 9). A notable increase was observed in all target groups, indicating broader reach of the training or sensitization activities in tobacco control.

Parties also mentioned several other groups that they had targeted in their programmes. These included religious, social and community leaders; police and local authorities; youth workers; trainees and their supervisors; military personnel; tobacco retailers; employees in

Fig. 8

Percentage of Parties that covered various areas in their educational and public awareness programmes (n=137 in 2016; n=162 in 2018)*



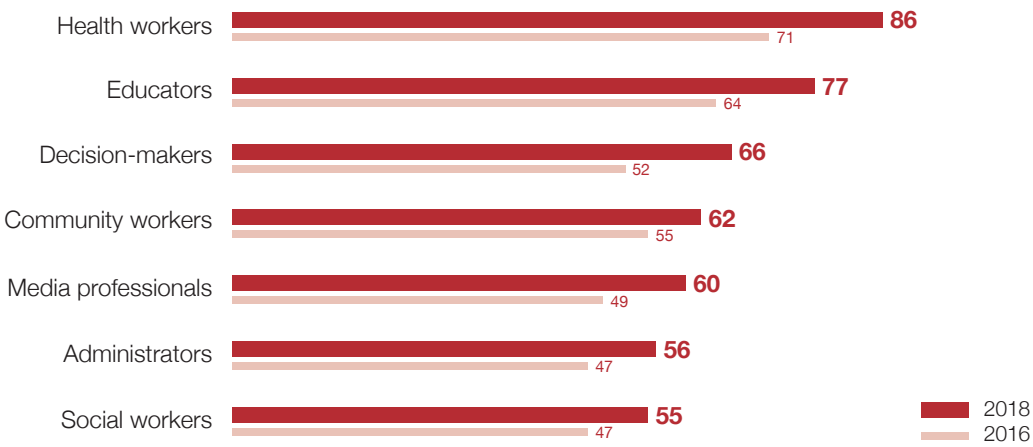
private organizations and non-health public sector; parents and foster-parents; and students.

Examples from progress reported by the Parties include training to local administrators and police officers in Malta following the smoking ban in cars when minors are present. Chad reported training young peer educators in smoking prevention. China reported that annual training sessions on tobacco control are organized in various cities to raise the awareness of local health authorities and establish an information exchange platform.

Awareness and participation of agencies and organizations and use of research to guide the development of programmes. Eighty-eight per cent (160) of all Parties involved public agencies and 83% (151) involved NGOs in the development and implementation of intersectoral programmes and strategies for tobacco control.

Fig. 9

Percentage of Parties with training and sensitization programmes on tobacco control targeting specific groups (n=180 in 2016; n=181 in 2018)



*Calculated among Parties that have implemented educationnal and public awareness programmes

In addition, 69% (124) of all Parties used research to guide the development, management and implementation of communications, education, training and public awareness programmes, as well as the required pretesting, monitoring and evaluation, as suggested in the Article 12 Guidelines. As compared to 2016, the proportion increased significantly. Very few Parties gave details as to how they use research in programme development and implementation; however, Australia provided comprehensive information on its TIS programme.

In addition to the groups included in the questionnaire, Parties reported the involvement of many other stakeholders in the development and implementation of strategies and programmes. These included academic and higher education institutions; community and scientific groups; professional colleges; police and military; the media; and international organizations, including WHO.

In Finland, Action on Smoking and Health (ASH) carried out and coordinated the activities of the Tobacco-free Finland 2030 network consisting of NGOs, public agencies, hospitals and research institutes. The network supports the objective of the Finnish Tobacco Act to have a tobacco- and nicotine-free Finland by 2030. It organized seminars and events, prepared statements, and initiated and emphasized the positive health and social gains from tobacco- and nicotine-free environment.

Several Parties also continued to highlight advances in strategic planning for educational and public awareness programmes in their progress notes. A number of Parties, such as Malta, Mongolia and Solomon Islands, reported that they either established a comprehensive national tobacco control communications strategy or action plan or were in the process of developing one. Belgium mentioned that in Brussels, a health promotion framework for 2018–2022 was adopted by the French-speaking Government in 2017 and one of the priorities addresses healthy lifestyles, including the promotion of healthy food, physical activity, and the reduction of alcohol and tobacco consumption.

AUSTRALIA

Tackling indigenous smoking

(Photo courtesy of Department of Health, Australia)

The National Tobacco Campaign contributes to reducing the adult daily smoking rate in Australia. The recent iteration of the campaign – Don't Make Smokes Your Story – was launched in 2016 and is intended to empower Aboriginal and Torres Strait Islander smokers aged 18–40 years to quit smoking. The campaign uses the theme of family to focus on encouraging quit attempts through a positive and empowering message that speaks directly to Aboriginal and Torres Strait Islander people. The campaign works with communities to develop culturally relevant smoking cessation resources and support community events to challenge the social norms around the acceptance of smoking. The TIS programme for 2018–2019 to 2021–2022 comprises:

- 37 organizations that have been provided funding through Regional Tobacco Control Grants (RTCG) to raise awareness and to design and implement smoking prevention and cessation activities tailored to local needs;
- a National Best Practice Unit (NBPU) to support best practices in RTCG activities;
- indigenous Quitline enhancement grants, which aim to improve the capacity of Quitline services to provide accessible and appropriate services to Aboriginal and Torres Strait Islander people;
- the Quitskills training programme, which provides training in brief intervention and motivational interviewing that aims to increase the number of suitably trained and qualified professionals working with Aboriginal and Torres Strait Islander smokers and their communities, including enhancements for young people, pregnant women and new mothers;
- a National Coordinator to deliver high-level advice to the Australian Government for the shaping of policies, as well as providing leadership and support to grantees;
- enhanced activities targeting priority groups for promising approaches for priority groups and particularly pregnant women and smokers in remote areas;
- a national evaluation to be continued in 2018 by an external evaluator, looking at the programme's appropriateness, effectiveness, impact and efficiency; and
- an assessment of the impacts and outcomes of the RTCG component that forms approximately 80% of the funding for the TIS programme. Approximately 39% of Aboriginal and Torres Strait Islander people over the age of 15 are daily smokers, 2.8 times the smoking rate for other Australians. It is estimated that smoking accounts for one in five Aboriginal and Torres Strait Islander deaths.

REDUCTION OF DEMAND FOR TOBACCO

KEY OBSERVATIONS

Tobacco advertising, promotion and sponsorship [Article 13]

- ***Parties progressed in broadening the scope of their tobacco advertising, promotion and sponsorship legislation to cover new and emerging tobacco and nicotine products.***
- ***Almost a third of all Parties still have not instituted a comprehensive ban on all tobacco advertising, promotion and sponsorship, despite it being one of the time-bound measures of the Convention.***
- ***Only about a third of all Parties have reported regulating cross-border advertising.***

Comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS). Of all Parties, 72% (131) reported having a comprehensive ban on all TAPS. However, Parties' definitions of a comprehensive ban on TAPS vary and do not always cover all of the specific measures called for by the guidelines for implementation of Article 13. As Fig. 10 shows, in 2018 the most commonly covered areas in the Parties comprehensive TAPS bans were tobacco sponsorship (87%), product placement (85%) and depiction of tobacco in entertainment media (73%).

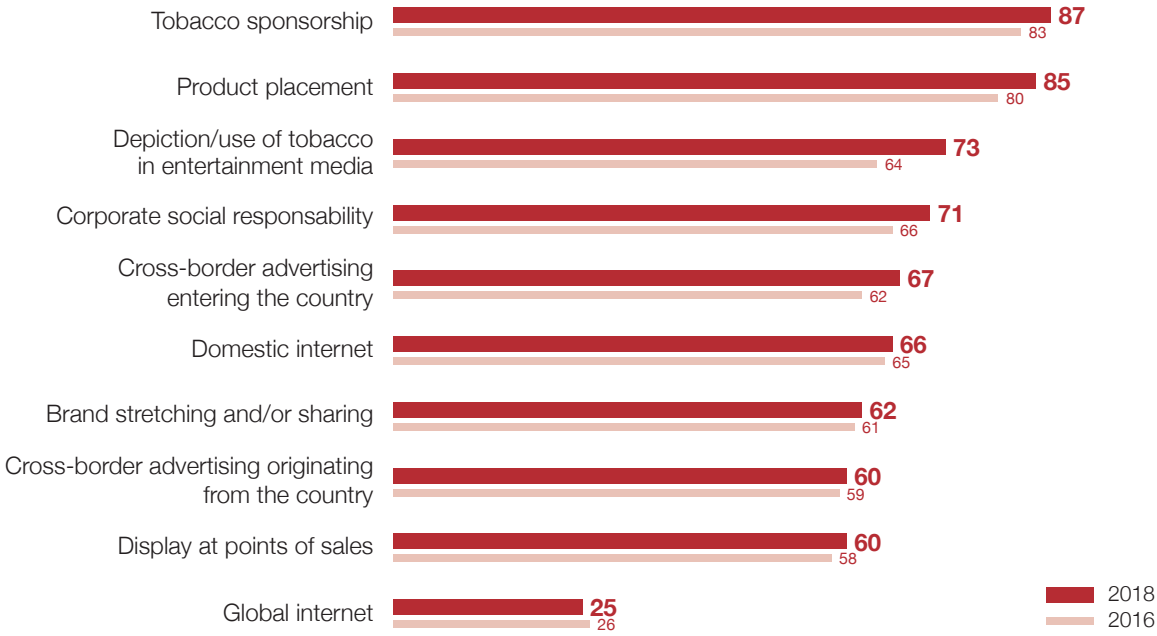
New TAPS legislation was reported by Azerbaijan, China, Georgia, Lithuania, Oman, Qatar, Slovenia, Thailand and Turkmenistan. In the 2018 reporting period, inclusion of different provisions strengthened overall, but notable progress was observed in the proportion of Parties that included the depiction of tobacco in entertainment media in their comprehensive bans (Fig. 10). This is an especially positive trend as many Parties previously shared the difficulties of its regulation in their implementation reports, and this measure is also in line with decision FCTC/COP7(5) of the seventh session of the Conference of the Parties.

In their progress notes, the Australian Capital Territory, the Czech Republic, Lithuania, Luxembourg, the Netherlands and Portugal reported amending their existing TAPS legislation to include electronic cigarettes. In addition, Portugal stated in addition to electronic cigarettes, the scope of their TAPS ban has been broadened since January 2018 to the advertising of cigarette paper, water pipes and devices for using heated tobacco products. Lithuania's new advertising ban covers also herbal products intended for smoking.

Several Parties highlighted their recent advances in banning tobacco sponsorship. China banned Internet advertising and the use of charitable donations to promote tobacco products. Slovenia's comprehensive new legislation bans, among other things, contributions and donations from the tobacco industry to any other entity. Luxembourg prohibited the sponsorship of electronic cigarettes in addition to sponsorship of tobacco. Lithuania banned any kind of public or private sponsorship of radio programmes with respect to tobacco, electronic cigarettes and their refills, as well as herbal products intended for smoking.

Fig. 10

Percentage of Parties reporting inclusion of selected provisions in their comprehensive ban on tobacco advertising, promotion and sponsorship (n=109 in 2016; n=131 in 2018)*



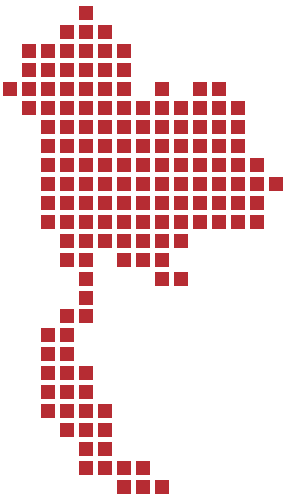
Cross-border advertising, promotion and sponsorship. Banning cross-border advertising – originating from one country and viewed in another – is the second time-bound measure under Article 13, in addition to the general TAPS ban. However, only 60% of the Parties' comprehensive TAPS ban was shown in 2018 to cover cross-border advertising, promotion and sponsorship originating in country. Only a limited number of Parties have put in place measures to tackle the issue of cross-border advertising such as penalties (36%) or cooperation in its elimination (30%).

Recent progress was highlighted by Lithuania, where the 2016 amended legislation encompasses a ban of any type of public or private sponsorship of events, activities or individual persons, which directly or indirectly promotes the use of electronic cigarettes, refillable cartridges of electronic cigarettes and/or herbal products intended for smoking, when it is associated with several countries that are members of the European Economic Area (EEA), takes place in several EEA countries or has cross-border effects.

Restrictions in the absence of comprehensive TAPS ban. Overall 27% (49) of all Parties reported that they did not implement a comprehensive ban for TAPS. Of these Parties, five (10%) indicated that they were precluded by their constitution or constitutional principles from undertaking a comprehensive TAPS ban. Of the Parties that only applied restrictions instead of a comprehensive ban, only a third (31%) required restrictions for all TAPS. Only one in 10 of the Parties without comprehensive TAPS ban required disclosure of tobacco advertising expenditures. Most common restrictions for TAPS were restrictions on radio (61%), television (59%) and print media (47%). The least restricted area was cross-border advertising originating from the country (14%), global Internet (18%), tobacco sponsorship in international events and activities (33%) and participants therein (27%).

* Calculated among Parties that have a ban on tobacco advertising, promotion and sponsorship

THAILAND



bans further tobacco product advertising, promotion and sponsorship

Thailand has been strengthening its tobacco control policies in the past 30 years and Article 13 of the WHO FCTC is no exemption to this. A ban on tobacco advertisement was first implemented in 1989. The latest updates to the legislation on tobacco advertising, promotion and sponsorship entered into force on 4 July 2017 under the Tobacco Products Control Act 2017 (BE 2560).

Article 35 stipulates that business operators and related persons shall not be allowed to sponsor or support individuals, groups or public and private agencies in any way. This includes promoting the image of tobacco products, manufacturers or importers of tobacco products, advertising of tobacco products, their manufacturers or importers and promoting tobacco consumption, in any way that interferes with tobacco products control policies. An exemption is still given for donations and humanitarian assistance in case of severe disasters. However, this kind of activities or news cannot be promoted to the public.

Furthermore, article 36 of the law bans retailers to display or to permit a display of tobacco products at points of sale. Display of names and prices of tobacco products along with display of tobacco product retail places must comply with the rules, procedures and conditions, but the regulations towards this end have not yet been published.

Tobacco use is still one of the most serious public health problems in Thailand, given that it constitutes the single most important risk factor for preventable deaths in the country, with over 51,000 deaths caused by smoking each year. Through the adoption of this law, that was elaborated on the basis of the Guidelines for implementation of Article 13 of the WHO FCTC, Thailand continues to be a leader in global tobacco control, while fulfilling its obligations under the Convention.

Before After

Display at point of sale before and after the 2017 amendment of the Tobacco Products Control Act (Photo courtesy of Ministry of Public Health, Thailand)

KEY OBSERVATIONS

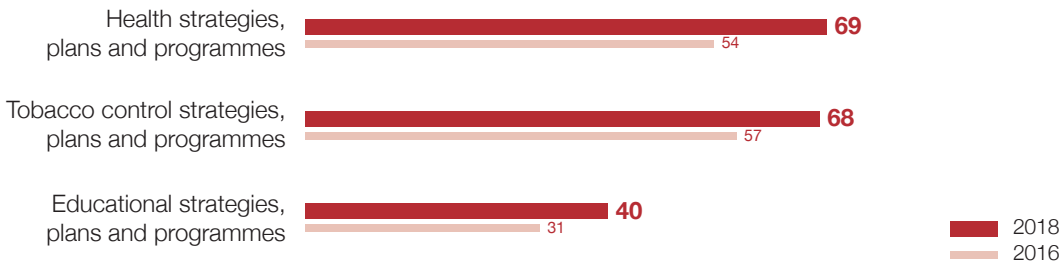
Measures concerning tobacco dependence and cessation [Article 14]

- ***As a positive development, Parties have included diagnosis, treatment and counselling services in their national tobacco, health and educational programmes, plans and strategies more actively than before.***
- ***Parties have strengthened their programmes promoting tobacco cessation, with local events, such as the World No Tobacco Day, media campaigns and programmes in health-care facilities being the most popular initiatives.***
- ***Slightly over half of all Parties declared having integrated tobacco dependence and cessation in the curricula of various of medical students and it was even less common in nursing, dentistry and pharmaceutics. Better inclusion of the methodology in the curricula would reduce the need for later extensive and more costly training of health workers.***

Inclusion of diagnosis, treatment and counselling services for tobacco cessation in national programmes, plans and strategies. Just above two thirds (123) of all Parties included tobacco dependence diagnosis, treatment and counselling services in their national tobacco control strategies, plans and programmes. A total of 69% (125) had included the same in their health programmes (Fig. 11). Over one third, 40% (72), had included it in educational programmes, plans and strategies. Inclusion of smoking cessation in various national programmes, plans and strategies became more common in 2016–2018. One recent example of progress in this area was provided by Malta, where a group of selected health professionals visited the Health Services Executive (HSE) in Dublin, Ireland, in 2016 to observe and learn in order to strengthen national tobacco cessation services in Malta. After the visit, the delegation continued to work together for the preparation of a draft Tobacco Action Plan, which is expected to form part of the national Tobacco Control Strategy.

Fig. 11

Percentage of Parties reporting the inclusion of diagnosis and treatment for smoking cessation in their national strategies, plans and programmes in 2016–2018



Programmes to promote tobacco cessation in the general population. The majority (80%) of all Parties have utilized the opportunities raised by local events, such as the World No Tobacco Day, to promote tobacco cessation (Fig. 12). A similar percentage of Parties designed programmes to promote cessation in health-care facilities. Over two thirds (71%) have run media campaigns to promote smoking cessation.

WHO

World No Tobacco Day: an awareness raising opportunity for WHO FCTC Parties

Every year, on 31 May, WHO and partners celebrate World No Tobacco Day (WNTD), highlighting the health and other risks associated with tobacco use and the policy interventions needed to effectively control it.

