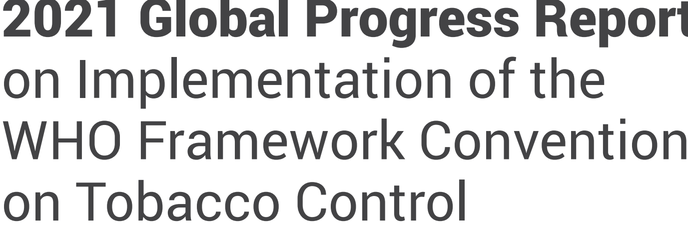
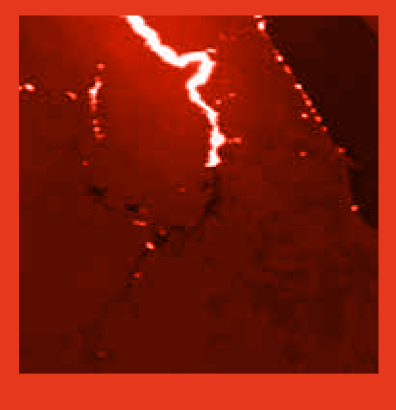


2021 Global Progress Report
on Implementation of the WHO Framework Convention on Tobacco Control



2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control

WHO Library Cataloguing-in-Publication Data

2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control.

1.Tobacco Industry – legislation. 2.Smoking – prevention and control. 3.Tobacco Use Disorder - mortality. 4.Tobacco – adverse effects. 5.Marketing - legislation. 6.International Cooperation. 7.Treaties. I.WHO Framework Convention on Tobacco Control. II.World Health Organization.

ISBN XXX-XX-X-XXXXXX-X

Acknowledgements

This report was prepared by the Convention Secretariat, WHO Framework Convention on Tobacco Control. Dr Tibor Szilagyi, Coordinator of the Knowledge Management, Reporting and Communication team of the Convention Secretariat led the overall work on data analysis and preparation of the report. The report benefited from the guidance and inputs provided by Dr Adriana Blanco Marquizo, Head of the Convention Secretariat. Hanna Ollila, from the WHO FCTC Knowledge Hub on Surveillance, coordinated the data analysis. Ramona Brad, Leticia Martínez López, Dominique Nguyen, Hanna Ollila, Robert Tripp and Tibor Szilagyi drafted some parts of the report. Special thanks for contributions by the other teams of the Convention Secretariat for their review of the various drafts. Important contributions were made by Alison Louise Commar of the No Tobacco Unit (TFI) of the WHO Department of Health Promotion to the section on the prevalence of tobacco use. Contributions to the analysis on specific articles of the WHO FCTC were received from WHO FCTC knowledge hubs, including from the Knowledge Hub on International Cooperation, the Knowledge Hub on Legal Challenges, the Knowledge Hub on Smokeless Tobacco, the Knowledge Hub on Surveillance, the Knowledge Hub on Taxation, the Knowledge Hub on Waterpipes, the Knowledge Hub for Article 5.3, and the Knowledge Hub for Articles 17 and 18. Special recognition goes to Martin Haitzmann and Nina Goltsch, from the Statistics Division of the United Nations Industrial Development Organization, an Observer to the Conference of the Parties, for data on global tobacco manufacturing trends. All these contributions are warmly acknowledged.

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Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Foreword

This *2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* is the ninth in the series of reports prepared since the entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) on 27 February 2005. The report was developed as the global community grappled with coronavirus disease 2019 (COVID-19), the most serious pandemic in more than a century. It is being published at a time when tobacco once again has been shown to be deadly, not only on its own but also by increasing morbidity and mortality related to COVID-19, which is caused by the severe acute respiratory syndrome coronavirus 2. The COVID-19 pandemic has overwhelmed health systems and economies worldwide, with many hospitals and clinics struggling to sustain operations during a pandemic that has claimed more than 4.3 million lives globally.

This report – although based primarily on the information submitted by the Parties to the WHO FCTC in the 2020 reporting cycle – was published in 2021 to coincide with the Ninth Session of the Conference of the Parties (COP9) to the WHO FCTC, which had been postponed one year due to the pandemic. To ensure that Parties are provided with the most up-to-date data at COP9, which will take place virtually in November 2021, Parties were requested to provide additional information on their implementation work, if any, covering the one year that has passed since the 2020 reporting cycle. This new information is included as a chapter in this report.

This 2021 Global Progress Report is also unique for three other reasons. First, this is the first time that the report includes baseline data related to the indicators of the *Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025*. This baseline data will provide the basis for measuring and monitoring how the Parties and various stakeholders cited in the Global Strategy embrace this strategic document.

Second, two additional approaches to data collection and analysis have been piloted in this report. All WHO FCTC Knowledge Hubs contributed, in various ways, to the analysis of the information reported by the Parties. In addition, the analysis of time-bound measures has now been complemented with a clustered analysis of indicators, which provides a more realistic picture of the comprehensiveness of approaches Parties are using in addressing the various complex requirements under these time-bound articles.

Third, this report is based on data collected during the 15-year anniversary of the entry into force of the Convention. Looking at further improvements and many innovative examples of implementation of the Convention – in a context in which an increasing number of Parties envisages an endgame strategy to reduce the use of tobacco products to a minimum – the Convention Secretariat is enthusiastic about the advances that the Parties are making collectively in addressing the global tobacco epidemic. The Convention Secretariat also is committed to further help Parties, even in these difficult times.

"The Convention Secretariat"

Executive summary

The 2020 reporting cycle for the WHO Framework Convention on Tobacco Control (WHO FCTC) was conducted in accordance with decision FCTC/COP4(16) of the Conference of the Parties (COP) to the WHO FCTC, using an online reporting platform established in 2016. While reporting is an obligation for all Parties in accordance with Article 21 of the Convention, it is also an opportunity for the Parties to share information and lessons learnt during their own implementation of the WHO FCTC, as well as to reflect on challenges, needs and implementation barriers.

This information could improve the understanding of fellow Parties on effective implementation practices that could also boost their implementation efforts. Data and information provided in the reports serve as a basis for all implementation assistance programmes conducted by the Convention Secretariat. Furthermore, they enable the COP "to keep under regular review the implementation of the Convention and take the decisions necessary to promote its effective implementation" (Article 23.5 of the Convention).

Data collection for the 2020 reporting cycle was conducted beginning 1 January 2020. The cut-off date for inclusion of reports in this 2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control was extended to 26 April 2020 – beyond the originally planned three-month reporting period – to allow more time for Parties to prepare their reports during the exceptional conditions created by the coronavirus disease 2019 (COVID-19) pandemic. Following the submission of the reports, the Convention Secretariat provided feedback to each reporting Party, and Parties had the opportunity to respond to the Convention Secretariat's feedback until 22 May 2020. All reports, information and data received by that date were taken into account in preparing this Global Progress Report. All reports submitted after this date will be analysed and referred to in the next Global Progress Report. It should be noted that the first reporting cycle of the Protocol to Eliminate Illicit Trade in Tobacco Products, a sister treaty to the WHO FCTC, was also conducted according to the same timeline as the reporting for the Convention.

Of the 181 Parties to the Convention that were required to report in the 2020 reporting cycle, 139 (77%) formally submitted their 2020 implementation reports, while most of the remaining Parties – those that have not submitted a formal, full report – updated some of their information in the online reporting database. Since the previous reporting cycle, one new Party, Andorra, acceded the Convention on 11 May 2020, but it will only need to report for the first time in the next reporting cycle. This analysis also includes a review of the 21 reports received in response to the additional (voluntary) questions on the use of implementation guidelines adopted by the COP for certain articles of the WHO FCTC.

The 2021 Global Progress Report is the first to be published following the adoption by the COP of the Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025. The report on the baseline data for the set of indicators identified in the Global Strategy is now integrated in this Global Progress Report (Chapter 7).

While the status of implementation has consistently improved since the Convention's entry into force in 2005, progress towards complete implementation of its various

articles remains uneven, with implementation rates ranging from 13% to 85%. For most articles, a small increase in the average implementation rate was observed between 2018 and 2020. Time-bound measures under the Articles 8 and 11 continue to be the most implemented, while the implementation of Article 13 – another time-bound requirement of the Convention – continues to lag well behind. The analysis in this report, which employed a new approach that combined various indicators under key articles of the Convention, found the implementation status for such new groups of indicators are lower, even for the time-bound articles (8, 11 and 13). This underlines the need for better utilization of the guidelines developed for the Parties. Furthermore, Annex 4 of this document for the first time provides Parties the opportunity to reflect upon their individual implementation status, by presenting the count of key provisions reported to be implemented under all substantive 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) seem to have been implemented most successfully.

Meanwhile, Article 17 (Provision of support of economically viable alternative activities), Article 18 (Protection of the environment and the health of persons) and Article 19 (Liability) continue to be the least successfully implemented. As almost one half of Parties indicate they have tobacco growing in their jurisdiction, it is vital for the Parties, 15 years after entry into force of the Convention, to strive for more advances in articles that have not been part of the traditional tobacco control toolkit, but are required under the Convention.

This Global Progress Report highlights, as usual, advanced practices in implementation of the Convention under each of the articles. For example:

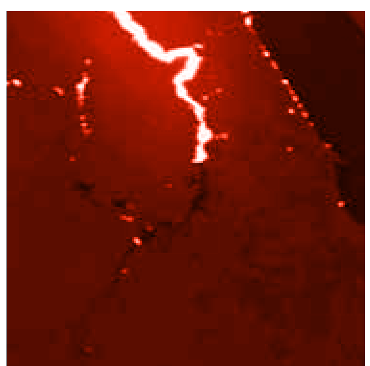
- Under Article 5 (General obligations), it has been noted that a growing number of Parties address its specific requirements as a "package" by developing national strategies and legislation and by establishing national coordinating mechanisms in parallel. Moreover, Parties' reports indicate that more Parties recognize the need to and engage in monitoring the tobacco industry and its actions, in accordance with the recommendation of the Guidelines for Implementation of Article 5.3 of the WHO FCTC.
- With respect to taxation of tobacco products (Article 6), some progress was detected in regions and subregions, while some countries have engaged in creating road maps of tax increases covering a number of future years, instead of implementing year-by-year increases.
- Under Article 8 (Protection from exposure to tobacco smoke), the already established pattern of extending smoking bans to outdoor areas and cars when children are present continued. Another important observation is greater emphasis by the Parties on enforcing smoke-free rules.
- In relation to Articles 9 (Regulation of the contents of tobacco products) and 10 (Regulation of tobacco product disclosures) of the Convention, there seems to be a positive tendency in banning characterizing flavours and additives in tobacco products.
- Under Article 11 (Packaging and labelling of tobacco products), an increasing number of Parties (16) have introduced or are in the process of introducing plain packaging.
- In relation to Article 12 (Education, communication, training and public awareness), additional Parties were able to further continue and extend their previously established communication campaigns, and more Parties seem to utilize programme evaluation results in designing their new campaigns.
- Under Article 13 (Tobacco advertising, promotion and sponsorship), an increasing number of Parties reported extending their advertising, promotion and sponsorship bans to novel and emerging tobacco products and nicotine products.

- On Article 14 (Demand reduction measures concerning tobacco dependence and cessation), a growing number of Parties reported having developed national guidelines for tobacco cessation and additional efforts have been put in place in a group of countries, also with the coordination of the WHO FCTC Knowledge Hub on International Cooperation in Uruguay, to integrate tobacco cessation with tuberculosis/HIV prevention and control programmes.
- Almost all measures required under Article 15 (Illicit trade in tobacco products) have demonstrated progress. This can be attributed, in part, to a renewed effort of the Parties to the WHO FCTC to also having become Parties to the Protocol. This tendency is especially notable in the introduction of tracking and tracing regimes for tobacco products.
- Under Article 16 (Sales to and by minors), the tendency of raising the legal age for purchasing tobacco products has continued, with new Parties setting their age limits to at least 18 years of age from previously lower limits.
- Under Article 17 (Provision of support for economically viable alternative activities), despite the fact that only less than one third of tobacco-growing Parties reported that they promote viable alternatives, some positive examples of good practices have also emerged in this reporting cycle.
- In relation to Article 19 (Liability), some major lawsuits against tobacco companies have been reported by several Parties.
- In the area of research, surveillance and exchange of information (Article 20) many Parties reported that they further strengthened their surveillance systems, with special regard to detecting patterns, as well as health and other consequences of tobacco consumption, and also importantly on recording exposure to tobacco smoke.
- In relation to international cooperation (Article 22), an increasing number of Parties reported receiving and providing assistance, and also more Parties recognize the assistance they have received from the WHO FCTC Knowledge Hubs.
- Regarding the novel and emerging tobacco products and nicotine products, it has been observed that the increase in the availability in national markets of smokeless tobacco, water pipes, and electronic nicotine delivery systems and electronic non-nicotine delivery systems (ENDS/ENNDS) demands that regulations need to be accelerated. In relation to heated tobacco products (HTPs), the availability and regulation are less common.

Despite the progress, implementation challenges remain and they prevent the Convention from achieving its full impact. In this reporting cycle, the most frequently mentioned implementation gap was the lack of financial resources, and the most frequently mentioned barrier was the interference by the tobacco industry, including the industries producing novel and emerging tobacco products and nicotine products.

It is important to note that the WHO FCTC is continuing to have an impact. For the second time – after it was first detected in the 2018 Global Progress Report – there is again a global decrease in tobacco use. There is, however, no room for complacency. There are still Parties that have not implemented all measures under the time-bound articles of the Convention. Moreover, in most of the Parties in which novel and emerging tobacco products and nicotine products are allowed in the market, they continue to gain market share at the expense of Conventional tobacco products.

1 Introduction



The 2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control is the ninth such report since entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) on 27 February 2005. The Global Progress Report has been prepared in accordance with decision FCTC/COP1(14) taken by the Conference of the Parties (COP) to the WHO FCTC at its first session, which established reporting arrangements under the Convention, 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 postponement of the COP due to the coronavirus disease 2019 (COVID-19) pandemic has also caused a delay in the publication of this report. In an effort to benefit from the delay, the Convention Secretariat requested, received and analysed updated data about Parties' implementation work up to early 2021, including on how the pandemic impacted progress on tobacco control.

Introduction

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 2020 reporting cycle and presents some advanced practices that Parties reported in addressing the measures required under the Convention. Second, the report highlights needs and challenges related to the implementation of the Convention, and formulates key observations and conclusions for consideration by the COP to be used during its decision-making to determine possible ways forward. Finally, for the first time this report provides baseline data for the indicators established by the Parties to measure progress made in implementing the Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025.

In the 2020 reporting cycle, two questionnaires were available for use by the Parties: 1) the core questionnaire, adopted by the COP in 2010 and subsequently amended for the 2014, 2016 and 2020 reporting cycles; and 2) a set of "additional questions on the use of implementation guidelines adopted by the Conference of the Parties", available for use by the Parties 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, reporting on the core questionnaire was conducted for the first time with an online questionnaire, and since 2018 the online questionnaire has been populated for each Party with the data from their latest available implementation report. It is important to note that the online platform hosting both reporting instruments remains active and open between reporting cycles, and Parties can amend data and submit their reports at any given time.

Of the 181 Parties to the Convention required to participate in this reporting cycle, 139 (77%) formally submitted their 2020 implementation reports via the online platform until the cut-off date for the inclusion of reports in this global analysis; however, more Parties submitted their 2020 reports in the months after the established cut-off date.[2] Several Parties also updated some of their data during the reporting cycle, but had not formally submitted their reports; the new data entered into the reporting platform by these Parties has also been taken account in the analysis. The number of Parties submitting their implementation report slightly decreased since 2018, when 142 Parties (78% of the 181 Parties in 2018) submitted their report in the given time frame. Since the publication of the 2018 Global Progress Report, an additional 10 Parties have submitted their 2018 report on the online platform, and several have updated some of their 2018 data prior to

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

2 The 2020 reporting period ended on 31 March 2020, 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 22 May was utilized. The following Parties had formally submitted reports by that time: Afghanistan, Algeria, Antigua and Barbuda, Armenia, Australia, Austria, Azerbaijan, Bahrain, Bangladesh, Belarus, Belgium, Belize, Benin, Bolivia (Plurinational State of), Bosnia and Herzegovina, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cabo Verde, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Djibouti, Ecuador, Egypt, El Salvador, Estonia, European Union, Fiji, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Guinea-Bissau, Guyana, Honduras, Hungary, Iceland, India, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kiribati, Kuwait, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Libya, Lithuania, Luxembourg, Malaysia, Mali, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Mongolia, Montenegro, Mozambique, Myanmar, Namibia, Nauru, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Niue, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Russian Federation, Saint Lucia, Samoa, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, Solomon Islands, Spain, Sudan, Suriname, Sweden, Syrian Arab Republic, Thailand, Republic of North Macedonia, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Uruguay, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam and Zimbabwe.

the opening of the 2020 reporting cycle. In this 2021 Global Progress Report, the updated 2018 dataset is used for the comparative analysis among all 181 Parties.

The regularly updated status of submission of reports can be viewed on the WHO FCTC website.[3] 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 regularly published in the WHO FCTC Implementation Database.[4]

In addition, 21 Parties[5] submitted information on their use of the implementation guidelines adopted by the COP by completing the additional questionnaire, and this information is also utilized in the report.

Methodological notes

In the Global Progress Report, implementation of the Convention is traditionally analysed on two levels: 1) as a percentage of the Parties implementing individual key measures; and 2) as an average of implementation rates across substantive articles. The calculation of the average implementation rates is provided in the footnotes to Chapter 2, titled Overall progress in implementation of the Convention. The complete list of key indicators is available on the WHO FCTC website.[6]As a change to the previous reports, the implementation of the smoking bans in different settings under Article 8, as well as the implementation of the different types of tobacco advertising bans under Article 13, is now assessed among all Parties, to provide a better picture of the implementation of these specific and mostly time-bound measures globally.

It should also 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 tobacco-growing Parties, but still the questionnaire allows for only little data collection on tobacco product manufacturing and on switching to alternative livelihoods among tobacco workers (in factories) and individual sellers (of tobacco products).

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 Parties' answers to the open-ended questions in the core questionnaire, responses to the additional questions, or on the news and updates identified or received from them in the period between the last two reporting cycles published in the WHO FCTC Implementation Database or on WHO FCTC social media. In addition to individual chapters on the implementation of the substantive articles, Parties experiences related to specific articles can be referenced under the sections on priorities, needs and gaps, and on novel and emerging tobacco products and nicotine products.

3 http://www.who.int/fctc/reporting/timeline-status/en/
4 See them under http://untobaccocontrol.org/impldb/updates/. Please note that this section is regularly updated as new information emerges from the Parties.
5 Antigua and Barbuda, Belgium, Benin, Burkina Faso, Costa Rica, European Union, Fiji, Georgia, India, Iran, Iraq, Jamaica, Japan, Lithuania, Netherlands, Nigeria, Panama, Papua New Guinea, Paraguay, Philippines and Spain.
6 http://www.who.int/fctc/reporting/party_reports/who-fctc-annex-1-indicators-current-status-implementation.pdf

In the 2020 reporting cycle, Parties' implementation of the Convention was assessed for the first time by also gauging the comprehensiveness of the implementation of the key provisions under substantive articles. For the report, the analyses among all Parties focused on the articles emphasized in the Global Strategy, namely, Articles 5, 8, 11 and 13. These analyses reviewed the implementation of a cluster of indicators derived from the reporting instrument (used in assessing the current status of implementation), with a detailed list of the combined indicators provided in the footnotes of the respective analyses in the article chapters. For Article 6, also included in the Global Strategy, a new analysis was also conducted in relation to total taxes.

Additionally, to provide Parties a new opportunity to reflect their current status with the implementation of the Convention, the count of the key provisions reported to be implemented under the substantive articles was calculated for all Parties. The selected provisions correspond to the key indicators defined and used in this report assessing the current status of implementation.[6] For Articles 8, 11 and 13, the same indicators were used as in the new analysis described above. For Articles 17 and 18, the count was calculated only among Parties that have reported tobacco growing. The results are available by Party in Annex 4 of this report.

Some limitations concerning data analysis should also be noted. The Parties' implementation reports are not subject to systematic validation. For example, the confirmation of responses against laws, regulations and programmatic documents (such as national strategies or action plans) 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 and the experience on the ground. In addition, the analysis of responses under Article 13 (Tobacco advertising, promotion and sponsorship) is also difficult and should be interpreted with caution, as Parties tend to interpret their regulation of tobacco marketing as comprehensive, while at the same time they indicate not having included in their bans various advertising and marketing means listed in the Annex to the Guidelines for Implementation of Article 13 of the WHO FCTC, which guides the understanding used during the analysis for defining the comprehensive ban on tobacco advertising, promotion and sponsorship.

Note on the data sources for figures and tables

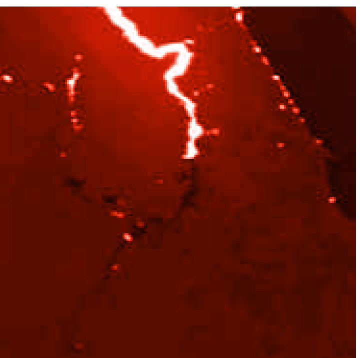
All figures and tables in this document have been prepared by the Convention Secretariat, based on information received in the reporting cycle, unless otherwise mentioned. Acknowledgments for the photographs published in this report are given for each photograph.

In relation to the figures, the percentages up to 100% reflect reports that were not submitted, the questions that were left without a response (including those that are "Not applicable" to the respective Party) and the "No" responses in the respective questions in the reports.

In the 2020 reporting cycle, Parties' implementation of the Convention was assessed for the first time by also gauging the comprehensiveness of the implementation of the key provisions under substantive articles.

Overall progress in implementation of the Convention

2



Current status of implementation[7]

The status of implementation on the Convention was assessed on the basis of information contained in the reporting platform for the WHO FCTC, which includes the new or amended data from those Parties that submitted their reports in 2020, as well as the information stored from previous reporting cycles. A total of 152 key indicators were taken into account across 16 substantive articles[8] of the Convention.

Fig. 1 presents the average implementation rate[9] of each substantive article with the latest available data by the Parties in the 2020 reporting cycle. The figure shows that the implementation rates across the articles are very uneven, ranging from 13% to 85%. The articles having the highest implementation rates, implemented on average by at least 65% of all Parties 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)
- Article 6 (Price and tax measures to reduce the demand for tobacco).

7 The status of the implementation was assessed as of 22 May 2020
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 required to submit their progress report (181 in 2020) that have provided an affirmative answer with respect to implementation of the provision concerned

They are followed by a group of articles for which the implementation rates are in the middle range, implemented by at least half of the Parties, and again in descending order:

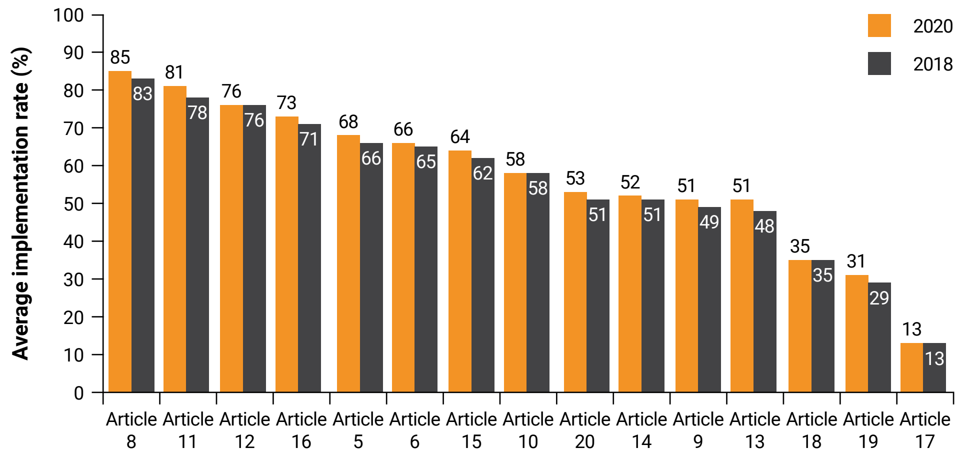
- Article 15 (Illicit trade in tobacco products)
- Article 10 (Regulation of tobacco product disclosures)
- Article 20 (Research, surveillance and exchange of information)
- Article 14 (Demand reduction measures concerning tobacco dependence and cessation)
- Article 9 (Regulation of the contents of tobacco products)
- Article 13 (Tobacco advertising, promotion and sponsorship).

The articles with the lowest implementation rates continue to be:

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

When assessing the overall implementation rates of the substantive articles among all Parties in the 2018 and 2020 reporting cycles,[11] a minor increasing trend was observed for all articles except Articles 12, 17 and 18 (Fig. 1). In contrast to the previous report, no major changes occurred in the average implementation rate of any single article, despite the overall improvement.

Fig. 1. Average implementation rates (%) of substantive articles in 2018–2020 (n=181)*

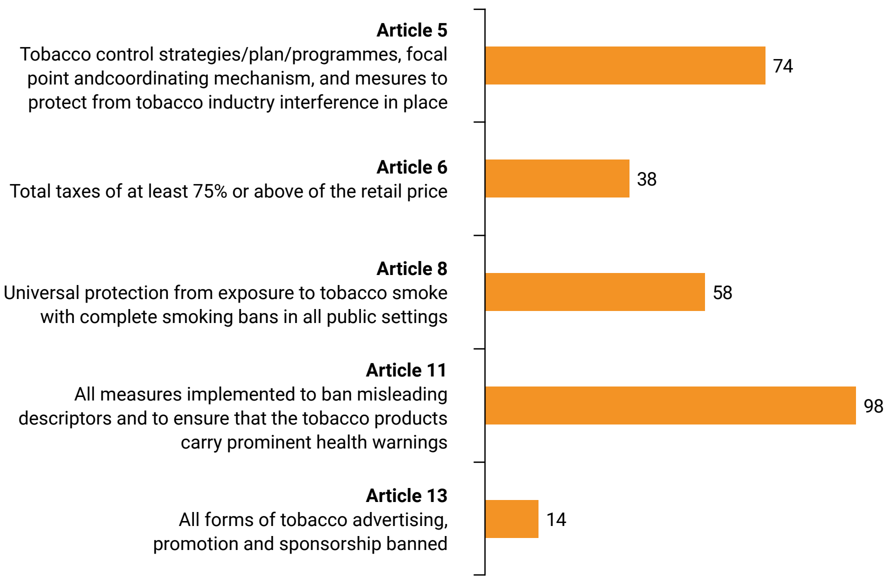


**Note: In 2020, for Articles 8 and 13, unlike in 2018, average implementation rates have been calculated among all Parties. The average implementation rates for Articles 17 and 18 are calculated only among Parties that report tobacco growing in their jurisdiction in the reporting instrument. The average implementation rates for Articles 8 and 13 are lower than in previous report due to the methodological changes. Please, refer to the Methodological notes for additional details.*

10 Average implementation rates for Articles 17 and 18 are calculated only among tobacco-growing Parties.
11 The 2018 implementation rates were recalculated among all 181 Parties to include all 152 reports submitted in the 2018 reporting cycle, not only those 142 that were submitted by the end of the designated reporting cycle of 2018.

As a new element in this Global Progress Report, for most of the articles prioritized in the Global Strategy, namely Article 5 (General obligations), Article 6 (Price and tax measures to reduce the demand for tobacco), Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship) new analysis was conducted to shed light on the comprehensiveness of measures taken by the Parties. This new analysis, presented below in the respective sections of the report, has revealed that although implementation rates of individual measures (that is, indicators) are high, a much lower percentage of Parties have implemented the most advanced measures of those articles in a comprehensive manner by implementing all of the key measures. As visible in the Fig. 2, the comprehensiveness of the implementation varies greatly among these articles. The highest number of Parties implementing all key measures were found in Articles 5 and 11, whereas very few Parties address the implementation of the Article 13 in a comprehensive manner.

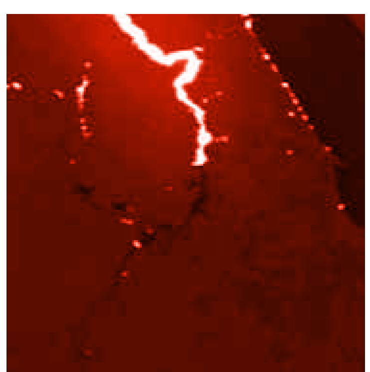
Fig. 2. Number of Parties that have reported implementing all the key measures under Articles 5, 6, 8, 11 and 13 by 2020 (n=181)*

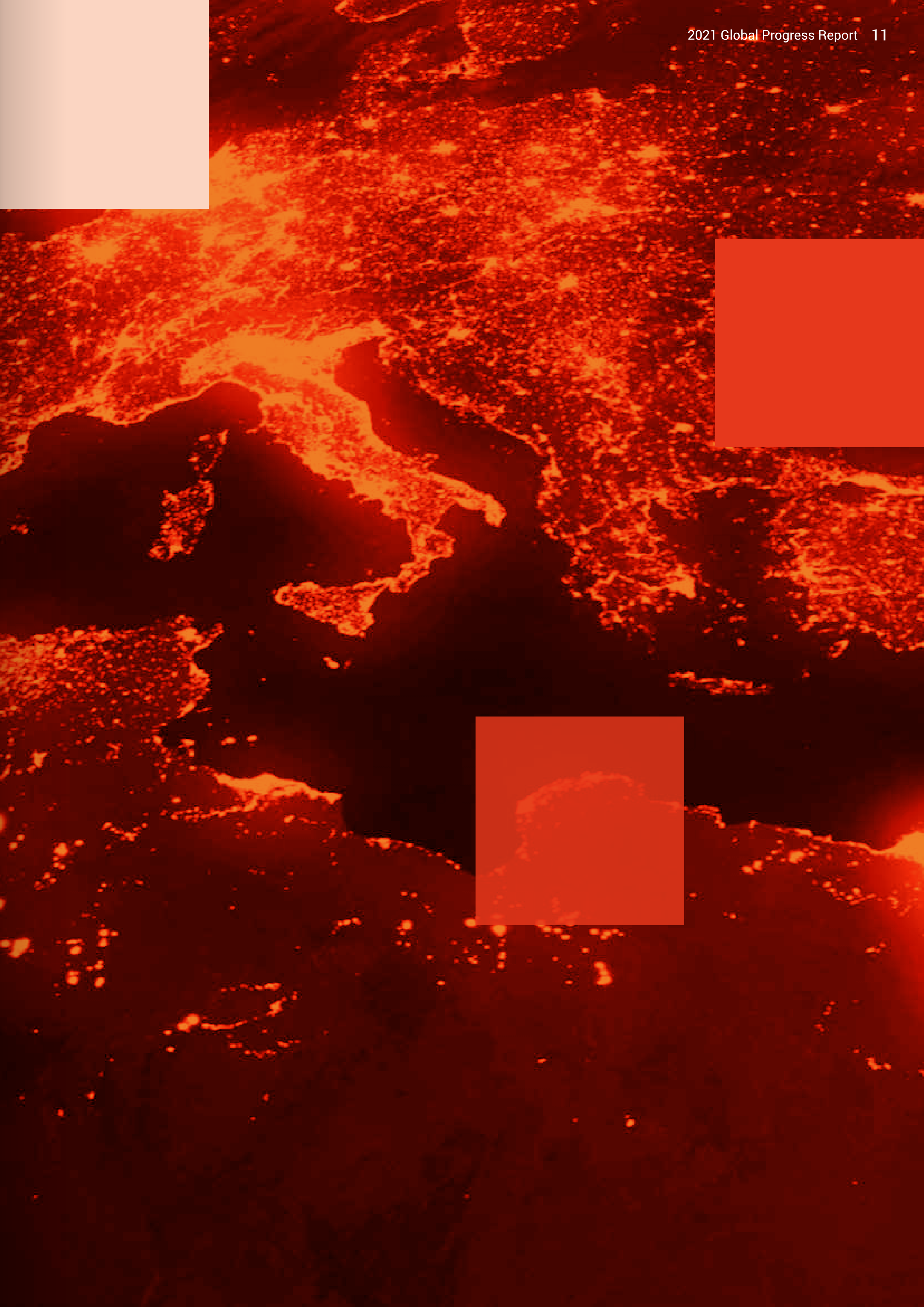


** Note: The included key measures are described in detail in the respective article chapters.*

Implementation of the Convention by provisions

3





General obligations (Article 5)

Key observations

- Parties have continued to make progress in enacting new or updating their existing tobacco control legislation or regulations to align them with the requirements under the Convention.
- As a new trend, many Parties address requirements under Article 5 in a comprehensive manner by developing legislation and a national strategy or action plan, and also by working on the establishment of the country's tobacco control infrastructure at the same time.
- With the amendment made to the reporting instrument in the section on Article 5.3 (new guidance provided to Parties in the reporting instrument and the step-by-step instructions), Parties seem to provide more detailed data as guided by the more specific open-ended questions. The new information received indicates that Parties devote more attention to preventing tobacco industry interference.
- Major legal challenges by the tobacco industry against laws or regulations implementing the WHO FCTC were concluded in favour of public health.

Comprehensive, multisectoral tobacco control strategies, plans and programmes (Article 5.1)
In 2020, some 71% of Parties had such strategies, plans and programmes in place. They are more prevalent now than in 2018 (67%).

Nineteen Parties reported having developed new strategies, plans and programmes since the previous reporting cycle, and one Party reported that its strategy is being developed. Of them, some Parties have reported integrating tobacco control in public health or development strategies, plans or programmes with broader scopes. This is a welcome tendency as it will on one hand raise the profile of the WHO FCTC and mobilize non-health sectors to contribute to the implementation of the Convention; on the other hand, it promotes the WHO FCTC as a key contributor to economic wealth and development. In this context, for example, Colombia included tobacco control in its 10-year plans for public health and for cancer control, and more recently, in the National Development Plan (2018–2022). In the Czech Republic, the National Drug Strategy (2019–2027) and its Action Plan for Implementation (2019–2021), approved by the Government, include tobacco control. The other Parties (Australia, Cabo Verde, Canada, Chad, Costa Rica, Cote d'Ivoire, Denmark, Iraq, Lithuania, the Netherlands, Paraguay, Poland, Russian Federation, Saudi Arabia, Tunisia, Turkey, and the United Kingdom of Great Britain and Northern Ireland) developed and adopted or revised their national tobacco control strategies, plans and programmes.

A few Parties (China, Denmark and the Netherlands) highlighted that many activities in their strategies, plans and programmes are targeted to youth. Also, as a tool for achieving a tobacco-free generation, an increasing number of Parties (or states or regions in case of countries with a federal structure) aim at making their societies smoke-free or tobacco-free. Overall, including the ones already mentioned in the previous reporting cycles, in the tobacco-free group we can count Canada, Finland, Ireland, Netherlands, and in the smoke-free group we have New Zealand and United Kingdom (including Northern Ireland, Scotland, Wales – and the territories Guernsey and Jersey); around half of them designated a target date for achieving the targeted status (tobacco-free or smoke-free). Also, along these lines, on 18 November 2019, the Government of the Russian Federation issued a decree through which it approved the "Concept for the implementation of the state policy to control the use of tobacco and other nicotine-containing products in Russia" until 2035. The aim of the Concept is to reduce the prevalence of tobacco and nicotine use, as well as the subsequent consideration of the phased withdrawal of tobacco and nicotine products from the market. The coordination

of such activities is carried out by the Coordination Council on Tobacco Control that operates under the Ministry of Health of the Russian Federation.

Infrastructure for tobacco control (Article 5.2(a)). A solid infrastructure for tobacco control is the basis of good governance which, in turn, ensures that WHO FCTC implementation is efficient and sustainable, and is protected from interference by the tobacco industry. The majority of Parties reported having a focal point for tobacco control and two thirds of Parties reported having a tobacco control unit. Furthermore, over two thirds of Parties reported having in place and operating national coordinating mechanisms for tobacco control (Fig. 3).

Fig. 3. Percentage (%) of Parties with tobacco control infrastructure in 2018-2020 (n=181)

Several Parties reported recent developments in this area. A number of Parties – Burundi (in relation to Article 15 of the Convention), Cabo Verde, China, Costa Rica, Gambia, Kiribati, Libya, Paraguay, Saudi Arabia, Sudan – reported that they have established a new national coordinating mechanism for tobacco control, or they have further developed or restructured their existing mechanisms. For example, in Paraguay, the National Executive Commission to Advise on the Implementation of the WHO FCTC was formed in 2019 through a Presidential Decree (Decreto No. 1711). The Commission composed of representatives of various ministries is expected to advise the president every six months. Similarly, in Libya, the National Committee to Combat Tobacco Use was created with the participation of ministries that implement measures related to tobacco use. A few additional Parties (Chad, El Salvador, Mexico, Peru and Venezuela) reported that they are in the process of establishing such national coordinating bodies.