Posters from previous WNTD celebration. (Source: http://www.who.int/tobacco/wntd/en/)

The World Health Organization and its Member States initiated the World No Tobacco Day in 1987 to draw global attention to the growing tobacco epidemic and the disease and health problems caused by tobacco use. Since then, different topics have been showcased in the yearly celebrations, from the vicious circle of tobacco and poverty to gender and marketing to women, tobacco free workplaces, smoking cessation, tobacco taxation, tobacco industry interference and illicit trade in tobacco products, among many others. On the occasion of the WNTD, individuals, institutions and governments showing exemplary leadership in tobacco control are presented awards in recognition of their activities.

Reports of the Parties to the Convention indicate that the celebration of World No Tobacco Day provides them with opportunities to highlight implementation of the WHO FCTC at national level, to advocate for evidence-based policies required under the Convention, to generate awareness and political will to strengthen implementation of effective tobacco control measures.

The Convention Secretariat is proud to support this WHO initiative and contribute to the yearly actions. Among others, the Secretariat works with WHO colleagues to select the themes for the yearly initiative, provide comments during the development of campaign and information materials prepared for distribution within the countries.

Sustaining this initiative over time is important in order to provide support and opportunity for countries to communicate and raise public awareness of the consequences of tobacco use, to emphasize its health, economic, social, environmental and other impacts, and eventually highlight the implementation of the WHO FCTC.

More details are available on: http://www.who.int/tobacco/wntd/previous/en/

For instance, a national mass media campaign on tobacco was conducted in 2016 for the first time in Tonga, themed *Tuku Ifi Leva* (Quit Smoking Now), and the second phase was also conducted in October 2017. The campaign is planned to continue as an annual event for five consecutive years to coincide with the timeline of the current national noncommunicable disease (NCD) strategy.

In Pakistan, the Ministry of National Health Services, in collaboration with Vital Strategies, launched the second national anti-tobacco mass media campaign in 2017. The "Sponge" video graphically shows the amount of tar found, after only one year, in the lungs of an average pack-a-day smoker. The cessation campaign appeared on 14 TV channels across the country over the duration of four weeks, as well as on the radio, community signage and billboards.

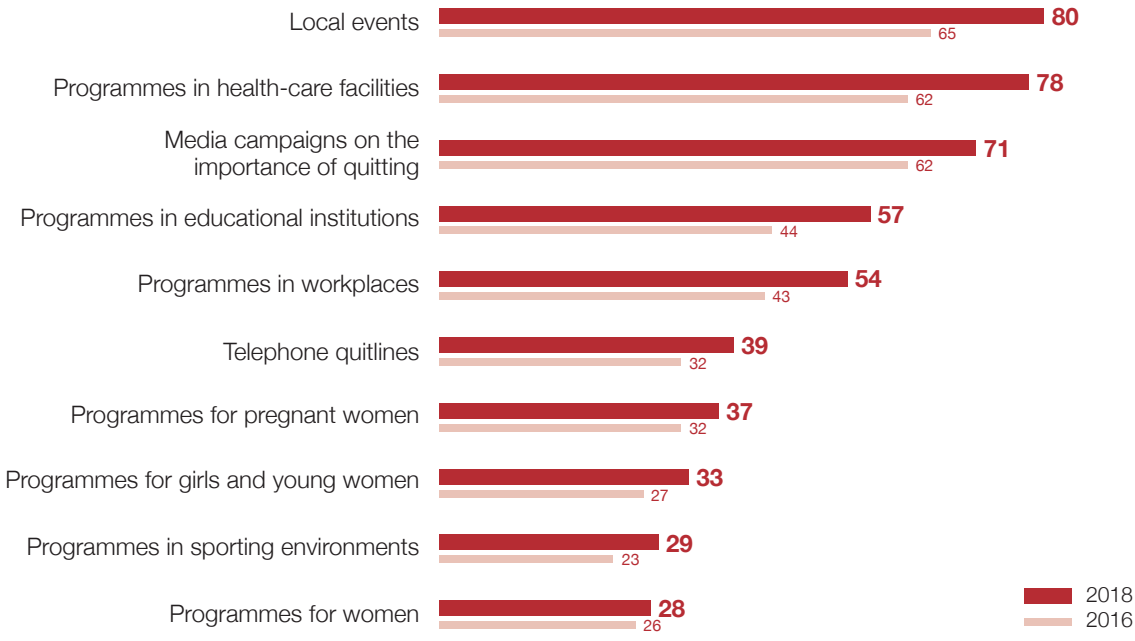
As compared to 2016, Parties strengthened their activities in promoting cessation in 2018 (Fig. 12). Programmes to promote cessation among women and in sporting environments remain the least utilized measures.

Group activity as part of the El Salvador cessation program of the «Addiction Prevention and Treatment Centers». (Photo courtesy of Fondo Solidario para la Salud - FOSALUD, El Salvador)

National guidelines, integration of cessation into health-care systems and involvement of various health professionals. Overall, 60% (109) of all Parties had national cessation guidelines based on scientific evidence and best practices. Several Parties continued to update their guidelines in the reporting period. For example, Mexico highlighted having developed a competency standard for providing brief advice for smoking cessation. Globally, 69% (124) of the Parties integrated diagnosis and treatment into their health-care systems, most commonly into primary health (Fig. 13).

Fig. 12

Percentage of Parties reporting programmes, events and quitlines to promote cessation of tobacco use (n=180 in 2016; n=181 in 2018)



No major changes were observed in terms of the different structures providing for diagnosis and treatment. Several Parties also mentioned that other structures within their existing health-care systems provided the services, for example, occupational health services and centres providing psychiatric care. Physicians, nurses and family doctors are the most involved health professionals (Fig. 14), but the overall involvement of health professionals remained on similar level as compared to 2016.

Curricula for health professionals. Slightly over half of the Parties (55%) reported that they included tobacco dependence treatment in the curricula of medical schools. Incorporating it to the curricula in the training of other health professionals was less common, but improved for all the studied professions in the 2018 reporting period (Fig. 15). Despite the small proportions of Parties integrating it to the curricula of students, a vast majority (86%) of Parties provided training and awareness activities to health workers in line with Article 12.

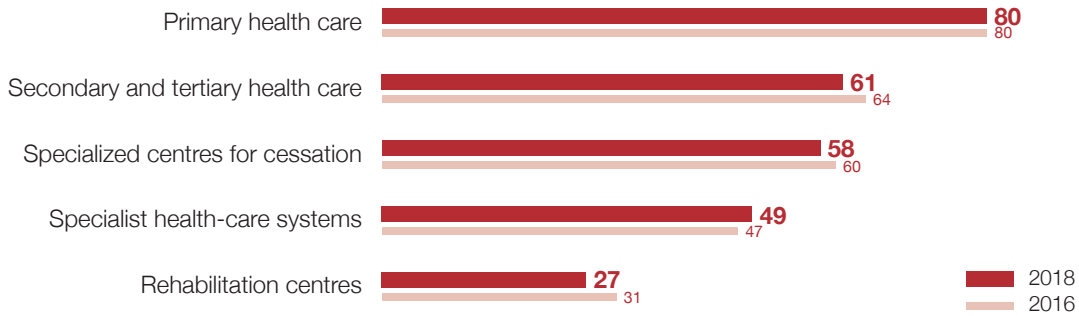
For example, Brunei Darussalam highlighted training nurses and smoking cessation counsellors in every government health centre since 2017. Mali trained more than 120 health workers in health counselling, education and smoking cessation. Bosnia and Herzegovina, as well as Ecuador, systematically trained medical doctors, nurses and health-care technicians. In Myanmar, since May 2017, primary health-care staff in 90 townships were trained in brief advice as part of the implementation of the *WHO Package of Essential Non-Communicable Disease Interventions for Primary Health Care in Low-Resource Settings*, know by the acronym PEN. A manual and guidelines were developed for this purpose by the Ministry of Health and Sports.

Public funding or reimbursement schemes for treatment costs. Out of the Parties that included diagnosis and treatment in their health-care systems, 83% covered fully or partially the costs of services and treatment in primary health care by public funding or reimbursement schemes. The percentage of Parties covering such services is provided in Fig. 16.

Accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence. More than half, 60% (109), of all Parties reported facilitating the accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence. Over nine out of 10 (94%) of these Parties had nicotine replacement therapy (NRT) legally available in their jurisdiction, and a majority also had bupropion (69%) and varenicline (68%) available. Of the Parties that had NRT legally available, half (50%) confirmed covering the costs of NRT fully or partially by public funding or reimbursement schemes. Of those that had bupropion or varenicline legally available, the costs were fully or partially covered in 53% and 47%, respectively, of the Parties. The proportions remained similar to the 2016 level.

Fig. 13

Percentage of Parties with programmes on diagnosis and treatment of tobacco dependence within health-care systems, by settings (n=102 in 2016; n=124 in 2018)*



* Calculated among Parties with programmes on diagnostics and treatment of tobbaco dependence

Fig. 14

Percentage of Parties with an involvement of health and other professionals in treatment and counselling programmes (n=102 in 2016; n=124 in 2018)*

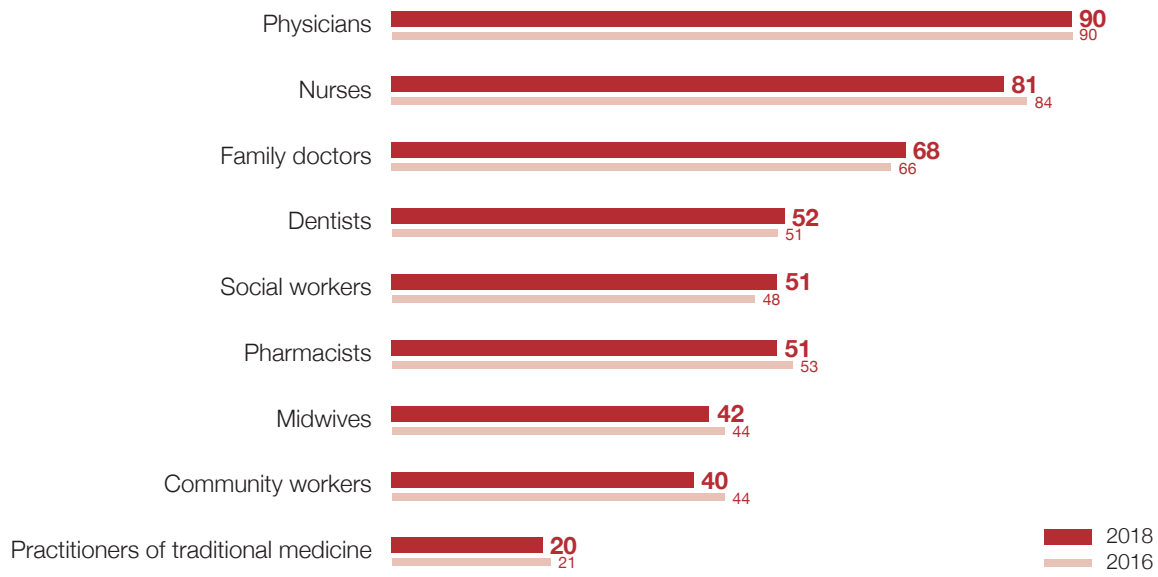


Fig. 15

Percentage of Parties reporting the inclusion of tobacco dependence treatment in the curricula of different health professionals (n=180 in 2016; n=181 in 2018)

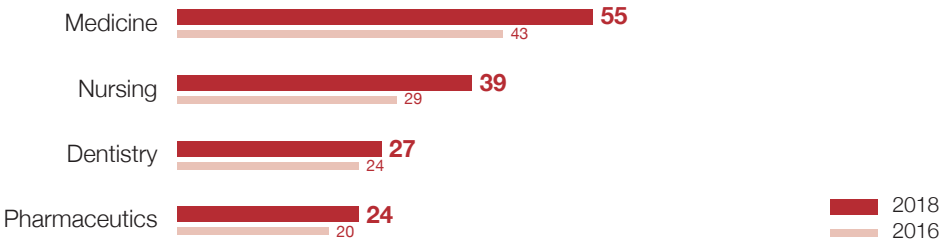
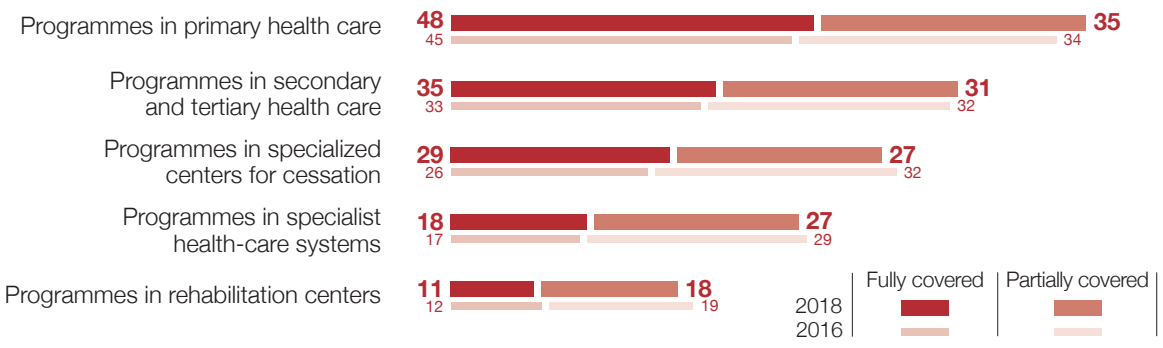


Fig. 16

Percentage of Parties where service and treatment costs are covered by public funding or reimbursement schemes (n=102 in 2016; n=124 in 2018)*



*Calculated among Parties with programmes on diagnostics and treatment of tobbaco dependence

MEASURES RELATING TO THE REDUCTION OF THE SUPPLY OF TOBACCO

KEY OBSERVATIONS

Illicit trade in tobacco products [Article 15]

- ***Compared to the last reporting cycle, more Parties have confirmed having legislation in place to address measures to control illicit trade in tobacco products.***
- ***The implementation of most of the measures under this article considerably improved as compared to the previous reporting cycle.***
- ***The ratification/accession to the Protocol to Eliminate Illicit Trade in Tobacco Products (the Protocol) has been advanced by many Parties, and came into force on 25 September 2018.***

Enacting or strengthening legislation against illicit trade. The average implementation of the provisions under Article 15 increased significantly from 50% in 2016 to 61% in 2018. Around two thirds of all Parties 72% (130) reported having adopted or strengthened legislation against illicit trade in tobacco products (Fig. 17).

Marking of packaging. Among all the Parties, it was most common to require markings to determine whether a tobacco product was legitimately and legally sold on the domestic market (66%) and to assist in determining the origin of the product (63%). Overall 63% of the reporting Parties also require the marking to be legible and/or presented in the principal language or languages of the country. However, only 38% require that unit packs of tobacco products for retail and wholesale use carry the statement "Sales only allowed in…" or have any other effective marking indicating the final market destination (Fig. 17).

Tracking and tracing. Over half, 52% (95), of all Parties required monitoring and collection of data on cross-border trade in tobacco products, including illicit trade. On the other hand, 18% reported having data on the percentage of smuggled tobacco products within their jurisdiction. One third, 35% (64), of all Parties had reported developing or implementing a practical tracking and tracing regime to secure the distribution system and assist in the investigation of illicit trade (Fig. 17).

The tobacco industry and those that promote its interests are increasingly advocating for tracking and tracing systems in line with their agendas. Related to this, Lithuania initiated a motion signed by the Minister of Health, the Chairperson of the Committee for Health, the Chairperson of the National Health Board, and the President of the National Alcohol and Tobacco Control Coalition to reject, at European Union level, the tracking and tracing system proposed by the tobacco industry called Codentify.

Confiscation and destruction. Over two thirds of all Parties, 69% (125), reported allowing the confiscation of proceeds derived from illicit trade in tobacco products, and similar percentage, 67% (121), monitored, documented and controlled the storage and distribution of tobacco products held or moving under suspension of taxes and duties. In addition, 70% (127) required the destruction of confiscated equipment, counterfeit and contraband cigarettes, and other tobacco products derived from illicit trade, using environmentally friendly methods where possible, or their disposal in accordance with national law.

Licensing. Around two thirds, 69% (124), of the Parties require licensing or other actions to control or regulate production and distribution in order to prevent illicit trade.

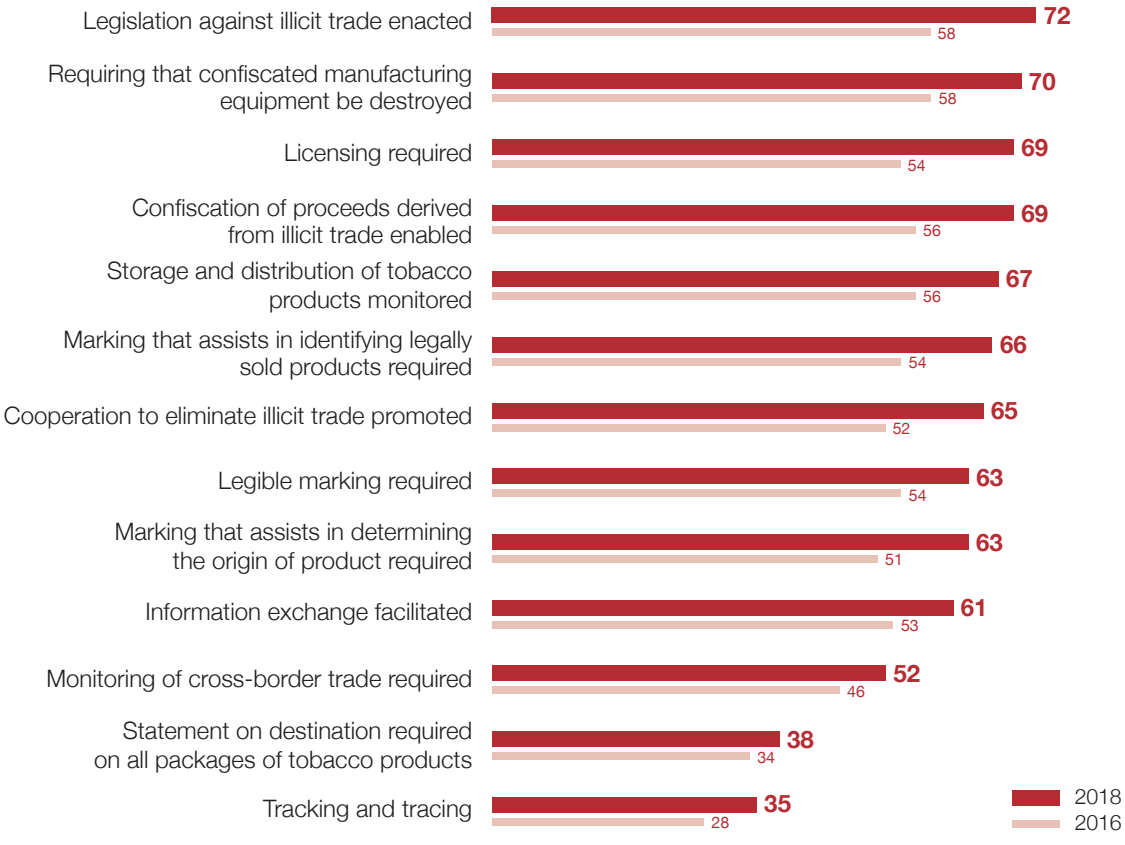
Since 1 January 2018 in Norway, wholesalers and retailers of tobacco products and tobacco surrogates, for example e-cigarettes and herbal tobacco, are required to register their products in a national tobacco sales registry. In the Islamic Republic of Iran, almost 33 000 tobacco retailers received a license to sell tobacco products since 2016.