Chad

Case study

Addressing Article 5 of the Convention in a comprehensive manner

Recent developments in Chad provide a good example on how measures required under Article 5 of the Convention can be addressed in a comprehensive manner. It is also an example on how implementation of the Convention could be strengthened if political will exists.

Chad, with assistance from the Convention Secretariat and its partners, carried out a needs assessment in 2017. In the post-needs assessment period, various activities were initiated in relation to Article 5, and they have led to recent impacts and outcomes.

In relation to Article 5.2(a), the National Multisectoral Committee for Tobacco Control, created in 2007 under the leadership of the Minister of Public Health, was further developed, and provincial subcommittees were created. The Committee – embodying participation from various ministries, civil society and other partners – established a working group to monitor tobacco industry interference in 2020. Regular coordination meetings are held at national and provincial levels.

Currently, a decree is being developed on the restructuring of the National Multisectoral Committee for Tobacco Control.

In relation to Article 5.2(b), a series of decrees have been elaborated to promote implementation of various articles to the Convention. These are as follows:

- On Article 5.3: Presidential Decree 1523 of 2019 on preventing tobacco industry interference. This decree is based on the recommendations of the Guidelines for Implementation of Article 5.3 of the Convention and has been developed with the assistance from the Union, a nongovernmental organization (NGO) that is accredited as an observer to the COP. The decree – among other measures – bans tobacco industry sponsorship (also in line with Article 13 of the Convention), calls upon civil servants to act to prevent tobacco industry interference and calls for transparency for any interactions that occur with the tobacco industry.
- On Article 8: Presidential Decree 1522 of 2019 on banning smoking in public places. The Decree comprehensively bans smoking in all workplaces, public places and public transport. It also prescribes fines for noncompliance and designated the authority (sanitary police) that monitors the implementation of these measures. The operation of the sanitary police is regulated in Presidential Decree 1611 of 2019.
- On Article 16: Joint Ministerial Decree of the Minister of Public Health and the Minister of Mining, Industrial Development, Trade and Promotion of the Private Sector on establishing tobacco sales points 179 of 2018. This decree reinforces the requirements of the Tobacco Control Act 2010 and prescribes rules for the placement and operation of tobacco sales units, and bans, for example, the operation of mobile sales points for tobacco.

All these presidential and ministerial decrees are based on and aim to further strengthen the implementation of the country's Tobacco Control Act of 10 June 2010.

In relation to Article 5.1, the Multisectoral Strategic Plan for Tobacco Control (2018-2022) and a communications plan for 2019-2023 were developed.

As part of mobilizing the society for its support for tobacco control measures, anti-tobacco clubs have been established in schools.

Chad is currently benefiting from assistance through the Convention Secretariat's FCTC 2030 project.

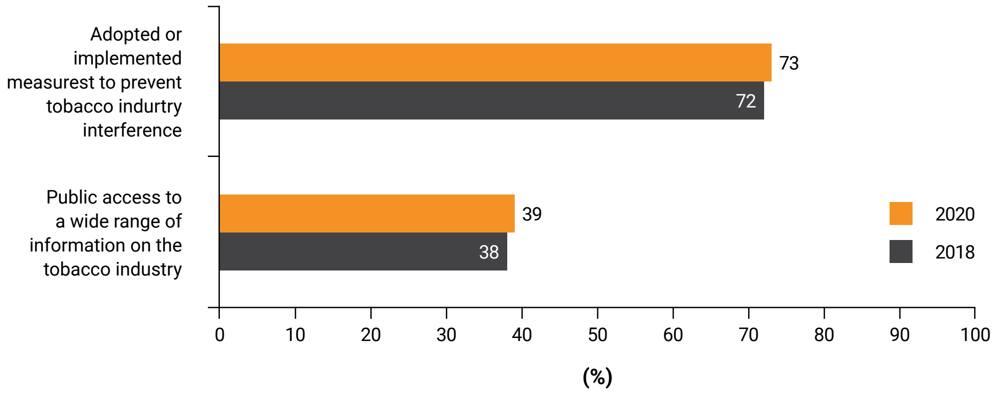
Adopting and implementing effective legislative, executive, administrative and/or other measures (Article 5.2(b)). Adopting national legislation or other executive, administrative and/or other measures are critical for implementation of the Convention, especially in the areas where the various sectors should work together to fulfil the requirements of the WHO FCTC.

In this reporting cycle, a number of Parties (Antigua and Barbuda, Belarus, Bolivia, Canada, China, Cote d'Ivoire, Gambia, Luxembourg, Saudi Arabia and Singapore) reported having developed new or having updated their existing tobacco control legislation (or equivalent executive or administrative measures), and two others (Cabo Verde and Chad) reported that they are in the progress of developing new legislation. For example, Gambia developed the Tobacco Control (Commencement) Order in 2018 and the Tobacco Control Regulations in 2019, following the adoption of the Tobacco Control Act in 2016. China adopted the first comprehensive health law that came into force on 1 June 2020; Article 78 of the law covers tobacco control. Antigua and Barbuda, Bolivia, and Cote d'Ivoire adopted their first-ever comprehensive tobacco control acts in accordance with the Convention.

Addressing requirements under Article 5 as a package, by working on at least two of the items (strategy, legislation and coordinating mechanism), was reported by many Parties, including Cabo Verde, Canada, Chad, Cote d'Ivoire, Gambia, Paraguay and Saudi Arabia. Of these, Cabo Verde, Chad, China and Saudi Arabia have done some work on all three areas. This is a welcome new trend and indicates that general obligations under the Convention could be used as cornerstones for making progress towards the full implementation of the Convention. Bahrain and Costa Rica also indicated that they have established a fund to sustainably support their national programmes, while Paraguay indicated that its programmes are funded through allocations from the national budget.

Protection of public health policies from commercial and other vested interests of the tobacco industry (Article 5.3) and related challenges. Overall, the majority of Parties have reported that they adopted or implemented some measures – of those recommended in the Guidelines for Implementation of Article 5.3 – to prevent tobacco industry interference (Fig. 4). Additionally, over one third of Parties reported providing public access to information on the activities of the tobacco industry. Practically, implementation rates for these measures have observed only minor changes since 2018.

Fig. 4. Percentage (%) of Parties implementing provisions under Article 5.3 in 2018–2020 (n=181)



Guidelines for Implementation of Article 5.3. Altogether 71% of Parties reported that they had utilized these Guidelines, with an observed increase from 2018 (68%). The actions reported by the Parties, in line with the recommendations of the Guidelines for implementation of Article 5.3, and in decreasing order of their mention, include the following: implementing an awareness campaign; conducting training workshops and sensitization activities on Article 5.3 for government employees; operating a repository or website to make information about the tobacco industry available to the public; having directives, guidelines, circulars or any other forms of guidance in place; and having in place or being in the process of developing a code of conduct. For example, in June 2019, to meet openness and transparency requirements of the Government of Canada, Health Canada's Tobacco Control Directorate implemented a web page containing a public record of meetings related to regulatory consultations with the tobacco and vaping industries, and information on science and technology matters. This project is in line with Principles 2 and 3 of the Guidelines for Implementation of Article 5.3. Mexico is currently reviewing its action protocol for public servants in contact with the tobacco industry. This document, which will be applicable to all states in Mexico, is in line with Article 5.3 of the WHO FCTC and its guidelines.

A specific aspect highlighted in the Guidelines for Implementation of Article 5.3 is the need to monitor tobacco industry activities at the country level. There are initiatives or developments at country and regional levels in this respect. For instance, in July 2019, the South Asian Regional Consortium Centre for Combating Tobacco was also inaugurated in Sri Lanka. The Centre serves as an observatory that monitors tobacco industry activities and implementation of Article 5.3 of the WHO FCTC in the South Asian region. Partner organizations of the Consortium are from Afghanistan, Bhutan, Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka. Among its projects is the Tobacco Unmasked, which provides evidence-based information on the tobacco industry, with detailed profiles of tobacco companies. The Tobacco Unmasked website[12] also contains profiles of tobacco industry allies, as well as those of institutions and individuals linked with the industry. Tobacco industry arguments and their responses against different policy processes are also reported to be used as reference. A mobile application to obtain information on tobacco industry activities is also underway. Additionally, Bangladesh, Egypt and Ukraine established tobacco industry monitoring centres, with the technical assistance of the WHO FCTC Knowledge Hub for Article 5.3.

Parties have also reported on legal challenges they faced during their implementation of the WHO FCTC (see also the chapter on Article 11). In November 2019, the Supreme Court of Kenya dismissed an appeal brought by British American Tobacco, ending the company's challenge to the Tobacco Control Regulations. The decision upheld on all grounds the earlier decisions of the High Court and Court of Appeal finding in favour of the Kenyan Ministry of Health. The Court found that there had been no denial of the right to public participation in the making of the regulations, that provisions implementing Article 5.3 did not discriminate against British American Tobacco because it was reasonable to treat the tobacco industry differently in light of its negative health impacts, that disclosure obligations did not violate tobacco companies' intellectual property rights or privacy because they were proportionate to the need to protect public health, and that a requirement for tobacco companies to contribute to a compensation fund was constitutionally valid. The decision is final and there is no further avenue for appeal. It is a landmark victory for public health and an important precedent upholding Article 5.3 implementation from legal challenge.[13]

12 http://www.tobaccounmasked.com/index.php/Main_Page
13 See details at: https://untobaccocontrol.org/kh/legal-challenges/supreme-court-kenya-rejects-british-american-tobacco-appeal-tobacco-control-regulations/; and https://www.tobaccocontrollaws.org/litigation/decisions/ke-20191126-british-american-tobacco-ltd-v

Australia

Case study

Guidance for Public Officials on Interacting with the Tobacco Industry

In line with its obligations and commitment to the WHO FCTC, on 1 November 2019, Australia published Guidance for Public Officials on Interacting with the Tobacco Industry.

This guidance document outlines the legal obligations placed on government agencies and officials, including those who are acting on behalf of any branch or level of government, such as consultants, by Article 5.3 of the WHO FCTC regarding protecting public health policies in relation to tobacco control from commercial and other vested interests of the tobacco industry. Consistent with requirements of Article 5.3 and decisions of the COP, it also extends the obligation to protect tobacco control policies from commercial and other vested interests of the tobacco industry to novel and emerging tobacco products and nicotine products, such as electronic cigarettes and heated tobacco products.

The guidance document is intended to be viewed as part of a comprehensive strategy of tobacco control. The document, guided by the principles of Article 5.3, acknowledges the fundamental and irreconcilable conflict between tobacco industry and public health policy interests. It demonstrates how the tobacco industry continues to try to undermine the role of governments in protecting public health policies. It upholds the importance of accountability and transparency when dealing with the tobacco industry, as well as preventive measures to protect its tobacco control policy setting from tobacco industry interference and interests.

Guidance for Public Officials on Interacting with the Tobacco Industry

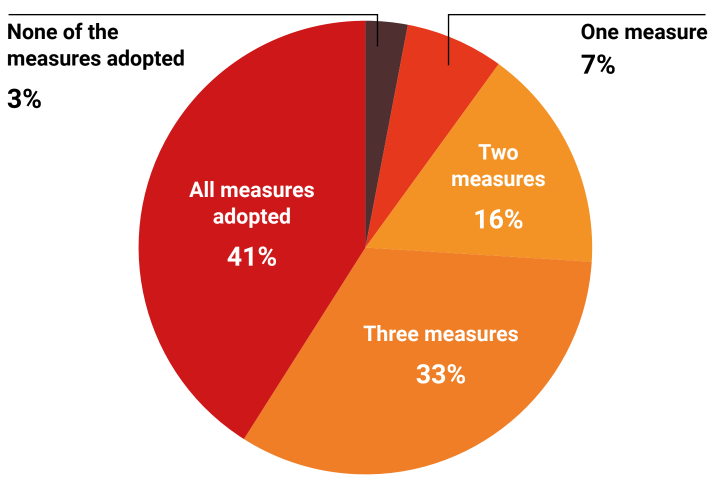
According to this guidance document, consultations with the tobacco industry should be strictly limited to what is necessary for public officials or agencies to enact effective tobacco control measures. Overall, the document highlights concrete and specific guidelines and recommendations in: 1) limiting interactions with the tobacco industry; 2) avoiding and managing conflicts of interest with the tobacco industry; 3) requiring information provided by the tobacco industry to be transparent and accurate; 4) rejecting partnership with the tobacco industry; 5) avoiding preferential treatment; and 6) unmasking the tobacco industry's "socially responsible" activities. All agencies are encouraged to incorporate this guidance document into staff induction materials.

Australia is among the few countries to adopt national guidance material that applies to all public officials on dealing with tobacco industry interference. It has been taking active steps to reduce prevalence of tobacco smoking, as well as in implementing effective regulatory frameworks and policies concerning tobacco control and tobacco industry interference.

Australia, which has been a Party to the WHO FCTC since 27 October 2004 and was the first country to apply plain packaging to tobacco, has among the lowest smoking prevalence rate in the world.

Comprehensiveness of the implementation of the Article 5. In addition to the analysis of the individual measures required under the Article 5, the comprehensiveness of the implementation was analysed by reviewing a cluster of measures related to the national strategies, tobacco control infrastructure and protection from the industry interference. The indicators used included national multisectoral tobacco control strategies, plans and programmes; focal points for tobacco control; national coordinating mechanisms for tobacco control; and measures to prevent tobacco industry interference. By 2020, less than one half (74 Parties) had adopted all these measures (Fig. 5). Additionally, one third (60 Parties) had adopted three out of these four measures.

Fig. 5. The number of measures[14] adopted under Article 5 by Parties, by 2020 (n=181)



14 The following indicators from the reporting instrument were utilized: 1) national multisectoral tobacco control strategies, plans and programmes; 2) focal points for tobacco control; 3) national coordinating mechanisms for tobacco control; and 4) measures to prevent tobacco industry interference.

Reduction of demand for tobacco

Price and tax measures to reduce the demand for tobacco (Article 6)

Key observations

- Reporting of data related to tobacco taxation and pricing, as required in Article 6.3 of the Convention, still remains a challenge for many Parties, especially for tobacco products other than cigarettes. Based on data submitted in the 2020 reporting cycle, three in four Parties provided tax information; however, less than one in three Parties provided 2020 price data.
- Neither the proportion of Parties earmarking 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 has changed since the previous analysis.

Taxation of tobacco products. In the most recent dataset, 153 Parties (85%) responded that they had implemented tax policies and, where appropriate, price policies on tobacco products, compared to 81% of Parties in 2018. After taking into account the information submitted in the 2020 reporting cycle, with 138 Parties (76%) reporting, there is sufficient information on tobacco taxes and prices to be included in the analysis. Most Parties provided data on cigarettes only. Forty-three Parties (24%) did not provide tax information, not even for cigarettes.

The global median total tax burden – that is, the sum of excise tax, value-added tax and/or other sales taxes, and other duties and levies, expressed as a percentage of the retail price – on the most popular price category of tobacco product is 60%, down from 63% when compared to the 2018 data. The World Health Organization (WHO) European Region continues to have the highest median tax burden, as was the case in the previous reporting cycle. Out of the aforementioned 138 Parties, 104 responded to the question on Total Tax Burden in the 2020 reporting cycle, and 34 Parties (25%) did not report on their average total tax burden. The analysis of these responses, represented in Table 1, also includes an additional 32 responses from 2018 to account for Parties that did not provide a response in 2020. From these 136 Parties that reported on their average total tax burden in 2018 and 2020, 38 Parties reported having an average total tax burden of at least 75% and above.

The median tax burden in the WHO African Region is 34% and remained unchanged since 2018 (Table 1). Globally, this represents the lowest median tax burden. Unfortunately, no positive change was detectable in the tax burden across all regions, except in the WHO Eastern Mediterranean Region, where the impact of the recent Gulf tobacco tax policy seems to be reflected in the figures.

Table 1. Total tax burden by WHO region, and global tax burden weighted and median, 2018 versus 2020

Median total tax burden		
WHO region	2018	2020
African	34%	34%
Americas	53%	49%
South-East Asia	76%	54%
European	78%	76%
Eastern Mediterranean	60%	68%
Western Pacific	63%	60%
Global tax burden weighted average and median[15]		
Weighted average global tax burden	57%	55%
Median global tax burden	63%	60%

Based on the latest information submitted in 2020, a total of 138 Parties reported on their cigarette excise structures. Of these, 119 Parties had reported on their tax structures in 2018 as well, making a comparison possible (Table 2). Ten out of the 119 reported that their excise tax structures had changed since the last reporting period. Two of these countries had an *ad valorem* system; one of these changed to a mixed system and one to a purely specific system. Three countries had a mixed system; two of them changed to a purely specific system and one to a purely *ad valorem* system. Three countries removed the specific excise tax and instead rely on import duties. The two remaining countries had a specific system; one country moved to a mixed system, and one to an *ad valorem* system. Table 2 shows that globally the most common tax structure is a mixed tax structure that incorporates both *ad valorem* and specific taxes.

Table 2. Cigarette excise regimes based on the 2020 reporting cycle, by WHO region

WHO region	Type of excise tax							Import duty only	%	Total no. reporting (i.e. with tax answer)	Without tax answer
	Specific only	%	Ad valorem only	%	Both specific and ad valorem	%	Total excise				
African	6	29%	6	29%	8	38%	20	1	5%	21	2
Eastern Mediterranean	3	17%	5	28%	5	28%	13	5	28%	18	0
European	3	9%	0	0%	30	91%	33	0	0%	33	0
Americas	4	22%	2	11%	12	67%	18	0	0%	18	0
South-East Asia	2	50%	1	25%	1	25%	4	0	0%	4	1
Western Pacific	15	71%	2	10%	3	14%	20	1	5%	21	1
Overall	**33**	**29%**	**16**	**14%**	**59**	**51%**	**108**	**7**	**6%**	**115**	**4**

A combination of specific and *ad valorem* rates remains the most-favoured excise regime in the European Region, used by a large proportion of Parties in that Region. Countries

15 The weighted average measure takes into consideration the total number of Parties in each region, in order to account for the differences between each region.
The median measure is useful for a skewed distribution and denotes the value which lies at the midpoint of that distribution.

that belong to the European Union (EU) are obliged to implement such a mixed system under EU Directive 2011/64/EU. Some 71% of Parties in the WHO Western Pacific Region have a purely specific tax system, which is recommended over an *ad valorem* tax by the Guidelines for Implementation of Article 6.

Important developments can be observed at regional or subregional levels. As an important development in the African Region, the recently adopted tax Directive C/DIR.1/12/17[16] of the Economic Community of West African States (ECOWAS) improves the excise tax structure, increases the level of excise tax and helps to harmonize excise duties on tobacco products. Historically, the tobacco tax rates of ECOWAS Member States have been lower than the global average and the average for sub-Saharan Africa. The new Directive requires ECOWAS Member States to set the ad valorem excise tax rate on tobacco products to at least 50% of the ex-factory value (for domestic production) or the cost-insurance-freight value (for imports) and, for the first time, introduces a minimum specific tax at a rate of US$ 40 per pack of 20 cigarettes (or US$ 0.02 per stick). The introduction of a specific excise tax component under the new Directive is a significant positive change that ensures that the excise tax in the ECOWAS region is more WHO FCTC-compliant.

In 2016, Member States of the Cooperation Council for the Arab States of the Gulf[17] agreed on collective tax reforms, including imposing, for the first time, excise taxeson tobacco products. This would be applied in the form of a selectivity tax of 100% on the net-of-tax price and a 5% value-added tax, based on the sum of the net-of tax price and the excise tax. Following this decision, the policy has since been rolled out across the GCC countries, and they have now all but one (Kuwait) implemented tobacco tax reforms.

Changes in taxation across reporting cycles. It is also important to detect a tendency for regular adjustments of tobacco tax rates in line with the recommendations of the Guidelines for Implementation of Article 6 of the WHO FCTC. An innovative initiative, adopted by some countries, is to announce a road map of tax increases for a number of future years. For example, the Philippines explicitly announced annual increases in the excise tax, between 2020 and 2023, followed by a 5% annual increase from 2024 onwards (see text box). Another example is Australia, which has been consistently increasing the excise tax on cigarettes by 12.5% each year since 2013, in four-yearly cycles. Finland has increased tax rates on average by 21% between 2018 and 2019. Tax increases are implemented every six months and were expected to continue in 2020 and 2021.

Price of tobacco products. Based on the most recent information, 126 Parties had sufficient information on prices (from any year) for domestic and/or imported brands of cigarettes to be included in the analysis on minimum and maximum prices for cigarettes. This information is presented in Table 3.

It is still a challenge for the Parties to provide *updated or current* price information in every implementation report they submit. Despite this challenge, there has been an improvement in the reporting of data on cigarette prices. For the 2020 analysis, out of the 126 Parties that had information on prices from any year, 39 of these 126 (31%) provided *current* price data for 2020. In comparison, 24 out of 142 Parties (17%) provided current price data in the 2018 reporting cycle.

16 Directive C/DIR.1/12/17 on the Harmonization of Excise Duties on Tobacco Products in ECOWAS Member States. Available: http://ecotipa.ecowas.int/wp-content/uploads/2018/05/3-DIRECTIVE-TOBACCO-2017-DEC-FOLDER.pdf

17 Previously known as Gulf Cooperation Council. The members of this regional group are: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates. It is to be recalled that in the European Union, tobacco taxation is also harmonized and regulated by the tobacco tax directive, last amended in 2011. https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:176:0024:0036:EN:PDF

Of the 138 Parties reporting in 2020, 66 Parties either did not have updated information about prices or provided no information at all, making comparisons with the previous reporting cycle impossible. Of the remaining 72 Parties, 58 (81%) reported that the price of tobacco products had increased since 2018. Four of these reported annual increases. Three Parties reported a decrease in the price of tobacco products, despite the fact that an excise tax was either introduced or increased. Eleven Parties reported no changes in the price of tobacco products from the last reporting period.

Table 3 presents maximum and minimum prices for a pack of 20 cigarettes of the most widely sold brands, expressed in US dollars using market exchange rates, by WHO region, for 2018 and 2020, as well as the ratio of the two prices within each region.[18]

Table 3. Minimum and maximum prices for a pack of 20 cigarettes in US dollars by WHO region in 2018 and 2020

WHO region	2018				2020			
	Minimum (country) US$	Maximum (country) US$	Ratio	Total reporting Parties in 2018	Minimum (country) US$	Maximum (country) US$	Ratio	Total reporting Parties in 2020
African	0.07	7.35	105.0	32	0.04	10.27	256.8	27
Americas	1.14	11.47	10.1	23	1.00	18.12	18.1	21
South-East Asia	1.22	4.55	3.7	7	0.24	2.60	10.8	4
European	0.87	14.79	17.0	39	1.12	14.79	13.2	33
Eastern Mediterranean	0.42	6.04	14.4	19	0.22	6.04	27.5	17
Western Pacific	0.90	16.54	18.4	22	0.78	20.23	25.9	24
Total				**142**				**126**

In accordance with the new data received, the European Region is the only region that experienced an increase of minimum prices and a reduction of the ratio of maximum to minimum prices between the two reporting periods. For the other five WHO regions, the reported minimum prices are even lower than in 2018; however, the reported maximum prices are higher in 2020 than in 2018 in four of the six regions. Subsequently, in five of the six WHO regions the ratio of maximum to minimum price is higher in 2020 compared to 2018, reflecting an increase in the maximum prices.

Earmarking tobacco taxes for funding tobacco control. Between the 2018 and the 2020 analysis there has been no change in the proportion of Parties reporting that they earmark tobacco taxes. With the inclusion of the latest information submitted in 2020, 34 (19%) of all Parties indicated that they earmark a percentage of their taxation income for funding any national plans, tobacco control strategies, or other activities, such as sport.

Tax- and duty-free tobacco products. Nearly two thirds of Parties (64%) indicated that they prohibit or restrict tobacco imports by international travellers, and 49% indicated they restrict the sale of cigarettes to international travellers. Both proportions remained at a similar level to that in 2018.

Guidelines for Implementation of Article 6. By 2020, 61% of all Parties reported having utilized these Guidelines, compared with 57% in 2018.

18 Data on cigarette prices presented in this table originate from the reports of the Parties submitted in 2020.

The Philippines

Case study

Navigating the political economy of tobacco tax reform

Republic Act No. 10351, popularly known as the Sin Tax Law, was enacted in 2012 and represented an important first step in the Philippines's long-term plan for tobacco tax reform. The law simplified the excise tax structure by collapsing multiple tiers to a single tier over a period of five years. The large increases in the excise tax made cigarettes substantially less affordable. Between 2012 and 2015, smoking prevalence in the Philippines among adults decreased from 29% to 25%,[19] with other sources reporting a reduction to 23.8%.[20] Over the same time period, smoking prevalence among youth (18–24 years) decreased from 35% to 22%.[21]

The law was passed despite the efforts of tobacco-industry lobbyists, who had successfully hindered previous excise tax reforms. The Sin Tax Law of 2012 demonstrated that tobacco taxation can be politically palatable and can achieve its developmental and health objectives. This paved the way for future tax reforms, described in the paragraphs below.

1. Achieving health and development objectives

Two laws – Republic Act No. 11346 and Republic Act No. 11467, enacted in 2019 and 2020, respectively – updated the tax rates for tobacco and introduced rates for heated tobacco/vapour products. The revenues from each product are intended to fund the attainment of health and other development objectives, as follows:

- **Of the 50% of total excise tax collected from tobacco products**, 80% will go to the National Health Insurance Program as part of the implementation of the Universal Health Care Act. The remaining 20% will be for the improvement of health infrastructure under the Health Facilities Enhancement Program.
- **Of the 100% of the excise tax from heated tobacco and vapour products,** 60% will go to the National Health Insurance Program as part of the implementation of the Universal Health Care Act, 20% for the Health Facilities Enhancement Program and the remaining 20% for programmes towards the attainment of the Sustainable Development Goals.

2. Earmarking to promote alternative livelihoods in accordance with Article 17 of the Convention

In Republic Act No. 11346, an allocation for the livelihood of tobacco farmers equivalent to 5% of revenue collection, but not exceeding 4 billion Philippine pesos (approximately US$ 80 million), was included. This is earmarked for tobacco-producing provinces in order to promote economically viable alternatives for tobacco farmers and workers in those areas.

The Philippines continues to implement the WHO FCTC Article 6 strategy by consistently and predictably increasing the excise tax to make tobacco products less affordable over time. According to the latest tax schedule for tobacco products (Republic Act No.

19 Kaiser, K., Bredenkamp, C., & Iglesias, R. (2016). Sin tax reform in the Philippines: transforming public finance, health, and governance for more inclusive development. World Bank Publications.
20 Global Adult Tobacco Survey: Country Report 2015.

11346) the unitary excise tax[22] increased to 45 Philippine pesos (US$ .90) in 2020, with an increase of 5 Philippine pesos (US$ .10) each year between 2021 and 2023, and then by 5% to adjust for inflation from 2024 onwards. This will further reduce cigarette consumption and improve domestic resource mobilization for financing universal health coverage and supporting tobacco farmers as they find alternative sources of income.

PhilHealth Executive Vice President and Chief Operating Officer Ruben John A. Basa, Health Secretary Francisco Duque, PhilHealth Acting Senior Vice President and Concurrent Vice President Nerissa R. Santiago, Finance Secretary Dominguez, and former Department of Finance Undersecretary and Chief Economist Karl Kendrick T. Chua exhibited their fist-fight-stance against 'Yosi Kadiri' after their joint press conference held 17 May 2019 in Manila reiterating the need for the Senate to act swiftly on the pending bill to increase sin tax revenues that will be spent on universal health care. (Photo courtesy of Dr Grace Fe R. Buquiran, Department of Health, Philippines)

21 Kaiser, K., Bredenkamp, C., & Iglesias, R. (2016). Sin tax reform in the Philippines: transforming public finance, health, and governance for more inclusive development. World Bank Publications.

22 RA 11467 Section 3 C. For cigarettes packed by machines

Protection from exposure to tobacco smoke (Article 8)

Key observations

- Article 8, a time-bound article that is among the priorities identified in the Global Strategy, remains the most-implemented article of the Convention; Parties have continued to make progress in strengthening their policies to ensure higher-level protection of their citizens from environmental tobacco smoke.
- There is an increasing number of examples where subnational jurisdictions build upon and strengthen already existing nationwide smoking bans to extend them to various outdoor areas. This is done through decrees, administrative and executive orders, and other mechanisms at the disposal of such subnational entities.
- More progress is still needed in moving from partial to complete smoking bans especially in the hospitality sector and private workplaces.

Measures to protect from environmental tobacco smoke. In 2020, overall, 94% of 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 minor increase as compared to 92% in 2018.

The majority of Parties (89%) include some kind of smoking bans in their national legislation, up from 84% in 2018. In addition, 27% of Parties reported that they have subnational legislation on smoke-free environments. On the other hand, 20% of Parties reported having smoking bans based on voluntary agreements. In their progress notes, several Parties described new legislative measures (or amendments of their existing legislation) to strengthen protection of their citizens from second-hand smoke. Those Parties that have reported that they adopted or enacted, since 2018, new legislation with measures concerning Article 8 of the Convention include Antigua and Barbuda, Belarus, Cote d'Ivoire, the Democratic Republic of the Congo, Georgia, Japan, Latvia, Lithuania, Malaysia, Mauritania, Niue, the Republic of Korea, Saint Lucia, Sweden and Thailand.

Requirements for smoke-free environments are most often included in Parties' comprehensive tobacco control laws. In other cases, measures concerning Article 8 of the Convention are included in more comprehensive – health promotion or public health – acts, along with other tobacco control measures. In many cases, laws are complemented by additional instruments, for example, regulations, decrees, and administrative and executive instruments, that provide more details on how the smoking bans need to be implemented by the authorities. Of those countries that previously had lower-level regulations (such as circular letters, ministerial orders or decrees) to establish smoke-free environments, many have replaced such instruments with national laws and corresponding regulations, at the same time making their regulatory framework more compliant and aligned to the requirements of the Convention.

There are also many examples where a combination of instruments (laws, regulations, decrees, administrative/executive orders or local ordinances, etc.) are being used by a Party. For example, in addition to nationwide measures, a number of Parties report that their subnational jurisdictions, including local governments, take the initiative to ban smoking in outdoor areas, as described above. In federal states such as Australia and Canada, subnational smoke-free policies are widespread, but countries that do not have a federal structure also use this option when at the national level, smoking bans are not yet enacted or they are not complete.

As an example we find the Republic of Korea, which has a national law providing a framework for action on tobacco control; the National Health Promotion Act 1995 sets the target facilities for the smoking ban and foresees fines for non-compliance. Based on it,

municipalities, by municipal bylaws, could designate non-smoking areas and impose fines. An administrative order – the Enforcement Regulations – specify the range of penalties in case of non-compliance, such as smoking in a smoke-free zone. Some institutions, such as student clubs at universities, companies and apartment dwellers have the power to adopt self-regulations (voluntary agreements) to ban smoking through bottom-up initiatives. Finally, and in a complementary manner, a number of private companies reflect employees' smoking habits in their performance assessments, as well as in hiring procedures. The Ministry of Health and Welfare awards a prize every year, on the World No Tobacco Day, to the company that has best demonstrated its efforts to promote the health of its employees, for example by running smoking cessation programmes.

Other examples among the many countries that use a combination of legislative, executive, administrative or other measures to provide for smoke-free environments, include but are not limited to Austria, Belarus, Chile, Croatia, the Czech Republic, France, Panama, Peru, the Philippines, Singapore, Thailand and Turkey. They have reported having more than two types of instruments – building on each other – to ensure the highest possible level of protection from environmental tobacco smoke.

As Fig. 6 shows, complete smoking bans are most common in aeroplanes, ground public transport, educational facilities and health-care facilities, and they are applied in these settings by more than 80% of Parties. Partial bans are still typical in hospitality establishments – restaurants, pubs, bars and nightclubs – and in private workplaces; around one third of Parties only have partial bans in these settings. As compared to 2018, complete smoking bans became slightly more common in most of the settings. Smoking bans in private vehicles are still not widespread.

Fig. 6. Percentage (%) of Parties that have reported having adopted complete or partial smoking bans in different settings 2018–2020 (n=181)

Setting	Year	Complete Ban	Partial Ban
Aeroplanes	2020	91	3
	2018	89	3
Ground public transport	2020	83	10
	2018	81	9
Educational facilities	2020	83	9
	2018	81	8
Health-care facilities	2020	82	11
	2018	79	10
Motor vehicles used for work	2020	77	16
	2018	75	16
Government buildings	2020	77	16
	2018	75	15
Cultural facilities	2020	72	19
	2018	69	20
Universities	2020	70	20
	2018	69	18
Trains	2020	66	9
	2018	62	10
Shopping malls	2020	65	26
	2018	62	24
Ferries	2020	60	18
	2018	58	17
Restaurants	2020	54	37
	2018	51	37
Private workplaces	2020	51	35
	2018	52	31
Pubs and bars	2020	46	34
	2018	45	34
Nightclubs	2020	45	32
	2018	44	30
Private vehicles	2020	17	20
	2018	15	22

(%)

The established trend of extending smoking bans to outdoor areas and cars when children are present continued. Among the outdoor areas concerned, playgrounds and sports stadiums are the most often covered, but other sites such as parks, public gardens, zoos, theme parks, water parks and even streets or parts of cities have also become smoke-free in some Parties. Also, in an increasing number of Parties, the concept of smoke-free villages and cities is spreading, and such measures are based on administrative/executive orders of subnational or local governments or other relevant authorities. China reported having now 20 smoke-free cities, covering one tenth of the total population of China. Fiji reported having four smoke-free villages and three smoke-free cities. In Kiribati, 224 communities (villages/maneaba halls) declared themselves smoke-free communities. In Mexico, three federal entities (states) have introduced laws to require smoke-free environments (Aguascalientes, Chiapas and Yucatan). Paraguay reported that 94 (out of a total of 254) of its municipalities have adopted smoke-free ordinances. The Islamic Republic of Iran reported that Qom became a smoke-free city, just as other holy cities have, such as Mecca and Medina in Saudi Arabia.

In the Philippines, there is an increasing number of local government units that adopted local ordinances to create 100% smoke-free environments; those implementing such ordinances could win the Red Orchid Award that acts as an incentive for the others to also take action. The communication component around the Red Orchid Award is also used to raise awareness of the need to strengthen implementation of smoke-free measures, in line with the Article 12 of the Convention.

Banning smoking in cars when children are present is also highlighted by some Parties, but the age definition of the child varies (it is usually 18 years, but other options are 12 or 14). In Italy and Lithuania, pregnant women are also protected this way, and smoking is not allowed in cars in their presence. In Bulgaria, smoking by those under 18 is forbidden even in those open public places where smoking is otherwise allowed.

Universal protection from the exposure to tobacco smoke. As reiterated in the Guidelines for Implementation of Article 8, Parties should strive to provide universal protection within five years of the WHO FCTC's entry into force for that Party, by ensuring that all indoor public places, all indoor workplaces, all public transport and possibly other (outdoor or quasi-outdoor) public places are free from exposure to second-hand tobacco smoke by law. To assess compliance with this obligation, the complete smoking bans reported by the Parties were analysed in clusters of key settings from the key indicators used in the reporting instrument.

Although the implementation rates by individual indicators are high in most of the settings, observing the indicators in clusters (for example, a combination of indicators), the picture is no longer that promising. Analysing implementation rates in clusters might be an indicator of the comprehensiveness of national legislations/regulations: the higher the clustered implementation rates, the more comprehensive the legislations/regulations adopted.

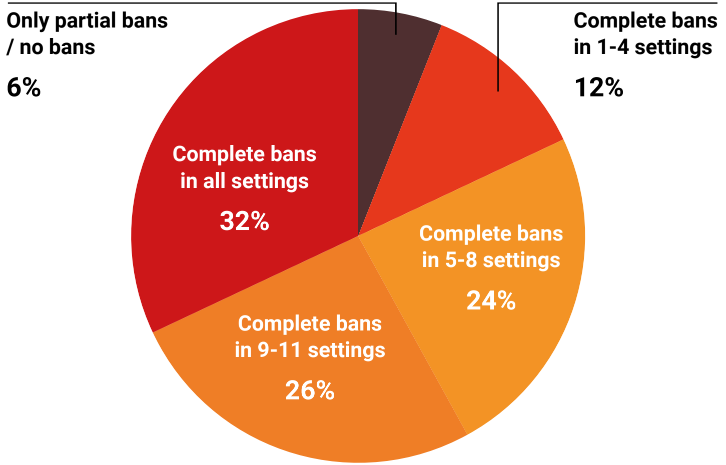
For universal protection in indoor workplaces and indoor public places, the following settings were included in the analysis: government buildings, health-care facilities, educational facilities, universities, private workplaces, motor vehicles used as places of work (for example, taxis, ambulances or delivery vehicles), cultural facilities and shopping malls. By 2020, only 75 Parties (41% of 181 Parties) have reported that they have complete smoking bans in all these settings.