Promoting cooperation. Overall 65% (117) of all Parties promote cooperation between national agencies and relevant regional and international intergovernmental organizations (IGOs) with a view to eliminating illicit trade in tobacco products.

To promote the entry into force of the Protocol, the Convention Secretariat organized and participated in several multisectoral, subregional workshops between 2016 and 2018. These workshops brought together officials from various government sectors involved in the ratification and implementation of the Protocol, including health, foreign affairs, customs, justice, law enforcers including the police finance and trade, along with members of civil society and IGO representatives. Members of the Panel of Experts on the Protocol were invited as facilitators. At least 55 Parties to the WHO FCTC have attended these workshops.

Fig. 17

Percentage of all Parties reporting on implementation of illicit trade control provisions (n=180 in 2016; n=181 in 2018)



#ItOughtToBeLaw

Achievements during the 2018 reporting period have led to another important milestone in the history of tobacco control, as more than 46 Parties to the WHO FCTC have also become Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products. The requirements set in Article 45 of the Protocol have been met and the Protocol will enter into force on 25 September 2018. Together with the WHO FCTC, the two treaties aim to tackle all aspects of the tobacco pandemic both globally and nationally.

The Protocol contains three categories of measures aimed at eliminating illicit trade in tobacco products: preventing illicit trade; promoting law enforcement; and providing the legal basis for international cooperation.

Parties are commended for their governments' efforts in ensuring the new Protocol entered into force. A clear message has been sent that the illicit tobacco market will be targeted under the framework of international cooperation by cost-effective measures that will protect particularly children and socioeconomically-disadvantaged populations from being exposed to low-cost and easily available tobacco products.

Key provisions of the Protocol focus on securing the supply chain of tobacco products through, among other things, licensing and record-keeping requirements, the establishment of national and regional tracking and tracing regimes, and a Global Information Sharing Focal Point to enhance cooperation among the Parties. Other measures are aimed at improving cooperation between law enforcement authorities by ensuring mutual legal and administrative assistance.

In addition to the entry into force of the Protocol, the Parties have continued to reinforce measures within their respective jurisdictions. Two thirds of all Parties have reported in 2018 having acted on WHO FCTC Article 15 by strengthening legislation against illicit trade in tobacco products. While the implementation of all measures under this article improved compared to the situation in 2016, further development and new measures are still needed, in particular cross-Party collaboration, which is comprehensively encompassed in the new treaty.

MEASURES RELATING TO THE REDUCTION OF THE SUPPLY OF TOBACCO

KEY OBSERVATIONS

Sales to and by minors [Article 16]

- ***Parties have strengthened the implementation of all provisions under the article.***
- ***A growing number of the Parties are in the process of increasing their minimum age for tobacco purchase.***
- ***There is still room for improvement especially in prohibiting the sale of tobacco products in any manner in which they are directly accessible, such as open store shelves, and from vending machines.***

Sales to and by minors. The vast majority of Parties, 85% (154), reported having prohibited sales of tobacco products to minors (Fig. 18). A smaller proportion (70%) also prohibited tobacco sales by minors. The legal age for tobacco purchases ranged from 15 to 24 years, with the average being 18 years.

The lowest ages reported were in Comoros (15). In Austria, Belgium, the Democratic People's Republic of Korea, Djibouti, Mali and The Former Yugoslav Republic of Macedonia the legal age to buy tobacco is 16, while it is 17 in Timor-Leste. The highest minimum ages were found in Japan, Thailand and Uzbekistan (20); Honduras, Mongolia and Palau (21); and Sri Lanka (24). Austria and Luxembourg mentioned in their progress notes that the minimum legal age for the purchase of tobacco products was raised from 16 to 18. In Brazil, the National Congress was processing a bill that would raise the minimum legal age to 21.

Eight out of 10 Parties prohibited the distribution of free samples to minors (83%) and to the public in general (77%).

Several Parties amended their legislation to cover new products in the ban of sales to minors. This includes electronic cigarettes in the Czech Republic, Poland and Slovenia and heated tobacco products in the Republic of Korea, which also banned the sale of any items mimicking tobacco products under the Juvenile Protection Act.

Requirements for tobacco retailers. A total of 66% (120) of all Parties required that all sellers of tobacco products place a clear and prominent indicator inside their point of sale about the prohibition of tobacco sales to minors. A similar proportion, 66%, requested that sellers of tobacco products ask the purchaser to provide evidence of having reached full legal age. Over half, 60%, of all Parties prohibited tobacco sales from vending machines, and 55% prohibited sales in any manner by which they are directly accessible, such as open store shelves. As an example of recent progress, Brazil prohibited the display of tobacco products in the proximity of sweets.

Prohibition of tobacco products with specific appeal to minors. A majority, 67% (122), of all Parties prohibited the sale of cigarettes individually or in small packs. In addition, 59% prohibited the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products.

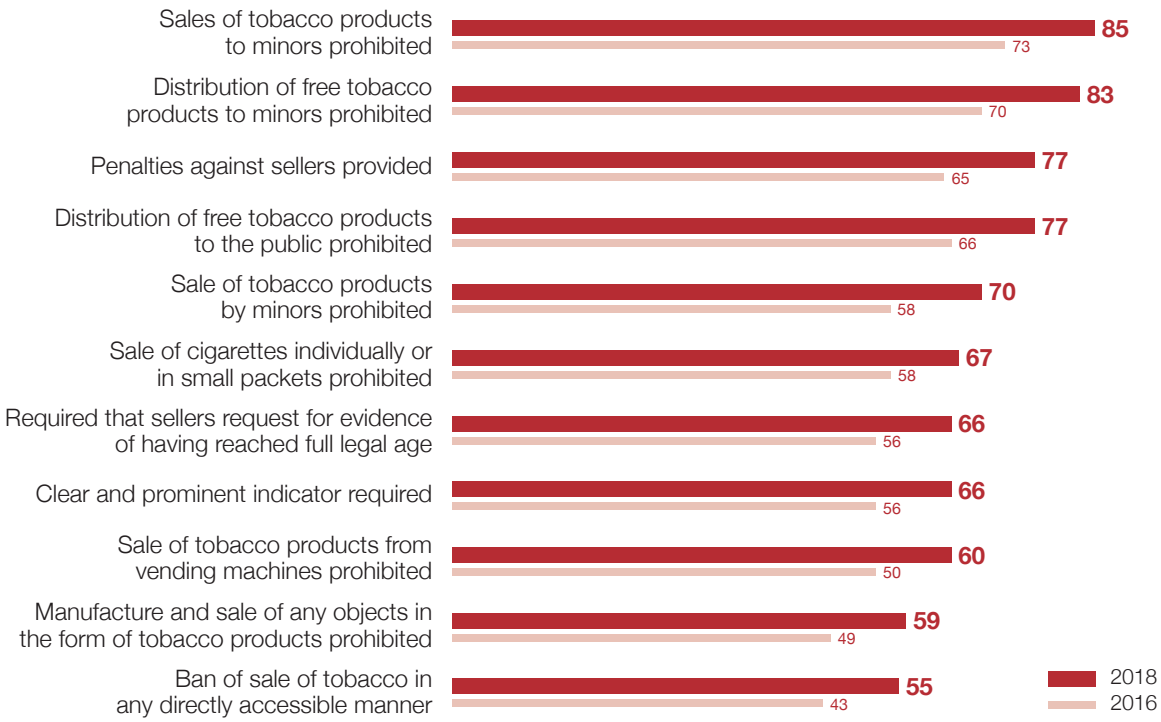
Enforcement and sanctions. Overall 77% (139) of all Parties provided penalties against

sellers and distributors in order to ensure compliance. Some Parties also took measures to improve the compliance with the legislation.

For instance, the Ministry of National Health Services in Pakistan issued a notification to all chief ministries in September 2016, noting that violations of tobacco control laws were observed across the country and all provincial governments should ensure strict compliance with existing legislation. The chief ministers were advised to make provisions for tobacco products not to be sold within 50 metres of educational institutions and to establish the prohibition of the of tobacco products to people under 18, among other actions. Police officers were encouraged and authorized to take action against all violators. Additionally, chief ministers were asked to issue necessary directives to relevant authorities to maximize compliance.

Fig. 18

Percentage of Parties reporting implementation of Article 16 provisions (n=180 in 2016; n=181 in 2018)



OTHER PROVISIONS

KEY OBSERVATIONS

Tobacco growing and support for economically viable alternatives [Article 17] and protection of the environment and the health of persons [Article 18]

- ***While there are examples of new diversification projects, the implementation rates of these two articles have not seen significant change during the 2016–2018 reporting period.***
- ***Among tobacco growing Parties, the share of tobacco leaf production in national gross domestic product (GDP) is typically below or around 1%.***
- ***An increasing number of Parties provided innovative examples of their projects protecting the environment and the health of people in relation to tobacco growing or manufacturing.***

Tobacco growing. Of all Parties, 50% (90) have reported tobacco growing in their jurisdictions. In this group, 84% (54) provided some information on the number of people working in tobacco growing, which varies widely, from a few hundred in, for example, Azerbaijan, Jamaica, Panama and the Republic of Moldova and to several hundreds of thousands in Brazil and Turkey and to 1.5 million in China.

In addition, 69% (44) of the Parties growing tobacco provided information on the share of the value of tobacco leaf production in the national GDP. The share was typically below or around 1%.

Economically viable alternative activities. Among the 90 tobacco-growing Parties, 27% (24) promoted viable alternatives for tobacco growers (Fig. 19).

Several Parties provided information on their activities. Sri Lanka announced it would gradually phase out tobacco growing by 2020 and provide alternative options to tobacco growers. Alternative crops to tobacco included potatoes (Sierra Leone and Tunisia); saffron (Afghanistan); corn, bean, mandarin oranges and avocados (Colombia); pineapples, sugar cane and coffee (Costa Rica); cocoa beans and coffee (Ecuador); and kenaf (Malaysia). Several Parties began promoting programmes that would replace tobacco growing with livestock (fish, dairy products and small livestock) production.

On the other hand, some Parties still incentivize tobacco growing as part of more general agricultural support programmes that do not make a distinction between supported crops.

In a very innovative project, France is helping tobacconists (tobacco sellers) gradually diversify their business model by selling other goods and offering additional services. A Transition Fund was created to support this project and a budget was earmarked of 20 million Euros per year until 2021.

FRANCE

An agreement to support tobacconists to diversify their activity

WHO FCTC Article 17 requires Parties to "promote, as appropriate, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers". While a number of Parties have implemented or promoted policies to help tobacco farmers diversify and shift from growing tobacco to other crops, there is little documented evidence on projects assisting tobacco sellers to shift away from selling tobacco.

The French Government has now developed and promotes a policy to provide alternatives to tobacco sellers. Through this policy tobacco sellers (the so-called "tobacconists") will be able to diversify their activity and become, in the long run, managers of a new local "convenience store".

In February 2018, an agreement was signed between the Public Action and Accounts Minister Gérald Darmanin and representatives of the national network of tobacconists to seal this commitment.

Tobacconists in France currently enjoy dual status as they on the one hand are independent retailers and on the other hand represent the state monopoly for tobacco retailing, under the supervision of the Directorate General for Customs and Indirect Taxation.

According to the text of the 2018–2021 agreement, the objectives of this initiative are to provide tobacconists with the means to evolve in the long term from tobacco retailing to a new type of convenience shop, responding to a variety of needs from the local communities.

Among many initiatives listed in the agreement, a "transition fund" was set up to provide resources to the project and help tobacconists diversifying from tobacco sales. The fund is expected to ensure a prosperous future for the 25 000 such businesses in the country. Other financial compensation is also available to businesses most vulnerable to the impact of the various tobacco control measures put in place.

This agreement demonstrates the Government's commitment to implement WHO FCTC in many areas, including Article 17, by promoting alternative activities and supporting tobacco

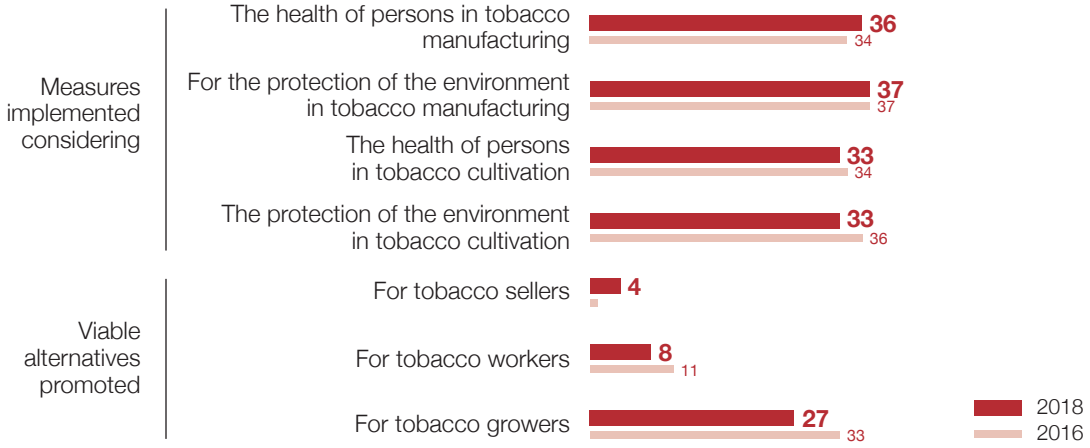
Protection of the environment and the health of people. Protective measures in tobacco cultivation and manufacturing are utilized by around one third of tobacco-growing Parties, and there was no notable progress in this area in 2016–2018 (Fig. 19).

Several Parties reported recent progress in the implementation of Article 18. China has reported on energy-saving and emission-reduction initiatives in the cigarette-production process. Ecuador, Panama and European Union Member States have comprehensively addressed the protection of the environment and the health of people working in the tobacco sector. Honduras has reported new multisectoral engagement on environmental protection, while Pakistan has organized training programmes for tobacco farmers regarding safe use of pesticides. In the Philippines, a particular focus has been placed on reforestation projects. In the Russian Federation, the Ministry of Health proposed a new ecological tax on cigarettes.

In India, the Ministry of Health and Family Welfare provided support to a public interest litigation case. This case was filed by the NGO "Doctors for You" at the National Green Tribunal aimed at declaring cigarettes and bidi butts as toxic waste, as well as addressing deforestation caused by tobacco curing and the adverse health impact of tobacco growing.

Fig. 19

Percentage of tobacco-growing Parties reporting implementation of protective measures in tobacco cultivation and manufacturing, and promoting viable alternatives (n=73 in 2016; n=90 in 2018)



PALAU

The Palau Pledge: raising awareness on environmental issues among visitors entering the country

Palau is the first nation on earth to change its immigration laws for the cause of environmental protection. Upon entry, visitors need to sign a passport pledge to act in an ecologically responsible way on the island, for the sake of Palau's children and future generations of Palauans. Palauans have also taken the pledge, from the president, the first pledgee, to traditional chiefs and residents.

Every tourist/ visitors/anyone who takes the pledge needs to follow sustainable tourism checklist or risk a fine. One item on the checklist are related to tobacco use: «Do not smoke in restricted areas.» Additionally, pledgers are warned as follows:

- Do not throw cigarette butts in the ocean or on the beach.
- Throw your butts away in appropriate receptacles.
- Do not pollute others with your second-hand smoke.

(Source: https://palaupledge.com)

This pledge is an excellent example of implementation of Article 18 of the Convention, as Palau agreed to have due regard to the protection of the environment in relation to tobacco use.

More details are available on: https://palaupledge.com/.

By the time of writing this report, almost 110 000 pledges were taken.

OTHER PROVISIONS

KEY OBSERVATIONS

Liability [Article 19]

- ***There is progress in Parties implementing measures that improve their compliance with Article 19 of the Convention, for example by including measures on liability in their tobacco control legislation, and half of the Parties have instituted these protective measures in their respective legislation.***
- ***The implementation of Article 19 is expected to strengthen after the launch of the Civil Liability Toolkit by the WHO FCTC Secretariat.***

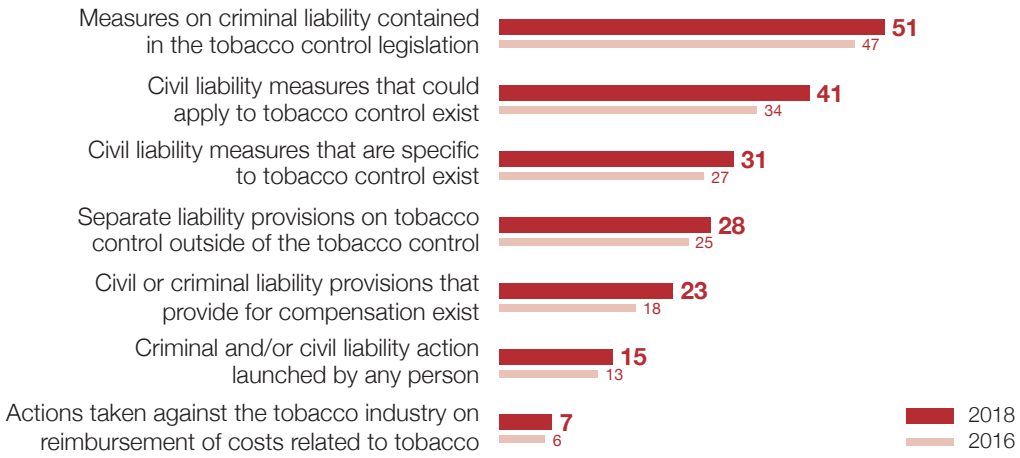
Of all the Parties, 51% reported that criminal liability is contained in their tobacco control legislation. Between 2016 and 2018, Parties strengthened their measures in all studied provisions under Article 19 (Fig. 20).