Additionally, 82 Parties (45%) have reported complete smoking bans in all pubs, bars and restaurants. The obligation of universal protection is best met in public transportation (another combined indicator), where altogether 146 Parties (81%) have reported by 2020 that they have complete smoking bans in both ground public transport (buses, trolleybuses and trams) and aeroplanes.[23]

23 Trains and ferries were excluded from the calculation as many Parties do not have these means of transportation.

Overall, meeting the obligation under the Convention to provide universal protection from the exposure to tobacco smoke, Parties should apply complete bans on tobacco use – by law – in all or in as many settings as possible. When assessing compliance in all the above settings together, only less than one third (58) of Parties have reported having complete smoking bans in all these settings (Fig. 7). However, additional 48 Parties have reported complete smoking bans in most of these settings (Fig. 7).

Fig. 7. Number of settings covered by complete smoking bans in indoor workplaces, indoor public places and public transport[24] reported by Parties by 2020 (n=181)



Mechanisms/infrastructure for enforcement. Some 82% of Parties reported having put in place a mechanism/infrastructure for the enforcement of smoke-free measures. Many Parties have provided details of the enforcement infrastructures they put in place including, as suggested by the Guidelines, the authority or authorities responsible for enforcement and a system for both monitoring compliance and prosecuting violators.

Effectively enforcing smoke-free legislation is a critical component of ensuring high impact, and learning from Parties' experience in enforcement needs to receive more attention in the future. The details Parties provided on their enforcement infrastructure and activities was therefore thoroughly analysed. The key stakeholders involved, the agencies and particularly the officials responsible for enforcement, the local governments and the judiciary system, and the ways they participate in and coordinate among themselves during the enforcement activities show significant variation among the Parties. Some general patterns could, however, be observed.

To start with, most Parties utilized the infrastructures and compliance mechanisms already in place for inspecting business premises and workplaces. More than 30 Parties indicated that in the government, health ministries (and, to a lesser extent, other ministries such as interior, justice and their affiliates, for example, public health agencies) have a role in the overall coordination of enforcement activities of smoke-free policies. To a similar extent, more than 30 Parties reported that the police force (in some cases sanitary police and civil police) has a role in the process, and a small number of Parties reported that customs also have a role in carrying out enforcement actions on the ground. Twenty-three Parties specifically highlighted the involvement of local governments and their local authorities, including fire, transport, housing and labour supervision authorities, as

24 List of included settings from the reporting instrument: 1) aeroplanes; 2) ground public transport (buses, trolleybuses and trams); 3) government buildings; 4) health-care facilities; 5) educational facilities; 6) universities; 7) private workplaces; 8) motor vehicles used as places of work (for example, taxis, ambulances or delivery vehicles); 9) cultural facilities; 10) shopping malls; 11) pubs and bars; and 12) restaurants.

recommended by the Guidelines for Implementation of Article 8. The inspectors employed by these authorities, whose duty is to supervise implementation of smoke-free rules, include health, public health, environmental, food security and consumer protection inspectors ("authorized officers"). The Marshall Islands reported that the Kumit Bobrae Coalition, a community-based non-profit organization, incorporated under the national law in March 2011, also has a role in enforcing smoke-free legislation.

Countries with federal structures, including Australia and Canada, reported that their enforcement infrastructure is complex and differs state by state. Australia provides a good summary of enforcement authorities by state, and Canada, in its description, provides examples of enforcement procedures. The United Kingdom of Great Britain and Norther Ireland submitted a document titled *Implementation of smokefree legislation in England: Guidance for council regulatory officers – second edition,*[25] as an example of a guidance document describing the enforcement infrastructure and its functioning. Colombia also submitted details of a platform with information on the surveillance infrastructure and initiatives of the capital Bogotá.[26]

Some Parties have established specific entities to enforce smoke-free rules or implement specific projects – mostly based on information technology – to help carrying out enforcement actions. For example, in Tonga, a special Tobacco Enforcement Unit was established within the Ministry of Health that conducts enforcement activities throughout the country, including its outer islands. In Turkey, an inspection system utilizing mobile devices is in use, through which even the pictures taken during the inspection are available online. Attached to it, there is a Green Detector Mobile Application, where law violations could be notified by anyone. A similar system available for the public to report violations of the smoke-free legislation is available in the Russian Federation.

Several Parties also reported strengthening their existing enforcement of smoke-free rules. For example, Azerbaijan introduced new types of penalties in its Code on Administrative Offences in relation to smoking in places where it is forbidden; even bus drivers who smoke while at work could be reported to the authorities. In Austria, the Constitutional Court confirmed that there should be no exceptions regarding complete smoking bans, irrespective of whether they are Conventional tobacco products or novel and emerging tobacco products; bans should therefore equally apply to all types of e-cigarettes and water pipes.

On the implementation side, 17 Parties specifically highlighted the importance of placing the responsibility for compliance on the owner, manager, caretaker or other person in charge of the premises that are subject to regulation, and the latter also identifies the actions they are required to take.

Further analysis and documenting of the functioning of smoke-free enforcement infrastructure could provide Parties with more practical, on-the-ground examples of successful interventions that could ensure effective application of the law. This is especially important in the few years following the adoption and enacting of smoke-free legislation, up until such rules become a daily routine and part of everyday practice.

Guidelines for Implementation of Article 8. By 2020, 73% of all Parties reported having utilized these Guidelines compared to 70% in 2018.

25 https://www.cieh.org/media/1258/implementation-of-smokefree-legislation-in-england-guidance-for-council-regulatory-officers-second-edition.pdf

26 https://saludata.saludcapital.gov.co/osb/index.php/datos-de-salud/salud-ambiental/libreshumo/

Seychelles

Case study

A Party engaged with WHO in a tobacco compliance pilot project

To strengthen WHO's ability to report accurate, quality, reliable and comparable data on compliance with tobacco control policies, WHO conducted a pilot survey project to test different approaches to collect data for monitoring compliance with smoke-free policies and bans on tobacco advertising, promotion and sponsorship. Seychelles was one of seven participating pilot countries in this 2019 study.

The Seychelles Tobacco Control Act, enacted in 2009, prescribes a total ban on smoking in all enclosed places and a total ban on all direct and indirect tobacco advertising, promotion and sponsorship. During its implementation, Seychelles engaged in evaluating compliance with the measures prescribed. Two Conventional compliance surveys were conducted in hospitality premises in 2011 and 2014.[27] With the country's inherent interest in monitoring compliance, Seychelles also engaged in the new WHO project in 2019.

In the pilot project, three data collection methods were utilized:

1. a Conventional survey conducted by trained data collectors in nationally representative sampled venues, which served as the "gold standard";
2. an expanded survey of experts, which sought input from 40-60 health professionals throughout the country; and
3. a crowdsourcing survey, which sought input from the public through reports of compliance and non-compliance using a mobile application (TobaccoSpotter).

In view of the small population of Seychelles, eligible venues for the Conventional survey included 829 registered health facilities, educational facilities, restaurants, bars, hotels, shops, media channels, transportation options and private offices in two main islands, Mahe and Praslin.

The crowdsourcing survey was introduced through a communication campaign during four weeks in order to encourage the participation of the public, through advertisements in printed media, programmes on the radio and posts in social media. Emails were sent to government offices, private organizations and youth groups to motivate participation of members of the public.

The Conventional and crowdsourcing surveys were broken down into three parts: smoke-free, point-of-sale, and media. For the smoke-free survey, participants were asked to observe health-care facilities, educational facilities, universities, government facilities, indoor offices, restaurants, pubs, bars, and public transportation. Participants were then asked a series of questions: "Did you see anyone smoking a Conventional tobacco product in any enclosed area of the venue? Using an electronic nicotine delivery system? Are there ashtrays and non-smoking signs visible?" These primary and secondary indicators were used to calculate a compliance rate for each smoke-free venue type. For the point-of-sale and media surveys, participants were asked to observe national television and radio, local magazines, billboards and outdoor advertising, and point-of-sale retail shops for advertisements, product displays, price discounts, brand stretching

27 Results of both previous surveys in Seychelles were analyzed and compiled in reports to the Ministry of Health, and results of the 2011 survey were published (Viswanathan B et al; Tobacco Control 2011;20:427-30).

and sharing, and tobacco sponsorship. These indicators were used to calculate a compliance rate for each point-of-sale and media type.

In total, there were 640 Conventional survey submissions, 891 crowdsourcing survey submissions and 60 expanded experts survey submissions.

Overall, the pilot project showed a high compliance by the public with the smoke-free measures in Seychelles. Compared to other methods, the crowdsourcing overestimated non-compliance as there was a tendency for users to only report abnormal situations (that is, non-compliance). Potentially, crowdsourcing could provide a cost-effective alternative to traditional compliance surveys, but more research is needed to build evidence about reliability and validity of data arising from crowdsourcing applications open to the general public. In addition, the social acceptability of the method needs further evaluation.

Tobacco Control Board members discussing the implementation of the pilot survey with the WHO team.

(Photos courtesy of Bharathi Viswanathan, Unit for Prevention and Control of Cardiovascular Diseases, Public Health Authority of Seychelles).

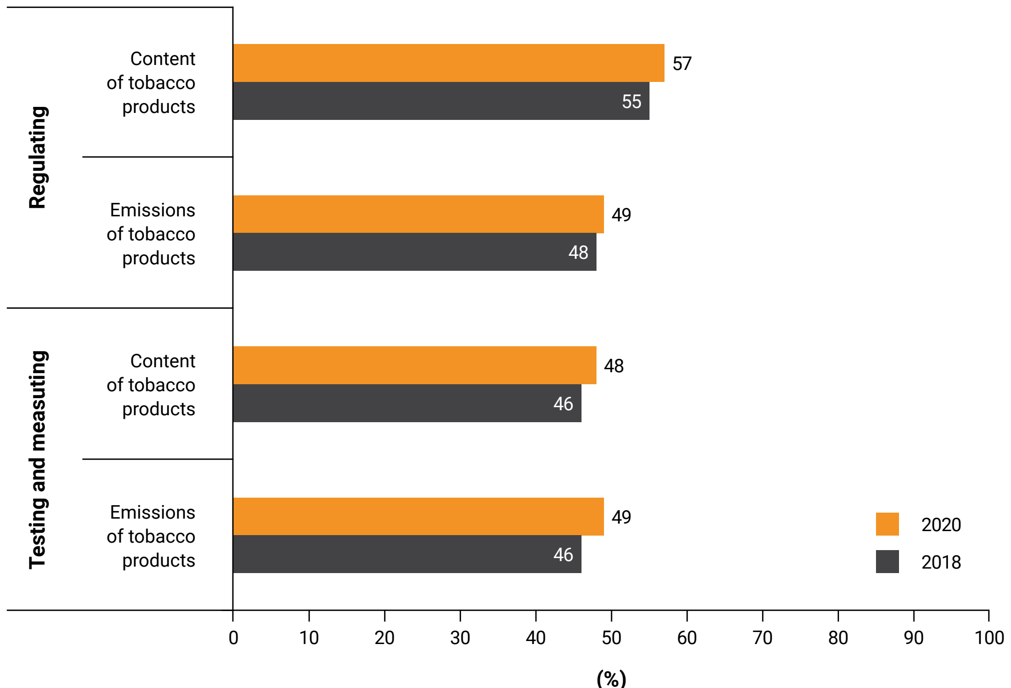
Regulation of the contents of tobacco products (Article 9) and regulation of tobacco product disclosures (Article 10)

Key observations

- Despite the progress observed in recent years, only around one half of all Parties regulate, test or measure the contents and the emissions of tobacco products.
- There seems to be a positive trend in banning characterizing flavours or additives in tobacco products.
- Over two thirds of Parties require the disclosure of information on the contents of tobacco products to government authorities, but less require the same for the emissions of products. Public disclosure, especially in relation to emissions, remains uncommon.

Regulating contents and emissions of tobacco products Based on the most recent information, over half of all Parties regulate the contents of tobacco products, and almost half the emissions. (Fig. 8)

Fig. 8. Percentage (%) of Parties that have reported implementing provisions under Article 9 in 2018–2020 (n=181)



Several Parties highlighted progress in regulating flavours and other ingredients such as additives, as well as design features that increase the attractiveness of the products, including colouring properties or the addition of attractive odours. Canada amended its Tobacco and Vaping Products Act to prohibit the use of menthol and cloves in all tobacco products in 2018. A menthol ban came into force in 2020 in all EU countries and also in Turkey. Belgium, Poland and Turkey also reported banning tobacco products containing flavourings in any of their components, such as filters, papers, packages and capsules, or any design features allowing modification of the smell or taste of tobacco products, their smoke intensity or the colour of their emissions. The regulations in Poland and Turkey also require that filters, papers and capsules do not contain tobacco or nicotine (see text box for additional details on the regulations in Turkey).

International Technical Workshop on Articles 9 and 10 of the WHO FCTC, Beijing, China, December 2019. (Photo courtesy of the Convention Secretariat).

Progress was also reported by the Parties in other areas. Australia reported that all cigarettes manufactured or imported into its jurisdiction are subject to the mandatory standard for reduced ignition propensity to prevent the fire risks, as recommended by the Partial Guidelines for Implementation of Articles 9 and 10. In addition, Australia reported that these articles were considered as part of the current thematic review of tobacco control legislation. The Philippines reported that their Republic Act No. 11467 reinforces the regulatory purview of the Philippine Food and Drug Administration over the producers of electronic nicotine delivery systems and electronic non-nicotine delivery systems (ENDS/ENNDS) and heated tobacco products (HTPs).

Examples of information exchange and inter-Party collaborative efforts to strengthen implementation of Articles 9 and 10 were also reported. China held an international symposium on the implementation of Articles 9 and 10 in Beijing by the State Administration for Market Regulation, the Ministry of Foreign Affairs, and the Chinese Academy of Inspection and Quarantine. Denmark reported the work in the EU Joint Action on Tobacco Control, which aims, among other things, to support implementation of the Tobacco Products Directive 2014/40/EU in the EU Member States. Specifically, the Joint Action facilitates the access to data on tobacco product content collected through the EU Common Entry Gate, assists Member States in networking and in strengthening the collaboration between research institutions and tobacco testing laboratories, and provides support to Member States in developing policies on product regulation and updating the list of priority additives, among others.[2826] The Islamic Republic of Iran noted a new report prepared in cooperation with WHO country office on the implementation of Articles 9 and 10, highlighting the policy gaps and proposing a way forward.

Testing and measuring of the contents and emissions of tobacco products. Around half of Parties reported that they test and measure the contents and emissions of tobacco products (Fig.8). Some Parties reported advancing legislation in this area. Côte d'Ivoire reported that new legislation requiring the analysis of the contents and emissions of tobacco products was passed in 2019, and the regulations are currently being developed. The Democratic Republic of the Congo reported that provisions related to Articles 9 and 10 were included in its public health legislation, which is awaiting the adoption and promulgation of the measures for the implementation. Mauritius reported that steps have been initiated to include measures required under Articles 9 and 10 of the Convention in its tobacco control regulation. Niue reported that its Tobacco Control Bill 2018 contained a provision to comply with Article 10, and the bill was passed in 2019. Palau reported that their comprehensive tobacco control legislation, including provisions to comply with Articles 9 and 10, was submitted to Congress. Paraguay reported that its national supervisory authority is preparing regulations for testing and measuring the contents and emissions.

28 More information of the JATC-1 project: https://ec.europa.eu/health/health-eu-newsletter-208-focus_en

Turkey

Case study

New regulations for flavours, additives and technical features

In Turkey, tobacco product regulation is incorporated in national tobacco control legislation. In addition to testing and regulating the contents of tobacco products, ingredients for filters have been limited, and filter ventilation and pressure-drop analysis were demanded by the abrogated Council Decision of Tobacco and Alcohol Market Regulatory Authority, published in the official gazette in 2014.[29,30] Turkey has access to an independent laboratory, and the analysis requested by the Ministry of Agriculture and Forestry is paid by the tobacco industry.

A Scientific Board authorized by the Ministry of Health evaluates the ingredients according to the WHO FCTC.

The regulation of contents and emissions of tobacco products were further developed in 2019 with the adoption of the Regulation on the Procedures and Principles Regarding Production Types, Labelling and Supervision of Tobacco Products. This new regulation, prepared by the Ministry of Agriculture and Forestry, was published in the Official Gazette on 1 March 2019 and came into effect on 5 January 2020.[31] The regulation sets several new requirements for ingredients, including the following:

- Cigarettes and roll-your-own tobacco with a characterizing flavour shall not be put in the market.
- Tobacco products containing the following additives shall not be placed in the market:
  a) vitamins or other additives that create the impression that a tobacco product has a health benefit or presents reduced health risks;

  b) caffeine, taurine or other additives and stimulant compounds that are associated with energy and vitality;

  c) additives having colouring properties for emissions; and

  d) for tobacco products for smoking, additives that facilitate inhalation or nicotine uptake; and additives that have carcinogenic, mutagenic, reprotoxic properties in unburnt form.
- Cigarettes and roll-your-own tobacco containing flavourings in any of their components, such as filters, papers, packages and capsules, or any technical features allowing modification of the smell or taste of the tobacco products concerned or their smoke intensity, shall not be placed in the market. Filters, papers and capsules shall not contain tobacco or nicotine.
- With the exception of preservatives and moisturizers, no additives shall be used in production of roll your own tobacco.

29 Board decision on Determining the Technical Features of the Filter Used in Tobacco Products published in the Official Gazette dated 09/05/2014 and numbered 28995.

30 Council Decision Regarding the Evaluation of Ingredient Notification and Data Found on the Toxicological Data Tables" published in the Official Gazette dated 30/05/2012 and numbered 28308.

31 Regulation on the Procedures and Principles Regarding Production Types, Labelling and Supervision of Tobacco Products" published in the Official Gazette dated 01/03/2019 and numbered 30701.

The 2019 regulation also granted the Ministry of Agriculture and Forestry of the right to charge proportionate fees to manufacturers for assessing whether a tobacco product has a characterizing flavour, and whether prohibited additives or flavourings are used. In addition, similar fees can be charged for assessing whether a tobacco product contains additives in quantities that increase to a significant and measurable degree the toxic or addictive effect, or the carcinogenic, mutagenic, reprotoxic properties of the tobacco product concerned, and the regulation granted the ministry the right to prohibit the placing in the market of such products.

Prior to the 2019 regulation, the use of menthol at any quantity was already prohibited with a Council Decision, published in the Official Gazette in 2015.[32] The ban took effect at the manufacturer level as of 1 January 2019, and at the retail level as of 5 January 2020.

32 Council Decision on Amending the Council Decision Regarding the Evaluation of Ingredient Notification and Data Found on the Toxicological Data Tables published in the Official Gazette dated 01/04/2015 and numbered 29313.

In addition, many Parties highlighted other progress in testing and measuring. Burkina Faso reported that results on nicotine and tar contents are now available from its national laboratory for both imported and locally produced tobacco. Denmark noted that yearly test cycles are performed in order to assess compliance with the EU Tobacco Products Directive and national legislation. In Poland, the Bureau for Chemical Substances had started in 2019 to verify notifications of tobacco products submitted for sale, in order to check for products with vitamins or additives that have carcinogenic, mutagenic or toxic effects for reproduction properties. The Republic of Korea reported that the Korea Food and Drug Administration had released results on contents analysis of 11 harmful substances (including nicotine and tar) of HTPs in 2018 and of severe lung disease-inducing substances (including hemp-induced substances and vitamin E acetate) from domestically circulated e-cigarette liquids in 2019.

Partial Guidelines for Implementation of Articles 9 and 10, in relation to Article 9. By 2020 52% of all Parties reported having utilized these Partial guidelines, with minor increase from 2018 (51%).

Disclosure to government authorities and the public. Based on the most recently updated information from the Parties' reports, around two thirds of Parties required manufacturers or importers of tobacco products to disclose information on the contents and emissions of the products to the national authorities (Fig. 9). Currently, around half of the Parties require such disclosures to be made available to the public. As compared to 2018, there was no improvement in the disclosures to the public, but a minor positive trend is visible in requiring the disclosure to the relevant authorities.

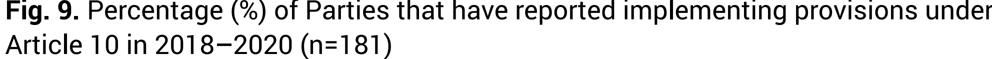
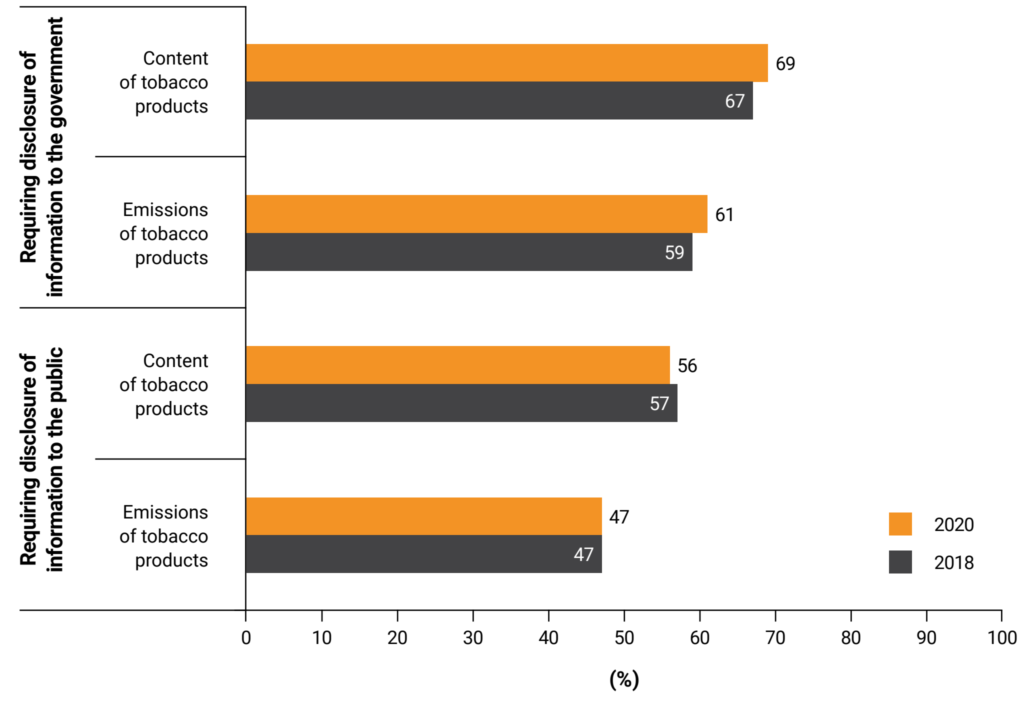


Fig. 9. Percentage (%) of Parties that have reported implementing provisions under Article 10 in 2018–2020 (n=181)



Several Parties reported recent progress with regards the disclosure of the information to the government authorities. Burkina Faso reported that their national laboratory now provides the National Tobacco Control Committee with information on the contents and emissions of samples of cigarettes sold on a regular basis. In Côte d'Ivoire, new legislation from 2019 requires manufacturers and importers of tobacco products to communicate annually to the Ministry of Health all information relating to the quality, quantity, composition and emissions of tobacco products. In Bahrain, tobacco product manufacturers are requested to submit annual reports about the contents of their products. In addition, a new system was set up in 2020 to register tobacco products with the Ministry of Health. The system shall record the constituents of each product and its pictorial warning. Honduras noted that their new national tobacco control plan foresees regulations for the disclosure of information on tobacco products.

In addition, Canada amended its Tobacco Reporting Regulations, which set out the requirements for the reporting of information on the sales, manufacturing processes, ingredients, constituents, emissions, and research and development activities, as well as promotional activities undertaken by tobacco manufacturers. The amendments served to update and clarify the requirements in order to make them more relevant to the current environment and to eliminate redundant requirements, as well as updated the official testing methods for the sampling and testing of tobacco products to reflect technological advances. The amendments are expected to enhance the quality and completeness of the information submitted by the tobacco industry.

A few Parties reported public disclosure of the information collected in the EU product notification process. For example, France reported that the National Agency for Food, Environmental and Occupational Health Safety makes information public, which does not fall under industrial and commercial secrecy. At the end of 2019, more than 2500 tobacco products were listed in the database as being declared for sale in France, and more than 28 000 products for vaping. Spain reported that the list of tobacco products and their emissions communicated to the EU Common Entry Gate portal (also mentioned above in relation to Denmark) are published on the website of the Ministry of Health, with monthly updates. Sweden reported that a list of tobacco products that have been reported to the Public Health Authority have been published on its website.

Partial guidelines for implementation of Articles 9 and 10, in relation to Article 10. By 2020, 51% of all Parties reported having utilized the Partial guidelines, with minor increase from 2018 (50%).

Packaging and labelling of tobacco products (Article 11)

Key observations

- This article continues be ranked second in terms of the highest implementation among all Convention articles, and also is second among the time-bound articles. Two thirds of all Parties now require that health warnings cover at least 50% of the main display area of tobacco packages, which occupies no less than 30% of the main display area in the majority of Parties.
- An increasing number of Parties have adopted plain packaging, accelerating the international trend to restrict the use of tobacco packaging as a form of advertising and promotion and to increase the effectiveness of the health warnings. In this regard, the World Trade Organization (WTO) Appellate Body's overall conclusion that plain packaging made a meaningful contribution to public health may encourage more countries to implement this measure.

Health warnings. Based on the latest information from the Parties, most require health warnings, but there are still 18 Parties not requiring any health warnings (Fig. 10). Some overall progress can be detected in the implementation of various requirements under Article 11; the progress is more significant in the size of the health warnings and the transition to pictorial health warnings. Almost two thirds of Parties reported health warnings covering 50% or more of the principal display areas of the package (59% in 2018), and 82% of Parties require a warning size of no less than 30% of the principal display areas (78% in 2018). Based on these two indicators, 36 Parties (20%) report that they have not yet reached the requirement of 50% or more of the principal display areas, but are requiring no less than 30%.

Several Parties have provided details of the measures they have taken to increase of the size of their health warnings. A 2019 law in Côte d'Ivoire established pictorial health warnings covering at least 70 % of the main surfaces of the packages of tobacco products. An amendment to the tobacco product regulations adopted by Central Organization for Standardization and Quality Control in Iraq has increased the size of pictorial health warnings from 30% to 40% on the front and back surface of packages. In Japan, from 1 April 2020, health warnings must occupy no less than 50% of the principal display areas. Montenegro adopted in 2019 pictorial health warnings covering 65% of main surface areas of the unit packet of smoking tobacco products. Pakistan reported that they have increased the size of the health warnings to 50% in June 2018, and then to 60% since June 2019. Singapore adopted new regulations in 2019 requiring that the size of the new set of graphic health warnings be increased to at least 75% of the principal display area. Sudan has also increased the size of the warnings from 30% to 75% of the package surface. Turkey adopted in 2019 a regulation increasing the size of the graphic health warnings to 85% of front and back surfaces of packages of smoking tobacco products.

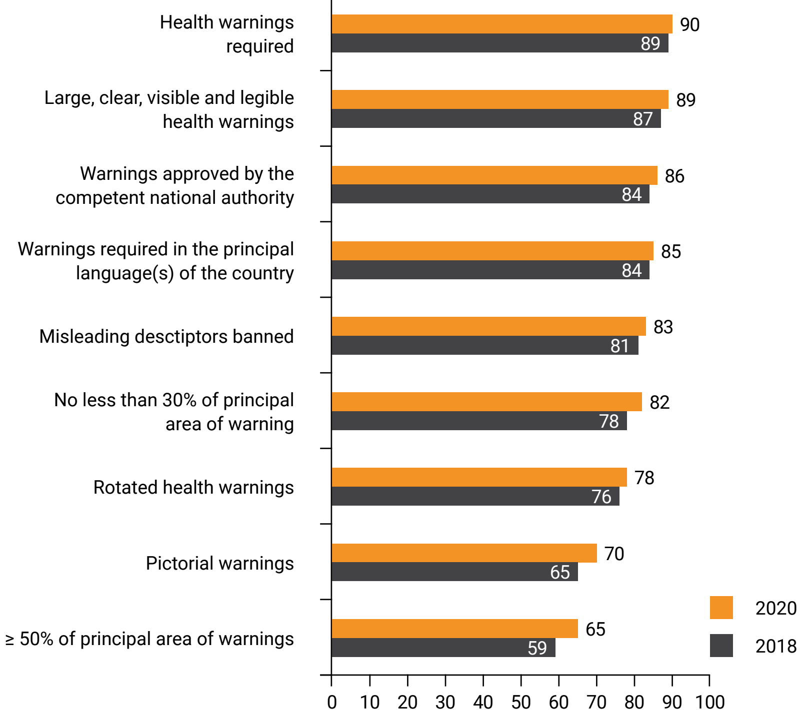
Many Parties (Colombia, Costa Rica, Ecuador, Mauritius, Panama, Peru, the Philippines, the Republic of Korea, the Republic of Moldova and Suriname) reported having adopted and/or implemented a new set of health warnings since the last report.
With respect to the language of health warnings, Suriname reported that since December 2018 the health warnings appear both official languages of the country (English and Dutch). Vanuatu's graphic health warnings, which occupy 90% of the front and back sides of packages, appear in three languages (Bislama, French and English).

The Government of Canada conducted a public consultation on new health-related labelling for tobacco products, proposing, among other suggestions, to print health warnings on individual cigarette sticks. The public consultation was conducted in late 2018, and its report was published in August 2019.[33] Health Canada was reported to be

33 https://www.canada.ca/en/health-canada/services/publications/healthy-living/consultation-new-labelling-tobacco-what-we-heard.html

working on regulations for a new round of package warnings and for the incorporation of warnings directly on the cigarette itself.

Fig. 10. Percentage (%) of Parties implementing the time-bound provisions under Article 11 in 2018–2020 (n=181)



Use of pictorial warnings. Around two thirds of all Parties required health warnings in the form of pictures or pictograms on tobacco product packaging (Fig. 10), a significant increase as compared to 2018.

A few Parties have reported introduction of pictorial health warnings. In Gambia, the pictorial health warnings required by the 2016 Tobacco Control Act needed to appear on cigarettes packs by the end of 2020. Niger also has required pictorial health warnings on all tobacco product packaging since November 2020. The Republic of Korea has developed and implemented pictorial health warning for HTPs, available in the country since June 2017.

Thailand has reported progress in several matters, by issuing two consecutive sets of regulations. The first one (B.E. 2561) restricted the use of promotional elements in the packaging. The second one, adopted in December 2018 (B.E. 2562), introduced plain cigarette packaging, making Thailand the first country in Asia to adopt plain packaging for tobacco products. Simultaneously, the pictorial health warnings will cover 85% of front and back surfaces, while text warnings cover 60% of the side areas.

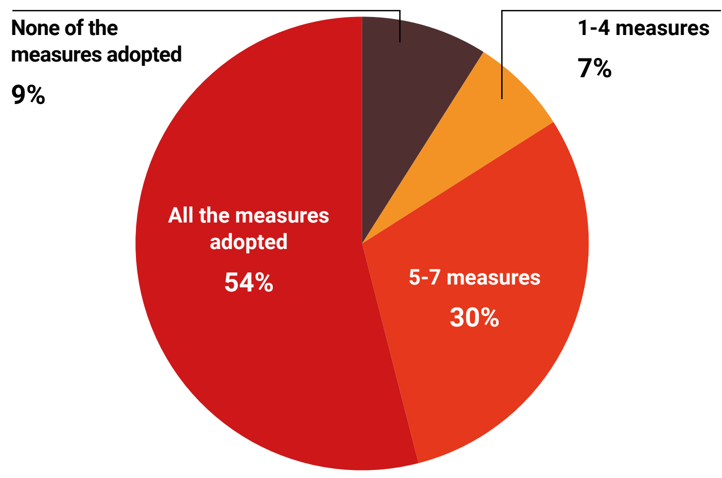
Research related to policies on packaging and labelling was reported by a few Parties. Senegal, Sudan and Viet Nam reported that they evaluate the effectiveness of the graphic health warnings. Specifically, Viet Nam evaluated the effectiveness of its previous set of graphic health warnings and, in addition, 12 new samples of health warnings were proposed for public consultation.

In terms of enforcement, Cambodia reported that it has carried out training of 490 tobacco inspection officers to conduct monitoring and enforcement of the Sub-Decree on Printing of Health Warning in Khmer Language and Pictorial on Tobacco Products Packages, adopted in 2015, and organized workshops for local authorities.

Prominence of health warning. As reiterated in the Guidelines for the Implementation of Article 11, larger warnings with pictures are more likely to be noticed, more likely to communicate health risks, and more likely to provoke a greater emotional response and increase the motivation of tobacco users to quit and to decrease their tobacco consumption, in comparison with small, text only health warnings. To assess the adoption of effective packaging and labelling measures, the following cluster of indicators was analysed from the Parties' reports: prohibition of misleading descriptors; health warnings required; health warnings approved by the competent national authority; rotated health warnings; large, clear, visible and legible health warnings; health warnings occupying no less than 30% of the principal display areas; health warnings occupying 50% or more of the principal display areas; and health warnings in the form of pictures or pictograms. By 2020, over half (98) of Parties have reported the adoption of all the above measures, and meeting the obligation of adopting and implementing effective packaging and labelling measures through prominent health warnings (Fig. 11). The low compliance under this article is more concerning, since the timeline for implementation of these measures is three years following the ratification of the Convention.

Additionally, among the 54 Parties that still implement only text warnings, seven Parties have reported that their text-only warnings occupy 50% or more of the principal display areas. Twenty-five Parties have reported that their text-only warnings do not even cover 30% of the principal display areas.

Fig. 11. Number of effective packaging and labelling measures[34] adopted by Parties reported by 2020 (n=181)



34 List of included measures from the reporting instrument: 1) prohibition of misleading descriptors; 2) health warnings required; 3) health warnings approved by the competent national authority; 4) rotated health warnings; 5) large, clear, visible and legible health warning;s 6) health warnings occupying no less than 30% of the principal display areas; 7) health warnings occupying 50% or more of the principal display areas; and 8) health warnings in the form of pictures or pictograms.

Plain packaging

Up until March 2021, plain packaging has been enforced and implemented by the following Parties, listed in order of the date of adoption:

Party	Date of adoption
Australia	1 December 2012
France	1 January 2017
United Kingdom of Great Britain & Northern Ireland	20 May 2017
New Zealand	6 June 2018
Norway	1 July 2018
Ireland	30 September 2018
Hungary	20 May 2019
Thailand	8 December 2019
Uruguay	22 December 2019
Saudi Arabia	1 January 2020
Turkey	5 January 2020
Slovenia	1 January 2020
Israel	8 January 2020
Canada	7 February 2020
Singapore	1 July 2020
Netherlands	1 October 2020
Belgium	1 January 2021

Additionally, plain packaging acts and regulations have been passed, and are only awaiting entry into force or implementation in Georgia (1 January 2023), while additional regulations need to be issued in Burkina Faso and Romania (current legislation includes enabling provisions to enact standardized packaging regulations). Finally, some other Parties have reported that they have also started working on their legislation and/or are interested in applying plain packaging, among which are Chile, Denmark, Ecuador, Finland, the Islamic Republic of Iran, Jordan, Kuwait, Lithuania, Mauritius, Panama, the Republic of Korea, South Africa, Sri Lanka, Sweden, Ukraine and Myanmar.

In another important international development on this matter, in June 2020, the WTO Appellate Body reported on the results of the dispute brought by several countries against Australia in relation to the plain (standardized) packaging legislation. The ruling confirms that plain packaging contributes to its public health objective, and this decision can be considered as a landmark legal victory for public health. For additional details, see the section on Liability (Article 19).

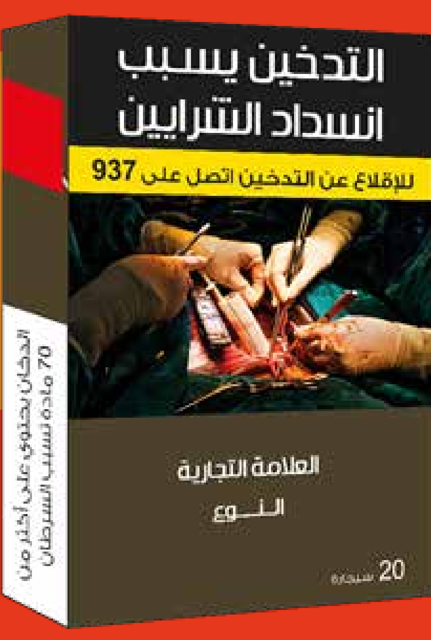
Saudi Arabia

Case study

Pioneering plain packaging in the Eastern Mediterranean

In June 2018, the Ministry of Health of Saudi Arabia prepared a draft proposal of the introduction of plain packaging to tobacco products. Following technical and legal review, as well as the feedback from the WTO, the proposal was approved as a technical regulation by the Saudi Food and Drug Authority.

The plain packaging regulations were issued in December 2018, which entered into force in August 2019, applied first to all imported tobacco products, and since January 2020 to all tobacco products, including cigarettes, cigars, tobacco molasses, loose tobacco and similar tobacco products. The adoption of this public health measure is expected to discourage youth from consuming tobacco products and support tobacco users to quit. This policy turned Saudi Arabia into the first country in the Eastern Mediterranean Region to adopt plain packaging, bringing it in line with the requirements of Article 11 of the WHO FCTC and its Guidelines for Implementation. The Saudi experience may pave the way forward in the Region, strengthening the implementation of the Convention. Moreover, this measure is under discussion to be adopted for optional implementation in other countries from the Cooperation Council for the Arab States of the Gulf.



Parties find it increasingly challenging to make further progress in strengthening their packaging and labelling measures. The tobacco industry continuously opposes the development, adoption and enforcement of packaging and labelling measures, and this matter is reflected in the Parties' reports. For example, in Afghanistan tobacco importers managed to obstruct the approval of pictorial health warnings and the requirement that the warning be written in some local languages. To fight the tobacco industry in the court, Colombia used the Guidelines for Implementation of Article 11 in order to defend the measures taken by the Ministry of Health to remove promotional and advertising elements from the packaging, thereby reducing the attractiveness of tobacco product packages. In Congo, the lack of a formal decree has prevented the application of the provisions of the law for packaging and labelling. The presence of representatives from tobacco industries in the tobacco products regulatory committee in Jordan has impeded the strengthening of existent regulations. The local manufacturers in Kiribati have not been complying with the adopted regulations, despite being committing an offence.

The tobacco industry has continued launching legal challenges to prevent, delay or weaken the adoption of tobacco control laws and regulations. A case has been reported as concluded in favour of public health: on 9 June 2020, the WTO Appellate Body ended the disputes that began in 2012 with publishing its report of the disputes brought by Honduras and the Dominican Republic against Australia.[35] It upheld the findings of the WTO panel that Australia's tobacco plain packaging laws contribute to public health and are consistent with the WTO-covered agreements. The Appellate Body concluded that "Honduras and the Dominican Republic have not succeeded in establishing that Australia's [tobacco plain packaging] measures are inconsistent with the provisions of the covered agreements at issue". It found that plain packaging was no more trade-restrictive than necessary for achieving its public health objective, that it was consistent with intellectual property obligations, and that Australia's plain packaging laws, in combination with other tobacco control measures, were "apt to, and do, make a meaningful contribution to public health".

This decision, a major victory for public health and tobacco control, puts an end to the disputes which began in 2012 and saw Cuba, the Dominican Republic, Honduras, Indonesia[36] and Ukraine (initially part of the complaint, Ukraine decided to withdraw in June 2015[37]) bring legal complaints regarding Australia's plain packaging laws. Plain packaging has now been implemented by 17 Parties, with more Parties being in the process of adopting it.

Guidelines for implementation of Article 11. By 2020, 69% of all Parties reported having utilized these Guidelines, with minor increase from 2018 (67%).

35 https://www.who.int/fctc/mediacentre/press-release/wto-landmark-legal-victory-tobacco-plain-packaging/en/
36 https://www.wto.org/english/tratop_e/dispu_e/cases_e/1pagesum_e/ds435sum_e.pdf
37 https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/WT/DS/434-17.pdf&Open=True

Education, communication, training and public awareness (Article 12)

Key observations

- Most Parties implement educational and public awareness programmes. Importantly, a number of Parties succeeded in sustaining and further developing campaigns or activities established in the previous reporting period, or prior to it.
- Parties have started highlighting and submitting the results from their campaign or programme-evaluation studies. Parties could benefit from such evaluation results, and they could also further encourage other Parties to build their new interventions on pre-tested and evidence-based methods.
- Many Parties strengthened the awareness and participation of a broader range of stakeholders in their communication and public awareness programmes, for example by organizing targeted training and sensitization campaigns for decision-makers, or by promoting strategic collaboration between educational and health agencies.

Implementation of educational and public awareness programmes. Based on the latest information available from Parties, most Parties (92%) reported that they had implemented educational and public awareness programmes. A number of Parties succeeded in continuing or further developing their previously established campaigns or activities. These include Austria, Azerbaijan, Belarus, Bulgaria, Costa Rica, the Democratic People's Republic of Korea, Ecuador, Fiji, Finland, France, Georgia, Germany, Jamaica, Lithuania, Mauritius, the Netherlands, New Zealand, Oman, Pakistan, Panama, Peru, the Republic of Moldova, Senegal, Singapore, Tonga, Turkey, the United Kingdom of Great Britain and Norther Ireland, and Viet Nam.

Among them, Panama reported having organized in June 2019 the third edition of "At Full Lung", a sporting event targeted to health and education professionals, students, and the general public. The event is accompanied by a day of physical activity (for example, Zumba) and a health fair with services such as vaccination, physical therapy, blood pressure measurement and nutritional counselling. Artistic performances with anti-smoking messages also take place. The proceeds from the event go to the tobacco control coalition of Panama.

New communication campaigns were reported by Fiji (no smoking in workplaces), Iceland (the costs of smoking), Jordan (legislation compliance campaign), Latvia (addictive substances including tobacco and e-cigarettes), Mexico (multi-channel youth campaign), Myanmar (second-hand smoke), Norway (health risks and smoking cessation), Poland (second-hand smoke, ENDS), Portugal (campaign for smoking women), the Republic of Korea (smoking, second-hand smoke and HTPs, the advantages of quitting), the Russian Federation (promotion of healthy lifestyles and the prevention of noncommunicable diseases) and in the United Kingdom of Great Britain and Northern Ireland (for example, Choices for Life campaign for youth in Scotland).

World No Tobacco Day continued to be the single most-often highlighted event by the Parties, noted by Afghanistan, China, Colombia, the Czech Republic, the Democratic People's Republic of Korea, Jamaica, Myanmar, Oman, Panama, Paraguay, the Philippines, Senegal, Turkey and the United Kingdom of Great Britain and Northern Ireland. For example, Colombia reported that on 2019 World No Tobacco Day, several actions were carried out in coordination with the health secretaries of territories, especially the health secretary of Bogotá, and on 2020 World No Tobacco Day, the National Cancer Institute was promoting a campaign to promote youth participation in World No Tobacco Day communications.

Target groups and messages of educational and public awareness programmes. Most Parties that had implemented educational and public awareness programmes targeted children or young people (96%), and most also adults or the general public (94%). The majority of Parties also reported having targeted women (78%), men (77%) and pregnant women (73%). For example, China reported that the All-China Women's Federation supports family members to jointly create a smoke-free living environment. Different activities include sharing information of the risks of tobacco use in their materials, and discussing the theme in their events and face-to-face meetings with families and parents.

The various focus areas have not changed notably since 2018. Targeting ethnic groups remained least common, with less than one third of Parties (29%) reporting it.

A number of Parties reported progress in programmes and activities, especially in the school context. For example, in Bahrain, a new campaign targeting primary schoolchildren aged 9 to 10 was launched to increase awareness of the harmful effects of tobacco and to prevent early experimenting. In Canada, a new Young Adult Prevention Strategy was established as a collaborative effort of local public health units and Smoke-Free Ontario partners. It aims to prevent the uptake of tobacco use and the escalation of social or experimental smoking to daily smoking, and includes initiatives such as smoke-free post-secondary campuses and referral to cessation services. Iceland reported the continuation of a school class programme that has been running for 11–15-year-old children some 20 years, with recent developments to include the prevention of the use ENDS in addition to tobacco use. In Iraq, a new smoke-free schools project has been initiated, targeting preliminary school students, their families and teachers. Peru reported that the Ministry of Health continues to operate an anti-smoking bus, which has circulated among educational institutions and universities since 2017. By 2020, it had reached 26 000 schoolchildren and university students.

World No Tobacco Day continued to be the single most-often highlighted event, noted by Parties from all WHO Regions.

Czech Republic

Case study

Initiative to promote health among the most vulnerable

In the Czech Republic, a five-year project – Effective Health Promotion for People at Risk of Poverty and Social Exclusion – was launched in 2018, which includes programmes dealing with tobacco use prevention and counselling. The project is implemented by the National Institute of Public Health and co-financed by the EU's European Social Fund. The initiative aims to support health decisions of the target group, which accounts for 1.5 million in the country, in the form of outreach interventions. Some 65% of the adult population of this group smoke, including pregnant women, and also face other risk factors, which results in shorter life expectancy and high morbidity.
(Photo courtesy of the National Institute of Public Health)

Tobacco Use Prevention Programme

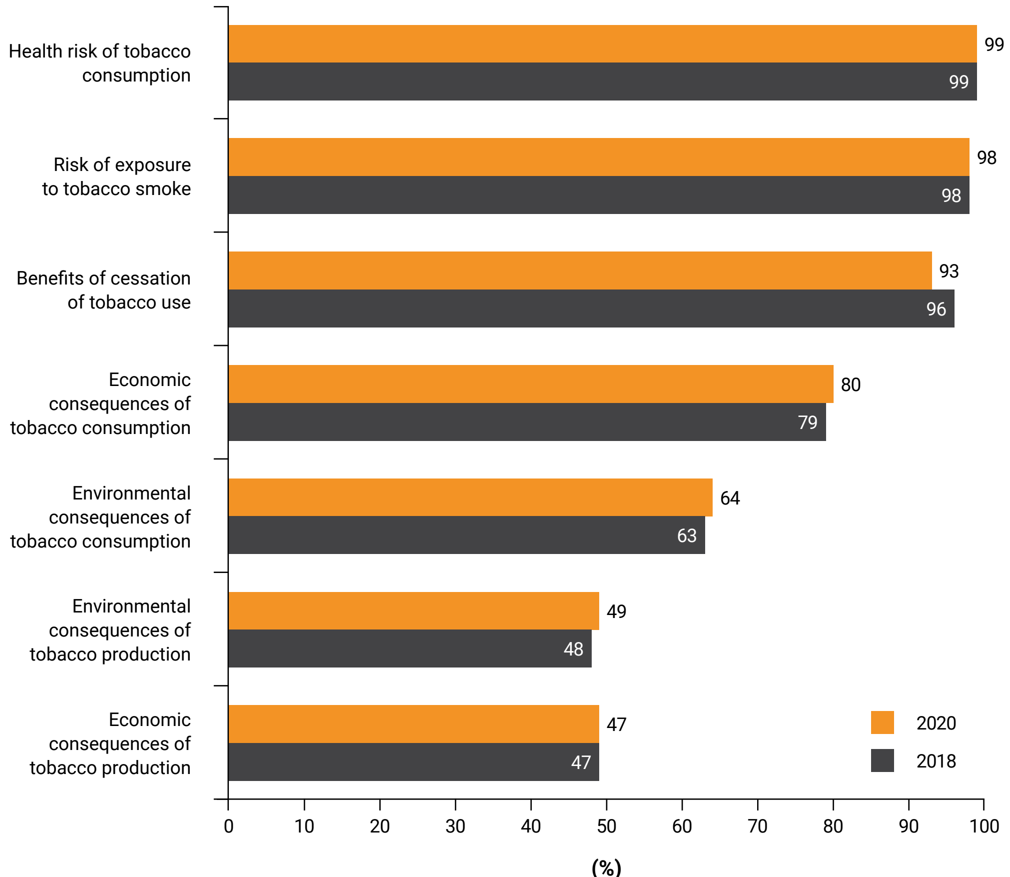
The project entails the establishment of missing infrastructure to support the health of the target group, including the establishment of regional health promotion centres for the implementation of new health promotion intervention programmes, which began in 2020. Two programmes focus on tobacco use by raising awareness on the consequences of tobacco use, including the risks of second- and third-hand smoke, and on tobacco cessation.

The output of the project is an expected improvement in knowledge about health and behaviour change of the target group that can be verified by a WHO health literacy test before and after interventions, as well as the availability of trained field workers and trained lecturers. On a long-term basis, the project is expected to reduce health inequalities, improve health and increase employment, with a consequent reduction in national economic losses from disease.

Photo courtesy of the National Institute of Public Health, Czech Republic

Almost all Parties that reported implementing these programmes covered the health risks of tobacco use and risks of exposure to tobacco smoke in their messages (Fig. 12). Most Parties also covered the benefits of cessation, but it became somewhat less common as compared to 2018. For other themes, the proportions remained similar. The economic and environmental consequences of tobacco production continue to be the least-covered areas in the programmes. As an example of communicating the benefits of quitting, Panama reported their activities in the communications related to COVID-19. For instance, several different messages and materials were prepared to raise awareness of the severity of COVID-19 infection for smokers.

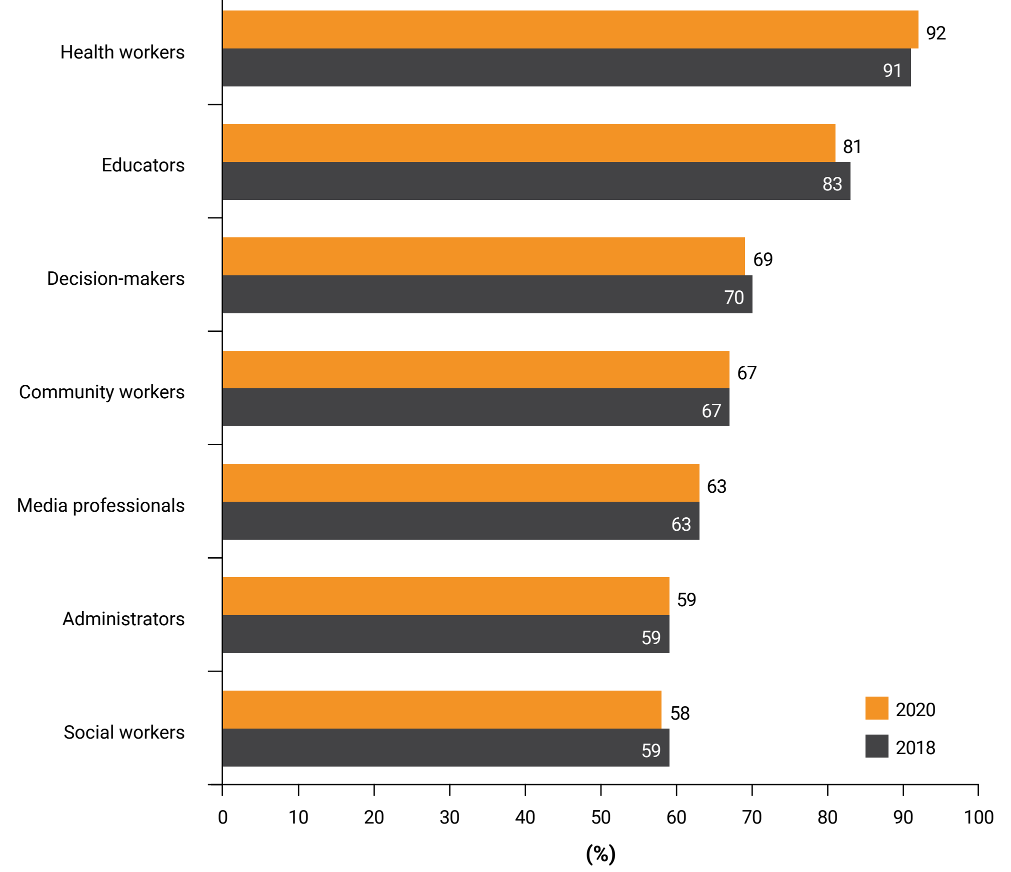
Fig. 12. Percentage (%) of Parties that covered various areas in their educational and public awareness programmes (n=162 in 2018; n=166 in 2020)*



** Note: Calculated among Parties that have included diagnosis and treatment in the health-care system.*

Addressing training or sensitization programmes on tobacco control to special groups. Among the Parties that had implemented educational and public awareness programmes, most had addressed their 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. 13). No major changes were observed in 2018–2020, with only a minor decrease in the proportion targeting educators.

Fig. 13. Percentage (%) of Parties that targeted their programmes to specific groups (n=162 in 2018; n=166 in 2020)*



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

Most examples of training addressed to health workers related to smoking cessation counselling or programmes, mostly focusing on brief advice and behavioural counselling. Many Parties successfully continued their previous training activities for this target group, but new training activities were reported by Brunei Darussalam, China, Hungary, Poland, Qatar, Spain and the United Kingdom of Great Britain and Northern Ireland. For instance, large-scale training activities took place in China on the national level by the Chinese Center for Disease Control and Prevention and the China–Japan Friendship Hospital, and local organizations provided training in provinces, cities, counties and in hospital-based smoking cessation clinics. In Poland, nationwide smoking cessation training was implemented within the National Health Programme. In Spain, an online course was developed in 2019, covering methods for brief advice on smoking cessation in primary care. In Wales in the United Kingdom of Great Britain and Northern Ireland, the Making Every Contact Count (MECC) initiative now includes a course module on smoking, which is designed for use by primary care workers.

Many Parties reported advancing their targeted training or programmes for decision-makers and other key stakeholders. In Armenia, with new funds from the Government,

various campaigns, training sessions and events were organized for government representatives, NGOs and local leaders to help them to raise awareness of the negative effects of tobacco and second-hand smoke on health. Côte d'Ivoire reported training and capacity-building for parliamentarians and senators, leading to the creation of a network of parliamentarians for tobacco control. In Djibouti, training was organized for personnel in community development centres, and a coaching group was created to support the fight against tobacco and drug addiction in the country. Peru reported new leadership training programmes in tobacco control. In Saint Lucia, two consecutive anti-smoking campaigns targeted policy-makers, educators, media and heath personnel. Sudan reported the establishment of specialized committees for tobacco control and media professionals. In Gambia, a nationwide sensitization campaign took place for hotels, restaurants and bar owners on the recent tobacco act and regulations.

Parties also continued to mention 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 private organizations and non-health public sector; parents and foster parents; and students. For instance, Afghanistan reported assigning a religious leader as a tobacco control ambassador. China reported that the new Healthy China Action Plan (2019–2030) requires extensive publicity and education on tobacco control. Among the new activities were a new national youth tobacco control volunteer alliance; meetings, academic conferences, and tobacco control forums to promote information exchange; and a workshop for media professionals. In addition, the National Health Commission issued a notice on strengthening the awareness raising activities at the local level, focusing on youth tobacco use and ENDS. In the Philippines, the Red Orchid Award recognizes exemplary work of local government units based on the strength of the efforts to implement smoke-free environments. Since the launch of the awards in 2009, some 109 Hall of Fame Awardees and 108 Red Orchid Awardees have been declared in cities and municipalities. In 2019, regional Red Orchid Awards were handed out.

Philippines Red Orchid Award ceremony in 2017. (Photo courtesy of the Department of Health, Philippines).

Awareness and participation of agencies and organizations, and use of research to guide the development of programmes. Among the Parties that had implemented programmes, most (96%) involved public agencies and the majority (89%) involved NGOs in the development and implementation of intersectoral programmes and strategies for tobacco control. Several Parties reported progress in the involvement of educational organizations on the national level. In Chile, a national education plan on tobacco had been designed and implemented jointly by the Ministry of Health and the Ministry of Education. The activities include annual campaigns, support materials for teachers, and regular workshops with parents and guardians in schools. Colombia reported a new strategic line focusing on school environments in the national plan *Pact for Colombia, Pact for Equity* for years 2018–2022. A new training module for substance abuse prevention, aimed at preschool, basic and middle school teachers, was developed, with a new pedagogical protocol for addressing substance abuse in school settings. Portugal reported that a protocol of cooperation between the Secretary of State for Education and the Secretary of State for Health was signed in 2018. The General Directorate of Education and the General Directorate of Health are now working together in order to reinforce smoking prevention in schools and to promote a tobacco-free generation. In Czech Republic, the Methodical *Recommendation on Primary Prevention of Risk Behaviour in Children and Youth*, a document developed by the Ministry of Education, Youth and Sports of the Czech Republic, was revised and published in 2019. Latvia reported that school programmes on health education topics, including tobacco prevention, for grades from 1 to 12 were developed in 2019. In Myanmar, the ministries of Education and Health jointly conducted a national seminar and workshops in 2019. Additionally, a peer education programme was launched, and the Ministry of Education collaborated with parents and teachers' association and student unions to raise awareness of tobacco use prevention.

Parties also continued to report 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 the military, the media, and international organizations including WHO. For example, Italy reported that since 2017, around 30 scientific societies have collaborated to create a tobacco endgame movement in Italy.[38]

Altogether 78% of Parties reported using research to guide the development, management and implementation of their communications, education, training and public awareness programmes, as well as requiring pretesting, monitoring and evaluation, as suggested in the Guidelines for Implementation of Article 12. A small increase in the percentage was observed as compared to 2018 (75%). However, very few Parties gave examples of this in their notes. In Australia, evaluation results were available from the National Tobacco Campaign titled Don't Make Smokes Your Story, which is focused on indigenous smokers, recent quitters and their families. In Ireland, an evaluation of the national QUIT campaign was commissioned and carried out in 2018. In the United Kingdom of Great Britain and Northern Ireland, Northern Ireland completed a midterm review of the 10-year tobacco control strategy, which includes activities relating to Article 12. Viet Nam reported results from a new evaluation study on the tobacco prevention campaign of the Tobacco Control Fund conducted in 2014–2018.

Guidelines for Implementation of Article 12. By 2020, 67% of all Parties reported having utilized these Guidelines, with minor increase from 2018 (66%).

38 https://tobaccoendgame.it/

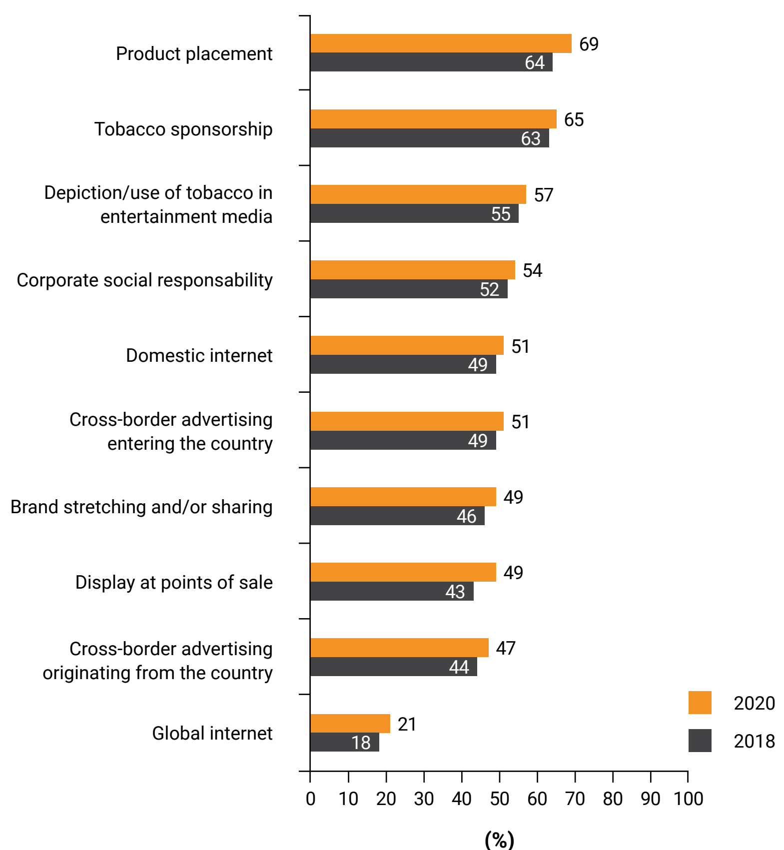
Tobacco advertising, promotion and sponsorship (Article 13)

Key observations

- More Parties report that they are including novel and emerging tobacco products and nicotine products in their tobacco advertising, promotion and sponsorship regulations.
- Despite this being a time-bound measure under the Convention, one quarter of the Parties are still to adopt a comprehensive ban on all tobacco advertising, promotion and sponsorship, in order to also comply with the priorities set by the Global Strategy.
- Despite the evidence showing the risk of exposure to advertisements and promotion via the Internet, especially in the case of children and young people, progress is needed in the majority of Parties to regulate this platform.

Comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS). Of all Parties, 75% reported having a comprehensive ban on all TAPS, with a minor increase from 2018 (73%). However, Parties' definitions of a comprehensive ban on TAPS vary and do not always cover all the specific measures called for by the Guidelines for Implementation of Article 13. As Fig. 14 shows, by 2020, among all Parties it was most common to ban TAPS related to product placement, tobacco sponsorship and depiction of tobacco in entertainment media.

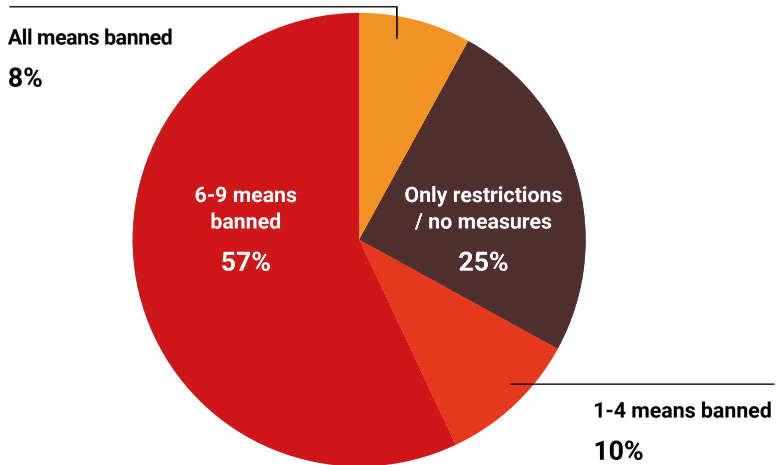
Fig. 14. Percentage (%) of Parties reporting having banned different types of tobacco advertising, promotion and sponsorship (n=181)



To further assess how the recommended scope of the comprehensive ban is met, an additional analysis was conducted for the above measures as a cluster among all Parties. By 2020, only 14 Parties, less than one in 10 of all Parties, have reported having banned all the listed types of TAPS, hence, instituted a comprehensive TAPS ban fully in line with the recommendations of the Guidelines for Implementation of Article 13 (Fig. 15). On a positive note, 103 Parties, over

half of all Parties, have banned most means of TAPS. A small number, 19 Parties, have banned only four or fewer types of TAPS. When revisiting the number of Parties that report having instituted a comprehensive TAPS – 136 Parties – this new analysis indicates that a number of Parties need to notably improve the coverage of their TAPS bans. Also, 45 Parties still continue to rely only on restrictions instead of bans, or have not limited TAPS at all.

Fig. 15. Number of means of tobacco advertising, promotion and sponsorship[39] banned by the Parties by 2020 (n=181)



New comprehensive TAPS legislation was reported by Armenia, Burundi, Côte d'Ivoire, Niue and Venezuela. Other Parties reported to be working or have ready for approval draft bills including new TAPS regulations, such as Bahamas, Belize, Denmark, Germany, Iraq, Jamaica, Lithuania, the Netherlands and the Republic of Cabo Verde. In the 2020 reporting period, various provisions have seen a slight strengthened inclusion in national legislation, but notable progress was observed in the proportion of Parties that included product placement, display at points of sale and cross-border advertising originating from the country in their comprehensive bans (Fig. 13). Improvements on the latter are aligned with the recommendations provided by the report of the Expert Group on Tobacco Advertising, Promotion and Sponsorship (FCTC/COP/8/7) and the latest COP decision on the topic (FCTC/COP8(17)).

The ban of the display of products at points of sale has been adopted in Pakistan and Samoa, while in Latvia and Georgia this measure was set to come into force in October 2020 and early 2021, respectively. In China, the State Administration of Radio and Television has instructed radio and television production agencies to implement relevant regulations, control scenes including smoking action in TV dramas, and avoid showing tobacco brand logos and related content, as well as avoid showing minors buying cigarettes, smoking or present while someone is smoking do not appear. Scenes that require smoking for "artistic needs" are replaced or reduced as much as possible. Furthermore, the Regulations on the Administration of Juvenile Programmes stipulate that "minor programmes must not contain content that expresses smoking and sales of tobacco", applied to juvenile programmes on radio, television and the Internet. In Turkey, Article 3/6 of Law No. 4207 was amended and declares: "It is forbidden to use and to display tobacco products in TV programmes, films, TV series, music videos, commercial and promotional films and works shown in cinemas and theatres. Also, it is forbidden to

39 List of included means of TAPS from the reporting instrument: 1) display of tobacco products at points of sales; 2) domestic Internet; 3) global Internet; 4) brand stretching and/or sharing; 5) product placement; 6) the depiction/use of tobacco in entertainment media; 7) tobacco sponsorship of international events/activities; 8) corporate social responsibility; 9) cross-border advertising originating from the country; and 10) cross-border advertising entering the country.

use tobacco products and images for commercial purposes or advertising purposes in the Internet, social media or similar environments open to the public."

Parties such as Belarus, China, Croatia, Montenegro, New Zealand and the Republic of Korea have incorporated in their TAPS legislation regulations for electronic cigarettes. Croatia and Montenegro banned the advertising and promotion of products that are not considered tobacco products, but which, due to their form, name or purpose directly encourage the consumption of such products, such as devices for the use of HTPs. The EU revised the Audio-visual Media Services Directive, extending the prohibition of audio-visual commercial communications of cigarettes and other tobacco products to electronic cigarettes and refill containers. This measure applies specifically to video-sharing platforms, which must include and apply this regulation in their terms and conditions. The revised directive entered into force on December 2018 and will have to be transposed in the EU Member States by 19 September 2020.

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 47% of all Parties had implemented this measure by 2020. As compared to 2018, the implementation of this measure improved, from 44% covering the measure in their TAPS ban. In 2018–2020, a positive trend from 36% to 41% was observed in imposing penalties for cross-border advertising, but still less than one third (30%) of all Parties cooperate on its elimination.

Restrictions in the absence of comprehensive TAPS ban. Overall, 25% of all Parties reported that they did not implement a comprehensive ban for TAPS. Of these Parties, only three Parties – Canada, Japan and Mexico – indicated that they were precluded by their constitution or constitutional principles from undertaking a comprehensive TAPS ban. Of the Parties that applied restrictions instead of a comprehensive ban, only over one third (36%) required restrictions for all TAPS. Only two (4%) of the Parties without a comprehensive TAPS ban required disclosure of tobacco advertising expenditures, with the situation even worsening from 2018 (five Parties, 11%). Most common restrictions for TAPS were restrictions on radio (64%), television (60%) and print media (47%). The least restricted areas were cross-border advertising originating from the country (18%), global Internet (22%) and tobacco sponsorship (38%). In restricting the tobacco sponsorship of international events and activities, there was a notable increase from 2018 (34%), also in restricting the sponsorship of participants therein (from 28% to 33% in 2018–2020).

Enforcement of the legislation. Burkina Faso reported the participation of civil society in monitoring compliance with the adopted regulations. The Broadcasting Commission in Jamaica has enforced the adopted regulations, providing advice to numerous advertisers and production houses on how to follow the regulations. In parallel the Children's Code for programming is under review and will strengthen the enforcement of tobacco advertising regulations, as well as those related to other harmful substances. The Ministry of Commerce of Saudi Arabia has also established a complete department for monitoring advertising, promotion and sales of tobacco products via the Internet, as all sites and social media that sell tobacco products are banned. Sanctions have been imposed on those breaching the advertising and promotion bans in China, Jamaica and Spain.

Implementation challenges. The control of the advertising and promotion incorporated in television and films, as well as in new social media platforms, has been identified by Panama, Paraguay and Viet Nam as challenging. In Panama, the Ministry of Health managed to communicate with an Internet platform (Google), indicating that the inclusion of TAPS in platforms accessed by Panama breach national regulations, and the platform sent a global communication establishing a total ban on advertising of tobacco products on its digital platforms.

Guidelines for Implementation of Article 13. By 2020, 65% of all Parties reported having utilized these Guidelines, with increase from 2018 (60%).

Banning cross-border advertising is the second time-bound measure under Article 13, in addition to the general TAPS ban, but only one out of three Parties have implemented it.

Parties' definitions of a comprehensive ban on TAPS vary and do not always cover all the specific measures called for by the Guidelines for Implementation of Article 13. This poses a challenge in assessing Parties' advertising and promotion bans.

Pakistan

Case study

Pakistan strengthens the ban on advertising and promotion in its territory

Pakistan has been intensifying its efforts to fully comply with the requirements of Article 13 of the WHO FCTC and its Guidelines for Implementation. The country reconstituted on September 2018 the Committee on Tobacco Advertisement Guidelines, established as required by Section 7 of the Prohibition of Smoking and Protection of Non-smokers Health Ordinance of 2002, with a clear mandate to make the regulation on tobacco advertising, promotion and sponsorship compliant with Article 13 of the Convention.

According to the aforementioned Section 7 of the 2002 Health Ordinance, no person or company shall advertise tobacco and tobacco products on any media or in any place and any public service vehicle, if such advertisement is not in accordance with guidelines prescribed for this purpose by a committee. For the success of this process, a key fact was the ousting of the tobacco industry observer from the Committee on Tobacco Advertisement Guidelines, notified on 26 September 2018, and the incorporation of representation from provincial governments, as well as health specialists.

The previous Prohibition of Smoking and Protection of Non-smokers Health Ordinance from 2002 already included a ban on advertising of tobacco products in print and electronic media. The new recommendations raised by the Committee in February 2019 were presented as a summary developed by the Tobacco Control Cell at the Ministry of Health, submitted before Cabinet of Pakistan for approval. Subsequently, new Statutory Regulatory Order 72(I) was notified by the Government of Pakistan on 30 January 2020, managing to close some gaps and loopholes that remained in the national law.

The new prescriptions include a ban of advertising at points of sale, either inside or outside or any other place, nor by use of any material. The electronic media shall no longer display tobacco products and the ban also covers all cinemas and theatres, banning the paid placement of tobacco products in these media. This order also bans the display and visibility of tobacco products inside or outside of a point of sale, including mobile or fixed retail outlets and street vendors. Furthermore, direct targeting of individuals, through promotional or informational material, including through social media or personal mail, is prohibited in the country. Another new regulation is the ban on payment or other contributions to retailers (such as free goods, gifts, discounts, among others) to encourage or induce them to sell specific products, and also to avoid the exclusive sale or prominent display of a particular product.

This law expands on the previous regulation, although there are still certain obligations that need to be incorporated to guarantee a comprehensive implementation of Article 13. However, Pakistan continues advancing in the protection of present and future of young generations from the tactics of the tobacco industry.