Several Parties (Czech Republic, Ecuador, Grenada, Poland and Turkey) indicated progress in the development or amendment of legislation. The Brazilian Government continued to gather information about liability actions, in the field of legal doctrine and jurisprudence, based on national and international law.

As implementation of Article 19 still poses challenges to the Parties, the Convention Secretariat has launched the *Article 19 Civil Liability Toolkit* to assist Parties in this area.

Fig. 20

Percentage of Parties with provisions for liability (n=180 in 2016; n=181 in 2018)



8th International Legal Training Course on law and noncommunicable disease prevention: The McCabe Centre for Law and Cancer recently completed its 8th International Legal Training Course on law and noncommunicable disease prevention. 14 participants from 12 WHO FCTC parties – Botswana, Laos, Marshall Islands, Mongolia, Myanmar, Nepal, Philippines, Solomon Islands, Sri Lanka, Uganda, Vietnam, and Zambia – attended the course, held at Cancer Council Victoria in Melbourne, Australia from 30 April to 18 May 2018. (Photo courtesy of WHO FCTC Secretariat's Knowledge Hub on legal challenges, Australia)

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL
SECRETARIAT

The WHO FCTC Article 19 Civil Liability Toolkit

Under Article 19 of the WHO FCTC, Parties agree to consider taking legislative action or promoting their existing laws to deal with criminal and civil liability. They should also provide each other with assistance in legal proceedings relating to liability, as appropriate and mutually agreed. Implementation of Article 19 provides an opportunity for the Parties to collaborate in their efforts to hold the tobacco industry liable for its misconduct. The importance of liability as part of comprehensive tobacco control is also recognized in WHO FCTC Article 4.5.

In accordance to COP7 Decision FCTC/COP7(11), the Convention Secretariat supported the development of an interactive and innovative web-based *Article 19 Civil Liability Toolkit* that aims to strengthen global civil liability systems where there is a perceived power imbalance between claimants and corporate defendants.

The Toolkit is intended to provide governments with advice about best practices and innovative reforms that would facilitate health-care cost recovery, public-interest litigation and greater access to justice for individual victims, including through collective redress.

It presents governments with the opportunity to avail themselves of effective means to hold the tobacco industry legally accountable for its conduct.

The Toolkit, launched at the World Conference on Tobacco or Health in Cape Town, South Africa, in March 2017, is available on the WHO FCTC information platform at http://untobaccocontrol.org/impldb/tobacco-control-toolkit/.

KEY OBSERVATIONS

Research, surveillance and exchange of information [Article 20]

- ***Parties strengthened their national surveillance systems for key indicators of the tobacco epidemic.***
- ***Around one half of all Parties had relatively recent data, from the last five years, for both adult and youth smoking. However, only one third of all Parties had similar recent data on smokeless tobacco use.***
- ***Availability of data on the economic burden of tobacco use and share of the illicit trade remained poor, despite improvement as compared to 2016.***

National systems for epidemiological surveillance. In 2018, a majority of Parties (71%) established a national system for surveillance of patterns of tobacco consumption (Fig. 21). In addition, 57% of Parties had surveillance system for exposure of tobacco smoke; 51% for determinants of tobacco consumption; 50% on social, economic and health indicators; and 44% for consequences of tobacco consumption. The percentages for all the mentioned increased as compared to 2016.

Research topics. The Parties most commonly developed and/or promoted research that addressed the determinants of tobacco use (67%), consequences of tobacco use (66%), and social and economic indicators related to tobacco consumption (63%). Only half of the reporting Parties developed or promoted research on tobacco use among women, particularly pregnant women, and treatment of tobacco dependence. Addressing alternative livelihoods in research remained still very rare (Fig. 22). In 2018, the Parties covered different topics in their research activities more broadly as compared to 2016.

Fig. 21

Percentage of Parties that have established national surveillance systems for different topics (n=180 in 2016; n=181 in 2018)

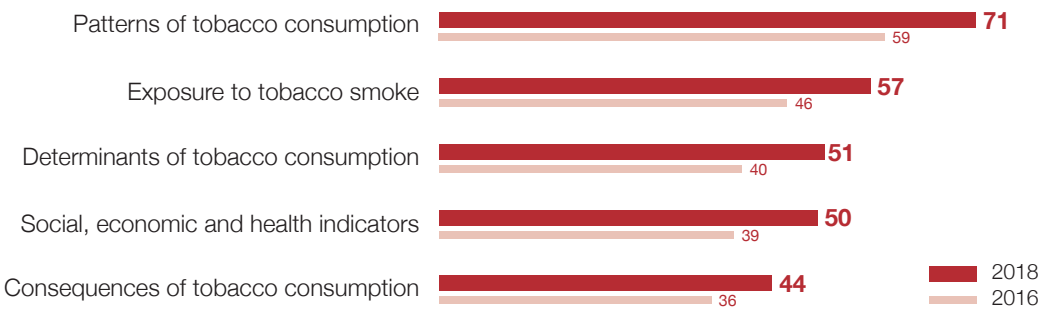
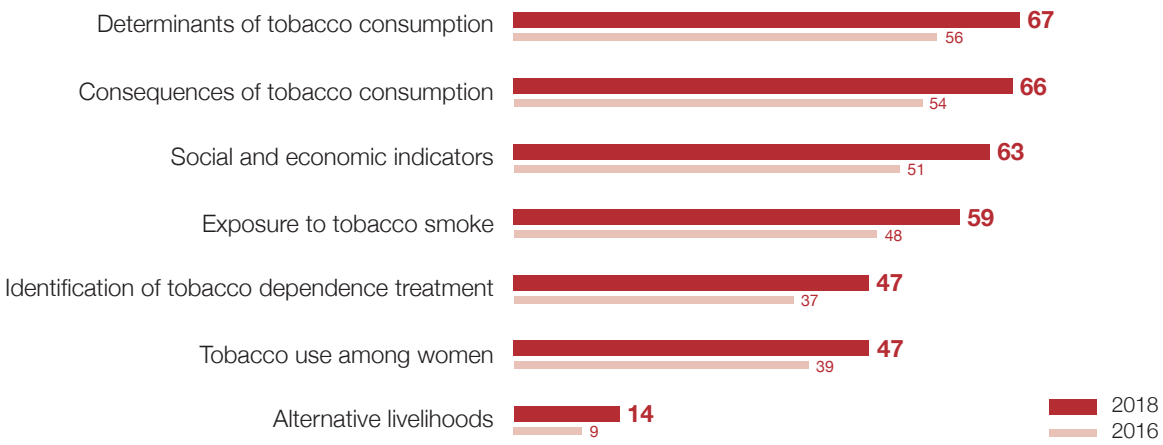


Fig. 22

Percentage of Parties developing and/or promoting research on different topics (n=180 in 2016; n=181 in 2018)



Several Parties reported progress in conducting new tobacco surveys and research activities. Trinidad and Tobago introduced a new framework for a surveillance system for tobacco and other related products. Myanmar conducted a trend analysis workshop, which compared the findings from *Global Youth Tobacco Survey* (GYTS) 2001, 2007, 2011 and 2016. Chile carried out a study on the living, working and financial conditions of the farmers whose main source of income derives from the cultivation of tobacco. Bahrain reported that research on the economic impact of tobacco use in the states of the Cooperation Council for the Arab States of the Gulf would be conducted in 2018. The United Kingdom of Great Britain and Northern Ireland mentioned that the *Tobacco Control Plan* for England committed Public Health England to update its evidence report on e-cigarettes and other novel nicotine delivery systems annually until 2022.

Availability of data on tobacco use. Of all Parties, 89% (161) had data available in the reporting platform on the prevalence of tobacco smoking among adults. Of these Parties, only 44 had available new data on adult smoking collected in the 2016–2018 reporting cycle. In this group, 33 Parties indicated that the new data was fully comparable to an earlier dataset, and seven Parties had partially comparable data due to some changes, for example the survey age group.

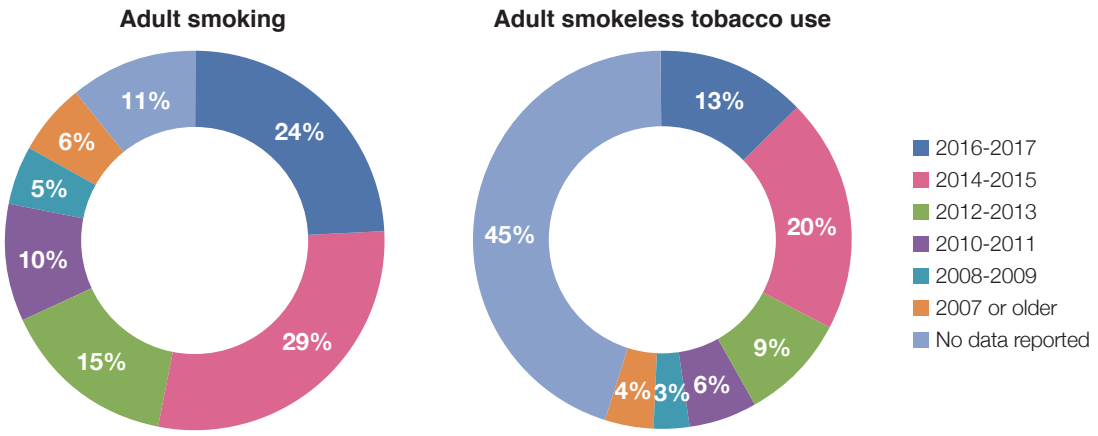
In addition, 55% (100) of all Parties had data available in the reporting platform on the use of smokeless tobacco among adults. Nearly a quarter of those had new data on this topic from the reporting period, with 16 indicating that the new data was comparable to an earlier dataset, and five had partially comparable data.

In terms of the data collected on adult smoking as well as smokeless tobacco use among the adult population, there was a large variation in the survey methods utilized by the Parties, with emphasis on national monitoring systems rather than cross-national surveys with standardized methodology, such as the WHO STEPwise Approach to Surveillance (STEPS) or the *Global Adult Tobacco Survey* (GATS).

With regard to how current the data were that the Parties were using to monitor tobacco use prevalence, around half (53%) of all Parties have adult smoking data collected in last five years, mostly from 2014–2017, whereas one third (33%) had data for adult smokeless tobacco use collected in the last five years. Only 11% of all Parties do not have any data on adult smoking, the respective proportion being 45% for smokeless tobacco (Fig. 23).

Fig. 23

Availability of prevalence data on adult smoking and smokeless tobacco use, among all Parties in 2018 (n=181)



Overall 95% (172) of all Parties have data available on prevalence of tobacco smoking among youth in the reporting platform. Twenty-three per cent (42) of the Parties provided new data on youth tobacco smoking from the 2016–2018 reporting period, and 38 of these were identified as having this data fully comparable to an earlier dataset, and additional two partially comparable.

In addition, 58% (105) had data available in the reporting platform of the use of smokeless tobacco among youth. In this group, 19 Parties had new data from this reporting period, but only 10 had the new data fully comparable to an earlier dataset, and one partially. Most of the youth data were collected with standardized methodology enabling some cross-national comparisons, mostly as part of the GYTS. Health Behaviour in School-aged Children (HBSC) study or the European School Survey Project on Alcohol and Other Drugs (ESPAD) were also utilized by several Parties.

Again when considering how current the data are that the Parties have for monitoring youth tobacco use, over half (55%) of all Parties have recent smoking data, from 2014–2017, whereas the respective proportion for youth smokeless tobacco use is less than third (28%). Only 5% of all Parties have not provided any data on youth smoking, but the respective proportion is 42% for smokeless tobacco (Fig. 24).

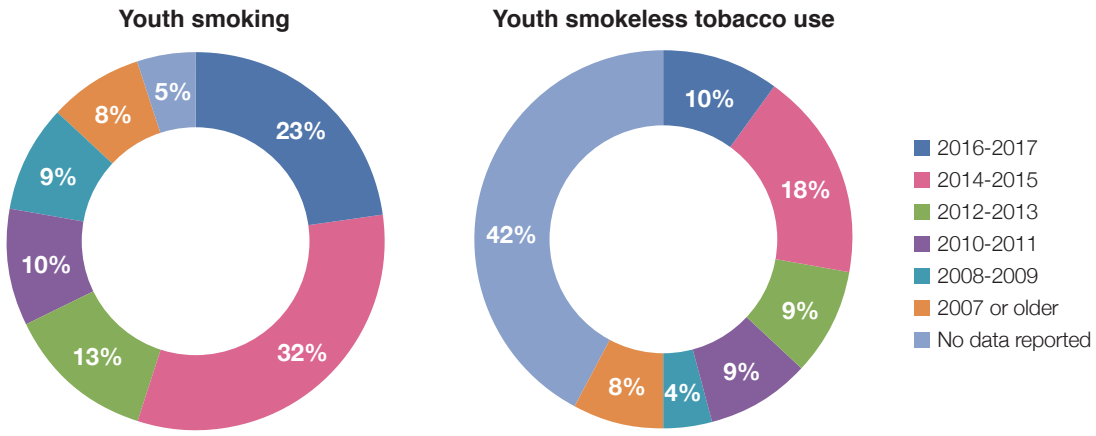
In addition, only 20% (37) of all Parties indicated that they had data of tobacco use in ethnic groups. As the preambule of WHO FCTC already acknowledges Parties' deep concerns about tobacco use among indigenous peoples, Parties are encouraged to focus more attention on collecting tobacco use data for ethnic groups including indigenous populations in order to be able to develop tailored programmes.

Availability of data on exposure to tobacco smoke. A majority, 83% (151) of all Parties now have data on exposure to tobacco smoke in their populations. The proportion increased from 2016, when it was 71%. The reported data originated typically from surveys implemented in 2014, but the range covered data collection from 2003 to 2018. Forty-five Parties reported exposure data that had been collected in the past three years.

Availability of data on tobacco-related mortality and economic burden. Almost one half of all Parties (45%) have information on tobacco-related mortality in their jurisdictions. The percentage increased from the 39% in 2016. Available data ranged from year 2000 to 2018, but it was typically collected in 2014. Only 29 Parties had mortality data collected after 2015. Seventy-

Fig. 24

Latest available prevalence data available on youth smoking and smokeless tobacco use, among all Parties in 2018 (n=181)



three Parties provided information on the number annual of deaths attributable to tobacco use in the population. The median figure was 11 400, but reported figures show broad variations depending on the size of the country. The highest figures were reported by Parties with large populations such as China, with 1.59 million tobacco-related deaths, India, with 900 000 deaths, the European Union (total of tobacco-related mortality cases in its 28 Member States) with 706 000 deaths, and the Russian Federation, reporting 310 000 tobacco-related deaths.

For the economic burden of tobacco, one third of Parties (34%) indicated that they had information available on this topic, as compared to 28% in 2016. A total of 60 Parties provided further details of the data they have. A number of Parties had data from both direct and indirect costs. The data was typically collected in 2013, but the data collection years ranged from 2003 to 2017. Despite the recent trend of conducting new studies in this area, most data that Parties referred to was relatively old, as only 13 Parties had data collected after 2015.

Share of illicit tobacco products on the national tobacco market. Only 18% (23) of the reporting Parties responded having information on the percentage of illicit tobacco products on the national tobacco market, with minor improvement since 2016 (13%). Only 29 Parties provided data related to the national market share of illicit tobacco products. In most cases, the data was provided by customs authorities and other government ministries or agencies.

Exchange of information and training and support for research. A total of 62% (113) of all Parties had regional and global exchange of publicly available national scientific, technical, socioeconomic, commercial and legal information. Information exchange was less common regarding the practices of the tobacco industry, as reported by 39% of the Parties. Exchange of information relating to the cultivation of tobacco was reported by 23% of the Parties. Almost two thirds (61%) provided training for those engaged in tobacco control activities, such as research, implementation and evaluation.

Database on laws and regulations. Sixty-six per cent (120) of all Parties maintained a database of national laws and regulations on tobacco control. Half (50%) reported that the database contained information on the enforcement of those laws and regulations. One quarter (25%) had established a database of pertinent jurisprudence.

KEY OBSERVATIONS

Reporting and exchange of information [Article 21]

- ***All Parties have reported at least once, and the Parties that have submitted all their required reports over the years, have already submitted a total of six datasets (reports).***
- ***At the time this report was prepared for the 2018 reporting cycle, 142 Parties (78%) "formally" submitted their latest reports on the reporting platform.[17] Most of the remaining Parties updated some information without formally submitting their report, but their data were used in the preparation of this analysis.***

The reporting platform, the content of the reporting instrument and the process of reporting has not changed since the 2016 reporting cycle. However, for the first time, Parties were not required to prepare their report from scratch: they were provided with the text of their latest implementation report. This enabled the reporting Parties to review data and information in the report, and only change, adjust or update those items that are no longer valid. This allowed them to report on the new developments that have occurred since the submission of their previous implementation report. As usual, submitted reports are made available in the public domain in the WHO FCTC Implementation Database,[18] where reports can be viewed and searched by the indicators that reflect the provisions of the Convention.

In 2017, the Convention Secretariat commissioned, completed and disseminated among the Parties, a report summarizing best practices in preparing and submitting WHO FCTC implementation reports.[19] The report demonstrated that the Parties are able to turn the reporting process to their advantage and also benefit from the many outcomes of the reporting process. These outcomes can all eventually promote national implementation of the Convention (Fig. 25).

Using this report and its observations, the Convention Secretariat convened a meeting for those Parties that have never submitted an implementation report. Angola, its Health Ministry and the WHO country office, kindly hosted that meeting in June 2017. The meeting provided hands-on assistance to Parties that have faced difficulties in reporting, and allowed them to access and work on their reports during the meeting. As a result of the work carried out at the meeting or shortly afterwards, all participating Parties have submitted their WHO FCTC implementation reports – this also means that all Parties to the Convention have now submitted at least one implementation report.

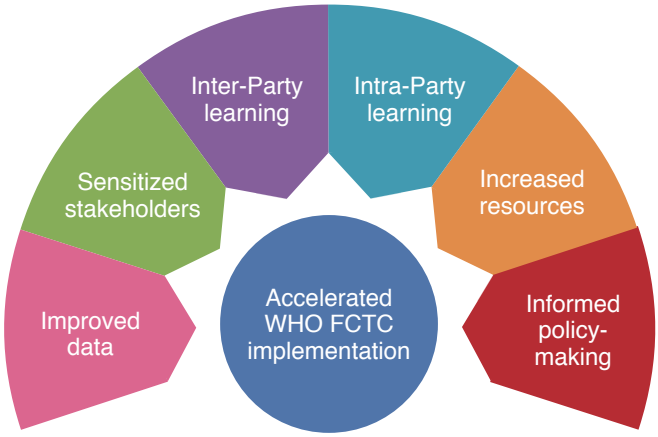
[17] The 2018 reporting period ended on 31 March 2018; but upon request from the Parties the data extraction date was extended. For the analysis presented in this report, data including all submissions and updates in the reporting system by 17 April 2018 was utilized. A regularly updated table presenting the status of reporting by the Parties, including the number of core reports and additional questions, and their submission dates, is available on the WHO FCTC website.

[18] http://untobaccocontrol.org/impldb/

[19] http://www.who.int/fctc/reporting/reporting-good-practices-who-fctc.pdf

Fig. 25

Outcomes of WHO FCTC reporting



Source: Good practices in Data collection, Preparation and Submission of FCTC Implementation Reports. WHO FCTC Secretariat. Geneva, 2017

The Secretariat also analyses the feedback from the Parties on the use of and further development of the reporting instrument. In most cases, Parties feedback was positive: they found it simple to complete and submit, found the questions to be direct and easy to understand, and appreciated the thoroughness of the survey.

Parties also provided suggestions on further improvements of the reporting instrument. Some Parties enquired whether they could expand more on yes-or-no questions. Some Parties were concerned of the connectivity issues they had; those that have very limited access to the

Internet, or have no Internet access, found it difficult to fill out the questionnaire online. The Parties also proposed that the questionnaire be made available in a Word document format, and some Parties would prefer the questionnaire to be shortened.

The Convention Secretariat has already addressed some of these concerns as they emerged during the reporting cycle. For example, Parties could expand on their achievements by using the space available to respond to open-ended questions related to the progress made in specific areas. For countries in which a regular Internet connection was a challenge, the Secretariat advised to explore whether the WHO country office could provide access to a working Internet connection. The Convention Secretariat also provided, upon request by the Parties, the Word version of the reporting instrument. It is to be noted that a PDF version of the questionnaire is permanently available on the website of the Convention Secretariat.[20] Upon request by some Parties, the Secretariat has begun collecting and publishing on its website versions of the reporting instrument in languages other than the six official United Nations languages – Arabic, Chinese, English, French, Russian and Spanish). It should be noted, however, that such documents are published for information only: they cannot be used for report completion as the implementation reports should be submitted in one of the official United Nations languages.

The evolution of the reporting instrument is ongoing: Parties may take decisions at the COP that might have an impact on the questions included in the reporting instrument. The possible adoption of the Medium-term Strategic Framework and the entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products will certainly result in some adjustments in the reporting instrument.

[20] http://www.who.int/fctc/reporting/reporting_instrument/

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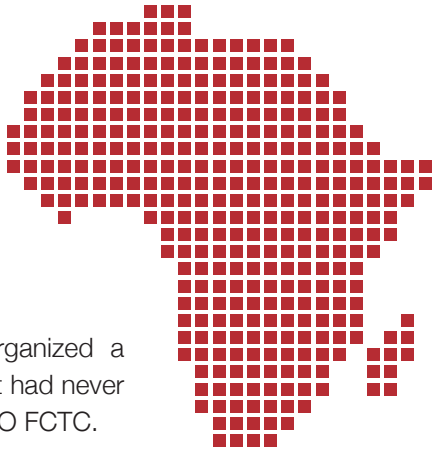


Workshop in Angola to ensure 100% reporting rate

On 20 June 2017, the Convention Secretariat organized a meeting with six Parties within the African Region that had never reported on their domestic implementation of the WHO FCTC.

The meeting engaged country officials responsible for WHO FCTC reporting and worked with them in entering data into the current reporting template to facilitate their successful completion and submission of their official reports.

Parties recognized that their reporting data were not just within the purview of the Ministry of Health, but rather required a whole-of-government approach. It became evident that the reporting process provided a useful tool for Parties to "tell their story" on the domestic implementation of the Convention and served as a useful resource to share within their leadership circles.

The exercise also provided insight to the Convention Secretariat on the complexities and challenges that exist for Parties with restricted or limited Internet access and the challenges in applying the reporting instrument in Parties with emerging national programmes. The experience in working with Parties helped shape the direction and development of an e-learning tool that will provide ongoing support for Parties.

The outcome of the session was positive – three of the six Parties submitted their reports during the meeting with the remaining three submitting shortly thereafter. All Parties to the WHO FCTC have now officially submitted their reports on the implementation of the Convention within their respective jurisdictions.

(Photo courtesy of Dr Tibor Szilagyi's personal collection)

OTHER PROVISIONS

KEY OBSERVATIONS

International cooperation [Article 22]

- ***Parties reported receiving assistance to establish or strengthen capacity in national tobacco control programmes.***
- ***Parties increasingly collaborated with each other, received assistance from other Parties and disseminated their experiences with neighbouring Parties.***

Areas of assistance. About one third of all Parties provided assistance to other Parties on expertise for tobacco control programmes, transfer of skills and technology, training and awareness of personnel (Fig. 26).

Over one half of the Parties have reported receiving assistance, especially in relation to the transfer of skills and technology (65%) and expertise for tobacco control programmes (64%). Providing and receiving assistance were more common in 2018 than in 2016.

Brazil and the Philippines have formed collaborative relationships with other Parties in providing and exchanging assistance. Brazil supported the Philippines in areas of alternative livelihoods and good governance, while the Philippines provided technical assistance to Malaysia, Mongolia, Maldives and Nepal on tobacco taxation. Both projects have been implemented in the frame of South–South and triangular cooperation, facilitated by the Convention Secretariat.

Noticeable trends in assistance were observed in the areas of litigation, taxation, legislation and programme development, technical support in developing policies relating to the Protocol, the implementation of Article 5.3, and workshops on strengthening the implementation of the WHO FCTC.

Implementation assistance through membership in regional and international organizations. Overall 22% (39) of all Parties encouraged the provision of financial assistance for low- and middle-income countries and for Parties with economies in transition to assist them in meeting their obligations under the Convention.

The Government of the United Kingdom of Great Britain and Northern Ireland invested £15 million to support 15 Parties in strengthening their implementation of the WHO FCTC provisions within the frame of the FCTC 2030 project under their development assistance contribution, setting an important example in the implementation of the SDG 2030 agenda.

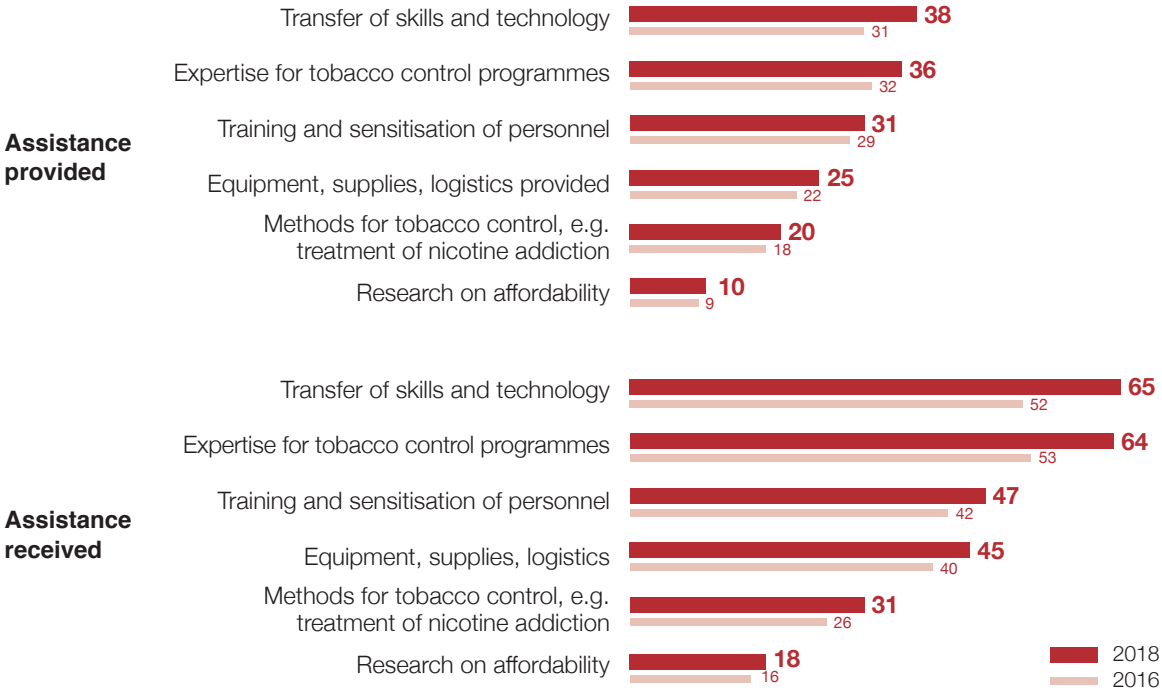
Australia and Norway also supported the Convention Secretariat by carrying out impact assessment missions and a number of additional activities as mandated by the Conference of the Parties. Canada provided a grant to the Convention Secretariat to support the work related to the development of the Medium-term Strategic Framework and a staff member to support the Secretariat's work in areas related to reporting and knowledge management. Netherlands has provided a secondment to the Convention Secretariat increasing the capacity of a small staff to react to requests from Parties to the treaty. It is important to

notice that Parties with earmarked taxes are also able to commit and support international tobacco control. One sound example is the invaluable contributions from Panama, that not only provided extrabudgetary funds to the Convention Secretariat to implement several activities, but also hosted a number of regional meetings to strengthen the implementation of the treaty.

All WHO FCTC Secretarit's knowledge hubs are now operational and backed by their respective government to support the implementation of the WHO FCTC in their respective areas of work and have now started conducting capacity-building activities and technical assistance in their respective work areas.

Fig. 26

Percentage of Parties reporting on provided or received assistance, by areas of assistance (n=180 in 2016; n=181 in 2018)



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FCTC 2030 Project

Consistent with decisions by the COP to the WHO FCTC, the Convention Secretariat initiated a new project to assist the Parties to strengthen implementation of the Convention.

The project, which will run until March 2021, enables the Convention Secretariat to provide intensive support to 15 Parties and therefore accelerate implementation of the treaty at the country level.

The direct support is focused on the achievement of the general obligations and the time-bound measures of the Convention, strengthening tobacco taxation, implementing other articles of the WHO FCTC according to national priorities and promoting the implementation of the Convention as part of the 2030 Agenda for Sustainable Development.

The following 15 Parties to the WHO FCTC were selected through an open and transparent process to receive direct support under the FCTC 2030 project: Cabo Verde, Cambodia, Chad, Colombia, Egypt, El Salvador, Georgia, Jordan, Madagascar, Myanmar, Nepal, Samoa, Sierra Leone, Sri Lanka and Zambia.

Through the FCTC 2030 project, in addition to the direct support for the 15 selected Parties, the Convention Secretariat is providing general support and materials for all low- and middle-income countries to promote implementation of the treaty. This support includes workshops, toolkits, South–South and triangular cooperation, as well as other forms of assistance to national governments.

Launch of the FCTC 2030 Project in Cambodia. (Photo courtesy of FCTC 2030 Project)

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SECRETARIAT · KNOWLEDGE HUB

WHO FCTC Secretariat's knowledge hubs established to assist Parties to the Convention

WHO FCTC Article 22 requires the Parties to cooperate directly or through competent international bodies to strengthen their capacity to fulfil the obligations arising from the Convention by promoting the transfer of technical, scientific and legal expertise and technology in order to establish and strengthen national tobacco control strategies, plans and programmes. As part of its overall knowledge management activities and as a response to various decisions of the COP, the Convention Secretariat has established seven knowledge hubs that have the responsibility to analyse, synthesize, and disseminate information and scientific evidence on specific areas of the Convention.

Working with a global scope, the knowledge hubs aim to provide all Parties with tailored assistance related to their technical expertise, which include: legal challenges; surveillance; smokeless tobacco; water pipes; taxation; international cooperation; and Article 5.3 of the Convention.

Parties wishing to learn more about any of the knowledge hubs or interested in receiving specific assistance can do so by visiting the website of each knowledge hub at http://untobaccocontrol.org/kh/.

Third meeting of the WHO FCTC Knowledge Hubs, University of Cape Town, South Africa, 10 March 2018. Representatives of the WHO FCTC Knowledge Hubs met in March 2018, on the sidelines of the WCTOH, to discuss matters related to implementation of Articles 5.3 (tobacco industry interference) and Article 20 (research, surveillance and exchange of information) of the Convention. Participants reviewed on how these articles cut across the work of the different hubs and how to facilitate implementation of these articles by the FCTC Parties. The meeting was kindly hosted by the WHO FCTC Secretariat's Knowledge Hub on Taxation, at the School of Economics at the University of Cape Town. (Photo courtesy of the WHO FCTC Secretariat's Knowledge Hub on taxation, South Africa)

4. NEW AND EMERGING TOBACCO PRODUCTS

KEY OBSERVATIONS

Smokeless tobacco, water pipe tobacco and ENDS/ENNDS

- ***The majority of the Parties had either smokeless tobacco, water pipe tobacco or electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS) available in their national markets.***
- ***Enacting and enforcing protective policies and regulations to these products increased significantly as compared to 2016, but nearly half of the Parties have adopted these policies and regulations following decisions of the COP.***

Smokeless tobacco and water pipes were traditionally used in several Parties to the Convention, but recently there has been an expansion of the availability of such products in many parts of the world. Additionally, the use of ENDS, such as e-cigarettes, and other novel tobacco products has become increasingly popular in many countries, as multinational tobacco companies and other manufacturers enter this new market.

With the aim to strengthen data collection regarding these products, questions on new and emerging tobacco products were included in the 2016 reporting cycle; they are now referred to in both the core questionnaire and the additional questions (optional module) of the reporting instrument.[21] The questions were repeated in the 2018 reporting cycle.

As seen in Fig. 27, over one half of all Parties declared having new and emerging products available in their markets. The most common was water-pipe tobacco (69%), followed by smokeless tobacco (65%).

ENDS sales worldwide are increasing. ENDS reached US$ 8.61 billion in 2016 and is expected to garner US$ 26.84 billion by 2023.[22]

The rapid growth of the e-cigarette industry is visible also in Parties reports, as 56% had ENDS/ENNDS in their national markets. In general, around half of all Parties had policies or regulations for these products in place. This was less common for ENDS/ENNDS.

Shisha bar in Crete, Greece. (Photo courtesy of Dr Vera Luiza da Costa e Silva's personal collection)

[21] These changes undertaken upon the mandate received from the COP which, at its sixth session, requested the Convention Secretariat to include such reference to these products. In case of ENDS/ENNDS: http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6(9)-en.pdf; in case of water-pipe tobacco products: http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6(10)-en.pdf (smokeless tobacco products were referred to already in the reporting instrument, the new focus is on specific policies targeted at such products).

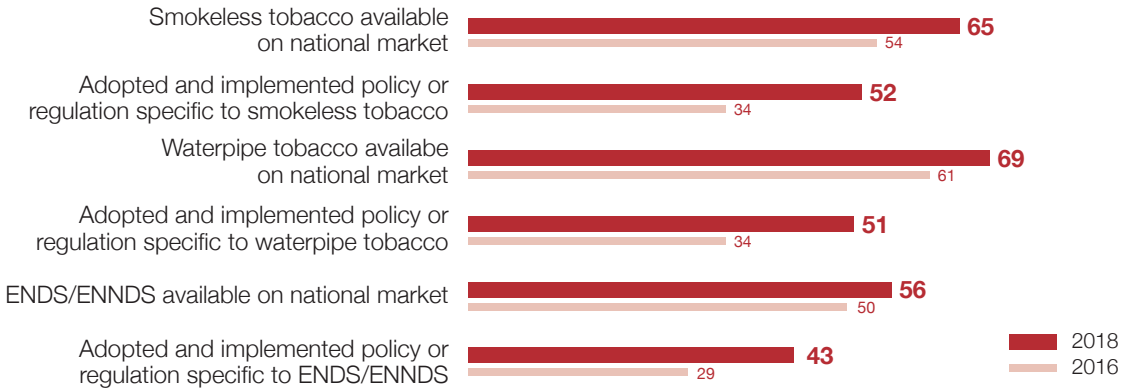
[22] http://www.who.int/fctc/cop/sessions/cop8/FCTC_COP_8_10-EN.pdf

Advertisement for e-cigarette shop in Dublin, Ireland. (Photo courtesy of Dr Vera Luiza da Costa e Silva's personal collection)

Examples of smokeless tobacco products. (Photo courtesy of the WHO FCTC Secretariat)

Fig. 27

Percentage of Parties reporting new and emerging tobacco products in national markets, and implementation of product-specific policies and regulations (n=180 in 2016; n=181 in 2018)



5. PREVALENCE OF TOBACCO USE

KEY OBSERVATIONS

Global trends of tobacco use

- ***Over half of the Parties, which reported in 2018 and held recent and comparable data, are experiencing decrease in youth smoking. An increase was nevertheless reported by 13% of the Parties, while for 24% the situation remained stable. In adult smoking, almost half were not observing significant changes in their most recent data, while 39% experienced a decreasing trend.***
- ***Trends to 2017 and projections to year 2025 show that most Parties need to accelerate tobacco control activities in order to achieve the voluntary global NCD target to reduce tobacco use by 30% between 2010 and 2025. Of note, 36 Parties are not projected to reduce smoking rates if effective policies are not urgently put in place.***
- ***To enable more accurate trend analyses, as well as estimates and projections, the Parties to the Convention need to strengthen their surveillance and monitoring systems, and more generally, scale up their implementation of Article 20 of the Convention and exchange collected data.***

Recent developments in tobacco use as reported by the Parties. Among the Parties that had provided comparable prevalence data in the 2018 reporting cycle, a small majority (58%) experienced a decrease in their youth smoking prevalence. An increase was, nevertheless, reported by 13% of the Parties, while for 24% the situation remained stable. For 5% the trend information could not be validated.