(Photo courtesy of Tobacco Control Cell, Pakistan)

Measures concerning tobacco dependence and cessation (Article 14)

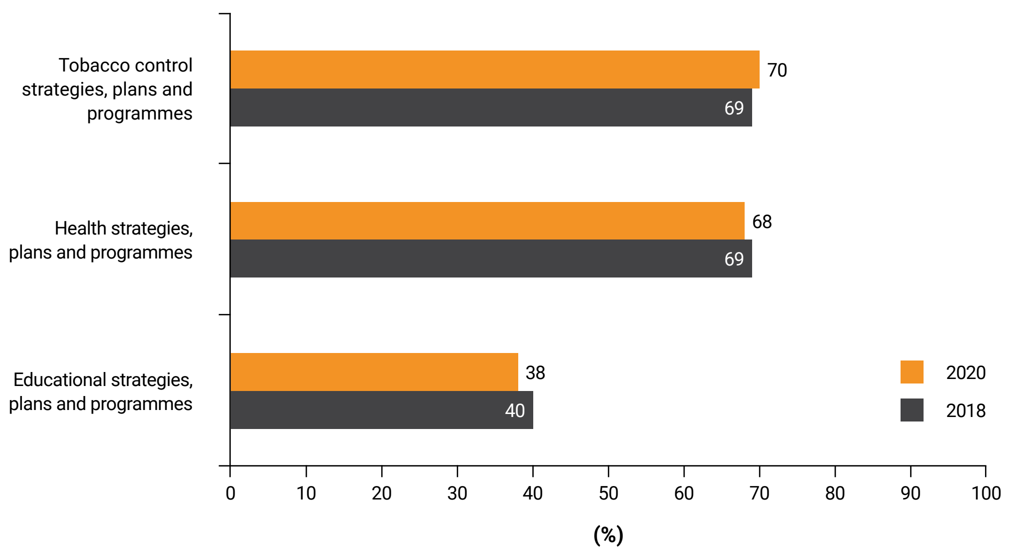
Key observations

- More Parties reported having developed or having in place national guidelines for tobacco cessation than in 2018, now with almost two thirds of all Parties having put them in place.
- Still, only over half of the Parties reported that they integrate tobacco dependence treatment in the curricula of medical schools, and even less in the curricula of other health professionals.

National guidelines on cessation. Overall, 64% of all Parties have reported having national cessation guidelines based on scientific evidence and best practices, a somewhat higher proportion than in 2018 (61%). Several Parties continued to update their guidelines in the reporting period. New guidelines were reported by Burkina Faso, Latvia and the Russian Federation. In Fiji, the Ministry of Health and Medical Services was developing national tobacco cessation guidelines in 2020. Finland reported that the national clinical guidelines addressing the treatment and prevention of nicotine dependence were updated in 2018. Italy reported that in 2020, the Italian Society for Tobaccology translated and disseminated the guidelines for smoking cessation produced by the European Network for Smoking and Tobacco (ENSP)[40], an observer to the COP. Mexico highlighted the recent development of a competency standard for the provision of brief advice in primary care.

Inclusion of diagnosis, treatment and counselling services for tobacco cessation in national programmes, plans and strategies. Around two thirds of all Parties included tobacco dependence diagnosis, treatment and counselling services in their national strategies, plans and programmes for tobacco control and for health (Fig. 16). In addition, over one third of Parties include these in their national educational strategies, plans and programmes. The proportions remained at similar levels as in 2018.

Fig. 16. Percentage (%) of Parties reporting the inclusion of diagnosis and treatment for smoking cessation in their national strategies, plans and programmes in 2018–2020 (n=181)



In the progress notes, Palau reported its utilization of a stepwise approach towards adopting a comprehensive national cessation policy, based on the recommendations

40 Tobacco cessation is one of the main focus areas of work of the ENSP. The tobacco cessation guide produced by ENSP is available in 18 languages (some of them are currently being designed and printed) on the regularly updated webpage: http://elearning-ensp.eu/mod/page/view.php?id=532.

of the Guidelines for Implementation of Article 14. A national situation analysis was completed through input from diverse stakeholders and a cessation policy will be drafted. The policy will include, among others, the designation of a cessation focal point, allocating a budget for tobacco cessation, integrating brief advice in the health-care system, making nicotine replacement therapy (NRT) available and affordable, prioritizing tobacco cessation among the health-care workers and pregnant women.

Around two thirds of all Parties included tobacco dependence diagnosis, treatment and counselling services in their national strategies, plans and programmes for tobacco control and for health.

WHO FCTC Knowledge Hub on International Cooperation engaged in promoting implementation of Article 14

The International Cooperation Centre for Tobacco Control (CCICT) based in Montevideo, Uruguay, has served as the WHO FCTC Knowledge Hub on International Cooperation since 2015.

In a recently completed project, the Knowledge Hub helped countries with high HIV infection and/or tuberculosis (TB) prevalence to implement the recommendations of Article 14 of the WHO FCTC. Furthermore, also as part of the project, the Knowledge Hub developed a manual to strengthen or create the necessary national mechanisms for the integration of tobacco cessation interventions in HIV/TB control programmes, and provide, to tobacco users who require it, the support available for the treatment of their addiction. The manual is available in "Resources" section of the Implementation Database, in Spanish and English.[41] The manual could be very useful for those Parties that wish to advance the application of Article 14 of the WHO FCTC in these vulnerable populations.

The treatment of tobacco dependence integrated with primary health care, and also in TB/HIV treatment programmes, under the close control of health professionals, has proven to be highly cost-effective to improve outcomes of three pathologies at the same time, those of TB, HIV and tobacco dependence.

Sitting from left to right: Beatriz Goja, MD; Diego Rodríguez, MSc; Elba Esteves, MD; Laura Llambí, PhD; Amanda Sica, Psy D. Standing: Miguel Asqueta, MD (Photo courtesy of WHO FCTC Knowledge Hub on International Cooperation, Uruguay)

41 https://untobaccocontrol.org/impldb/article-14/

Activities and programmes to promote tobacco cessation in the general population. The majority of Parties (81%) have reported that they utilized the opportunities raised by local events, such as the World No Tobacco Day, to promote tobacco cessation. In addition, over two thirds (73%) have carried out media campaigns on the importance of quitting (see also the section on Article 12), and over one third (39%) provide telephone quit lines for the general population. Around one third of Parties reported they had programmes specially designed for pregnant women (39%) and for women in general (30%). No major changes were observed in these proportions since 2018.

Several Parties noted progress in their telephone counselling services. Canada reported that in Ontario, since October 2019, citizens have had easy access to smoking cessation support through Telehealth Ontario. This is a free call service that provides smokers with professional medical advice, health information and referrals to health services. In Panama, during the COVID-19 pandemic, smoking cessation counselling was given through the automated call system (ROSA). In Georgia, a free quit line has recently been established, providing brief consultation by a trained counsellor. Jordan reported that a number for the quit line has been set and staff training took place in 2020. In Lithuania, a pilot quit line project was implemented in 2019. Poland reported that a Smoker Aid Phone Clinic was now operational. The Russian Federation reported that in 2019, over 650 000 calls were received on their healthy lifestyle counselling telephone line, including tobacco cessation.

Additionally, China reported that the China–Japan Friendship Hospital (WHO Collaborating Centre for Tobacco Cessation and Respiratory Diseases Prevention), which also organized an international seminar on the implementation of Article 14, joined the WHO cessation project and developed a new smoking cessation application. Hungary reported that the National Methodology Centre for Smoking Cessation Support coordinated the development of a new software application. In addition, in Norway, the smoking and smokeless tobacco cessation software application, Slutta, was being continuously updated and renewed, and was launched with open-source code in 2019. Since the launch of the application in 2013, it has been downloaded over 800 000 times in a country with a population of 5.4 million.

Activities and programmes to promote tobacco cessation in different settings. Programmes to promote cessation were most common in health-care facilities, reported by over three quarters (78%) of Parties. In addition, over half of the Parties reported such programmes in educational institutions (59%) and in workplaces (54%). Less than one third (31%) reported programmes in sporting environments. The proportions remained on similar levels as in 2018.

A few Parties reported progress, especially in workplaces. For instance, Belgium reported a new workplace-based prevention programme in Flanders led by the Institute for Healthy Living. In practice, a company coach assists with raising awareness about healthy choices, which includes provision of smoking cessation support. The Republic of Korea reported that a smoking cessation campaign took place at several workplaces. In Cambodia, 150 health professionals were trained to provide brief interventions in workplaces and communities, and to promote smoke-free health facilities.

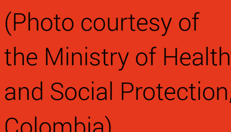
Integration of cessation into health-care systems and involvement of various health professionals. Some 69% of Parties reported that they integrated diagnosis and treatment into their health-care systems. Of these Parties, the majority reported having integrated it into primary health care (Fig. 17). No major changes were observed in terms of the different structures providing for diagnosis and treatment as compared to 2018. Several Parties also continued to mention that other structures within their existing health-care systems provided cessation services, for example, occupational health services and centres providing psychiatric care.

Colombia

Case study

Building capacity to treat tobacco dependence

In 2016, the Ministry of Health and Social Protection of Colombia developed a guiding document for the establishment of a programme to address tobacco addiction and to help tobacco cessation. The aim of this guide is to help the development and implementation of the national tobacco cessation programme in a way that it is integrated in the country's health services and is based on evidence-based interventions. Two cities, the capital of Bogota and the city of Cartagena, as well as the departments of Cundinamarca, Santander and Valle del Cauca, have implemented the programme since then, and six additional departments are in the initial stages of its implementation.



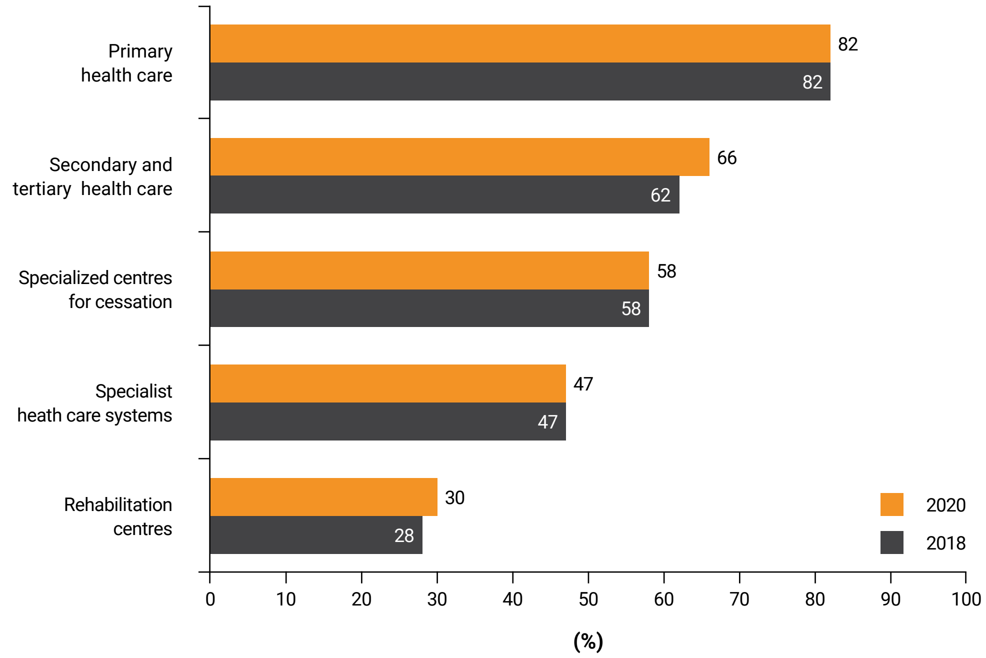
(Photo courtesy of the Ministry of Health and Social Protection, Colombia)

Under these programmes, capacity-building workshops have been held in the different cities and 553 health professionals have been trained to date. Currently, and in parallel, there is a continuing educational programme through the virtual platform of the National Learning Service which, by 2019, had trained 1600 additional health professionals on tobacco cessation, using this virtual modality. Likewise, the Ministry of Health and Social Protection is promoting the application of brief advice at primary health care level, and the training of teams to comprehensively address the needs of those with tobacco dependence.

The combined effect of this set of interventions is to support those Colombians who are ready to quit tobacco use, thus reducing the burden of tobacco use, with efficient coordination at all levels of the national administration.

New specialized centres for tobacco cessation were reported by Burkina Faso, Costa Rica, Jordan, Panama, Sudan and Turkey. Of note is that Libya, a country in civil war, reported success opening a number of smoking cessation clinics through primary health care, and to organize training in cooperation with WHO for physicians to work in smoking cessation clinics.

Fig. 17. Percentage (%) of Parties with programmes on diagnosis and treatment of tobacco dependence in health-care systems, by type of services/settings in 2018-2020 (n=125 in 2018; n=125 in 2020)*



** Note: Calculated among Parties that have included diagnosis and treatment in the health-care system.*

Improving the outreach of the current services was noted by a few Parties. For example, Malaysia reported that the number of smokers who registered to Malaysia Quit Smoking Services (mQuit), both in the public and private facilities, increased since 2018. In addition, a new website was established to inform the public about available services, and a new No Smoking signage with the mQuit promotion was launched in 2019 to accompany the implementation of smoke-free restaurants. A few pilot projects were also reported. In Chile, pilot testing for an intervention in primary care took place in three communities in the metropolitan region. The intervention protocol has now been evaluated, and the intervention was expected to be further developed and implemented in 2020–2021. Latvia reported that a pilot study on group counselling was conducted and evaluated. Mexico reported that a pilot project on brief counselling based on a competency standard was implemented and evaluated.

Improving the provision of support for special groups was reported by several Parties. In Canada, the renewed Tobacco Strategy brings an added focus to subgroups of the population who face higher rates of tobacco use and health inequalities. The Public Health Agency of Canada has provided funding for several smoking cessation projects. Finland reported that the Finnish Lung Health Association (FILHA) has several projects for smoking cessation targeting vulnerable population groups. New Zealand had developed guidance to support stop smoking services to better engage with young Māori women smokers. In Norway, a new pilot project to enhance smoking cessation for heavy smokers was starting in 2020. The project includes cooperation between healthy life centres, hospitals and general medical practices, among others, and partial reimbursement of pharmaceutical products. The Republic of Korea noted the distribution of Triple Crown Life Coaching Program (CROWN) booklet to encourage adolescent smokers to quit from 2019. In Thailand, cessation services were implemented together

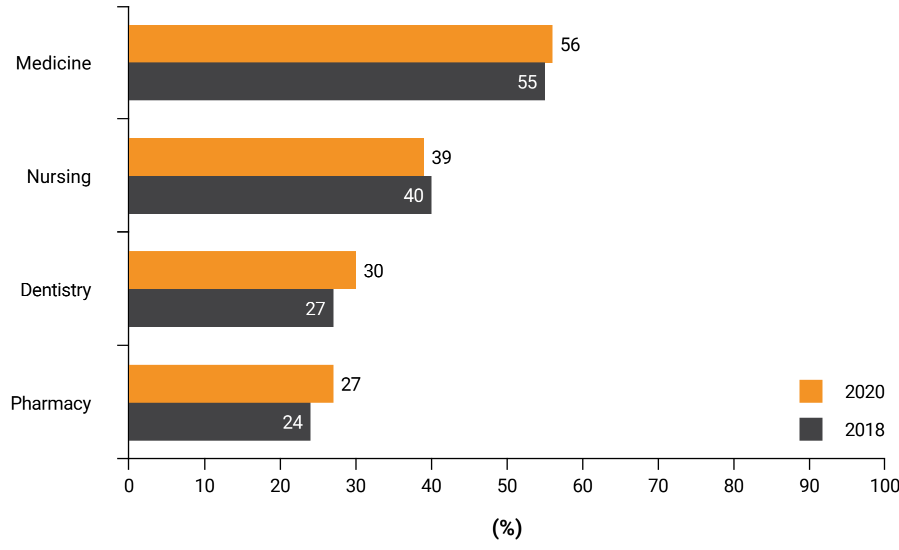
with the new smoke-free policies in prisons and correctional institutions nationwide.

The majority of Parties that have included diagnosis and treatment in the health-care system reported the involvement of physicians (90%), nurses (81%) and family doctors (67%) in offering counselling. Over half of Parties involved dentists (56%) and social workers (52%), with a minor increase as compared to 2018 (53% and 50%, respectively). Involving pharmacists (47%) became slightly less common than in 2018 (50%). Over one third of Parties involved midwives (42%) and community workers (38%). In addition, one in five (22%) Parties reported that practitioners of traditional medicine have a role in assisting tobacco cessation.

Some Parties provided examples of their new projects involving different professionals. In Styria, Austria, the programme called “Smoke-free in Six Weeks” involves group counselling for adults and youth by psychologists and physicians trained to provide cessation advice. Bosnia and Herzegovina reported that the Public Health Institute of the Republic of Srpska had implemented a project with family doctors (primary health care) in six community health centres. In Brunei Darussalam, multi-professional teams organize anti-tobacco exhibitions and roadshows, where they deliver brief advice and refer smokers to the nearest cessation clinic. In Bulgaria, teams of specialists in pulmonary diseases have carried out screening events in the cities of Blagoevgrad, Sofia and five settlements in Vratsa region, under the motto “Stop Now for Better Health Tomorrow”. The screening campaign aimed at early detection of lung diseases of smokers and those exposed to environmental tobacco smoke, and it is organized and financed by the Ministry of Health as part of the Noncommunicable Disease Prevention National Programme 2014–2020.

Curricula for health professionals. Slightly over half of the Parties reported that they included tobacco dependence treatment in the curricula of medical schools (Fig. 18). Incorporating it to the curricula in the training of other health professionals was less common, and it improved only for pharmacy and dentistry professions, as compared to 2018 data. A positive example was reported by Portugal, where more emphasis was placed on training of health professionals from undergraduate schools in providing brief interventions.

Fig. 18. Percentage (%) of Parties reporting the inclusion of tobacco dependence treatment in the curricula of different health professionals in 2018-2020 (n=181)



Public funding or reimbursement schemes for treatment costs. Out of the Parties that included diagnosis and treatment in their health-care systems, the majority (83%) covered fully or partially the costs of services and treatment in primary health care by public funding or reimbursement schemes. In their progress notes, some Parties reported advancing the access to free cessation services. For example, Belgium reported that in some communities

the participation in group or individual counselling was made free of charge. In Finland, the Council for Choices in Health Care in Finland, a permanent body appointed by the Government that works in conjunction with the Ministry of Social Affairs and Health, started to prepare the recommendations for the inclusion of smoking cessation services in the range of public health services in 2018. The recommendations were expected to be ready in 2020. In the Philippines, with the passing of the Universal Health Care Act, the Government expands its existing benefit packages for brief advice for smoking cessation.

Accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence. Over half (61%) of all Parties reported facilitating the accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence. The majority (90%) of these Parties had reported that they have NRT legally available in their jurisdiction, and around two thirds had bupropion (64%) and varenicline (64%) available. The most common other pharmaceutical products reported to be available were cytisine, referenced by seven Parties, and nortriptyline, referenced by five Parties. For example, Canada reported that cytisine – considered a natural product with healing properties – is available in their jurisdiction for the treatment of tobacco dependence without prescription. Côte d'Ivoire and Jordan reported that they included NRT in their national lists of essential medicines.

Of the Parties that had NRT legally available, over half (53%) reported covering their costs fully or partially by public funding or reimbursement schemes. Among the Parties that had bupropion and varenicline legally available, the costs were fully or partially covered at 56% and 55%, respectively. The coverage of the costs of varenicline improved notably from 2018 (50%).

In their progress notes, Iraq reported that due to insufficient financial support to provide the NRT in all primary health care centres that implement brief smoking cessation interventions, they try to locate only one centre in each province to provide free medications. The Netherlands reported that since January 2020, pharmaceutical products and prescription drugs for smoking cessation are free when used in combination with behavioural support. In Qatar, a reimbursement scheme is in place for NRT in public health facilities and private pharmacies, and a referral system has been established to support referral to health-care facilities that provide smoking cessation services. Thailand reported that varenicline was made available free for smokers under social security funds nationwide. The United Arab Emirates reported that smoking cessation medicines are free of charge for their citizens.

Guidelines for implementation of Article 14.By 2020, 59% of all Parties reported having utilized these Guidelines, with minor increase from 2018 (57%).

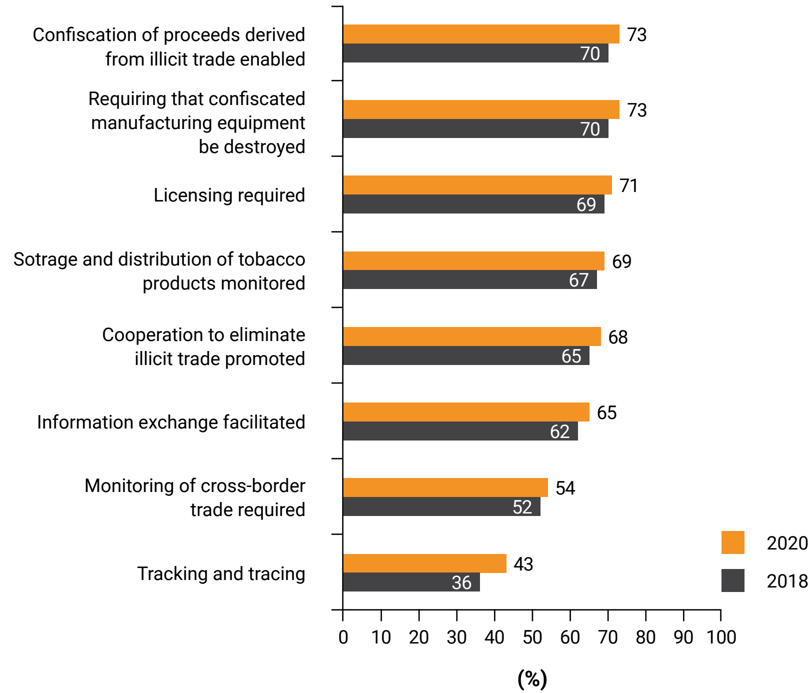
Measures relating to the reduction of the supply of tobacco

Illicit trade in tobacco products (Article 15)

- The 2020 reporting cycle marked the first time that the Parties to the WHO FCTC that are also Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products had to report on their work carried out under the Protocol.[42]
- The implementation of most of the measures under this article continued to improve as compared to previous data. For example, notable progress was detected in the development of tracking and tracing regimes to further secure the distribution system and assist in the investigation of illicit trade.

Enacting or strengthening legislation against illicit trade. For most measures implemented under Article 15 of the Convention, progress has been detected as compared to previous data. Overall, around two thirds of all Parties (76%) reported having adopted or strengthened legislation against illicit trade in tobacco products, with a continued increase from 73% in 2018. Changes in the implementation rates of the individual measures are explained in the following paragraphs.

Fig. 19. Percentage (%) of all Parties reporting on implementation of illicit trade control provisions in 2018–2020 (n=181)



42 To gain a more comprehensive picture on global progress in measures related to the control of illicit trade in tobacco products, also read the first Global Progress Report on the Protocol to Eliminate Illicit Trade in Tobacco Products.

Confiscation and destruction. The majority of Parties reported allowing the confiscation of proceeds derived from illicit trade in tobacco products, and around two thirds monitored, documented and controlled the storage and distribution of tobacco products held or moving under suspension of taxes and duties (Fig. 19). In addition, the majority required the destruction of confiscated equipment, counterfeit and contraband cigarettes, and other tobacco products derived from illicit trade, using environmentally friendly methods when possible, or their disposal in accordance with national law.

A couple of Parties provided recent examples in this area. In China, the General Administration of Customs has successively organized and carried out joint special operations to combat smuggling under the National Gate Sword campaign. These operations targeted Conventional tobacco products, as well as ENDS and HTPs. In collaboration with relevant departments, China Customs repeatedly carried out public destruction of confiscated cigarettes. In Colombia, in 2018–2019 seven criminal structures dedicated to the smuggling and illegal trade of cigarettes were dismantled, 59 people were captured, and 368 assets were confiscated with a value of US$ 27 million. Lithuania and the Bolivarian Republic of Venezuela reported that they recently started using non-intrusive inspection equipment, such as an X-ray system, to make the detection of illicit trade in tobacco products, and in particular cigarettes, more effective.

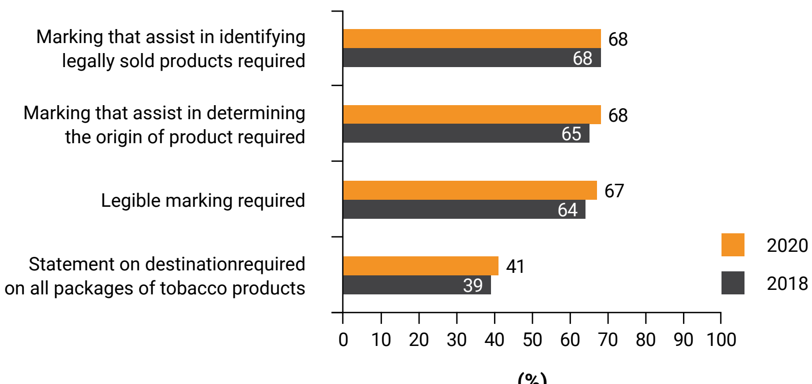
Licensing. Almost three quarters of the Parties now require licensing or other actions to control or regulate production and distribution in order to prevent illicit trade, with a minor increase from 2018 (Fig. 19). For example, in Nicaragua, registration of tobacco importers and distributors became compulsory in 2019. Licenses are granted to importers, distributors and manufacturers complying with the mandatory labelling, with the inspection of the premises of their company if they have registration.

Tracking and tracing. Over half of Parties reported that they require monitoring and collection of data on cross-border trade in tobacco products, including illicit trade. Over one third of Parties reported developing or implementing a practical tracking and tracing regime to secure the distribution system, and assist in the investigation of illicit trade, with a notable increase from 2018 (Fig. 19). This increase could also be attributable to the fact that the introduction of a tracking and tracing regime is a time-bound measure under the Protocol.

For example, on 20 May 2019, the EU-wide system of traceability and security features for tobacco products became operational. It is the world's largest tracking system of this kind, capturing data for every pack of tobacco products and providing authorities with visibility over all activity along the supply chain. During its first 10 months of operations, the EU traceability system tracked and traced over 21 billion packets of cigarettes and roll-your-own tobacco products through the network of over 1.4 million registered facilities in the EU.

Promoting cooperation. Overall, around two thirds of Parties reported promoting cooperation between national agencies and relevant regional and international intergovernmental organizations (IGOs) with a view to eliminating illicit trade in tobacco products (Fig. 19).

Fig. 20. Percentage (%) of Parties reporting requiring marking on packaging (n=181).

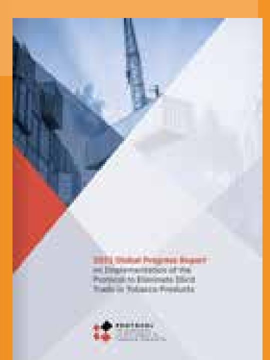


Marking of packaging. As seen in Fig. 20, around two thirds of Parties reported that they require markings to assist in determining whether a tobacco product was legitimately and legally sold on the domestic market and/or to assist in determining the origin of the product. Similarly, around two thirds of Parties reported requiring the marking to be legible and/or presented in the principal language or languages of the country. However, to a significantly lesser extent, only less than half of Parties 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.

Share of illicit tobacco products on the national tobacco market. The information collected from the Parties suggests that measuring illicit trade in tobacco products is still an important challenge for them. Only 21% of the reporting Parties responded as having information on the percentage of illicit tobacco products in the national tobacco market, with minor improvement since 2018 (18%). Thirty-three Parties provided data related to the national market share of illicit tobacco products. In most cases, the data were provided by customs authorities and other government ministries or agencies.

The first report on the implementation of the Protocol published in 2021

In accordance with Article 32 of the Protocol to Eliminate Illicit Trade in Tobacco Products, its Parties are required to report periodically on their implementation. At the time this report was prepared, 62 Parties had ratified the Protocol, of which 57 were required to report in the 2020 reporting cycle.



Sharing information on a Party's work and its progress in implementation of the Protocol, as well as documenting challenges encountered, promotes shared learning and a better understanding of how the measures required under the Protocol could be implemented efficiently. This is also a critical means that could help identify areas where more assistance is needed by the Parties.

In parallel with this WHO FCTC Global Progress Report, the first report of this kind for the Protocol was also developed. It provides baseline data and some examples of implementation of the various aspects of the Protocol.

As requested by the First Session of the Meeting of the Parties to the Protocol in decision FCTC/MOP1(10), the Protocol questionnaire has the same format as the WHO FCTC questionnaire and has been integrated into the existing reporting platform. In 2019, the Convention Secretariat, which serves as the secretariat of both the WHO FCTC and the Protocol, developed the Protocol reporting instrument covering the various Protocol provisions. The questionnaire was piloted with a few Parties before being finalized in the last quarter of 2019. The reporting cycle was launched together with the one for the WHO FCTC on 18 December 2019, and was conducted in the same way as the one for the WHO FCTC.

The submitted reports confirm that Parties to the Protocol are in different stages of implementation. The report also highlights the areas that pose challenges and where addressing gaps will be important as we progress with the implementation of the Protocol. The Parties reports and information reported under each treaty provision, except for those sections that are confidential, can be accessed through the Protocol Implementation Database.[43]

The 2021 *Global Progress Report on the Implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products* is the first that provides baseline data for the implemented measures. To ensure appropriate monitoring of implementation of the Protocol, there will be need for Protocol Parties to strengthen their efforts to meet their reporting obligations, with a greater number of them needing to share their national data on implementation progress, needs, gaps and challenges.

43 https://untobaccocontrol.org/impldb/

Sales to and by minors (Article 16)

Key observations

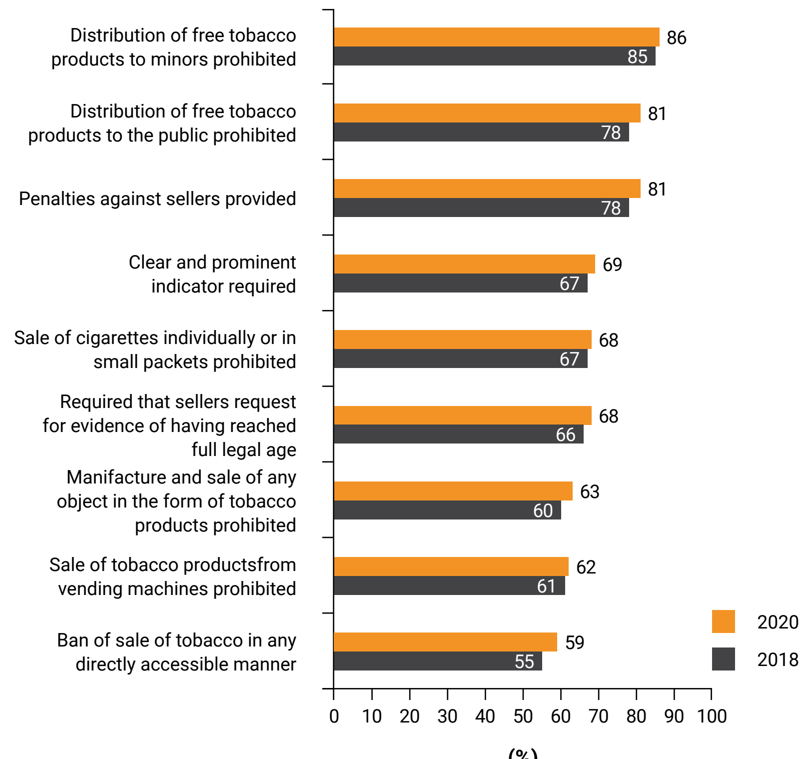
- Parties continued to strengthen the implementation of all provisions under Article 16.
- Still, 18 Parties have not reported prohibiting sales of tobacco products to minors, and six Parties reported that the minimum age for tobacco purchases is below 18 years of age.
- The provisions for prohibiting the sale of tobacco products in any manner in which they are directly accessible, such as open store shelves and from vending machines, continue to need further attention from the Parties.

Sales to and by minors. Overall, the implementation of all measures under Article 16 improved as compared to 2018. In 2020, altogether 90% of Parties reported having prohibited sales of tobacco products to minors, and the majority (76%) also by minors. The legal age for tobacco purchases ranged from 15 to 24 years, with the average being 18 years.

The highest legal age was found in Sri Lanka (24), followed by Honduras, Kuwait, Mongolia, Palau, Samoa and Singapore (21); Japan, Thailand and Uzbekistan (20); and Nicaragua and the Republic of Korea (19). The lowest legal age reported was by Comoros (15 years), followed by Djibouti, Mali, the Republic of North Macedonia (16), and the Democratic People's Republic of Korea and Timor-Leste (both 17). Important steps were taken by two Parties that previously had one of the lowest age limits, namely, Austria and Belgium. In Austria, the selling of tobacco and related products including ENDS and water pipes to minors under the age of 18 (up from 16) were prohibited beginning in January 2019. In addition, the legal age for both purchasing and consuming tobacco products is now 18. In Belgium, the age limit was also raised from 16 to 18 years, also including ENDS.

A number of Parties reported other progress in adopting new measures to set the minimum age of tobacco sales or purchases. Many Parties had now set an age limit of 18. These include Congo, Côte d'Ivoire, Gambia, Montenegro, Saint Lucia and Tuvalu. Jordan reported that new regulations had been issued in 2019 to set an age limit of 19 years for the purchases of HTPs and ENDS. Lithuania reported that the Ministry of Health registered a draft amendment to the Tobacco Control Law in March 2020 in the Parliament to introduce a ban of sale of devices intended for consumption of tobacco and related products for people under 18 years.

Fig. 21. Percentage (%) of Parties reporting on implementation of Article 16 provisions in 2018–2020 (n=181)



Requirements for tobacco retailers. Around two thirds of Parties required that all sellers of tobacco products place a clear and prominent indicator inside their points of sale about the prohibition of tobacco sales to minors (Fig. 21). A similar proportion requested that sellers of tobacco products ask the purchaser to provide evidence of having reached full legal age. Around two thirds of all Parties prohibited tobacco sales from vending machines, and over half prohibited sales in any manner by which they are directly accessible, such as open store shelves. The majority of Parties prohibited the distribution of free samples to minors and to the public in general.

Some new requirements for tobacco retailers were also noted by the Parties. For example, in Côte d'Ivoire, the 2019 law introduced several new requirements for retailers. It prohibits tobacco sales in educational institutions including higher education; in health-care institutions; in sports, cultural or government facilities; and in the immediate vicinity (a radius of 200 metres) of other institutions indicated by the law. Additionally, online sales, vending machines and free distribution were prohibited.

Montenegro reported that they now require a prominent indicator of the age limit to purchase tobacco products to be displayed in retail stores. In the Netherlands, only standardized (plain) vending machines operated under the supervision of a salesperson will be allowed by 2022.

Prohibition of tobacco products with specific appeal to minors. Around two thirds of all Parties prohibited the sale of cigarettes individually or in small packs (Fig. 21). A similar proportion prohibited the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products. Some progress notes provided by the Parties also were related to these measures. In Côte d'Ivoire, the sale of tobacco individually was prohibited, and a minimum pack size of 20 cigarettes was set in 2019. The manufacture, sale, distribution and offering or giving away candies, toys or any other material with the shape or the taste of tobacco or a tobacco product were prohibited. In Seychelles, regulations prohibiting the sales

of individual cigarettes and requiring a minimum size of 10 cigarettes per package came into force in 2019. In Tuvalu, the 2016 amendments to the Tobacco Act 2008 also prohibit the sale or offer for sale of loose cigarettes and loose tobacco.

Enforcement and sanctions. The majority of Parties provided for penalties against sellers and distributors in order to ensure compliance with the regulation (Fig. 21). Some Parties reported progress in increasing the sanctions. Azerbaijan reported that a new amendment to the Code of the Azerbaijan Republic on Administrative Violations now provides penalties (100 Azerbaijani manat) for obtaining, giving or receiving tobacco products as a minor. Previously, the Code already provided penalties for sales to minors. In Denmark, the fines for sales to minors were raised, and sellers who repeatedly sell tobacco to minors may now be temporarily banned from selling tobacco. The Islamic Republic of Iran also reported increased penalties, while Côte d›Ivoire, Montenegro and Seychelles introduced new penalties.

Strengthened enforcement or monitoring activities were noted by some Parties. For instance, France reported results from a new compliance study conducted among tobacconists in 2019. The most frequently encountered non-compliance was observed in having the required sign displayed at the point of sale, requiring proof of the legal age and preventing the sales to minors. In Serbia, the inspectors have been granted the right to use “mystery shopping” to help detect violations.

Singapore

Case study

Raising the minimum legal age for tobacco products

As part of Singapore's ongoing efforts to reduce smoking prevalence, the Ministry of Health raised the minimum legal age for the purchase, use, possession, sale and supply of tobacco products from 18 to 19 years old on 1 January 2019. The minimum legal age was subsequently raised to 20 years old on 1 January 2020 and was to be raised to 21 years old on 1 January 2021.

Local research found that a large proportion of smokers start smoking at a relatively young age. Nine of 10 young smokers aged 18-39 years have their first puff before the age of 21 years, and two thirds of under-aged smokers get their tobacco from friends and schoolmates.

The aim of raising the minimum legal age is to prevent youth from picking up smoking by limiting access to tobacco products, and to further denormalize smoking, particularly for those below 21.