Adult smoking prevalence decreased during the reporting cycle for a third (39%) of the Parties with recent comparable data, and nearly half (45%) did not observe significant changes in the prevalence, hence being in a stable situation. However, one in 10 (9%) saw an increase, and for 6% the trend could not be validated.

For the use of smokeless tobacco, few conclusions can be drawn due to the limited availability of recent comparable data among Parties.

Comparable estimates for prevalence of smoking and smokeless tobacco use. Global and regional trends in tobacco smoking were calculated by the WHO Department of Prevention of Noncommunicable Diseases using data reported in 2018 and earlier COP reports, together with other national surveys available in the public domain. The statistical model[23] used to calculate these estimates overcomes issues of comparability due to different age ranges, years and tobacco indicators covered by surveys.

WHO-modelled estimates made it possible to compare smoking rates in 2017 with rates in 2005, even though many Parties have not conducted national surveys in those particular years.

Among all Parties globally in 2005, an estimated 24% of people aged 15 or older were current smokers (39% of males and 8% of females). By 2017, smoking prevalence dropped to 19% (33% of males and 5% of females). Smoked tobacco includes cigarettes and/or any other smoked

tobacco product (for example, pipes, cigars, cigarillos, bidis, kreteks and water-pipe tobacco), according to the varieties surveyed by each Party. Current smoking means smoking either daily or occasionally at the time of the survey.

All World Bank income groups of Parties are trending downwards with average current smoking rates (Fig. 28). In 2005, high-income Parties had collectively the highest average smoking rate at 29%, but by virtue of steeply declining rates in many high-income countries, by 2017, the upper middle-income countries are now estimated to have the highest average rate at 24%. Low income Parties have on average the lowest smoking rates, but among these Parties there is a mix of levels and trends, and over a third are without sufficient national surveys to monitor the trend.

While data regarding smokeless tobacco use is increasing over time, there are still many Parties not asking about smokeless tobacco use in national surveys. Consequently, there are insufficient data to measure changes over time at the global level. Using the most recent data about current smokeless tobacco use reported in surveys completed by Parties since 2007, the average prevalence among Parties globally was 6.2% (8.1% of males and 4.4% of females). In total, 98 Parties have collected data on smokeless tobacco use since 2007, therefore these averages are only indicative.

Regarding tobacco use among young people, the majority of Parties are beginning to consistently monitor youth aged 13–15 years over time. It should soon be possible to calculate trend estimates of tobacco use among youth globally. Using the most recent data about current cigarette smoking reported in surveys completed by Parties in 2007–2017, the average prevalence among 163 Parties with surveys was 8.9% for boys and 4.0% for girls. On average, boys smoked at a rate more than double that of girls, however, in 20 Parties, girls smoked at a higher rate than boys. The same surveys reveal that around 4.3% of boys and 2.4% of girls in Parties consume smokeless tobacco.

Towards meeting tobacco use reduction targets

The WHO *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (resolution WHA66.10) includes a voluntary target to reduce the prevalence of tobacco use among persons aged 15 and older by 30% in relative terms between 2010 and 2025. Meeting this target will contribute greatly to the overarching target of a 25% reduction in premature mortality from NCDs. Looking beyond 2025, the SDG agenda also includes specific actions to reduce deaths from NCDs, one of which is to strengthen the implementation of the WHO FCTC in all countries, as appropriate.

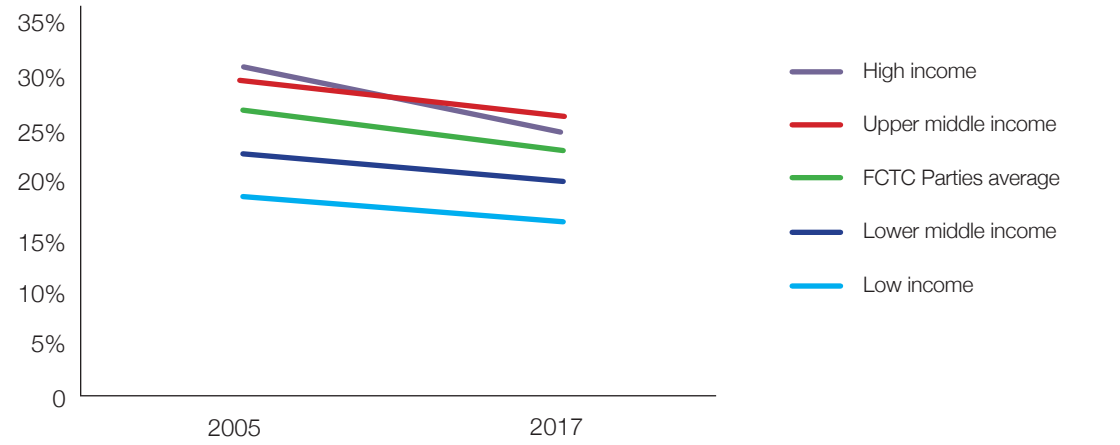
WHO estimates show that 23 Parties, or 13% of Parties, are likely to achieve the target by 2025 (Fig. 29). An additional 76 Parties, or 42% of Parties, are decreasing and need only accelerate the decreases they are already achieving. Of note, 36 Parties are expected to experience no decrease in smoking prevalence unless effective policies are urgently put into place. Trends are unknown in 45 Parties where no survey or only one nationally representative survey since 1990 has been reported. Most Parties need to accelerate tobacco control activities in order to achieve the NCD target.

These trend estimates reflect the effects of tobacco control actions already implemented by the Parties prior to conducting their most recent survey. Where no survey has been conducted since a policy was implemented, the effects of the new policy will not be seen until the next survey has been conducted. These projections, therefore, reflect only what has been captured in surveys to date and will be subject to recalculation as new policies are implemented and new surveys are released.

[23] WHO uses the data from surveys reported by Parties in their 2018 implementation reports to augment the WHO tobacco use prevalence data set, in order to calculate comparable trend estimates of smoking. The method for the estimation is described in the article "Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control"; Bilano, Ver et al.; The Lancet , Volume 385 , Issue 9972 , 966 – 976; http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60264-1/abstract

Fig. 28

Estimated trend in current smoking prevalence, ages 15+, by World Bank income groups

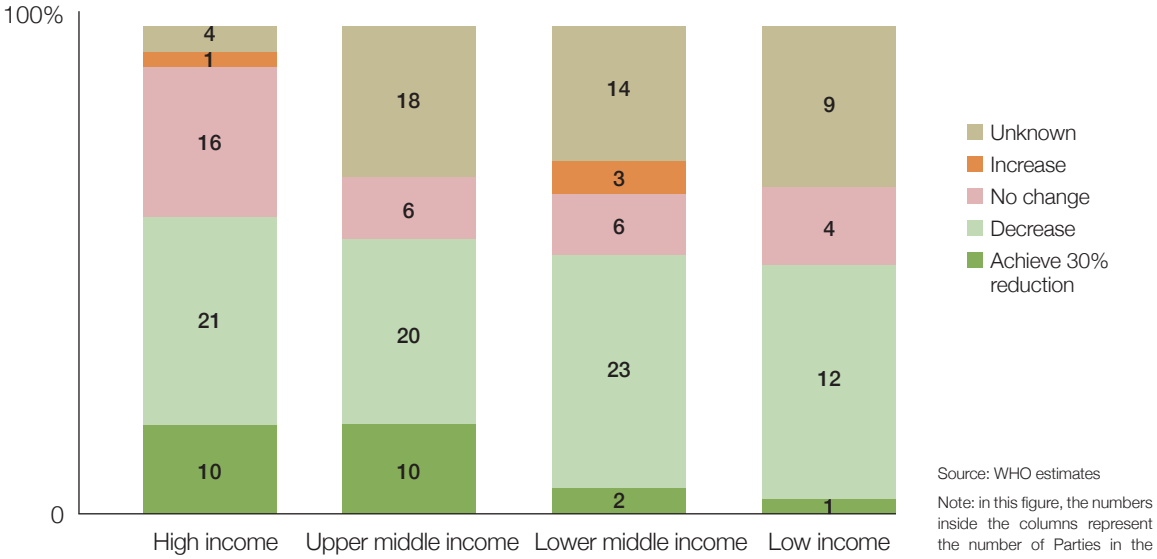


Source: WHO estimates

Fig. 29

Projections for WHO FCTC Parties on achieving the 30% relative reduction target in 2025, by World Bank income group

Number and proportion of FCTC Parties who might meet 30% relative reduction in tobacco smoking between 2010 and 2025



Source: WHO estimates

Note: in this figure, the numbers inside the columns represent the number of Parties in the respective category.

6. PRIORITIES, NEEDS, GAPS AND CHALLENGES

Priorities. Most reporting Parties gave details on their priorities, with obligations under Article 5 of the Convention (General obligations) being the most frequently mentioned. These priorities include developing legislation, regulations, national strategies and action plans, as well as establishing or strengthening the national tobacco control infrastructure (coordinating mechanism, capacity, etc.)

Programmes to support tobacco cessation (Article 14) and education, communication and public awareness (Article 12) were also highlighted. More than one fifth of the Parties considered enforcement of various WHO FCTC measures as an imperative, and 23 Parties indicated that they addressed ratifying/acceding the Protocol as a prime concern. A new issue was raised, with a dozen Parties now considering novel and emerging tobacco products as a serious issue that needs to be tackled, and 11 Parties also see adopting plain packaging as a prime concern.

Needs and gaps. Of all the Parties, 60% (108) identified specific gaps in the implementation, and 101 also commented on needs and gaps. Of those, almost two thirds – even several high-income countries – indicated that the financial resources available for national tobacco control do not match their needs. Around one third reported the same for human resources, or a combination of the two shortcomings. Some Parties indicated specific needs for technical assistance, including tobacco taxation, drafting of legislation, conducting various research projects and scaling up of their cessation programmes. Some Parties also noted issues such as a lack of political will, insufficient intersectoral cooperation and mobilization of non-health sectors for tobacco control.

Constraints and barriers. More than 40 challenges encountered by Parties were enumerated. Similar to the previous reporting cycles, Parties of all income levels noted that interference by the tobacco industry and its allies was the most common challenge to overcome. Some Parties specifically mentioned that the target of the tobacco industry interference is the non-health sectors. The second most frequently mentioned challenge was the lack of capacity and the need for appropriately skilled/trained personnel.

Other constraints mentioned by more than 10 Parties each include: lack or insufficient coordination among sectors; lack of effective law enforcement; absence, weakness or delay in passing/implementing national legislation/regulation; insufficient or unsustainable financial resources or competing priorities in resource allocation; and a lack of awareness of the WHO FCTC or the harmful effects of tobacco. Political instability and lack of political commitment, as well as insufficient support or involvement from the civil society, were also mentioned by several Parties.

An increasing number of Parties indicated that the arrival of new and emerging tobacco products on their respective market was a growing challenge for both regulators and enforcers of tobacco regulations. Around two thirds of Parties have smokeless tobacco products, water pipes, and/or ENDS/ENNDS available in their national markets. Around half of the Parties adopted and implemented some kind of policies or regulations specific to those products.

7. CONCLUSIONS

1. Overall, implementation of the Convention has improved since the issuance of the *2016 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* for the majority of the Articles and indicators. Smoke-free environments; tobacco packaging and labelling; and education, communications and public awareness programmes are the leading three areas best implemented. This notable progress makes us cautiously optimistic and hopeful in terms of future strengthening of implementation of the Convention globally, with a view to close implementation gaps through initiatives guided by the COP and also referred to in the draft Medium-Term Strategic Framework that will be presented to the Eighth session of the Conference of the Parties (COP8).

2. Strengthened implementation has already started showing its impact, with a number of Parties observing a decrease in tobacco use among both adults and young people. However, we need to be cautious when interpreting such decrease, as in parallel there seems to be an increasing body of evidence showing an increasing trend in the use of ENDS/ENNDS and other novel nicotine products. Future monitoring of the tobacco epidemic, including WHO FCTC reporting, should be quickly enabled to allow for the measuring of this trend.

3. A large number of Parties still have no policies in place to protect public health policies from the commercial and other vested interests of the tobacco industry in line with Article 5.3 of the Convention, thus there should be a clear focus on this area in the future. Efforts to monitor the activities of tobacco companies should be strengthened in each Party and new programmes to raise awareness on the efforts of the tobacco industry to interfere with policy-making should be intensified. Parties should benefit from the establishment of the WHO FCTC Secretariat's Knowledge Hub for Article 5.3 and should seek assistance from the hub to promote their programmes, including the establishment of Obesrvatories of the Strategies of the Tobacco Industry, if necessary.

4. Many Parties reported a range of strong initiatives to reduce the demand of tobacco products through implementation of the time-bound provisions of the Convention. A domino effect has been observed among Parties introducing increasingly larger pictorial warnings and plain packaging. A growing number of Parties amended their smoke-free legislation to extend their smoking bans to outdoor public places or to include novel tobacco products in their bans. Several Parties strengthened their advertising bans, including extending them to novel tobacco products. Implementing time-bound provisions should be considered strong priorities by the Parties in which there are still gaps in implementing these policies. Specifically, in the area of tobacco advertising, it is important to strengthen policies with cross-border effects by benefiting from the work of the COP-mandated expert group on this matter.

5. There were also developments in the area of tobacco taxation. More Parties are now using excise taxes and more are moving towards mixed tax systems. Large excise tax increases and better planning of future increases in tobacco taxation will certainly make the health impact and tobacco-related revenue estimation more computable. Many Parties reported that reducing the affordability of tobacco products was a priority. The scaling up of the operation of the WHO FCTC Secretariat's Knowledge Hub on Taxation

allows for better provision of assistance to Parties and building national capacity for more predictable policy actions that are in line with the requirements of Article 6 and its Guidelines.

6. Progress has been observed in implementation of supply-side reduction measures. An increasing proportion of Parties reported new measures to control the illicit trade of tobacco products. Many Parties have ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, making possible its entry into force on 25 September 2018. The entry into force of the Protocol could provide new impetus to collaborative efforts to counter the illicit trade of tobacco products both nationally and internationally.

7. Among the wide range of implementation measures to reduce the supply of tobacco, the minimum age to purchase tobacco products continues to be raised by an increasing number of Parties to at least 18 years. There are also new examples documented on switching to alternatives to tobacco growing and protecting the environment in relation to tobacco production and use. Further scaling up of implementation of Article 17 will also help address the health, social and environmental consequences of tobacco growing, including but not limited to halting child labour in relation to tobacco growing.

8. Advances in research and surveillance under Article 20 are contributing to an improved monitoring system of progress in implementation of SDG Target 3.a (Strengthen implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate) and of WHO's global NCD targets. The Convention Secretariat, as co-custodian of SDG Target 3.a, will work with WHO to promote appropriate monitoring and voluntary reporting of measures taken for the implementation of the Convention at United Nations level.

9. Despite the progress, in many Parties, the lack of human and financial resources remains frequently cited as a barrier to strong implementation, alongside insufficient political commitment. There is need to achieve full policy coherence at the national level to ensure that implementation of the relevant policies under the WHO FCTC are embedded in the sectoral policies developed and implemented by various government ministries. This is even more important with new evidence of the increased vulnerability of non-health sectors vis-a-vis interference by the tobacco industry. Integration should be carried out with other health and development programmes at national level, including in the collaborative efforts with the United Nations System, for example United Nations Development Assistance Frameworks.

10. Several recent initiatives supported or carried out by the Convention Secretariat – such as strengthening joint needs assessment and post-needs assessment activities, promoting the establishment of tobacco industry monitoring centres (observatories), the new WHO FCTC Knowledge Hub focusing on Article 5.3, the ambitious FCTC 2030 Project and the development of the creative Article 19 Civil Liability Toolkit – are important means to support Parties in the areas where implementation rates are lower. Information exchange and collaboration between Parties in implementation of the Convention continues to be of crucial importance and South-South and triangular cooperation initiatives have been strengthened with the support of the Convention Secretariat. Even

though an increasing number of Parties have started to put in place measures to include new and emerging tobacco products, including ENDS/ENNDS, in their existing legislation (smoke-free laws, bans on advertising, promotion and sponsorship, regulations on contents and emissions, and requirements for packaging and labelling), comprehensive and concerted actions are needed with the participation of all concerned stakeholders to address the proliferation of such products in line with decisions of the Conference of the Parties, including through the development of specific policies to control their use, specially among young people.

11. The implementation of the Convention is at crossroads. There are international developments that could provide impetus to WHO FCTC implementation, including the opportunities for integration with other horizontal programmes, such as those on NCDs, tuberculosis and HIV/AIDS. International cooperation, a basic feature that could have a strong role in assisting Parties with their work on WHO FCTC implementation, is to be strengthened. WHO FCTC implementation needs to be the business of all sectors – not only the health sector – and policy coherence must be ensured in matters related to tobacco in all sectoral policies. The new Medium-Term Strategic Framework, expected to be adopted by COP8, should generate additional action and should provide more coordination for technical assistance programmes and frameworks. New and innovative approaches in financing tobacco control should provide the resource-base of intensified action.

The Secretariat of the WHO Framework Convention on Tobacco Control
World Health Organization
Avenue Appia 20, 1211 Geneva 27, Switzerland
Tel. +41 22 791 50 43
Fax +41 22 791 58 30
Mail: fctcsecretariat@who.int
Web: www.who.int/fctc

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WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

SECRETARIAT

Good country practices in the implementation of WHO FCTC Article 5.3 and its guidelines

Report commissioned by the Convention Secretariat

Prepared by Mary Assunta

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Introduction

In 2008, the Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control (WHO FCTC) adopted Guidelines[1] to assist Parties in their implementation of Article 5.3. Since then many Parties have made progress and established measures to protect their policies from interference by the tobacco industry. However, many Parties continue to report that tobacco industry interference persists and is the single biggest challenge to tobacco control efforts.

In 2016, the Convention Secretariat's report to the Conference of the Parties at its seventh session (COP7), Implementation of Article 5.3 of the WHO FCTC, noted that the tobacco industry remained the greatest barrier to implementation of the convention for a number of Parties.[2] The tobacco industry continues to prevent, weaken and delay effective implementation of the convention and also to engage in and interfere with international organizations. The report acknowledged the need for additional measures to counter such efforts.

Subsequently, COP7 requested the Convention Secretariat to facilitate sharing of best practices among Parties to implement Article 5.3.[3] This document was prepared in response to that decision.

Information for this report was obtained from the Party reports submitted to the WHO FCTC database, particularly from Parties' answers to additional questions on Article 5.3 implementation. Additional information was obtained through searches on Parties' websites, the International Legal Consortium of the Campaign for Tobacco-Free Kids website, and direct communication with officials from Parties' departments/ministries of health via the Convention Secretariat.

This report provides a selection of advanced practices in implementing Article 5.3. It draws from a variety of Parties' experiences, including those recommended in the guidelines. While some Parties have taken a whole-of-government approach, which is the ideal, others have adopted measures to protect the ministry/department of health from interference by the tobacco industry as a first step. Others have introduced policies on certain measures recommended in the guidelines, such as transparency. This report also provides examples of the denormalization of the tobacco industry, such as the banning of tobacco-related corporate social responsibility (CSR) activities and divestments from the tobacco business.

I. Legislative requirements covering Article 5.3 of the Convention

In the following examples, Article 5.3 has been included as a component in the Party's tobacco control legislation.

1. Uganda: Comprehensive law on tobacco control with Article 5.3 provisions survives legal challenge

Among the stated purposes of Uganda's Tobacco Control Act (2015) is to "insulate tobacco control policies, laws and programmes from interference by the tobacco industry".[4] The Tobacco Control Act makes it the duty of the government to protect tobacco control policies from tobacco industry interference and to ensure transparency of any interactions with it.

Part VIII of the Act closely follows the terms stated in Article 5.3 Guidelines regarding the protection of tobacco control policies from commercial and other vested interests of the tobacco industry. These include:

- duty of Government
- government interaction with the tobacco industry
- prohibition on partnerships and endorsements of the tobacco industry
- prohibition on voluntary contributions from the tobacco industry
- prohibition on incentives or privileges for tobacco businesses
- penalty for contravention of proposed measures

- prevention and management of conflicts of interest.

Article 5.3 Guideline Principles	**Uganda Tobacco Control Act 2015**
Principle 1: *Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies.*	The Tobacco Control Act aims to "control the demand and supply of tobacco and its products to the population … to promote the health of persons and reduce tobacco related illnesses and deaths". Part VIII of the Act addresses tobacco industry interference.
Principle 2: *Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur.*	**Duty of Government** "Ensure that there is transparency in the interactions of Government with the tobacco industry."
Principle 3: *Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry.*	**Prohibition on partnerships and endorsements of the tobacco industry** Prohibition on "non-binding or non-enforceable agreement, memorandum of understanding, voluntary arrangement or tobacco industry code of conduct in the place of legally enforceable tobacco control measures". "Prohibition on voluntary contributions from the tobacco industry."
Principle 4: *Avoid conflicts of interest for government officials and employees.*	**Prevention and management of conflicts of interest** "A person shall not be assigned a position to contribute to or where the person is likely to contribute to the formulation, implementation, administration, enforcement or monitoring of public health policies on tobacco control activities if that person has engaged in any occupational activity with the tobacco industry within less than two years of the proposed assignment." "Contravention of this measure is punishable by a fine, imprisonment for a term not less than 5 years and compensation to the government as the situation may deem."
Principle 5: *Require that information provided by the tobacco industry be transparent and accurate.*	**Contents of reports by the tobacco industry to the Committee are to include the following.** • "The quantity of tobacco or tobacco product manufactured, imported or distributed by the manufacturer, importer or supplier, the quantity which is sold, and the revenues from the sales. • "The corporate taxes owed and paid. • "The contents and emissions of the tobacco product. • "The tobacco product revenues and profits. • "All activities attempted or undertaken to influence the formulation or implementation of any policy or legislation, directly or indirectly, related to tobacco control or public health. • "The identification of lobbyists and lobbying firms and all other persons, including employees used for the purpose of taking or attempting action to influence the formulation or implementation of any policy or legislation."
Principle 6: *Denormalize and*	All forms of tobacco-related socially responsible activities are

regulate activities described as "socially responsible" by the tobacco industry, including but not limited to activities described as "corporate social responsibility".	prohibited.
Principle 7: *Do not give preferential treatment to the tobacco industry.*	"Prohibition of incentives or privileges to tobacco businesses."

In November 2016, British American Tobacco (BAT) Uganda challenged the Tobacco Control Act through a petition filed in Uganda's Constitutional Court. They claimed that over 20 clauses in the Act were unconstitutional, including the provisions relevant to Article 5.3, i.e. the prohibition on the government's employment of individuals who have been involved in any occupational activity with the tobacco industry and the prohibition on the grant of incentives or privileges to the tobacco industry. In May 2017, BAT Uganda filed an application in court for a temporary injunction on the implementation of tobacco control activities. The Government of Uganda submitted that the spirit behind the provisions in the act is to protect both current and future generations from the devastating health, economic and environmental effects of tobacco as guided by the WHO FCTC, to which Uganda is party.[5] The Constitutional Court dismissed BAT's application on the basis that it had no justifiable grounds for an injunction. The ruling was made on 18 May 2017, a day before the Tobacco Control Act became fully operational. The Constitutional Court reserved the reasons for its ruling for the judgment in the main petition, which is still pending as of the publication of this report.

The Act established a national Tobacco Control Committee. Key officials from the Ministry of Health and the Center for Health, Human Rights and Development (representing civil society) met the senior management and technical team of the Office of the Prime Minister to agree next steps.[6] The team also sought meetings with relevant ministries on the tobacco control committee to offer a briefing on tobacco industry tactics and the need to insulate tobacco control laws from commercial and vested industry interests.

Center for Health, Human Rights, Development (CEHURD) and other civil society groups met the Ministry of Agriculture, Animal Industry and Fisheries senior management and the technical team to discuss effective implementation of the Tobacco Control Law.[7]

19 April 2017: The Center for Health, Human Rights and Development met the Office of The Prime Minister and discussed next steps for the implementation of the Tobacco Control Act (2015).[8]

2. Gabon: Importance of implementing a mechanism to facilitate legislation on Article 5.3

Gabon's comprehensive tobacco control legislation, adopted in 2013,[9] provides measures to protect tobacco oversight policies from commercial and other interests of the tobacco industry. It begins with an important overarching principle of protection for tobacco control policies:

"The implementing decrees of the law, although elaborated in 2014, were not promulgated till 2016. We are convinced that it is the tobacco industry that caused this delay. While the decrees had already been drawn up and were forwarded to the Council of State for verification of conformity, the tobacco industry would propose organizing a workshop to draw up other implementing decrees instead of those already in circulation."

— Dr Frédéric Mbungu Mabiala, Director of the National Programme of Mental Health and Control Against Tobacco, Alcoholism and Drugs, Ministry of Health, Gabon.

> "The State shall ensure that the activities or attempts of the tobacco industry do not discredit, impair and compromise the national and international public policy relating to tobacco control. It shall also ensure that any action to enable the commercial interests or other special interests of the tobacco industry does not interfere with the development and implementation of the tobacco policy." (Chapter 7, Article 32). [9]

The law and its implementing decree require that interactions between the government and the tobacco industry must be transparent and justified. They ban tobacco industry participation in tobacco control-related meetings and activities, define and prohibit tobacco industry-related conflicts of interest for public servants, and require the tobacco industry to provide information periodically on their activities and products.[10]

The industry is responsible for damages and other losses resulting from the effects of tobacco use, which are to be compensated in accordance with the provisions of the law. "The activities of the tobacco industry must not undermine or call into question actions for tobacco control. The tobacco industry cannot conduct the following activities:

- carry out philanthropy or patronage actions
- use lobbying firms or pressure groups
- carry out disinformation campaigns
- fund research
- use opinion leaders or other industries
- create and use front organizations." [10]

Failure to comply with the provisions concerning interference by the tobacco industry and its representatives is punishable by a fine of FCFA 5 million to FCFA 50 million (€7625 to €76 250), and/or imprisonment from three months to two years if the interference is accompanied by corruption. The same penalty is applicable to any official or representative of the State who participates, authorizes or tolerates any illicit activity on the part of the tobacco industry.

Although Gabon developed five WHO FCTC-compliant implementing decrees in 2014, tobacco industry interference delayed their enforcement until April 2016.

Gabon faces challenges, including difficulty in collecting information on the activities of tobacco companies. According to a Ministry of Health official, when information is requested from the tobacco industry: "They often refer you to the Gabonese Tobacco Board, which is a platform for marketing tobacco products in Gabon. It is therefore difficult to have all the accurate information about their affairs."[11]

Civil society has called for a tobacco factory located in the heart of the capital city to be relocated in accordance with the provisions of the law. In recent months, this factory has halted production. Currently, tobacco sold in Gabon is imported. The Gabonese state was a major shareholder in this factory. It manufactured cigarettes in Libreville and its share of ownership has since been reduced to 10 percent.[12]

The Article 5.3 component of the Gabon's Tobacco Control Law (Chapter 7) provides for the law to protect tobacco control policies, and to treat a tobacco state enterprise like any other company within

the tobacco industry. The tobacco industry proposed a pro-industry law in the legislature but it was rejected.

3. Republic of Moldova: Ending Memoranda of Understanding, and contributions from the tobacco industry

The Tobacco Control Law[13] adopted in 2015 aims to protect tobacco control policy from commercial and other vested interests of the tobacco industry, and to prevent and manage conflicts of interest for public servants. Chapter 4: Article 17.10-13 covers four aspects of Article 5.3.

1) Prohibition on partnership with and support from the tobacco industry. This includes non-binding agreements and memoranda of understanding (instead of legal tobacco control measures) and financial or other contributions from the tobacco industry.
2) Prohibition of voluntary contributions, financial or otherwise, from the tobacco industry or its representatives. This includes any contribution that aims to promote the tobacco industry or its corporate image.
3) Prevention and management of conflicts of interest. This includes prohibiting any person who is or has been involved in the management and/or promotion of enterprises in the tobacco industry in the last 24 months, from participating in the development and implementation of public policy on tobacco control.
4) Raising public awareness and public education. This requires the Ministry of Health to develop and distribute information on the "necessity to protect public policies on tobacco control from the commercial and other interests of the tobacco industry, and from strategies and practices used, openly or covertly, by the tobacco industry, to undermine and obstruct the development and implementation of public policy on tobacco control, including charitable contributions to public and private organizations", in addition to the risks of cultivating and processing tobacco and the toxicity and addictiveness of tobacco and the health risks of tobacco use.

This law was agreed after much delay and interference from the tobacco industry by the U.S. Chamber of Commerce, which has a seat on the regulatory review panel. It actively lobbied against Moldova's legislation, significantly delaying its enactment. The Chamber's tactics included complaining to the President that the legislative measures were extreme.[14] However, Article 5.3 supports the protection of health policy from vested commercial interests, and the law was passed.

II. Intersectoral circulars and guidelines

The following two examples show how circulars and guidelines can be applied across the civil service, as well as to government officials on the national committee responsible for WHO FCTC implementation.

1. Philippines: A Joint Memorandum Circular to protect the bureaucracy from tobacco industry interference

In 2010, the Philippine Civil Service Commission (CSC) and Department of Health (DOH) issued Joint Memorandum Circular (JMC) No. 2010-01[15] to protect the bureaucracy from tobacco industry interference. This JMC provides a code of conduct for all government officials in relation to the tobacco industry. It is consistent with the Article 5.3 Guidelines. Broad policy definitions of the tobacco industry include all those that work for or on behalf of the industry, and those who work to further its interests.

Consistent with the Anti-Graft and Corrupt Practices Act of the Philippines[16] and the WHO FCTC, this JMC requires all public officials to:

- reject any interaction with the tobacco industry unless strictly necessary for its regulation, supervision and control;
- make all "necessary" interactions public and transparent;
- reject any form of direct or indirect contribution from the tobacco industry; and
- disclose any interest in the tobacco industry.

The CSC has jurisdiction to hear complaints relating to violations of the JMC by public officers under its disciplinary authority, which are subject to administrative proceedings.

Following the issuance of the JMC, several government departments enacted their own codes of conduct to implement the circular in a manner relevant to their department's work. The DOH developed monitoring forms to promote compliance with its 2010 internal policy, which is a more stringent version of the JMC that applies to all DOH agencies and personnel. The Department of Education (DepEd) adopted a policy to prohibit tobacco industry donations to, or sponsorships of, public schools and warned those reported to have received tobacco-related CSR indirectly.[17] In 2016, the regulations concerning DepEd were further strengthened in order to include private educational institutions.[18]

Other government agencies that have issued their respective regulations compliant with the JMC include the Department of Social Welfare and Development (DSWD), the Department of Labour and Employment, the Department of Science and Technology, the Department of Foreign Affairs, the Bureau of Internal Revenue, and the Metro Manila Development Authority.

The JMC has helped create awareness about tobacco industry interference and the obligations of non-health departments in implementing the WHO FCTC. When a multinational tobacco company approached the Bureau of Customs (BOC) to be a "partner" in curbing the illicit tobacco trade, the BOC sought advice from the CSC and was informed that it would violate the JMC to pursue such a partnership.

The Department of Health set up an interagency committee on Article 5.3 to facilitate implementation of the JMC. It is composed of high-level officials and staff from various government agencies, such as the CSC, DOH, DepEd, DSWD, and the Office of the President, as well as civil society representatives.

The DOH and CSC, in partnership with civil society representatives, have conducted several workshops across the country to raise awareness about tobacco industry interference, Article 5.3, and the JMC. CSC personnel and lawyers serve as resources in these capacity-building activities among government agencies, including at the local government level. The CSC has also developed monitoring and reporting procedures to ensure that the policy is effectively implemented.

Denormalizing tobacco-related "corporate social responsibility" (CSR) activities is an important component of tobacco industry regulation. The Secretary of Health has sent warning letters to the recipients of tobacco company donations, highlighting possible violations of advertising laws and the obligation to protect public health from the vested interests of the tobacco industry. When the tobacco industry conducted activities with the National Tobacco Administration (NTA), the CSC informed the NTA that such activities are a form of unnecessary interaction that violates the JMC. While it is a big challenge to eliminate tobacco industry interference completely, the JMC is an effective tool to manage it.

2. Brazil: Ethical Guidelines for National Committee on WHO FCTC

In 2012, the Brazilian Minister of Health ordered that ethical guidelines[19] be established for the members of the Intersectoral Committee for Implementation of WHO FCTC and its Protocols (CONICQ). It is composed of representatives from 18 ministries and federal-level agencies. CONICQ is responsible for implementing intersectoral policies to ensure that the country complies with the convention. The Minister of Health presides as the President of the Committee.

The purpose of the ethical guidelines is to prevent interference by the tobacco industry in public policy for tobacco control and ensure that the conduct of CONICQ members accords with the WHO FCTC Article 5.3 Guidelines. The ethical guidelines highlight the fact that public health interests are irreconcilable with the interests of the tobacco industry and state that CONICQ's activities must be transparent and accountable, in accordance with the Article 5.3 Guidelines. The guidelines facilitate the adoption of measures to ensure that the National Tobacco Control Policy is implemented in an atmosphere free of pressure, as well as to ensure the integrity and impartiality of the work carried out within CONICQ.

The guidelines include a clause on conflicts of interest. It states that to prevent a situation with a potential conflict of interest, the CONICQ member should withdraw from its activities for as long as the situation persists. The guidelines stipulate that when interaction between a government representative and the tobacco industry is necessary, it must be in the form of an official hearing. The government representative must be accompanied by another public servant. Furthermore, a record of the hearing must be prepared, including a list of persons present and the matters discussed.

In addition, CONICQ members are prohibited from accepting gifts, services, and research funding from the tobacco industry. The guidelines require members of CONICQ to avoid participation in seminars or similar events promoted or sponsored by the tobacco industry.

CONICQ conducts regular meetings with various government representatives such as the Ministry of Foreign Affairs, the Ministry of Finance, the National Health Surveillance Agency and others.

Members of CONICQ also formed part of the Brazilian delegation to the seventh session of the COP (COP7)

III. Regulations on Article 5.3

Some Parties have utilized Article 5.3 of the Convention to protect health ministries from interference by the tobacco industry as a first step, since tobacco control falls within the jurisdiction of this department. This has the potential to extend government-wide as a next step. Below are examples from Panama and Thailand.

1. Panama

Prior to Panama's ratification of the WHO FCTC in 2004, there were agreements with the tobacco industry that had to be revoked with the convention's entry into force. Panama has no voluntary agreements with the tobacco industry. Panama adopted and implemented a code of conduct for public officials setting the standards for any dealings with the tobacco industry.

In 2012, the National Commission for the Study of Smoking was granted new functions aimed at monitoring compliance for implementation of the WHO FCTC and its guidelines, including Article 5.3 (Resolution 745 of 2012)[20].

The Ministry of Health designated this commission to deal exclusively with the tobacco industry or representatives/groups representing them. The commission will interact with the tobacco industry

only when, and to the extent strictly necessary, to enable effective regulation of the industry and its products. All interactions between the commission and the industry shall be carried out in a transparent manner. The procedures are set out below.

i. In no case shall a member of the commission meet the tobacco industry or with persons or groups representing them, or organizations affiliated with it.

ii. Meetings should follow the written agenda, and no additional topics should be addressed.

iii. The commission shall draw up the meeting's minutes. These shall be kept in the archives of the General Directorate of Public Health. If required, this material may be made public by the internal commission, DIGESA or at the request of organizations recognized as leaders in the implementation of the WHO FCTC, its protocols and/or guidelines.

iv. No member of the Commission may have, or have had. in the three years prior to and after his/her designation, any relationship with the tobacco industry or with persons or groups representing it, or organizations affiliated with it.