The proposal to raise the minimum legal age was debated and passed in Parliament on 7 November 2017 as part of the Tobacco (Control of Advertisements and Sale) (Amendment) Bill 2017, following public consultations conducted from December 2015 to March 2016, and from 13 June to 10 July 2017. The law applies to both tobacco retailers and those who supply any tobacco products to a person below the minimum legal age.

Raising the minimum legal age complements previous measures designed to protect youth from the harms of tobacco – for example, the sale of tobacco products by vending machines, the sale of individual cigarettes and the sale of imitation tobacco products (such as candy) are all banned. ENDS and HTPs are also banned in the country.

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

Key observations

- Among tobacco-growing Parties, over two thirds still do not promote viable alternatives for tobacco growers, and over nine in 10 do not promote alternatives for tobacco workers or individual sellers.
- Parties could benefit from more standardized monitoring and data collection in relation to the number of tobacco growers and workers in their jurisdiction.
- Innovative new measures to reduce the environmental consequences of tobacco packaging and filters were adopted, affecting a number of Parties.

Tobacco growing. Of all Parties, 48% reported tobacco growing in their jurisdictions. The proportion was slightly larger than in 2018 (46%). As a positive development, Côte d'Ivoire reported that its law adopted in July 2019 introduced a prohibition on industrial cultivation of tobacco, with three years transition time.

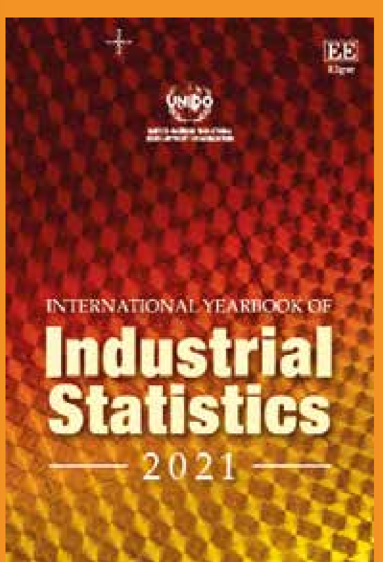
It is evident from Parties' reports that there is large variation in the availability and quality of data on tobacco growing and the number of people employed in the primary production phase. For example, Canada reported monitoring the number of tobacco farms and licensed tobacco growers, but not specifically the number of workers involved. Among several other countries, Croatia reported that the tobacco-growing sector employs mostly seasonal workers, making it a challenge to estimate the exact number of such workers. On the other hand, many Parties had better availability of data on the land used for tobacco cultivation, or on the amount of produced tobacco. Although the data provided by the Parties mostly originate from official agriculture or labour statistics, some rely solely on the estimates from the tobacco growers' associations or from the tobacco industry. Among the Parties that were able to provide the exact share of the value of tobacco leaf production in the national gross domestic product, the figure was typically well below 1%.

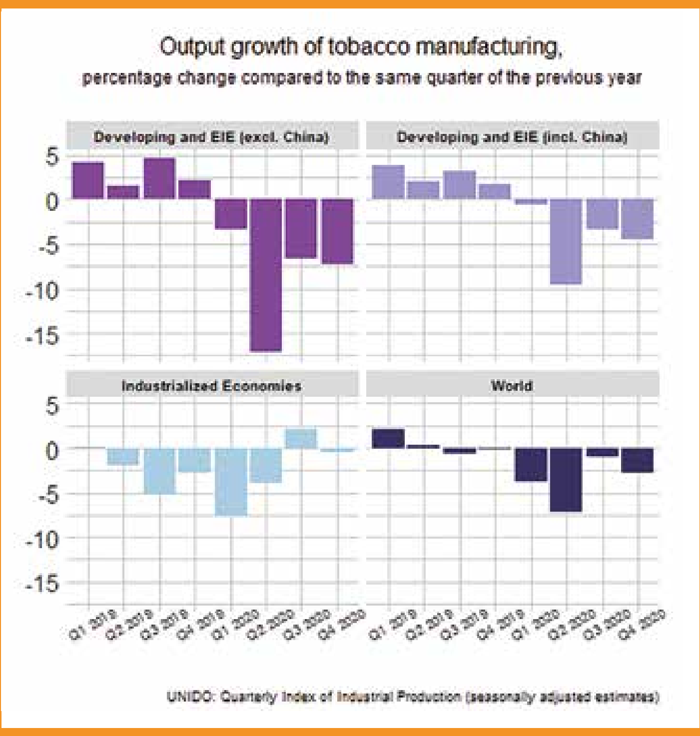
United Nations Industrial Development Organization:[44] recent trends of global tobacco products manufacture

The annual growth of value added in tobacco manufacturing measured in constant 2015 prices globally decreased by 1.6% from 2015 to 2019, following an increase of 0.7% from 2010 to 2015, as shown in Table 1.9 of the *International Yearbook of Industrial Statistics 2021* published by the United Nations Industrial Development Organization's (UNIDO).[45] Value added consistently declined in industrialized economies, whereas developing and emerging industrial economies showed a more diverse growth pattern.

An illustration of more recent developments is based on seasonally adjusted index numbers of quarterly industrial production focusing on the variable output rather than value added.[46]

On a year-on-year basis, global tobacco production experienced a steady decrease throughout 2019. The global outbreak of COVID-19 further reinforced this downward trend in 2020, as plenty of countries halted parts of their economic activities for several months. Compared to the same period of the previous year, seasonally adjusted growth estimates showed a contraction of 2.8% in the fourth quarter of 2020. Furthermore, for 2020 an output drop of 3.7% was measured, whereas in 2019 an increase of 0.4% was reported. For 2020, a drop in the output of tobacco manufacturing was also observed for industrialized economies (-2.5%), as well as for developing and emerging industrial economies (excluding China) (8.6%), whereas China witnessed an increase of 0.9%.

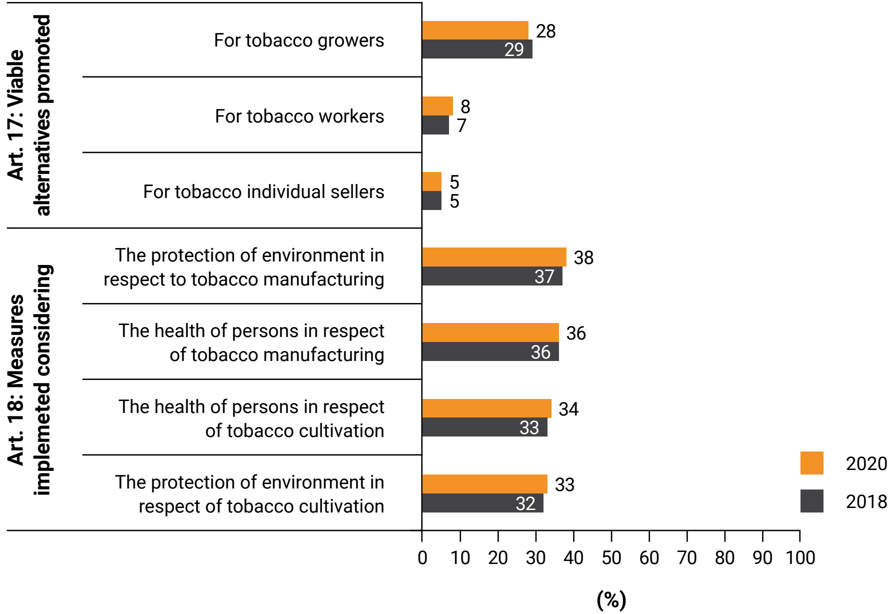




44 United Nations Industrial Development Organization (UNIDO) is an observer to the Conference of the Parties.
45 https://www.unido.org/resources-publications-flagship-publications/international-yearbook-industrial-statistics
46 https://www.unido.org/resources-statistics/quarterly-report-manufacturing

Economically viable alternative activities. Among the tobacco-growing Parties, less than one third promote viable alternatives for tobacco growers, and less than one in 10 do so for tobacco workers and individual tobacco sellers (Fig. 22). Many tobacco-growing Parties reported ongoing projects to raise awareness and provide training for tobacco farmers or workers in viable alternatives. Alternative crops to tobacco included, for instance, mushrooms, flowers, radishes and organic rice (China); corn, panela (unrefined whole cane sugar) and lemon (Colombia); cocoa (Ecuador); and kenaf (Malaysia). A few Parties supported transition to livestock or food processing.

Fig. 22. Percentage (%) of tobacco-growing Parties reporting implementation of protective measures in tobacco cultivation and manufacturing, and promoting viable alternatives in 2018–2020 (n=84 in 2018; n=87 in 2020)



For example, China reported that over the years 2012–2019, the cultivation area for tobacco has decreased from 1.41 million hectares to 890 000 hectares. During the same period of time, the number of tobacco farmers has halved, from 1.84 million to 924 000. Non-tobacco revenue was reported to have increased by 9 billion yuan in 2019. Various crop rotation models of tobacco, food, medicinal plants and others have been planned and initiated in recent years, and new projects include soilless cultivation of vegetables. Malaysia reported that the kenaf cultivation area and number of kenaf[47] growers have been increasing steadily, and the number of tobacco growers has decreased from 134 in 2017 to 115 in 2019. In the Philippines, Livelihood Training Courses for Tobacco Farming Families were carried out in 2018. For instance, courses were given on meat processing; the production of noodles, bread and pastries; agro-mechanic work and *sari-sari* (neighbourhood convenience) store management.

Ecuador reported that the Ministry of Production, Foreign Trade, Investment and Fisheries has offered factory workers and small tobacco sellers entrepreneurship services, such as training in business development, to support the transition to viable alternatives. In Uruguay, the work to support the transition of the tobacco workers after the closure of the cigarette manufacturing facility began in the Ministry of Public Health in 2013. The former tobacco workers have been trained to carry out tasks related to the supervision of tobacco control regulations, carry out awareness-raising activities, and to prepare and distribute materials for these purposes. The contract for this cooperative has been renewed every two years.

47 Kenaf (Hibiscus cannabinus) is a fast-growing plant of the hibiscus (Malvaceae) family. The name is also applied to its fibre, one of the bast fibre group, used mainly as a jute substitute.

Mexico indicated that the Ministry of Agriculture and Rural Development works at the national level with tobacco-producing states, promoting economically viable alternatives, helping tobacco producers to convert agricultural production to more profitable alternative crops and developing planning based on a multidimensional study of the crops produced in Mexico. The Strategic Planning applied until 2030 is focused on productivity, profitability and competitiveness to combat poverty and promote more balanced regional development, considering profitable strategic crops, productive potential, human capital, water availability and agro-climatic conditions of tobacco producing areas.

In 2020, the Convention Secretariat published a new report, *Country practices in the implementation of Article 17 (Economically sustainable alternatives to tobacco growing) of the WHO Framework Convention on Tobacco Control*,[48] with funding from the European Commission. The report provides examples of measures and progress from the following Parties, in the order of appearance in the report: Sri Lanka, Egypt, Bangladesh, Oman, the European Union, Bulgaria, Spain, Canada, Brazil, the Philippines, China, Kenya, Malaysia, United Republic of Tanzania and Mexico. Examples relate to generation of political commitment, development of legislation, financial schemes to support diversification, studies to understand the socioeconomic context of tobacco farming, the potential role of NGOs in promoting economically viable alternative activities and potential South–South cooperation.

Policy options and recommendations in relation to Articles 17 and 18, for Article 17. By 2020, 26% of tobacco-growing Parties reported having utilized these policy options and recommendations, a minor increase from 2018 (24%).

Protection of the environment and the health of people. Protective measures in tobacco cultivation and manufacturing have been reportedly put in place by around one third of tobacco-growing Parties, and there was no notable progress as compared to 2018 (Fig. 22). Nevertheless, some Parties reported recent progress in the implementation of Article 18. Bolivia and Chile reported that tobacco cultivation and manufacturing are now subject to current environmental and occupational health regulations. In the Islamic Republic of Iran, a law on soil conservation was ratified in the Parliament in 2019. Iraq reported that the Ministry of Health issued a list of instructions for tobacco manufacturing with regards the storage of the products and protection of workers in these factories.

As a forward-looking regional initiative, the European Union reported that the Directive 2019/904 on the reduction of the impact of certain plastic products on the environment[49] (Single-use Plastics Directive – SUPD) was adopted in 2019. The SUPD provides for measures for tobacco products with filters; it requires that they bear a conspicuous, clearly legible and indelible marking on its packaging or on the product itself, informing consumers of the presence of plastics in the product, and of the resulting negative impact of littering, as well as of the need for appropriate waste management for the product. Ban on marking requirements would enter into force on 3 July 2021. In addition, the Directive introduces extended producer responsibility schemes covering the cost to clean-up litter, applied to products such as tobacco filters.

Policy options and recommendations in relation to Articles 17 and 18, for Article 18. By 2020, 28% of tobacco-growing Parties reported having utilized these policy options and recommendations, a minor increase from 2018 (18%).

48 The report is available at https://www.who.int/fctc/publications/techseries/en/
49 The Directive is available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32019L0904&from=EN

Many tobacco-growing Parties reported ongoing projects to raise awareness and provide training for tobacco farmers or workers in viable alternatives. There are examples of alternative crops, provided by the Parties, and a few other Parties supported transition to livestock or food processing.

Brazil: the Fundação Oswaldo Cruz will serve as the new WHO FCTC Knowledge Hub for Articles 17 and 18

On 9 July 2020, the Convention Secretariat and Fundação Oswaldo Cruz, known as Fiocruz, signed a memorandum of understanding to establish the WHO FCTC Knowledge Hub for Articles 17 and 18. The new Knowledge Hub will develop, analyse, synthesize and disseminate to WHO FCTC Parties, knowledge and information on economically sustainable alternatives to tobacco farming, as well as on the harmful effects of tobacco growing to the environment and the health of smallholder farmers.

The organization hosting the Knowledge Hub, Fundação Oswaldo Cruz, is an institution of the federal public administration under the Ministry of Health of Brazil. Its mission is to produce, disseminate, and share knowledge and technologies aimed at the strengthening and consolidation of the Brazilian Unified Health System and contribute to the promotion of health and quality of life of Brazilian population.

The Centre for Tobacco and Health Studies (CETAB) of the National School of Public Health Sergio Arouca was designated by Fiocruz to implement the activities of the Knowledge Hub, given its extensive experience in developing research and technical cooperation projects related to Articles 17 and 18 of the Convention over the last few years. In particular, CETAB was instrumental in developing guidelines for comprehensive health care for tobacco growers. In relation to Article 17, CETAB has been monitoring technical issues and policy aspects of the National Programme for Diversification in Tobacco Growing Areas, along with governmental entities, such as the National Commission to Implement the WHO FCTC, as well as NGOs.

CETAB, as the Knowledge Hub for Articles 17 and 18 of the WHO FCTC, is expected to provide assistance (research, capacity-building, organization of courses, training programmes, webinars, scientific conferences and other activities) to primarily tobacco-growing Parties by using a multisectoral and interdisciplinary approach, in accordance with the policy options and recommendations adopted by the COP for Articles 17 and 18, and also in line with the 2030 Agenda for Sustainable Development.

Tobacco grower in Brazil. (Photo courtesy of Marcelo Moreno, manager of the Knowledge Hub for Articles 17 and 18)

Liability (Article 19)

Key observations

- Criminal liability measures in tobacco control legislation became notably more common in this reporting cycle.
- Major lawsuits against tobacco companies are in progress in several Parties.

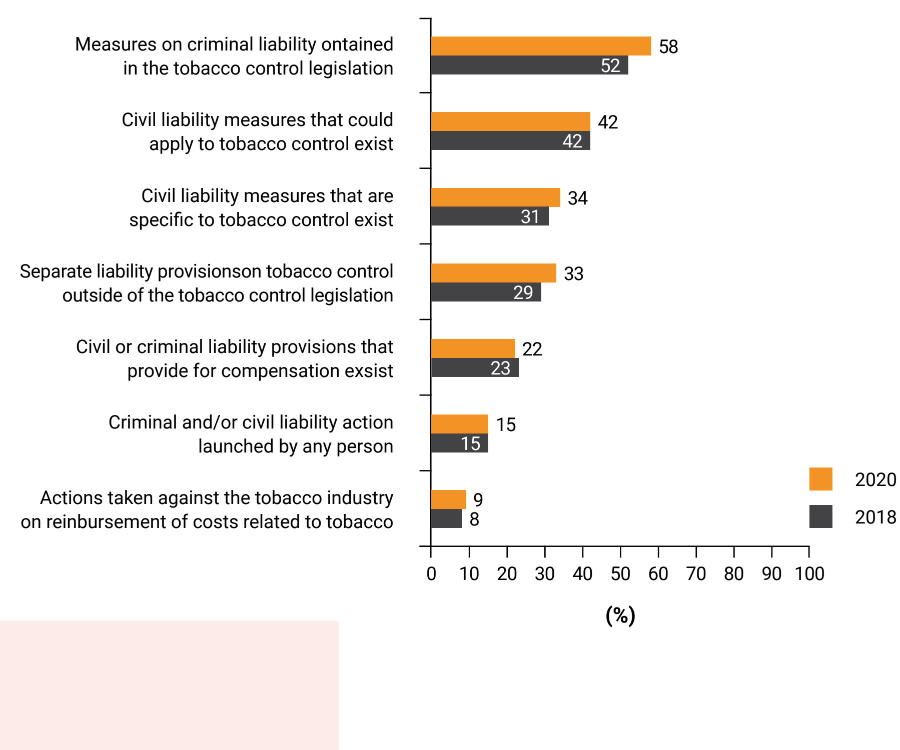
Over half of the Parties reported that criminal liability is contained in their tobacco control legislation (Fig. 23). Between 2018 and 2020 there was a notable increase in the proportion of Parties that have reported including criminal liability measures in their tobacco control legislation. Georgia reported having separate criminal liability provisions in relation to tobacco control, under the Criminal Code of Georgia, which provides criminal liability for the release, storage, sale or transportation of excisable goods without excise stamps. In the Philippines, liability can be incurred by the tobacco industry for violations against regulations on novel and emerging tobacco products, as adopted by the Food and Drug Administration.

In addition, it became more common to have civil liability measures that are specific to tobacco control, and separate liability provisions on tobacco control outside of the tobacco control legislation. Still, only less than one in 10 of Parties reported actions taken against the tobacco industry on reimbursement of costs related to tobacco.

For example, in Azerbaijan the new amendments to the tobacco control law stipulates that "physical and legal persons have the right to demand compensation for damages inflicted on their lives and health and property as a result of breach of law by other persons". In Namibia, victims of second-hand tobacco smoke may launch a complaint to the relevant authorities if they feel offended by anyone smoking in their presence. Similarly, the Supreme Court of the Russian Federation issued a ruling, in accordance with which compensation for moral damage was recovered for violation of a citizen's rights in the field of health protection from exposure to second-hand tobacco smoke and the consequences of tobacco consumption, for example, smoking on a balcony in an apartment building.

There are also a greater number of liability cases reported by the Parties. For example, in May 2019, the Brazilian Government launched a liability action against the tobacco industry, seeking to recover health-care costs for smoking-related diseases (see case study). In Canada, in May 2019, the Quebec Court of Appeal upheld a class action decision awarding more than 15 billion Canadian dollars in damages to people affected by tobacco-related diseases, with tobacco companies facing a further 500 billion Canadian dollars in cost-recovery lawsuits from provincial governments. The litigation and payments had been suspended until September 2020 pending settlement negotiations between the companies and all of their creditors. Litigation for the recovery of health-care costs also continues to progress in the Republic of Korea. A case brought by civil society in the Netherlands seeking to invoke the criminal liability of the tobacco industry was concluded in December 2018, with the Dutch Court of Justice declining to order prosecutions – the Court recognized the social relevance of the goal of eliminating tobacco use and moving towards a smoke-free society, but determined that the achievement of this goal should be achieved through further tobacco control legislation rather than the Dutch criminal system. Panama has launched several criminal investigations relating to offences regarding illicit trade in tobacco products.

Fig. 23. Percentage (%) of Parties with provisions for liability in 2018-2020 (n=181)



Between 2018 and 2020 there was a notable increase in the proportion of Parties that have reported including criminal liability measures in their tobacco control legislation.

Brazil

Case study

Health-care cost recovery action launched

Tobacco use is the leading cause of preventable death in the world, and it is no exception in Brazil. Every year, 156 000 people are killed by tobacco products in the biggest country in South America (12.6% of all national deaths), with direct and indirect costs to the Brazilian health-care system representing US$ 17 billion annually. However, revenues from the tobacco industry only cover a fraction of that amount, with government revenue generated by tobacco taxes reaching only US$ 3.5 billion.

On 21 May 2019, to protect the lives and health of Brazilians, Brazil's Office of the Attorney General (Advocacia-Geral da União) filed an historic lawsuit against multinational tobacco companies and their Brazilian subsidiaries to recover funds spent on the treatment of tobacco-related diseases in Brazil's health-care system. The lawsuit seeks to recover the federal Government's expenses over the last five years in relation to 26 diseases caused or aggravated by tobacco consumption and exposure to tobacco smoke, as well as a share of projected future costs.

The lawsuit also asks for the payment of indemnity for collective moral damages caused by the deceptive conduct of tobacco companies, who hid the harmful effects of these products.

Furthermore, the lawsuit considers behaviours including the omission and manipulation of information about the harmful effects of smoking, second-hand smoke and the addictive power of nicotine.

The litigation highlights the colossal impact from tobacco on health services and the Government's commitment to implement the WHO FCTC, especially Article 19, which encourages Parties to "consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate". The Brazilian Government is taking this initiative promoting its existing laws according to the provisions established by the Brazilian Constitution and civil legislation.

This lawsuit, the first of its kind in Latin America, follows similar legal actions previously taken in Canada and the United States of America, which have resulted in the tobacco industry being ordered to pay billions of dollars in fines.

In May 2020 the defendants responded to the lawsuit, and recently the Brazilian Prosecution Office (Ministério Público Federal) filed a petition asking the judge to intervene in the case considering the social and public interest involved.

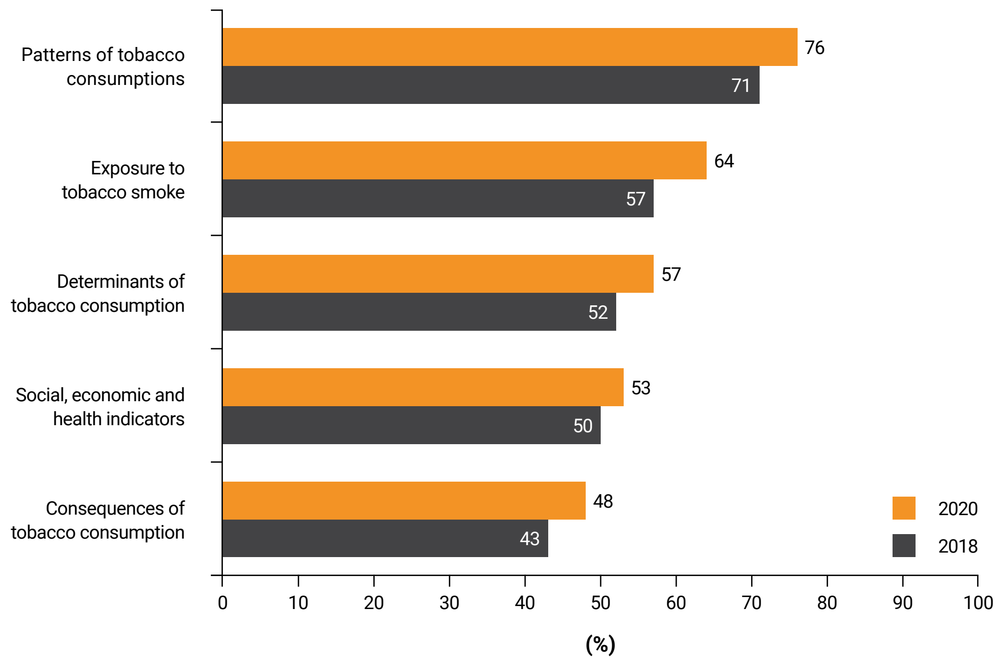
Research, surveillance and exchange of information (Article 20)

Key observations

- The reports show that Parties continued to strengthen their national systems for epidemiological surveillance of determinants, patterns and consequences of tobacco use. Improvement was observed especially in the surveillance systems for the exposure to tobacco smoke.
- Most Parties report having some data on indicators related to the use, determinants, patterns or consequences of tobacco use originating from thematic national research, but it remains less common to have regular monitoring of such indicators in place. It is therefore important to devote more attention to the development of such tobacco surveillance programmes in accordance with Article 20.2.
- Important progress in new collaborative research and investment case studies were reported, especially by low- or middle-income countries, resulting in notably better availability of data on tobacco-related mortality and economic burden as compared to 2018.

National systems for epidemiological surveillance. By 2020, the majority of Parties reported having established a national system for epidemiological surveillance of patterns of tobacco consumption (Fig. 24). In addition, around two thirds of Parties had a national surveillance system for exposure of tobacco smoke; and over half for determinants of tobacco consumption and on social, economic and health indicators. Almost half of the Parties had established a national surveillance system for consequences of tobacco consumption. The percentages for all the indicators mentioned continued to increase from 2018, with notable improvement especially in the proportion of Parties having the national epidemiological surveillance system for exposure of tobacco smoke.

Fig. 24. Percentage (%) of Parties that have established national surveillance systems for different topics in 2018–2020 (n=181)



A number of Parties collect their national data within global or regional epidemiological surveillance systems focused on tobacco or NCDs. For example, 55 Parties have referenced

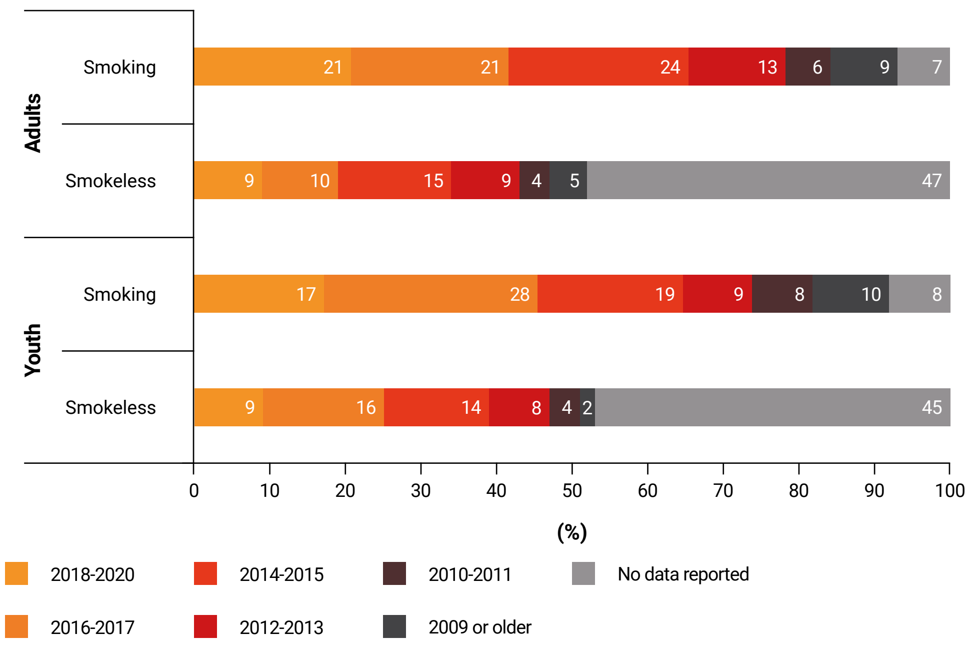
adult tobacco use data collected within the WHO STEPwise approach to NCD risk factor surveillance (STEPS), and 19 reported results from the Global Adult Tobacco Survey (GATS). Other data mostly originates from national demographic or health surveillance systems. For youth data, the Global Youth Tobacco Survey (GYTS) is the single most-referenced survey, reported by 107 Parties. It is followed by the Health Behaviour in School-aged Children (HBSC) survey, referenced by 10 Parties, Global School-based Student Health Survey (GSHS), by eight Parties, and the European School Survey Project on Alcohol and Other Drugs (ESPAD), by five Parties. Many Parties also referenced their own national school surveys.

Availability of data on the prevalence of tobacco use and exposure to tobacco smoke. Over 90% of all Parties have provided prevalence data for adult and youth tobacco smoking in the reporting platform. One in five of all Parties reported new data on adult tobacco smoking collected or published in the 2018–2020 reporting cycles, with a slightly smaller proportion reporting new data for youth smoking (Fig. 25, see also Annex 2). Slightly over half of all Parties have reported prevalence data for adult and youth smokeless tobacco use. Only one in 10 Parties have reported new smokeless tobacco data from the 2018–2020 reporting cycle for either adults or youth.

The majority (84%) of Parties have reported having data on exposure to tobacco smoke in their populations. Thirty Parties reported new exposure data from the 2018–2020 period. In addition, only 23% of all Parties indicated that they had data of tobacco use in ethnic groups.

Reports by the Parties also reveal that most Parties have reported to have some exposure data (84%, as noted in the previous paragraph), but exposure is still not being monitored systematically, with only 64% of the Parties reporting that they have included exposure to tobacco smoke in their regular surveillance related to tobacco (Fig. 24). It seems that additional Parties have now started the systematic monitoring for exposure, but overall there are no major changes in the proportion of Parties already having exposure data.

Fig. 25 Latest reported prevalence data on smoking and smokeless tobacco use among adults and youth, among all Parties in 2020 (n=181)



Many Parties were expecting results from recently conducted surveys, such as the HBSC in 2017–2018 and the ESPAD in 2019. Over 40 Parties reported that new surveys were planned for 2020. This is expected to increase considerably the number of Parties having recent prevalence data.

Importantly, many Parties that have only recently initiated tobacco control monitoring, or that have relatively infrequent tobacco surveillance history, had new or recent data available on the reporting platform. For adult tobacco use, these include Afghanistan, the Democratic People's Republic of Korea, Ecuador, Gambia, North Macedonia, Oman, Turkmenistan, the United Arab Emirates and the United Republic of Tanzania. For youth tobacco use, these include Antigua and Barbuda, Bolivia, China, Gambia, Iraq, Kiribati, Madagascar, Mauritania, Turkey, Tuvalu and Viet Nam.

In addition to the prevalence of smoking and smokeless tobacco use, Parties have the possibility to report on prevalence of water-pipe tobacco use. In the 2020 reporting cycle, new questions were also introduced for novel and emerging tobacco products and nicotine products, such as ENDS/ENNDS and HTPs. The availability of the data on these products varies greatly among Parties, and the data remain subject to separate analyses (see chapter 4 on Novel and emerging tobacco products and nicotine products).

Availability of data on tobacco-related mortality and economic burden. At the time of this analysis, half of Parties (50%) reported that they have information on tobacco-related mortality in their jurisdictions. The percentage continued to increase notably from 44% in 2018. Available data ranged from 2000 to 2019, but only 20 Parties have reported mortality data collected after 2017. Some 81 Parties provided information on the number of annual deaths attributable to tobacco use in the population at any past datapoint. The reported figures show broad variations depending on the size of the country. A number of Parties reported over 50 000 annual tobacco-related deaths, including Bangladesh, Brazil, France, Germany, Italy, Japan, Mexico, Myanmar, Pakistan, the Republic of Korea, the Russian Federation, Senegal, Thailand and the United Kingdom of Great Britain and Northern Ireland. For the economic burden of tobacco, over one third of Parties (40%) indicated that they had information available, with a clear increase as compared to 34% in 2018. Seventy-two Parties provided further details of the data they have. The data collection years ranged from 2005 to 2019. Only 17 Parties had data collected in the 2018–2020 reporting period.

Several Parties reported new collaborative efforts or involvement of new organizations in research on the economics of tobacco control. The Bangladesh Cancer Society collaborated with the University of Dhaka, the American Cancer Society and Cancer Research UK in 2018 to estimate direct and indirect costs attributable to tobacco use and exposure to second-hand smoke in Bangladesh. In Peru, a new collaboration between the Group for the Analysis of Development and the Institute of Peruvian Studies was developed to carry out a study, as well as a seminar on tax policies and tobacco demand. In Serbia, the Institute of Public Health of Serbia was conducting a study on the economic and social impact of tobacco use in 2019, with the support from WHO and the Ministry of Health. Senegal reported on a study carried out by Consortium for Economic and Social Research and the National Tobacco Control Programme. The United Arab Emirates reported a new study on the economics of tobacco in the Member States of the Cooperation Council for the Arab States of the Gulf.

Many Parties reported results from their investment case studies for tobacco control; such studies are implemented in all Parties that are partner in the FCTC 2030 project. For example, Armenia, which recently became an FCTC 2030 Party, reported that estimates of the direct and indirect costs of NCDs have been calculated using a model developed by WHO and the United Nations Development Programme (UNDP). The model calculated projections for incidence, prevalence and mortality for diabetes, cardiovascular diseases and chronic respiratory diseases between 2018 and 2033. The tobacco control measures

were found to have the highest return on investment. In Jordan, another FCTC 2030 Party, a study published in 2019 showed that tobacco use causes annually 1.6 billion Jordanian dinars in total economic losses, the equivalent of 6% of the 2015 GDP. Large productivity losses from tobacco use (87% of all tobacco-related costs in Jordan) indicate that tobacco use impedes development in Jordan beyond health. Several other FCTC 2030 Parties also referenced their recent investment cases for tobacco control.

Research topics. The majority (71%) of Parties developed and/or promoted research that addressed the determinants of tobacco use, and it became more common as compared to 2018 (68%). Around two thirds of Parties were developing and/or promoting research on the consequences of tobacco use (66%), and social and economic indicators related to tobacco consumption (64%). Over half (59%) of the Parties developed and/or promoted research on exposure to tobacco smoke. Less than half (46%) reported it on tobacco use among women, particularly pregnant women, and a similar percentage (46%) on identification of effective programmes for the treatment of tobacco dependence. Developing and/or promoting research on the identification of alternative livelihoods remained very rare, reported by only 15% of Parties.

Several Parties reported new research to develop or assess their tobacco control policies. For instance, Azerbaijan, Brunei Darussalam, Cambodia, China, Fiji, Italy and the Philippines reported on new surveys related to compliance with tobacco control policies, especially smoke-free policies in various settings. The European Commission had commissioned a Eurobarometer survey on the illicit trade in cigarettes, which was carried out in the (then) 28 Member States of the EU and published in 2019, and several studies to assist the drafting of a report on the application of the EU Tobacco Products Directive in 2021. In the Republic of Korea, a number of research projects were funded from the National Health Promotion Fund in 2018–2019. Some examples among the many covered themes in these projects include tax and price policies, plain packaging, health inequalities, HTPs and other novel products, and a research review of legislation on tobacco product safety and regulation. In Spain, a previous evidence review on e-cigarettes is currently being updated, and a new evidence review on HTPs was published on the website of the Ministry of Health.

In Costa Rica, the Ministry of Science, Technology and Telecommunications, the Ministry of Health, and the National Council for Scientific and Technological Research signed a memorandum of understanding in September 2018 to promote research that contributes to improving prevention, diagnosis and treatment of tobacco dependence. In October 2018, the first call for applications for research funding was opened within the joint framework titled *Research, Technological Development and Innovation in Health Programme on Tobacco Control and Related Health Issues*. The funding was aimed at public institutions and consortia made up of public agencies and private non-profit institutions, as well as small and medium-sized companies, certified by the Ministry of Economy, Industry and Commerce. The second call for applications took place in June 2019.

In 2018, a project by the WHO FCTC Knowledge Hub on Tobacco Surveillance in Finland was carried out to assist low- and middle-income countries in the establishment of tobacco surveillance systems. In the project, technical assistance was provided through webinars and materials that remain available at the Knowledge Hub website.[50]

50 All WHO FCTC Knowledge Hub websites can be accessed from: https://fctc.who.int/coordination-platform/knowledge-hubs

Exchange of information and training, and support for research. Two thirds of Parties have reported the regional and global exchange of publicly available national scientific, technical, socioeconomic, commercial and legal information, a few percentage points higher than in 2018 (63%). Information exchange was less common regarding the practices of the tobacco industry, as reported by 41% of the Parties. A minor increase was observed as compared to 2018 (39%). The exchange of information relating to the cultivation of tobacco was reported by 24% of the Parties. Around two thirds (63%) of Parties reported providing training for those engaged in tobacco control activities, such as research, implementation and evaluation.

Some practical examples of regional information exchange were reported. For instance, Denmark reported the participation of the Ministry of Health and the Danish Health Authority in meetings with their counterparts under the Nordic Council. Paraguay reported that while holding the Pro Tempore Presidency in the Southern Common Market (MERCOSUR), it was resuming the activities to fulfil the commitments arising from the Intergovernmental Commission for Tobacco Control of MERCOSUR, which aimed at restarting discussions to seek consensus on tobacco control policies, as well as exchange information and cooperation among the countries in the region. In Peru, new national organizations have started to be involved in research on the economic aspects of tobacco control, such as the Development Analysis Group and the Institute of Peruvian Studies, including collaboration with the Permanent National Commission on Tobacco Control, a civil society organization. In Saudi Arabia, a website for the National Tobacco Control Committee was created to facilitate information dissemination and exchange.

Database on laws and regulations. The majority (71%) of Parties maintained a database of national laws and regulations on tobacco control, up from 68% in 2018. Around half (52%) reported that the database also contained information on the enforcement of those laws and regulations. One in four Parties (25%) had established a database of pertinent jurisprudence. For example, Canada reported two databases operated by NGOs. Physicians for a Smoke-free Canada maintains a website on litigation involving tobacco companies. In terms of providing access to tobacco-related laws, regulations and jurisprudence, the Canadian Legal Information Institute is a member of the Free Access to Law Movement, which includes the primary stakeholders involved in free, open publication of law throughout the world.[51]

51 Available at: https://www.canlii.org/en/

Suriname

Case study

Strengthening surveillance to protect the youth

Suriname aims to protect its current and future generations from the effects of tobacco consumption and exposure to tobacco smoke. The reduction of tobacco initiation is among its priorities, and monitoring tobacco use in line with the requirements of Article 20 of the Convention is part of the strategy towards this aim. On World No Tobacco Day 2018, a new set of prevalence data from the Global Youth Tobacco Survey/Global School-based Student Health Survey were published. This was the fourth round of these studies in the country; data were collected from a nationally representative sample of the youth population on a collaborative initiative between national institutions and international organizations.

The results show a decrease as compared to 2009 in the prevalence of current tobacco users, cigarette smokers and smokeless tobacco users, as well as exposure to tobacco smoke at home and in other enclosed public places. In this round, new questions were introduced to collect national data for the first time on the use of water pipes (8.5% of the students) and electronic cigarettes (5.9% of the students).

The launch of the survey results served as an opportunity for the Ministry of Health to raise awareness among sectors working with youth specifically on the risks of novel tobacco products and on the importance of monitoring their consumption. In order to complement tobacco control and prevention strategies, an intersectoral working group was formed, consisting of representatives from seven ministries, mandated to develop an action plan for further strengthening the measuring of and implementation of measures to better control tobacco use among youth. The plan includes the reinstatement of a national health- promoting school committee to implement a “safe and healthy school” project, to promote smoke-free environments in all schools, to raise awareness on tobacco product regulation and to incorporate tobacco prevention in student and educator curricula.

Intersectoral working group, composed by representatives from the Ministries of Education, Home Affairs, Finance, Regional Development, Social Affairs, Youth and Sports, and Health. (Photo courtesy of the Ministry of Health, Suriname)

Reporting and exchange of information (Article 21)

Key observations

- At the time of the preparation of this report, 139 Parties (77%) submitted their full reports for the 2020 reporting cycle through the reporting platform.[52] Most of the remaining Parties updated some information without formally submitting their report.
- The first *Indicator Compendium for the Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025* was developed, and the baseline data on the Global Strategy indicators were collected. They are included in the present report as a separate chapter.

Since 2018, a pre-filled online reporting instrument has been available to Parties for their submission of the most up-to-date information on their implementation of the Convention. As usual, the submitted reports have been made available in the public domain in the WHO FCTC Implementation Database,[53] where reports can be viewed and searched by Parties and indicators of the reporting instrument. It is also to be noted that an updated PDF version of the online questionnaire is available on the website of the Convention Secretariat,[54] and this allows for the distribution of the questions among the different data providers, should there be a need. For the same purpose, and upon request of some Parties, the Convention Secretariat has also made available the reporting instrument in Microsoft Word format. Additionally, the core questionnaire has been provided to some Parties, upon request, in Portuguese, but for information only; the reports should still need to be submitted in one of the official United Nations languages.

In the reporting instrument, Parties have the possibility to provide feedback on their experience with the use of, and on further development of the reporting instrument. While the pre-filled online reporting instrument is mostly appreciated, several Parties noted that they would benefit of the possibility of exporting the online questionnaire as it is being filled, or having it as a separate Microsoft Word file. This was seen useful especially when several different stakeholders participate in the reporting process, which is often necessary in order to gather the adequate information under different articles. The possibility of exporting the questionnaire was also seen useful in the cases where Parties have difficulties with Internet access, or when there is need to access a back-up copy of the document. For this purpose, the provision of the Microsoft Word version of the questionnaire was found to be a useful alternative.

Some Parties continued to call for shortening of the questionnaire. Some notes on the level of detail enabled by the fields in the online questionnaire, repetition of the upload of supporting documents, correction of some translation errors of the non-English versions, and request for more conditional questions to be shown only if the respective measure is in place were also made. A few Parties called for better explanation of the need and importance of the additional questions on the use of implementation guidelines adopted by the COP. Accommodating the subnational variation in the regulations and activities to the responses remains challenging for some Parties with federal systems. Difficulties in fulfilling the reporting obligations in emergency situations and during the COVID-19 pandemic were also noted.

In general, the development of the reporting instrument is a constantly evolving process. Parties may take decisions at the COP that might have an impact on the questions included in the reporting instrument. Since the launch of the online reporting instrument, the Convention Secretariat has also noted the need to improve information gathering on progress in the implementation of the different articles. The current reporting instrument contains 16 open-ended questions where Parties can provide progress information;

52 A regularly updated table presenting the status of reporting by the Parties, including the number of core reports and additional questions, as well as their submission dates, is available on the WHO FCTC website.
53 http://untobaccocontrol.org/impldb/
54 http://www.who.int/fctc/reporting/reporting_instrument/

however, not all Parties utilize this opportunity and, in many cases, the previously reported progress information is left in place in the subsequent reporting cycles, which slows down the analysis of data.

Since 2016, the questions in the reporting instrument have remained mostly unchanged. Questions on ENDS/ENNDS were included for the first time 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.55 In 2020, the questions of the availability of ENDS/ENNDS in the national market, and the regulations concerning these products, were divided to provide information separately for ENDS and ENNDS. In addition, new questions of the availability and regulation of HTPs were added. In 2020, the prevalence section of the reporting instrument was also broadened with questions on the prevalence of the use of ENDS, ENNDS and HTPs. In light of the large variation in the availability and type of data concerning the prevalence of the use of these products, and the rapid developments in the range of novel products, the questions in the reporting instrument require further refining.

As described above, it is now evident that the reporting system of the WHO FCTC would benefit from further improvements as we approach data collection that will lead to the publication of the 10th Global Progress Report in 2023. The external audit carried out by the Office of the WHO External Auditor, when reflecting on the operations of the Convention Secretariat at the end of 2018, noted that "with the evolution, guidelines to act as assurance parameter in responding to the questionnaire are therefore suggested to be included to exact veracity, consistency and completeness of information". The audit recommended that quality assurance guidelines be developed that could serve as "a tool that can complement the WHO FCTC reporting platform and arrangements as a whole, hence, assist the Secretariat's implementation and accomplishment reporting, which is the GPR [Global Progress Report], deliver the highest possible quality and validated data within committed resources and timelines for all its intended users". As we advance towards the 10th reporting cycle of the Convention, it would be timely to reflect upon the recommendations of the audit and work out options to improve data quality and reporting to better assist decision-making by the COP.

With the adoption of the *Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025*, some of the information provided by the Parties in their implementation reports also serves as an important data source for the reporting on the progress in the implementation of the Global Strategy. In December 2019, the WHO FCTC Knowledge Hub on Surveillance hosted an expert meeting to finalize the first edition of the *Indicator Compendium for the Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025*. The Indicator Compendium was developed in response to the mandate given to the Convention Secretariat by the Eighth Session of the Conference of the Parties (COP8) to collect baseline data for the range of indicators identified in the Global Strategy and to report, on a biennial basis, on the progress in its implementation. Following the development of the Indicator Compendium, the first compilation of baseline data for the Global Strategy indicators has been published as part of this report.

With the entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products, a new reporting instrument for the Protocol was developed, and the first reporting cycle of the Protocol was opened parallel to the WHO FCTC reporting cycle. The series of the

55 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).

Global Progress Reports published by the Convention Secretariat expanded in 2020, with the first *Global Progress Report on the Implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products*.

Additionally, in 2020, the Convention Secretariat commissioned and published the *Guide for WHO FCTC Parties on including SDG Target 3.a in Voluntary National Reviews*, available on the Convention Secretariat website. As part of regular follow-up and assessment of progress towards the SDGs, the 2030 Agenda for Sustainable Development encourages country-led voluntary national reviews (VNRs) to share experiences and lessons learnt in pursuing the SDGs. Including Target 3.a (Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate) in a VNR is an important element in raising awareness of implementation of the WHO FCTC. When addressing implementation of Target 3.a in a VNR, it is recommended that Parties not only include data on Indicator 3.a.1, but also describe policy results, implementation achievements and lessons learnt, and explain the links between WHO FCTC implementation and other goals.

In light of the large variation in the availability and type of data concerning the prevalence of the use of these products, and the rapid developments in the range of novel products, the questions could be further refined to capture them.

International cooperation (Article 22)

- More Parties reported providing or receiving assistance in 2020 than in 2018.
- Parties recognize as important sources of assistance WHO and other United Nations agencies, the Convention Secretariat, the Parties themselves, regional organizations, NGOs and the WHO FCTC Knowledge Hubs.
- More and more Parties notice that the WHO FCTC Knowledge Hubs are increasingly active in helping Parties in accordance with Specific Objective 1.1.2 (Strengthen the role of knowledge hubs in assisting the Parties) of the Global Strategy.

Areas of assistance. Over one third of Parties reported that they provided assistance to other Parties on expertise for national tobacco control strategies, plans and programmes, and on the transfer of skills and technology. In addition, training and awareness of personnel in accordance with Article 12 was reported by around one third of Parties (Fig. 26). Providing assistance was least common for methods and research related to the treatment of nicotine addiction.

Around two thirds of Parties have reported receiving assistance, especially in relation to expertise for national tobacco control strategies, plans and programmes, and to the transfer of skills and technology. Based on the reports, Parties are more likely to provide or receive assistance in 2020 as compared to 2018, and encouragingly there are more Parties reporting on their collaborative projects.

As part of the qualitative information provided by the Parties on the assistance they received or provided it becomes evident that the partner base for tobacco control is broadening.

Assistance received by the Parties. Parties enumerated a number of IGOs, including from the United Nations family, as sources of aid for their tobacco control efforts. Among them, WHO and the Pan American Health Organization (WHO Regions of the Americas) at various levels of the Organization, including headquarters, regional and country offices, as well as WHO collaborating centres are the entities mentioned most often; the two have received more than 70 mentions. They are followed by the Convention Secretariat, including its flagship project, FCTC 2030, and its Knowledge Hubs. UNDP, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank, and the United Nations Interagency Task Force on the Prevention and Control of NCDs (UNIATF) were also mentioned as aiding tobacco control at the country level.

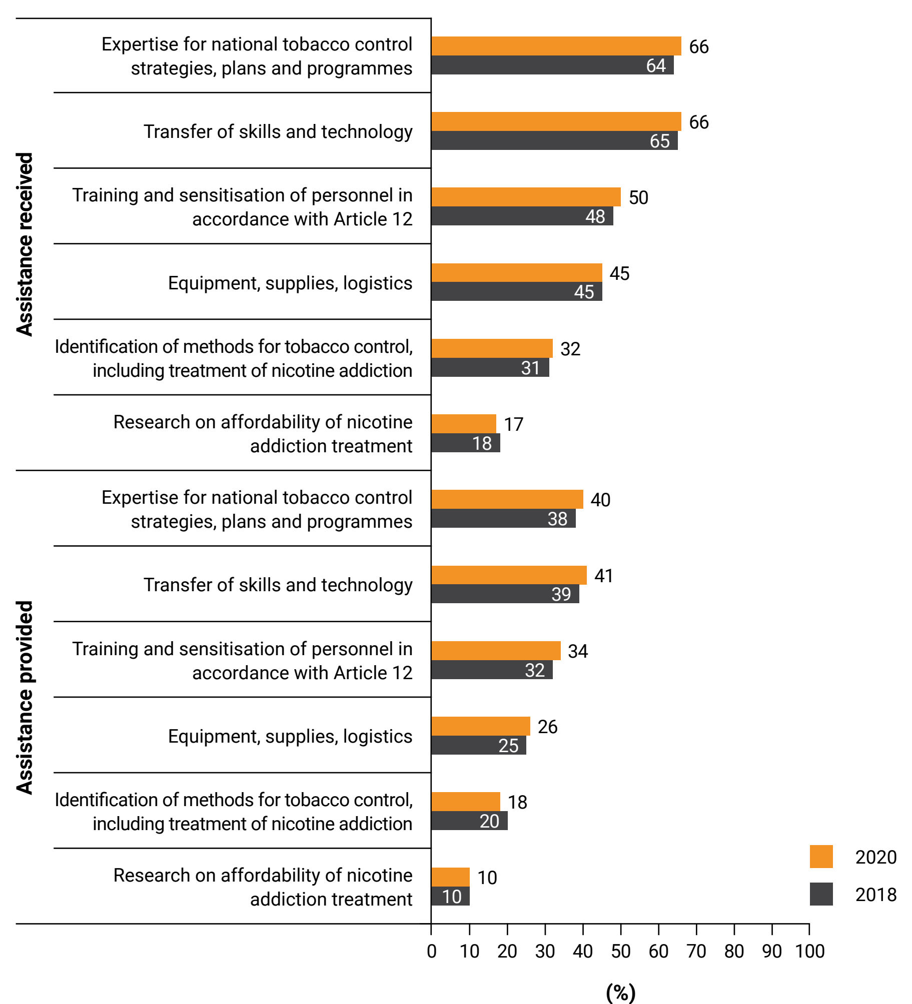
Another broad group providing assistance are the Parties themselves. Australia, Brazil, Canada, China, Ecuador, El Salvador, the European Union, Jordan, Kenya, Norway, Qatar, Thailand, the United Kingdom of Great Britain and Northern Ireland and Uruguay were mentioned at least by one another Party as source of assistance. Additionally, national institutes from various Parties were also listed as providers of assistance, among them the United States Centers for Disease Control and Prevention (United States of America is a non-Party) was the most frequently mentioned.

Regional entities, including the Caribbean Public Health Agency, the Clinical Trials Community for Africa, the East African Community, the Economic Community of West African States (ECOWAS), the Eurasian Economic Union, the Cooperation Council for the Arab States of the Gulf and the Inter-American Drug Abuse Commission were mentioned as sources of assistance. Universities from the United States of America (University of California at Los Angeles, University of California at San Francisco, Johns Hopkins University and Emory University) have also provided assistance to some Parties.

Civil society organizations, as recognized in the Preamble of the Convention in Article 4.7 and by the Global Strategy, are doing their utmost to help the Parties in their implementation of the Convention and this is well recognized by the Parties themselves. NGOs and IGOs that are observers to the COP – African Capacity Building Foundation, Corporate Accountability, the Campaign for Tobacco-Free Kids, ENSP, the Southeast Asia Tobacco Control Alliance, the Pacific Community, the Union (and Vital Strategies) – and also NGOs that are not yet observers to the COP (World Lung Foundation, Vichealth, Lung Cancer Foundation of Australia, Quit Victoria and European Respiratory Society) were also recognized by the Parties. The contributions of NGOs that are observers to the COP are also highlighted in their biennial reports are available on the website of the Convention Secretariat.[56] Bloomberg Philanthropies and the Bill & Melinda Gates Foundation were also mentioned as providing financial resources for tobacco control work in the Parties.

These partners provide support in many areas related to the implementation of the Convention (Fig. 26), also in accordance with Strategic Objective 1.1 of the Global Strategy (Give priority to enabling action to accelerate WHO FCTC implementation, including effective forms of technical and financial assistance to support Parties in the identified priority action areas).

Fig. 26. Percentage (%) of Parties reporting on providing or receiving assistance, by areas of assistance in 2018-2020 (n=181)



56 https://www.who.int/fctc/cop/observers_ngo/

The Convention Secretariat, its Knowledge Hubs, WHO and various observers to the COP offer various types of assistance in the areas listed in Fig. 26. Some of the initiatives Parties identified for assistance on legal and regulatory matters in their 2020 reports include:

- The FCTC 2030 project aims to scale up implementation of the WHO FCTC in low- and middle-income Parties by providing intensive support to a selected group of countries, as well as implementation resources for all Parties. Several Parties have used support from the FCTC 2030 project to pass new tobacco control laws. (See the specific example of Madagascar in the text box below.)

- The World Health Organization and its regional offices provide assistance to Parties in several areas relating to the development, implementation and enforcement of tobacco control laws and regulations, and collaborate with the Convention Secretariat and its Knowledge Hubs (as foreseen in Specific Objective 1.2.2 of the Global Strategy) in these areas.

- The Knowledge Hub on Legal Challenges, based at the McCabe Centre for Law and Cancer in Melbourne, Australia, runs an International Legal Training Programme on Law and Noncommunicable Diseases, with a substantial focus on tobacco control. The programme focuses on law and regulatory measures for tobacco control and to address other NCD risk factors in the context of ensuring policy coherence between health, trade, investment and sustainable development, as well as practical skills in multisectoral collaboration; developing, implementing, and enforcing laws; and defending legal challenges. Participants receive direct technical support to complete priority projects after the course, which have included legal drafting projects and the defence of legal challenges. The Knowledge Hub also maintains resources on trade law, investment law and domestic legal challenges to WHO FCTC implementation, and it is in the process of developing online courses for Parties.[57]

- The International Legal Consortium of the Campaign for Tobacco-Free Kids offers Parties assistance with the development and drafting of tobacco control laws, including training and direct technical assistance with the drafting and development of laws and regulations. The International Legal Consortium also provides resources, including toolkits on plain packaging and e-cigarette regulation and the Tobacco Control Laws website,[58] and administers the Anti-Tobacco Trade Litigation Fund[59] which could support Parties with the financial cost of defending legal challenges.[60]

Beyond receiving assistance for the development of legislation, regulations and policies, as described above, several Parties indicated that they received assistance in some particular areas of the WHO FCTC. Among the providers of assistance, the Knowledge Hub on Taxation guides Parties in relation to the development or revision of laws and

57 Further information is available from https://untobaccocontrol.org/kh/legal-challenges/
58 www.tobaccocontrollaws.org
59 https://www.tobaccofreekids.org/what-we-do/global/legal/trade-litigation-fund
60 Further information is available from https://www.tobaccofreekids.org/what-we-do/global/legal/what-we-do

regulations on tobacco taxation. The Knowledge Hub (based at the Research on the Economics of Excisable Products unit at the School of Economics at the University of Cape Town) runs training and technical assistance programmes related to the economics of tobacco control, tobacco tax and illicit trade in tobacco products, and it could also provide more targeted and individualized assistance to Parties upon request. The WHO FCTC Knowledge Hubs on International Cooperation (Uruguay), Surveillance (Finland), Smokeless Tobacco (India), Water Pipes (Lebanon) and Article 5.3 (Thailand) offer assistance to Parties within their areas of expertise, which may involve legal, regulatory and policy issues, as appropriate. For example, the Knowledge Hub for Article 5.3, in response to the current COVID-19 pandemic, conducted webinars and prepared new resources that can be used to address tobacco industry interference during the pandemic.

Assistance provided by the Parties. In their reports, many Parties have also described the assistance they provide to other Parties for the implementation of the Convention. The forms of assistance include, but are not limited to, providing licence to use health warnings; hosting WHO FCTC meetings; hosting other Parties for study visits, mostly focused on enforcement and visiting tobacco testing laboratories; and providing financial resources to the Convention Secretariat, enabling the latter to provide assistance to Parties.

Some examples of assistance provided can be found in some of the following examples. Jordan assisted Tunisia in training trainers on tobacco cessation. The Philippines provided technical assistance to Myanmar and Viet Nam, particularly in relation to Article 6 of the WHO FCTC.

Singapore supports the Parties to the Convention and helps capacity-building in the area of tobacco product regulation and testing. Between 1 March 2018 to 31 January 2020, Singapore provided tobacco-testing support to regulatory agencies for countries in South-East Asia and the Western Pacific, thus helping these countries fulfil their obligations under the WHO FCTC. Various forms of tobacco product samples received from Fiji, Kiribati, the Federated States of Micronesia, Niue, Palau, Samoa, Solomon Islands, Timor-Leste and Tonga were tested in Singapore, assisting those countries that do not have a national laboratory that could carry out tests of tobacco products; information deriving from these tests serve as a reference and contribute to carrying out product regulation activities in these countries. Singapore also participates, through WHO Tobacco Laboratory Network and as a Party, in many WHO FCTC activities and programmes related to product regulation. Similarly, Kenya reported that they hosted other Parties on study tours and experience sharing regarding implementation of measures to control illicit trade in tobacco products (Article 15), and in particular tracking and tracing of tobacco products. Kenya also hosted the Government of Uganda on a benchmarking tour in regard to tobacco control legislation.

Australia, the EU, Norway, Panama, the Republic of Korea and the United Kingdom of Great Britain and Northern Ireland provided financial resources to the Convention Secretariat to help Parties in their implementation work. These included support for other projects crafted in accordance with the workplan adopted by the COP. Particularly, Australia, Norway and the United Kingdom of Great Britain and Northern Ireland provided generous funding to support the FCTC 2030 project. Regional collaborative efforts also play an important role in knowledge dissemination and sharing. China, the EU, Panama and the Republic of Korea reported that they organized and hosted various meetings related to the implementation of some WHO FCTC articles. Regional initiatives, such as the Nordic Network for Tobacco Control, the Central Asian Tobacco Control Network and the Joint Action on Tobacco Control under the EU are just examples of regional collaborative efforts highlighted in several Parties' reports.

In relation to the assistance they provided, some Parties also referred to in-country initiatives. These included reach-out to other non-health sectors, through training and information sessions. Decision-makers in parliaments, public officials in all ministries, health and educational professionals, inspectors and other law enforcers, and the NGO community are a few examples of those who were reported as being targeted with specific tobacco-related information programmes by the health sector.

Implementation assistance through membership in regional and international organizations.
Overall, only 22% of Parties reported having 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, with no change from 2018.

Promoting WHO FCTC implementation through membership in regional and international organizations usually warrants effective collaboration among various government sectors within the country, as the Party might be represented in different forums by different government departments. It is therefore critical that all of them “speak with the same voice”, but for this to happen, good governance and efficient intersectoral cooperation is a must. Along these lines, Canada reported that it endorsed, at the 337th session of the Governing Body of the International Labour Organization (ILO), a decision that could ensure that the ILO does not accept funding from the tobacco industry. Panama reported its effort to promote WHO FCTC implementation in various forums in WHO and WHO Region of the Americas (Pan American Health Organization). Saudi Arabia reported its support at the Cooperation Council for the Arab States of the Gulf for the regional approach in tobacco packaging and, specifically, plain packaging.

Madagascar

Case study

Multisectorialism in the FCTC 2030 project

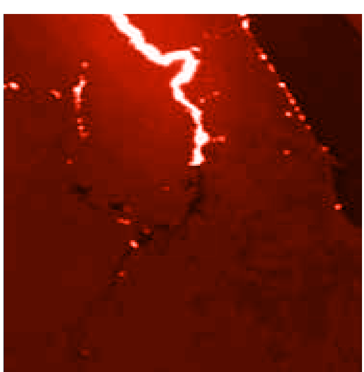
In Madagascar, the FCTC 2030 project has provided support to the Ministry of Health in convening other sectors to strengthen their engagement on tobacco control. In 2018, UNDP, the Convention Secretariat, WHO and the Ministry of Health in Madagascar facilitated a five-day retreat to strengthen multisectoral coordination on tobacco control and to develop the country's national strategy. The retreat was hosted by the National Tobacco Control Office of the Ministry of Health and was attended by 25 representatives from 10 government sectors.

United Nations agencies involved in the strategy retreat provided targeted guidance and support based on desk reviews and interviews informing a comprehensive gaps analysis. Government representatives were sensitized as to their sectors' roles in tobacco control – including how tobacco control advances the interests of their own sectors – and they identified requirements under the WHO FCTC that lay within the remit of their sectors.

The national strategy's first priority includes a set of activities to strengthen tobacco control institutional capacity, including the country's national and regional-level coordination mechanisms. Through the strategy's action plan, Madagascar will strengthen coordination and hold other sectors accountable that have committed to activities, timelines and their general roles in tobacco control.

In addition to culminating in the development of the national strategy, approved in 2019, the retreat created much-needed momentum among government stakeholders for strengthening Madagascar's National Coordinating Mechanism, the Comité Consultatif pour la Lutte Antitabac (CCoLAT). To this effect, the Government of Madagascar currently works with the Convention Secretariat, WHO and UNDP under the FCTC 2030 project to strengthen the capacity of members of the CCoLAT, and improve multisectoral and multi-stakeholder participation in the tobacco control policy-making and implementation. Through this, the National Tobacco Control Office has been receiving support from the FCTC 2030 project to improve CCoLAT's terms of reference and has created technical working groups within the committee to focus on priority areas such as taxes on tobacco products, graphic health warnings on tobacco packages or updating its tobacco control policies into a comprehensive tobacco control legislation.

Novel and emerging tobacco products[61] and nicotine products



61 According to WHO, "new" or "novel" tobacco products, in addition to containing tobacco, must meet at least one of the following criteria:

- New or unConventional technology is used, such as vaporization of tobacco into the lungs or use of menthol pellets in a cigarette filter.
- The product type has been on the market for less than 12 years; these include dissolvable tobacco products.
- The product type has been on the market for longer, but the market share has increased in areas in which the type was not traditionally used, such as smokeless tobacco products being introduced into countries where they were not previously available.
- The product is marketed, or work has been published to allow it to be marketed, with the claim that it could reduce exposure to harmful chemicals.

WHO study group on tobacco product regulation: report on the scientific basis of tobacco product regulation: fifth report of a WHO study group. Available at: http://apps.who.int/iris/bitstream/handle/10665/161512/9789241209892.pdf?sequence=1

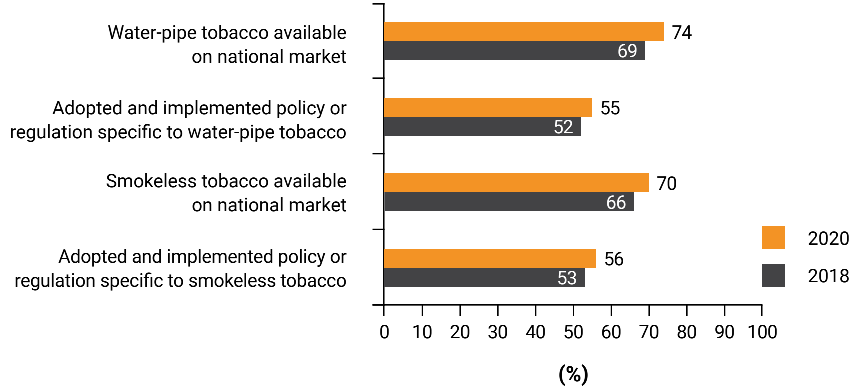
Key observations

- The availability of smokeless tobacco, water pipes and electronic nicotine and non-nicotine delivery systems (ENDS/ENNDS) on national markets has increased. The policies and regulations specific to these products have become more common, but continue to lag behind the availability of the products.
- Heated tobacco products (HTPs) are less available and less regulated, signalling that this is an area for increased action in the future.
- Some good practices in implementation of the Convention with respect to smokeless tobacco have been documented, including on testing and measuring the contents of such products.

Smokeless tobacco and water-pipe tobacco products

Smokeless tobacco and water pipes were traditionally used in several Parties, but recently there has been an expansion of the availability of such products in many parts of the world. As seen in Fig. 27, the majority of Parties declared having water-pipe tobacco available in their national markets, closely followed by smokeless tobacco. The availability of both tobacco products increased as compared to 2018. Over one half of Parties indicate having in place policies applicable to smokeless tobacco and water-pipe tobacco products, also with some increase from 2018.

Fig. 27. Percentage (%) of Parties reporting smokeless tobacco and water-pipe tobacco products in national markets, and implementation of product-specific policies and regulations 2018–2020 (n=181)



A few Parties noted advancing their regulations for water-pipe tobacco under different articles of the Convention. For example, the United Arab Emirates Federal Tax Authority imposed a ban on the supply, transfer, storing and possession of water-pipe tobacco and e-cigarettes that do not have digital tax stamps. The scheme aims to combat tax evasion and allows for digital tracking of designated products from their manufacturing facility to consumers. The ban had been previously scheduled to come into effect on 1 June 2020; however, due to the pandemic, implementation was postponed until 1 January 2021. In 2018, the Saudi Food and Drug Authority issued a regulation that requires plain packaging on tobacco molasses (water-pipe tobacco) as of 1 January 2020 (for further details, see the chapter on Article 11). In Austria, the Constitutional Court confirmed that there should not be any exceptions regarding a complete ban of tobacco use in various places, irrespective whether they are Conventional (smoking) tobacco products or novel and emerging tobacco products, including all types of e-cigarettes, water pipes and shishas/hookahs.

Precipitated by the COVID-19 pandemic, the Government of Egypt adopted firm control measures by banning the use of water pipes in cafes and public places, imposing fines and confiscation to non-complying cafes. A multisectoral approach – a collaborative action of the ministries of health and interior and local authorities – was put in place for the first time to monitor the implementation of the ban. Early results indicate that the manufacturing of one of the water-pipe tobacco products, the muassel, has significantly declined since the beginning of the pandemic, as demands have decreased by more than 90%.

In March 2020, the WHO Regional Office for the Eastern Mediterranean and the WHO FCTC Knowledge Hub on Water Pipes released evidence indicating that water-pipe tobacco use worsens health outcomes of COVID-19 patients and contributes to spreading the virus. In the WHO Eastern Mediterranean Region alone, 17 countries banned water-pipe tobacco use in public places in light of the COVID-19 pandemic. Several awareness-raising campaigns also took place. Examples of these regulations and activities are available on the website of the WHO Eastern Mediterranean Region.

Smokeless tobacco and water pipes were traditionally used in several Parties, but recently there has been an expansion of the availability of such products in many parts of the world, but only over one half of Parties indicate having in place policies applicable to them.

India

Case study

Operating national tobacco testing laboratories

A myriad of forms of smoking and smokeless tobacco are produced and consumed in the various states of India. Tobacco smoke contains more than 7000 chemicals and many of them can cause cancer. These include polycyclic aromatic hydrocarbons; tobacco-specific nitrosamines; aromatic amines; volatile carcinogens such as formaldehyde, acetaldehyde, 1,3-butadiene and benzene, as well as various metals. Also, there are a large number of chemical components in smokeless tobacco products, among them 28 are proven carcinogens.[62,63] The most abundant group of carcinogens is the tobacco-specific N-nitrosamines, and no safe level of this chemical has been ascribed.

To address this challenge, the Government of India enacted comprehensive legislation, the Cigarette and Other Tobacco Products Act, 2003 (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution of tobacco products) and launched the National Tobacco Control Programme through the Ministry of Health and Family Welfare. Establishment of National Tobacco Testing Laboratories is one of the key deliverables of the National Tobacco Control Programme.

In line with the requirements of 2003 Act, as well as those of Articles 9 and 10 of the WHO FCTC and their Partial Guidelines, the country's need for capacity to test toxicants, emissions, contents and constituents of various tobacco products is being met by the establishment of the three National Tobacco Testing Laboratories. They were established at the Central Drug Testing Laboratory in Mumbai, the Regional Drug Testing Laboratory in Guwahati and the National Institute of Cancer Prevention and Research (NICPR) in Noida, which also hosts the WHO FCTC Knowledge Hub on Smokeless Tobacco. A guideline for testing smokeless tobacco products has been developed and is being implemented across the laboratories.[64]

The National Tobacco Testing Laboratories are envisaged as accredited world-class laboratories engaged in providing analytical facilities for raw tobacco and tobacco products to generate scientific information for public health. The analysis of tobacco products depends upon the type of tobacco sample; manner of its collection, storage, transport and handling in the laboratory; and the type of method of analysis.

There are six major types of equipment procured by all the three testing laboratories. These are the continuous flow analyser, near-infrared spectrometer, smoking machine (rotary) with CO analyser, pressure drop weight circumference and ventilation measurement apparatus, gas chromatograph with detectors, and an environmental chamber. Additionally, a process for procurement of five semi-major types of equipment (one for each laboratory) through the Central Medical Services Society for 31.5 Indian rupees (approximately US$ 430 000) is under way.

62 National Cancer Institute, smokeless tobacco or Health, an International Perspective. Bethesda, MD: National Cancer Institute, Smoking and Tobacco Control Monograph 2

63 International Agency for Research on Cancer. Smokeless Tobacco and some Tobacco specific N-Nitrosamines, Lyon, France: World Health Organization International Agency for Research on Cancer, 2007, IARC Monograph on the evaluation of Carcinogenic Risks and Human Volume 89.

64 Ministry of Health and Family Welfare, Govt. of India. Operational guidelines for National Tobacco Testing Laboratories. https://ntcp.nhp.gov.in/assets/document/Operational-Guidelines-for-NTTL.pdf

These laboratories are the first of their kind in the WHO South-East Asia Region and will generate information on a variety of smoking and smokeless tobacco products currently consumed in India and the neighbouring countries.

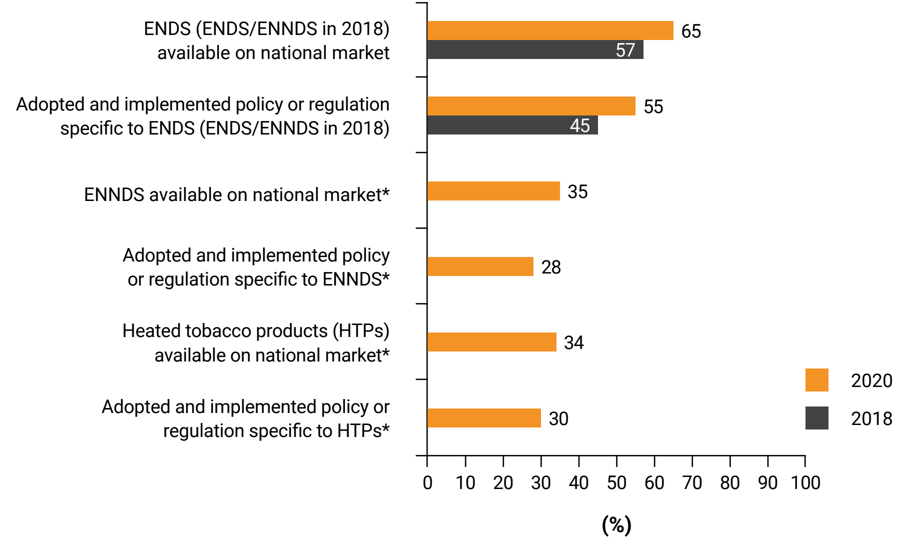
Smoking machine at the Testing Laboratory in Noida

(Photo courtesy of the National Institute of Cancer Prevention and Research, Noida (India))

Electronic nicotine delivery systems (ENDS), electronic non-nicotine delivery systems (ENNDS) and heated tobacco products (HTPs). The rapid growth of the e-cigarette industry is also reflected in Parties' reports, as around two thirds had reported having ENDS in their national markets (Fig. 28). In 2020, over half of Parties had reported that they have policies or regulations for these products. As compared to 2018, there was a notable increase both in the availability of these products in national markets, and in the policies or regulations for these products, but a gap still exists between the two. In addition, around one third of the Parties reported they have ENNDS and HTPs in their national markets (Fig. 28), but only less than one third reported they have policies or regulations for either ENNDS or HTPs.[65]

Some Parties indicated in their reports that there have been active marketing campaigns by the industry to promote novel and emerging tobacco products and nicotine products in recent years, while their current national legislation does not address these products. A few Parties reported being aware and concerned about these products entering their domestic market, especially targeting the younger population. Additionally, many Parties mentioned issues related to novel and emerging tobacco products and nicotine products as constraints and barriers in their implementation of the Convention (see further details in the Priorities and Comments chapter). Several Parties have begun to address these challenges, for example by including the relevant national authorities in the process to raise awareness and amend current tobacco control legislation in order to broaden their scope in terms of the novel and emerging tobacco products and nicotine products included in them (see the example of Israel).