3. Thailand

In 2013, the "Regulation of Department of Disease Control Regarding How to Contact Tobacco Entrepreneurs and Related Persons B.E. 2553 (2010)" was established[21] to protect the Thai Department of Disease Control from tobacco industry interference. The Department of Disease Control is the lead department for tobacco control. The regulation applies specifically to the department and is a good first step towards implementing Article 5.3. The WHO FCTC recommends that governments create awareness on the harm of tobacco and it is therefore important to support the department to ensure it can exercise its functions without interference.

The regulation states that contact between an official and entrepreneur or related person may be made only if necessary and specifically only for action under the tobacco products control law, or any other WHO FCTC measures, in order to ensure the effective control of tobacco products. If contact is made, the following information shall be recorded: (1) date and time of contact; (2) name and title of the responsible official; (3) name, title and address of the entrepreneur or related person; and (4) record of the issues discussed. If an entrepreneur or related person requests a meeting, they shall submit an official letter of intent describing its purpose to the Director of the Office of Tobacco Control or the Director of the Office of Disease Prevention Control.

In the event that a meeting takes place, the regulation clearly specifies how it shall be conducted. The regulation requires the entrepreneur or related person to sign a letter before the meeting starts certifying that they will neither take photographs or record sound nor publicize its contents for commercial benefit. The official shall produce the summary of the meeting and is responsible for making its contents available to the public.

Government organizations are prohibited from accepting donations from the tobacco industry. The tobacco state enterprise, the Thai Tobacco Monopoly (TTM), is treated in the same way as other tobacco companies. All tobacco control policies apply to both private tobacco companies and the TTM. The TTM is not involved in tobacco control policy development. Initially only the TTM was prohibited from engaging in CSR activities, but from July 2017 there has been a complete ban on all tobacco-related CSR activities in Thailand.

Thailand's new tobacco control law, Tobacco Products Control Act B.E. 2560, went into effect in July 2017. To implement the law, a "National Tobacco Products Control Committee" will be established whose criteria exclude anyone who, "owns, is a related person or a stakeholder in a business involving tobacco products whether directly or indirectly".[22] This rule is an important development for Thailand in its efforts to implement Article 5.3 and also applies to the state-owned tobacco enterprise (Article 5.3 Guidelines, Principle No. 8).

In addition, the tobacco industry is required to provide information about tobacco production, import and marketing expenses as required in Recommendation 5.2 of the Article 5.3 Guidelines: "The

manufacturer or importer of tobacco products have the duty to report the volume of production or importation into the Kingdom, market share, marketing expense, income and expense as per Article 35, annual report, audited financial statement and any other information for the benefits of tobacco products control to the Committee." [22]

IV. Transparent interactions with the tobacco industry deemed necessary

World Health Assembly resolution WHA54.18 on transparency in tobacco control, citing the findings of the Committee of Experts on Tobacco Industry Documents, stated that "public confidence would be enhanced by transparency". They called on WHO to "continue to inform Member States on activities of the tobacco industry that have negative impact on tobacco control efforts".[23] Article 5.3 in Principles 2, 3 and 5 underlines the importance of accountability and transparency.

> Recommendation 2.2: Where interactions with the tobacco industry are necessary, Parties should ensure that such interactions are conducted transparently. Whenever possible, interactions should be conducted in public, for example, through public hearings, public notice of interactions, disclosure of records of such interactions to the public.
>
> Recommendation 5.1: Parties should introduce and apply measures to ensure that all operations and activities of the tobacco industry are transparent

Several Parties have established measures requiring transparency when dealing with the tobacco industry. The following are some examples.

1. European Union

The European Ombudsman reported the establishment of measures to limit interactions with the tobacco industry and to ensure the transparency of those interactions that do occur in line with Recommendation 2 of the Article 5.3 Guidelines. The European Ombudsman published the following on its website[24]:

> As a body that investigates complaints about maladministration in the institutions and bodies of the European Union, the European Ombudsman is particularly keen to ensure strict compliance with the overall ethical framework that applies to EU officials including, transparency, conflicts of interest, revolving doors and accountability.
>
> In complying therefore with Article 5(3) of the Convention and its implementing Guidelines the Ombudsman has thus decided to proactively publish online:
>
> (i) any planned meetings of herself, members of her Cabinet, and her staff with representatives of the tobacco industry (including lawyers, advisors, consultants and lobbyists acting on behalf of tobacco companies)
>
> (ii) the list of participants of such meetings, and
>
> (iii) the minutes drawn up after a meeting has taken place
>
> In line with the Ombudsman's commitment to strengthen further transparency and maintain an open dialogue with stakeholders, the Ombudsman and her staff will only interact with organizations and self-employed individuals acting on behalf of the tobacco industry who already feature in the Transparency Register jointly set up by the Commission and the European Parliament.
>
> Moreover before any meeting request can be agreed, the Ombudsman and her staff will remind representatives of the tobacco industry of the above rules.

2. Australia

The Australian Department of Health, in accordance with Article 5.3 Guidelines, informs the public of any meetings it holds with the tobacco industry by making an announcement on its website.[25] For example, its consultations in relation to plain packaging measures were notified on the website. The

records of such meetings start from 2009, after the WHO FCTC Article 5.3 Guidelines were adopted, and indicate which tobacco company met the department and the issue discussed.

The Australian Government also maintains a Register of Lobbyists and a Lobbying Code of Conduct (2008) to ensure that contact between lobbyists and government representatives is conducted in accordance with public expectations of transparency, integrity and honesty.[26] Lobbyists from certain tobacco companies are registered.[27]

Furthermore, it is a legal requirement in Australia that any donation to a registered political party valued at AUS$ 10 000 or greater must be declared to the Australian Electoral Commission, and donor annual returns are posted online.[28] The register shows the tobacco industry made contributions towards elections between 1998 and 2011. The Australian Government currently does not accept donations from the tobacco industry. The New South Wales Electoral Commission banned donations from the tobacco industry in 2004.[29] The Australian Labour Party has banned such donations since 2004, while the Liberal Party banned them in 2013.

3. New Zealand

In implementing Article 5.3, the New Zealand Ministry of Health states it is, "required to observe complete transparency in its dealings with the tobacco industry". Since 2011, the ministry has maintained a publicly available online register of meetings with the tobacco industry.[30] The ministry indicates the date of such meetings, who attended, and the topics discussed.

The New Zealand government does not have any partnerships with the tobacco industry. No incentives, privileges, benefits or preferential tax exemptions are granted to the tobacco industry. The Ministry of Health also makes available on its website annual tobacco returns filed by tobacco manufacturers and importers.[31]

V. Policy on curbing tobacco industry interference at diplomatic missions

Decision FCTC/COP6(14)[32], adopted by the Parties at the sixth session of the COP (COP6) urged Parties "to raise awareness and adopt measures to implement Article 5.3 and its implementing Guidelines among all parts of government including diplomatic missions".

The United Kingdom of Great Britain and Northern Ireland is the first Party to have specific guidelines on tobacco for its diplomatic missions. Guidelines for overseas posts[33] were revised to clarify that support given to the tobacco industry by diplomatic posts should be consistent with the WHO FCTC and Article 5.3, as well as the United Kingdom government's commitment to protect public health policy from the commercial and other vested interests of the tobacco industry. Its definition of the tobacco industry is also based on the WHO FCTC. The guidelines for overseas posts state:

> The Department of Health (DH) have decided to be more prescriptive in relation to the provision of support to the tobacco industry, to ensure any such support is consistent with the provisions of the WHO Framework Convention on Tobacco Control (FCTC). The Government takes very seriously its obligations as a Party to the (FCTC). This includes the treaty commitment at Article 5.3 to protect public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry.
>
> For the purposes of the guidelines, taking into account Article 1 of the FCTC, the WHO provides the following definition: 'Tobacco industry' means tobacco manufacturers, wholesale distributors, and importers of tobacco products. In addition, the term 'tobacco industry' includes tobacco growers, associations or other entities representing any of the above, as well as industry lobbyists.

The guidelines list activities that overseas posts cannot engage in, including:

- involvement in activities with the specific purpose of promoting the sale of tobacco or tobacco-related products;

- encouraging investment in the tobacco industry, or providing any assistance in helping tobacco companies influence non-discriminatory local business policies to their advantage (e.g.: taxation, plain/standardized packaging, etc.);
- attendance or otherwise supporting receptions or high-profile events, especially those where a tobacco company is the sole or main sponsor and/or which are overtly to promote tobacco products or the tobacco industry (such as the official opening of a United Kingdom tobacco factory overseas);
- endorsing, supporting, forming partnerships with, or participating in activities of the tobacco industry that could be described as "socially responsible" that relate, for example, to public education or that are aimed at improving public health;
- lobbying against any local administration's policies that are aimed at improving public health.

Since the tobacco industry has utilized front groups, think tanks, and research institutions to do its bidding, the guidelines also require diplomatic posts to verify such institutions: "Posts should also endeavour to verify whether an organization, body, group or institution that makes any approach regarding tobacco control has any affiliation to or link with the tobacco industry. Posts may wish to make any disclosed links transparent."

These Guidelines for overseas posts serve as a good example of implementation of the COP6 decision on Article 5.3 related to diplomatic missions.

VI. Denormalizing tobacco-related corporate social responsibility activities

The tobacco industry's core activities to manufacture, promote and sell a harmful product are in conflict with the goals of public health policies with respect to tobacco control. Article 5.3 Guidelines recommend that Parties "denormalize and, to the extent possible, regulate activities described as 'socially responsible' by the tobacco industry, including but not limited to activities described as 'corporate social responsibility' (CSR)" (Recommendation 6).

Both WHO FCTC Article 5.3 and Article 13 Guidelines identify CSR activities by the tobacco industry as a form of sponsorship, conclude that the resultant publicity qualifies as advertising and promotion, and recommend they both be prohibited. The table below lists Parties that have legislated to impose bans on tobacco-related CSR activities.

Parties that have banned tobacco-related CSR activities, grouped by WHO region

WHO AFR	Chad, Ethiopia, Gabon, Guinea, Madagascar, Mauritius, Niger, Seychelles, Togo, Uganda
WHO AMR	Brazil, Panama, Uruguay
WHO EMR	Bahrain, Djibouti
WHO EUR	Georgia, Republic of Moldova, Norway, Russian Federation, Spain, Turkmenistan
WHO SEAR	Maldives, Nepal, Thailand
WHO WPR	Lao People's Democratic Republic

Mauritius was among the first Parties to ban tobacco related CSR activities in 2008. The Public Health Act defines sponsorship to mean "any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use directly or indirectly".[34] Tobacco companies usually conduct CSR activities to promote their corporate name. Therefore, the Mauritius ban says, "no person shall promote or cause to promote - a trade mark, manufacturer's name, logo or brand name associated with a tobacco product" and cannot "offer any

scholarship or any form of sponsorship in relation to "a trade mark, manufacturer's name, logo or brand name associated with a tobacco product."

Nepal has a well-defined ban on tobacco-related CSR activities. It prohibits tobacco manufacturers and related parties from providing "any financial, technical, material, and structural assistance to educational seminary, theatre, religious discourse, preaching or health related organizations operated by government, non-government or private sectors". [35] The law prohibits acceptance of financial, material and other assistance from the tobacco industry. The ban on CSR activities also prohibits public officials from accepting assistance and awards, as well as participating in national and international programmes like meetings, trips, training, seminars and conferences organized by invitation and with the assistance of tobacco companies.

Other Parties have instituted partial bans on tobacco-related CSR activities, such as banning publicity or restricting the tobacco industry to certain specified CSR activities. However, these restrictions have been found to be ineffective, as the tobacco industry can still exploit loopholes and continue to conduct CSR activities in order to access high-level officials and gain political influence.

An example of this policy gap was the Philippine DepEd's Department Order No. 6/2012[36], restricting interaction by officials with the tobacco industry. The order includes a prohibition on the tobacco industry contributing funds to schools and school officials. However, this order was limited to public schools and the tobacco industry continued its CSR activities in private schools. In 2016 the DepEd closed this loophole by issuing Department Order No. 48 s. 2016 (Policy and Guidelines on Comprehensive Tobacco Control)[37]. This prescribes rules on how parents, teachers, and school officials of private and public schools can facilitate the enforcement of the ban on sponsorships, including so-called CSR of the tobacco industry.

VII. Divestment from the tobacco business

Recommendation 7.2 of the Article 5.3 Guidelines calls upon Parties that do not have a State-owned tobacco industry not to invest in this industry and related ventures. Several Parties have started to divest their sovereign wealth funds and pension funds from the tobacco business.

1. New Zealand

The New Zealand Superannuation Fund (NZ$ 34.5 billion) has a policy to exclude tobacco manufacturers. This is in order to maintain consistency with the Fund's mandate to adopt best practice portfolio management, maximize returns without undue risk and avoid prejudice to New Zealand's reputation as a responsible member of the world community.

According to Adrian Orr, the Chief Executive Officer:

> In assessing the issue of tobacco manufacture, the Board concluded that the Fund's investment in this sector was inconsistent with our responsible investment standards. This decision was based on product safety issues and New Zealand's commitment to specific international conventions.[38]

By 2010, all of the Crown's financial institutions had discontinued their investments in tobacco.[39]

2. Australia

Australia's state superannuation fund, First State Super (AUS$ $81 billion), was among the first state pension funds to divest from tobacco in 2012. Although a key consideration of the Board was the impact that divestment could have on earnings, an analysis found that this would be negligible.[40]

According to Michael Dwyer, the Chief Executive Officer of First State Super:

> Our decision to divest from tobacco manufacturers reflects both the strong views expressed by our members, our employers and our support for Government initiatives to minimise tobacco consumption. We are comfortable that the decision does not compromise our ability to deliver good returns outcomes to members. We made the right decision for members of First State Super and I'm proud of that.[39]

The director of the Future Fund, Australia's Sovereign Wealth Fund, announced in 2013 that its board had decided to drop its AUS$ 222 million-stake in the tobacco industry, given tobacco's health consequences and addictiveness. The investments were divided among BAT, PMI, and JTI.[41] Similarly, the governments of the Australian Capital Territory, New South Wales and South Australia have begun divesting their public investments in the tobacco industry.[42]

3. Norway

Ethical standards prevent the Government Pension Fund Global from investing in tobacco companies.[43]

4. France

In December 2016, the French Pension fund, *Fonds de reserve pour les retraites* (FRR), announced that it will no longer invest in tobacco and coal, and that by the end of 2017 this decision would apply to nearly all its existing investments. The FRR decision on tobacco was based on the understanding that engaging with companies would not lead to progress "because the whole purpose of engagement would be to demand that they should stop their activities altogether".[44] Any remaining tobacco investments will be removed in 2018.

VIII. Treating a State-owned tobacco industry in the same way as any other tobacco industry: Thailand case study

Article 5.3 guidelines apply to all tobacco companies, regardless of the ownership (Recommendation 8 of the guidelines). The Thai Tobacco Monopoly (TTM) is a state-owned enterprise, yet the Thai government does not distinguish it from any other tobacco company.

Thailand: Implementation of Recommendation 8

Recommendation 8.1: Parties should ensure that the State-owned tobacco enterprises are treated in the same way as any other member of the tobacco industry in respect of setting and implementing tobacco control policy.	Tobacco control laws apply to all tobacco companies operating in Thailand, including TTM. For example. • Any public consultation on tobacco control which involves the tobacco industry, applies equally to the TTM and other tobacco companies. • No exceptions or privileges are given to the TTM. For example: - no extra phase-in implementation time for tobacco control measures; - ban on tobacco-related CSR activities since 2017. • No special benefits are given to the TTM. For example, tax on tobacco products applies equally to all tobacco companies, including the TTM.
Recommendation 8.2: Parties should ensure that the setting and implementation of tobacco control policy is free from oversight or involvement by the tobacco industry.	The National Tobacco Products Control Committee's criteria exclude anyone who "owns, is a related person or a stakeholder in a business involving tobacco products whether directly or indirectly".[45] This criterion applies to TTM as well as to other tobacco companies.
Recommendation 8.3: Parties should ensure that representatives of State-owned tobacco industry do not form part of delegations to any meetings of the Conference of the Parties, its subsidiary bodies or any other bodies established pursuant to decisions of the COP.	TTM executives/staff/representatives are not members of the Thai delegation to the COP or any WHO FCTC-related meeting, nor do they belong to any subsidiary body of the COP.

The Ministry of Health faces challenges from the tobacco industry when developing and implementing tobacco control measures. However, it refers to the requirements under WHO FCTC Article 5.3 (an international obligation) when dealing with the tobacco industry. Thailand is noted for its achievements in stringent tobacco control policy over the years. It presents a good example of a Party that has successfully managed to implement Article 5.3 Recommendation 8 while having a state-owned tobacco enterprise.

Conclusions

This report provides a range of examples of Article 5.3 measures WHO FCTC Parties have implemented to protect health policy from vested commercial interests. It is best when these protective measures are applied government-wide as some countries have done, either through national legislation or a circular. This government-wide approach stops the industry from utilizing non-health departments to represent its interests to undermine or weaken tobacco control. A few Parties have put in place measures to protect their Department/Ministry of Health as a first step.

It is important to establish transparency procedures when conducting all meetings with the tobacco industry. Several jurisdictions make information from these interactions public via their websites. This puts an end to the industry's misuse, misrepresentation or exploitation of such meetings for its advantage. Many jurisdictions have banned tobacco-related CSR activities, as recommended in Article 5.3, which aims to denormalize the tobacco industry. This measure severs the industry's access to high-ranking officials and the use of these activities to promote tobacco business.

The tobacco industry will not stop interfering in governmental decision-making. Implementation of Article 5.3 is crucial to achieve effective tobacco control measures.

Useful links and references:

Resources on Article 5.3: http://apps.who.int/fctc/implementation/database/article/article-5/resources.

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