Fig. 28. Percentage (%) of Parties reporting novel and emerging tobacco products and nicotine products in national markets, and implementation of product-specific policies and regulations, 2018–2020 (n=181)



** Note: New question in the WHO FCTC reporting instrument in 2020.*

65 For the first time in this reporting cycle, questions were used to measure the prevalence under the new questions in the reporting instrument related to the prevalence of use of novel and emerging tobacco products and nicotine products (HTPs, ENDS, ENNDS and other), both in adults and young people. The information received is still limited; only 23 Parties reported for such products in adults, and 31 Parties for young people. Hopefully, in the years to come, additional Parties – where such products are allowed to be introduced in the national market – will measure and report on the use of these products. For adults, the highest reported ENDS prevalence (men and women combined) was 16.7% (Brunei Darussalam) and the lowest reported prevalence was 0.3% (Georgia and Luxembourg). For HTPs, the same figures were 4.7% (Lithuania) and 0.2% (Germany). Among the youth, the highest reported ENDS prevalence (boys and girls combined) was 37.8% (Spain) and the lowest was 1.1% (Mexico). In case of HTPs, the same figures were 10.3% (Russian Federation) and 0.1% (Germany).

Israel

Case study

Expanding tobacco control regulation to novel and emerging tobacco products and nicotine products

Overcoming strong tobacco industry interference and stagnation in policy-making for tobacco control, the Knesset (Israeli Parliament) successfully adopted in 2018 the seventh amendment to the law titled Prohibition of Advertising and Restriction of Marketing of Tobacco and Smoking Products, closing existing loopholes and aiming at protecting the health of minors.[66]

This new law extends the definition of tobacco products by including not only HTPs, but also other products, such as ENDS/ENNDS, and products for smoking based on herbs without any tobacco. This expanded definition allows a ban on the sale of e-cigarettes to minors and to applies the smoke-free law to the use of these products in public places.

The requirement for an annual report on ingredients and emissions that every manufacturer or importer must file includes also all the aforementioned products.

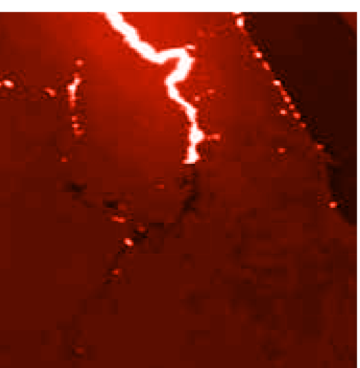
The most innovative element is the application of plain packaging to e-cigarettes and e-liquids since January 2020, including the health warning that “This product is highly addictive and harmful to your health”, which must appear in two official languages. Each one covers 30% of the two main areas of the package or bottle. Plain packaging is also compulsory for smokeless tobacco products and HTPs, including text health warnings covering 65% of the package area, the same as for cigarettes.

These amendments are in line with the guidance provided by the COP to address the challenges posed by novel and emerging tobacco products and nicotine products, and seek to apply to these products measures required under the various articles of the WHO FCTC.

66 https://ijhpr.biomedcentral.com/articles/10.1186/s13584-020-00384-3

Prevalence of tobacco use: trends and projections

5



Key observations

- Trends through 2019 and projections to 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, 124 Parties are not on track to achieve the reduction target unless effective policies are urgently put in place.
- To enable more accurate trend analyses, as well as estimates and projections, the Parties to the Convention need to continue to strengthen their surveillance and monitoring systems, and more generally, scale up their implementation of Article 20 of the Convention and exchange collected data.

Comparable estimates for prevalence of smoking and smokeless tobacco use.

Under Article 20, Parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants, and consequences of tobacco consumption and exposure to tobacco smoke. The progress with surveillance systems and the types of prevalence data reported by the Parties are described in the chapter on Article 20. Additionally, the prevalence of current smoking and smokeless tobacco use among adults and youth, as reported by the Parties, is available in Annex 2.

To further utilize the prevalence data provided by the Parties, global and regional trends in tobacco use were calculated by the WHO Department of Health Promotion using data reported in 2020 and in earlier reporting cycles, together with other national surveys

available in the public domain. The statistical model[67] 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 tobacco use rates in 2019 with rates in 2005, even though many Parties have not conducted national surveys to measure prevalence in those particular years.

Between 2009 and 2020, 167 Parties collected nationally representative data on one or more indicators of tobacco use. From these surveys, 161 Parties reported tobacco smoking indicators, 157 reported cigarette smoking indicators, 112 reported smokeless tobacco indicators, and 126 Parties reported on any tobacco use including both smoked and smokeless types of tobacco. These surveys were combined with earlier surveys back to 1990 to estimate trends in tobacco use. Parties without data on smokeless tobacco use are assumed to have negligible levels of use.

The global average rate of current tobacco use of all Parties in 2005 is estimated at 29% of people aged 15 or older (46% of males and 13% of females). By 2019, smoking rates dropped to an average of 22% (37% of males and 8% of females). Tobacco use includes use of smoked and/or smokeless tobacco products, depending on the varieties commonly used in and surveyed by each Party. Current use means either daily or occasional use at the time of the survey.

All World Bank income groups of Parties are trending downwards with average current tobacco use rates (Fig. 29). In 2005, lower-middle-income Parties had collectively the highest average tobacco use rate at 38%, but by achieving the fastest decline in average rate, by 2019 this income group had reduced to 25%, only slightly above the average rate for all Parties. Slowest progress is occurring among the upper-middle-income Parties, with an overall reduction from 26% in 2005 to 23% in 2019. Low-income Parties have on average the lowest smoking rates.

67 WHO uses the data from national surveys reported by Parties in their 2020 implementation reports to augment the WHO tobacco use prevalence data set, in order to calculate comparable trend estimates of tobacco use. 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. 29. Estimated trend in current tobacco use prevalence, ages 15+, by World Bank income groups, 2005–2019

Source: WHO estimates

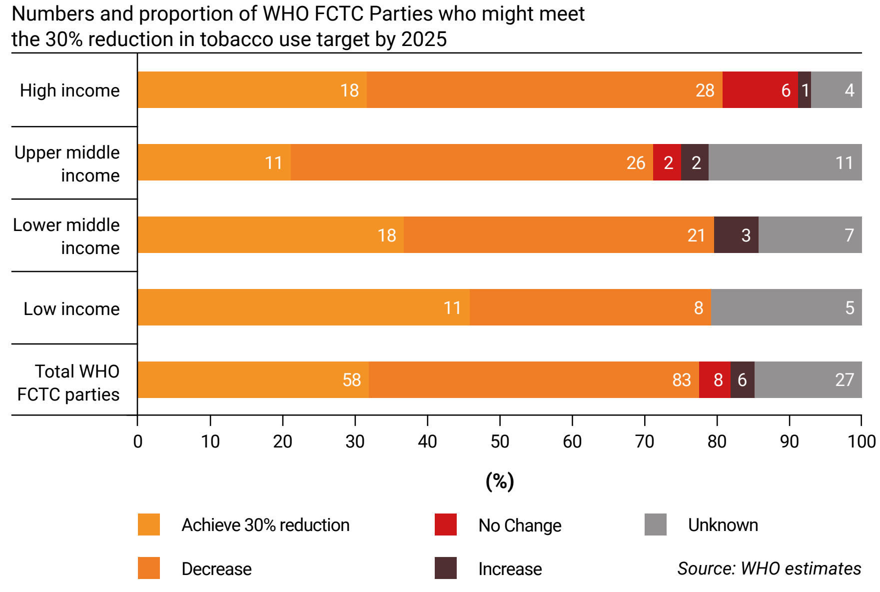
Regarding tobacco use among young people, the majority of Parties are consistently monitoring youth rates over time, particularly among those aged 13–15 years. Some 156 Parties completed a national school-based survey between 2009 and 2019 that measured current tobacco use or current cigarette smoking. Using data from these surveys, the average prevalence of tobacco use among children aged 13–15 years was 10.2% overall (12.8% for boys and 7.3 % for girls). On average, boys used tobacco at a rate close to double that of girls, however, in 19 Parties, girls used tobacco at a higher rate than boys. Looking only at cigarette smoking reported in these surveys, the average prevalence among children aged 13–15 was 5.3% overall (6.9% for boys and 3.3 % for girls).

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 people aged 15 years 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. The SDGs include Target 3.a that calls for strengthening implementation of the WHO FCTC in all countries, as appropriate, with an indicator to measure age-standardized prevalence of current tobacco use among people aged 15 years and older.

WHO estimates show that 58 Parties (32%) are likely to achieve the target by 2025 (Fig. 30). An additional 83 Parties (46%) have decreasing rates and need only accelerate the work they are already doing. Of note, eight Parties are expected to experience no decrease in smoking prevalence, and another six Parties can expect tobacco use rates to increase unless effective policies are urgently put into place. Trends are unknown in 27 Parties where insufficient nationally representative surveys have been reported. Most Parties need to accelerate tobacco control activities in order to achieve the NCD target.

Fig. 30. Projections for WHO FCTC Parties on achieving the target of 30% relative reduction of current tobacco use prevalence ages 15+ in 2025, by World Bank income group*

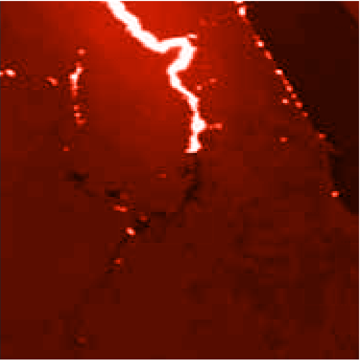


**Note: in this figure, the numbers inside the columns represent the number of Parties in the respective category.*

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. Earlier estimates in this report series referred to tobacco smoking rates only. These estimates of tobacco use are not comparable with earlier estimates.

Only one in three Parties are likely to achieve the tobacco use target by 2025, therefore, most Parties need to accelerate tobacco control activities in order to reach it, and subsequently, the respective NCD target.

6 Priorities, needs and gaps, and challenges



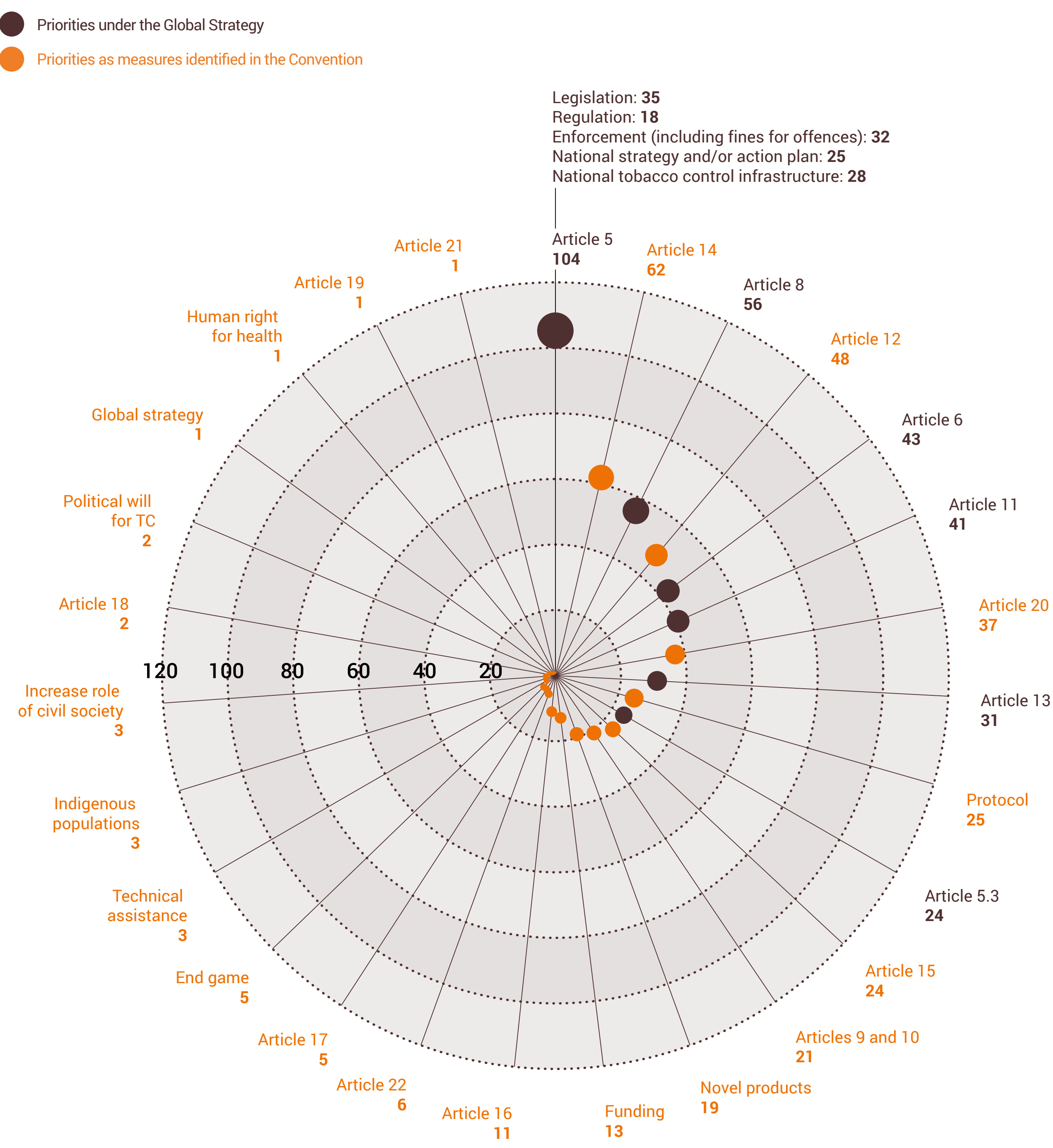
Priorities

This question was responded to by most of the Parties. In the responses, there is a clear over-representation of the obligations that correspond to the objectives of the Global Strategy, most importantly under Article 5 (General obligations) of the Convention. The main priorities mentioned include the development of legislation, enforcement of existing regulations including the imposition of fines for offences, the establishment of a national tobacco control infrastructure, the development of a national strategy and/or action plan on tobacco control, and the elaboration of regulations, in this order of occurrence. These items under Article 5 were mentioned on 104 occasions.

Article 14 (Demand reduction measures concerning tobacco dependence and cessation) was the second-highest priority, followed by Article 8 (Protection from exposure to tobacco smoke), Article 12 (Education, communication and public awareness), Article 6 (Price and tax measures) and Article 11 (Packaging and labelling). The ratification and/or implementation of the Protocol, as well as implementation of Article 15 of the WHO FCTC (Illicit trade in tobacco products) also ranked high among the priorities.

The appearance of novel and emerging tobacco products and nicotine products in markets continues to make their control a priority for some Parties – including banning or regulating these products, enforcement of adopted regulations, awareness raising on the risks of their consumption, and monitoring the appearance of new products – and a few mentioned their focus on tobacco endgame strategies for the first time. Fig. 31 below presents the various priorities mentioned by the Parties, also reflecting the number of times the priorities were mentioned.

Fig. 31. Priorities highlighted by Parties



Needs and gaps. Similar to 2018, 60% of Parties responded that they have identified specific gaps between the resources available and the needs identified in implementation of the Convention. A more detailed analysis of gaps and needs of those 139 Parties that submitted a report in the 2020 reporting cycle was conducted. Of these, 78 Parties commented on their gaps, with 26 Parties reporting one gap and 52 Parties reporting more than one gap.

Of the 78 Parties that reported gaps, 53 of those Parties the reported gaps have not changed since 2018. In 15 cases, the gaps have partially changed, as some gaps were closed and/or some others were either changed or newly added to the list. This finding might indicate that the Parties alone, if not provided support, are not able to address their implementation gaps. There is a need, therefore, for coordinated action by those stakeholders that are in a position to help these Parties make progress in their implementation work.

Some Parties, in presenting the gaps they identified, refer to either WHO FCTC needs assessments, NCD capacity assessment exercises or the investment case reports as processes that helped them in identifying their needs and gaps. It is, therefore, important to pursue such exercises and build on them when providing the necessary assistance to Parties to address those needs and gaps.

The most frequently mentioned gap, with around one third of reporting Parties mentioning it, is the lack of sufficient financial resources. Some of the Parties argue that the resources provided by government are not sufficient and some indicate that their sole funder is either WHO or a partner/donor from outside the country. Closing this gap would mean the need for more attention to be given to Article 26 of the Convention and Specific Objective 3.2.3 of the Global Strategy (Mobilize sustainable resources for tobacco control).

The second-most frequently mentioned gap, reported by around one quarter of Parties, relates to the limited staff and technical capacity in the country. Within this context, specifically, the need for more resources in the area of enforcement of various tobacco control measures was mentioned by one tenth of Parties that submitted a report in the 2020 reporting cycle.

Parties also enumerated a series of specific technical needs and gaps (Table 4). Among the technical needs, the five most frequently mentioned are: strengthening tobacco cessation work; need for more awareness-raising activities; research, monitoring and surveillance activities; strengthening tobacco product regulation; and tobacco taxation and economic research, including investment cases for tobacco control.

Table 4. Gaps reported by the Parties in relation to technical areas under various WHO FCTC articles

Article 4.7	• Limited NGO participation in WHO FCTC implementation
Article 5	• Limited staff, technical capacity for the implementation of WHO FCTC, including at the subnational/local level; training of public officials on matters related to WHO FCTC • Absence of a comprehensive tobacco control programme, plan or strategy • Absence of WHO FCTC-compliant national legislation or regulations • Insufficient multisectoral cooperation • Non-functional intersectoral committee, lack of budget for national coordination meetings • Lack of interest of non-health ministries in tobacco control • Lack of involvement of professional associations • Lack of political will and commitment, tobacco control is not a priority
Article 6	• Absence of a taxation policy • Low tax rate
Article 8	• Need to regulate smoke-free environments • Need for strengthening enforcement activities
Articles 9 and 10	• Lack of understanding of data on emissions and ingredients • Lack of policies on implementation of Articles 9 and 10 • Lack of laboratory testing capacity
Article 11	• Need to introduce plain packaging
Article 12	• Low awareness on implementation issues (on the content of the law, on tobacco industry interference, absence of media campaigns or educational materials, and media strategy targeting the young generation) • Need for training of those involved in tobacco taxation on the impact of higher tobacco taxes
Article 13	• There are loopholes in the legislation concerning advertising • Point-of-sale advertising still not banned
Article 14	• Issues related to tobacco cessation services (non-existence, the promotion of such services, training of service providers) • Unavailability of medications/nicotine substitution therapy • Absence of a national quit line • Absence of national cessation guidelines or a comprehensive tobacco cessation programme
Article 15	• Need to address illicit tobacco trade and/or to ratify/accede the Protocol • Lack of a tracking and tracing regime and licensing
Article 16	• Sale of individual sticks are still allowed • Shelves are directly accessible to buyers
Article 17	• No alternative livelihood programmes available • Lack of research on alternative crops
Article 18	• No measures in place on the protection of the environment
Article 20	• More research and/or analytical capacity is needed (in the following areas: alternative livelihoods; illicit trade of tobacco; health and economic impact of tobacco use; monitoring and evaluation of tobacco control legislation and its impact; novel and emerging tobacco products; factors that determine quitting; epidemiological studies on tobacco use in youth and adults) • Need for an investment case study
Novel and emerging tobacco products and nicotine products	• Need more awareness on novel and emerging tobacco products and nicotine products • Need more capacity to address these products
Article 26	• Financial resources are not available, or they are insufficient • More funding available to allow for participation in the COP

The needs and gaps reported by the Parties under this question of the reporting instrument will inadvertently present overlaps with the constraints and barriers section.

Constraints and barriers. Strategic Objective 3.2 of the Global Strategy aims at supporting and encouraging Parties in their efforts to remove barriers to country-level tobacco control efforts. Out of the 139 Parties that formally submitted an implementation report in the 2020 reporting cycle, 31 Parties reported one implementation barrier and 74 reported more than one barrier. The rest of the Parties have not reported any constraints or barriers.

Of those 105 Parties that reported constraints or barriers, 64 Parties have not reported them for the first time, and in case of 19 Parties the constraints or barriers reported have only partly changed as compared to their previous report. These findings indicate that persisting constraints or barriers evolve very similarly to the gaps identified between needs and resources available, as presented in the previous section. Again, there is a need for more and targeted assistance provided to these Parties so that they are able to move from this deadlock and to remove the existing barriers, as foreseen in the Global Strategy.

Looking at the constraints and barriers reported by the Parties, one could observe that they resonate well with the specific objectives listed under Strategic Objective 3.2 in the Global Strategy. An analysis of the reported barriers is provided below, in the decreasing order of how many Parties mentioned them.

Similarly to the previous reporting cycles, more than one third of Parties submitting a report in the 2020 reporting cycle (46 Parties), independent from their income levels, noted that interference by the tobacco industry and its allies was the most common barrier to face in implementing the Convention. In a related matter, more than 10 Parties referred to industries producing novel and emerging tobacco products and nicotine products as industries that try to interfere with policy-making.

There were other constraints/barriers that were also reported by more than 20 Parties. They were the lack of human resources and technical capacities at the national level, and the lack of sufficient and sustainable financing for tobacco control programmes. Furthermore, Parties also highlighted the lack of or insufficient intersectoral coordination among the sectors as a barrier to implementation. On many occasions, non-health sectors were mentioned as the sectors that need to be more involved in the implementation of the Convention, with the finance sector specifically mentioned on a few occasions. For example, one Party specifically mentioned that their finance law does not allow for a direct appropriation of resources for tobacco control, although this could be a solution for the insufficiency of financial resource allocation.

Relating to governance, more than 10 reporting Parties cited the insufficient or lack of political will and commitment or low priority given to tobacco control among other competing priorities. Political instability (including the prevailing global pandemic) and frequent changes in the political arena and personnel was also not conducive to efficient tobacco control in several Parties. One Party (the Democratic Republic of the Congo) reported that improved subnational coordination of tobacco control would be beneficial, and another Party (Djibouti) reported that more regional and intergovernmental cooperation could have a better impact on the national outcomes. Lack of sufficient civil society involvement was mentioned as a barrier by three Parties.

The Russian Federation described an interesting regional barrier to progress. The Eurasian Economic Union (EAEU) – to which the Russian Federation is a member – is not a Party to the WHO FCTC, which creates obstacles to the implementation of certain provisions of the Convention in the territory of the EAEU Member States. The barrier consists of those international trade agreements that govern the relations between the Russian Federation and other EAEU countries and represent a constraint to the harmonization of excise taxes on tobacco products, thus preventing the increase in tobacco excise taxes in the Russian Federation to the level recommended by WHO. The

reference made by the Russian Federation to this issue should remind us that much of the progress in Parties to the WHO FCTC is related to putting in place – at the national level – the policies adopted by such regional blocks. Reference to the EU Member States is a logical one, as they are Parties to the Convention. But the measures taken by the Caribbean Community (CARICOM) or the Cooperation Council for the Arab States of the Gulf and ECOWAS to promote implementation of Article 11 and Article 6, respectively, are examples of positive outcomes from such regional groups and could boost implementation of tobacco control measures in multiple Member States.

An increasing number of Parties mention enforcement-related difficulties. There are more than 20 Parties that reported that difficulties in carrying out the enforcement of existing tobacco control measures, specifically those concerning smoke-free environments and sales to and by minors can be considered as barriers to effective implementation. Fourteen Parties reported that they consider not having a tobacco control law – or a delay in the adoption of a tobacco control law or related regulations – an implementation barrier.

More than 10% of reporting Parties pointed to the lack of awareness or the need for more awareness-raising activities of the various actors as a barrier to implementation. The lack of awareness emerged as barrier in a number of contexts. For example, some Parties reported the lack of awareness of the WHO FCTC of various stakeholders including decision-makers, the lack of information related to the impact of tobacco use on users, and the lack of information of existing laws and regulations among the public and also among those that need to implement those measures as an impediment to compliance. These findings highlight the need to strengthen addressing Article 12 of the Convention in a comprehensive manner with specific messages focused on the groups of stakeholders that are in need of more information.

More than 10 Parties reported that they consider the issues related to novel and emerging tobacco products and nicotine products as an implementation barrier. The lack of research on these products, the surge of marketing strategies by the producing companies, and the non-existing or incomplete regulatory environment add to this challenge. The Russian Federation described the challenges it faces in relation to novel products, and the dangers they pose to minors, in more detail. In 2019, oral products appeared on the market that are consumed by chewing or sucking, which do not contain tobacco leaf, but nicotine. According to the current legislation of the Russian Federation and the applicable regulations of the EAEU, they do not fall under the definition of tobacco products, and therefore they became accessible to minors. One example of this product is British American Tobacco's LYFT that is now sold in the countries of the EAEU. It is similar to snus but does not contain raw tobacco; however, it contains however nicotine and various food additives, including flavourings. Servings of the product are called "packs" or "pauchi". The release into the market of this product provoked the mass apparition of nicotine products in various forms (candies, pastilles). Taken together, this led to cases of nicotine-poisoning among the minors, therefore, urgent measures had to be taken to withdraw these products from the market, and – through legislation – to ban them completely.[68] Gambia and Ghana reported considering the spread of shisha a new implementation barrier, which needs to be addressed through legislation.

In spite of the decisions already taken by the COP and the plethora of technical materials available on this matter, Parties could benefit from more targeted information and guidance when they face such challenges. Please see the section on "novel and emerging tobacco products and nicotine products" for more information on approaches taken and policies applied by some Parties.

68 The law has since been passed on 31 July 2020. More information is available at: https://untobaccocontrol.org/impldb/russian-federation-new-regulations-on-nicotine-containing-products-adopted/

Several Parties referred to particular area and articles of the Convention that pose implementation constraints. Seven Parties referred to low taxes and difficulties encountered in tobacco taxation as implementation barriers, and the same number of Parties indicated that tobacco cessation is an area where they need more work to be carried out. Four Parties mentioned illicit trade, and three additional Parties indicated that not having ratified the Protocol can be seen as an implementation barrier. Implementation of Articles 9 and 10 of the Convention and, specifically, not having an accredited laboratory to test tobacco products, Article 13 (enforcement), Article 17 (funding alternatives for small farmers), Article 20 (programme/policy and tobacco industry monitoring) are also mentioned as barriers by a few Parties.

The most frequently reported gap is the lack of sufficient financial resources, and the most reported challenge/barrier continues to be the interference by the tobacco industry.

Further information received from the Parties in early 2021

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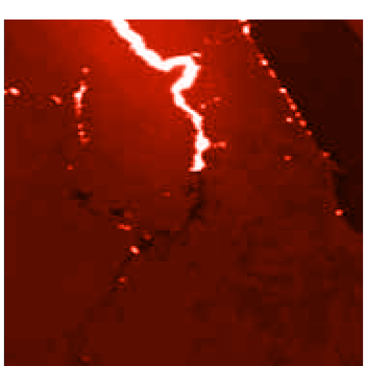


The Convention Secretariat, after the Ninth Session of the Conference of the Parties to the WHO FCTC was postponed in 2020 due to the COVID-19 pandemic, reached out to the Parties in order to gather the most updated information on the implementation of the Convention. Parties were invited to provide any implementation news and new data that have occurred or been gathered since the submission of their 2020 reports. Seventeen Parties had sent updates by the end of February 2021.

Twelve Parties reported having adopted new legislation or regulations or other administrative or executive measures on any articles of the WHO FCTC after the submission of their 2020 reports. Among them, Belgium, the Czech Republic, Denmark, the Russian Federation, Serbia, Slovakia and Uruguay reported having increased their tobacco taxes. A trend is observed to require higher taxation on products such as e-cigarettes and their refill liquids, as well as HTPs. Most of these Parties incorporate these regulations in a "tax calendar", which also covers Conventional tobacco products, and plan tax increases in upcoming years

In relation to Article 13, Belgium has banned the use of trademarks of tobacco products on signs inside and in front of tobacco shops and newspaper shops selling tobacco products, and Germany adopted additional TAPS bans, including a ban on cinema advertising (except for films labelled "No youth release") and on the provision of free samples outside specialist shops (from January 2021). In addition, Germany banned outdoor advertising for Conventional tobacco products beginning in 2022, HTPs beginning in 2023 and electronic cigarettes and refill containers beginning in 2024.

In Australia, the Therapeutic Goods Administration announced that nicotine was rescheduled (reclassified) for non-therapeutic human use from “dangerous poison” to “prescription only”, and a doctor’s prescription is required to legally access nicotine e-cigarettes and liquid nicotine in Australia. The Russian Federation established the regulation of nicotine-containing products and devices for their consumption in line with Articles 6, 8, 9 and 10, 11, 12, 13, 14 and 16, among other articles, of the Convention.[69] A new Tobacco Act was adopted in Denmark in December 2020, as part of the National Action Plan on Children and Youth Smoking. The new act covers a wide range of measures for e-cigarettes and refill containers, including a ban on display at points of sale and on flavours other than tobacco, as well as plain packaging; the latter also applies to HTPs. “Tobacco surrogates” are defined in this Tobacco Act as products containing nicotine and not containing tobacco, that are not tobacco products or e-cigarettes (with nicotine pouches being the first of these products in the market), and will also be subject to incorporating health warnings and tax measures. Additionally, the law bans the use and sale of tobacco products, tobacco surrogates, herbal smoking products and e-cigarettes at education centres under certain conditions, and mandates a stricter ban on (direct and indirect) advertising and sponsorship, among others. In January 2021, the Danish Safety Technology Authority established a prohibition on selling cigarettes if they contain menthol as it is considered part of the ban on additives that enhance inhalation, not simply being characterizing flavours already prohibited by the European Tobacco Products Directive.

The EU, since the adoption of the Directive 2019/904 on the reduction of the impact of certain plastic products on the environment[70] (Single-use plastics Directive or SUPD), has had approved a regulation[71] on single-use plastics, establishing harmonized marking specifications for, among other things, tobacco products with filters and filters marketed for use in combination with tobacco products, and which contain plastics. The SUPD is described in more detail in the chapter on Articles 17 and 18.

Some other Parties indicated having respective bills under discussion. In Chile, a proposal is being discussed to regulate ENDS/ENNDS as tobacco products, in parallel with another one seeking plain packaging, banning the use of additives (including flavours) and banning the display of tobacco products at points of sale. In Spain, draft legislation aims at expanding smoke-free environments, regulating e-cigarette consumption and promotion as tobacco products, increasing tobacco taxes, and adopting plain packaging.

In relation to ***adopting new national tobacco control strategies, plans or programmes***, Denmark confirmed that the new Tobacco Act was developed as part of the *National Action Plan on Children and Youth Smoking*. In the EU, the *Beating Cancer Plan* was published, including a section on “Achieving a tobacco-free Europe” containing a clear target of less than 5% tobacco use prevalence by 2040 and actions relating to tobacco control at the EU level. On August 2020, Italy approved the new *National Prevention Plan 2020–2025*, containing an objective on the fight against NCDs and their risk factors, among which is tobacco use, aiming at applying an intersectoral and interdisciplinary approach integrating effective policies in line with the WHO FCTC.

Additional Parties provided information about developing strategies, plans or programmes. Belgium is working to establish a plan to create a tobacco-free generation. Chile is developing a national plan on smoking cessation for the population aged 18 years and over. Similarly, Slovakia is working on a new strategy for smoking cessation counselling centres, set up at regional public health offices. Spain confirmed drafting a *Comprehensive Tobacco Prevention and Control Plan for 2021–2025*.

69 See details at: https://untobaccocontrol.org/impldb/russian-federation-new-regulations-on-nicotine-containing-products-adopted/
70 The Directive is available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32019L0904&from=EN
71 https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=uriserv:OJ.L_.2020.428.01.0057.01.ENG

On ***innovative approaches to promote the priorities identified in the Global Strategy***, only two Parties reported advances, and both in relation to Article 8 of the WHO FCTC. On one hand, Belgium provided information about a civil society initiative – Generation Smoke Free[72] – focused on creating as many smoke-free environments for children as possible, in order to ensure that every child born as of 2019 can grow up smoke free, preventing them from starting to smoke and becoming addicted to tobacco products or e-cigarettes. On the other hand, Denmark noted that the new Tobacco Act also introduces Smoke-free School Hours for all primary schools and youth education, which includes the use of smokeless tobacco and e-cigarettes.

In relation to the ***publication of new studies or research***, seven Parties reported the launch of results from new prevalence surveys: national surveys of adults in the case of Panama and Spain; surveys among students and young people in the Czech Republic, Denmark, Portugal and Uruguay; and a survey on the attitudes of Europeans towards tobacco and e-cigarettes in the EU.

A good number of research papers have been published in several Parties, including on the use of tobacco products (Czech Republic and Slovakia), on lifestyle habits during the COVID-19 pandemic including tobacco use (Sweden), and on the impact of tobacco control measures on health-care costs (Uruguay).

From Italy, a few research papers involved national researchers and covered issues related to the Italian context, such as the profile of young people using e-cigarettes and tobacco products and the promotion of smoke-free homes, as well as studies among several European countries, such as a profile of smokers, exposure to second-hand smoke by children in outdoor spaces, and studies on the burden of disease from smoking and exposure to second-hand smoke in children and adults.

The Government of Germany evaluated the effect of sales bans on e-cigarette and e-shishas, which came into force in 2016, on the consumption of these products by minors. The report will be published by the end of 2021.

In view of the COVID-19 pandemic, certain Parties adopted or implemented tobacco control policies, aiming to support control of the pandemic. The Government of Botswana banned the importation and sale of tobacco or tobacco-related products from March to June 2020, and the use, sale and hiring of shisha is still prohibited. In Germany, the Federal Centre for Health Education launched a special online Blog titled Corona and Smoking, and the Drug Commissioner of the German Federal Government initiated a nationwide campaign targeting smoking cessation. The Ministry of Finance of the Russian Federation, as one of the justifications for an increase in excise rates by 20%, indicated the need to fulfil the social obligations of the state in the face of growing budget spending due to the pandemic. Spain issued recommendations for tobacco consumption in confined situations; this was done in the form of a position paper, developed in coordination with the autonomous regions' authorities, about tobacco and novel products' consumption during the pandemic. A paper on the relationship between nicotine and COVID-19 was also developed, and an evaluation of the impact of the current pandemic on tobacco prevalence was carried out.

In some instances, tobacco control measures were delayed due to the competing priorities created by the pandemic. For example, Botswana found it challenging to progress with the implementation of the WHO FCTC, including the delay in passing the comprehensive tobacco control bill, as well as the establishment of cessation centres across the country to support those who are willing to quit.

72 https://www.generationsmokefree.be/generation-smoke-free

8

Global Strategy to Accelerate Tobacco Control – baseline data for Global Strategy indicators

Indicators of the Global Strategy to Accelerate Tobacco Control: a status report of baseline data

The Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the implementation of the WHO FCTC 2019–2025 was adopted by COP8 through decision FCTC/COP8(16). The decision also required the Convention Secretariat to: 1) collect baseline data for the range of indicators identified in the Global Strategy; and 2) to report, on a biennial basis, on progress in implementation of the Global Strategy, as part of its regular biennial global reports on the implementation of the Convention.

The Global Strategy contains 20 indicators that are intended to measure progress in implementation of the objectives under its three strategic goals. To describe these indicators, the Convention Secretariat developed an Indicator Compendium for the Global Strategy, available on the Convention Secretariat's website.[73] This report intends to provide baseline data for the Global Strategy indicators, and it is the first in this series. Its regular update will allow the detection and documentation of progress in implementation of the Global Strategy by the stakeholders.

This status report is based on information collected up until the end of 2019. For those indicators that are based on the Parties' WHO FCTC implementation reports, the reports submitted in the 2018 reporting cycle were used as the baseline. Additionally, the figures from the 2020 reporting cycle are also provided to detect any development. For other indicators, the information was collected through desk research or information collected from stakeholders in accordance with the description provided in the Indicator Compendium. For those indicators for which information was not available in the reporting instrument of the WHO FCTC, proxy indicators and/or additional data sources were used according to the methodologies defined in the Indicator Compendium. In the latter case, this status report also makes some suggestions on how to further develop the respective indicators, or what additional resources and data should be used.

Status by strategic goals and indicators

The current status for each indicator will be presented in the order these indicators appear in the Global Strategy.

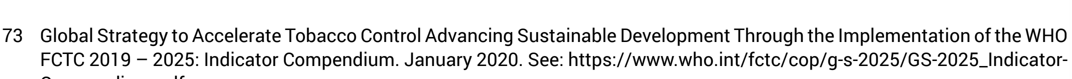
Strategic Goal 1: Accelerating Action

Indicators under Strategic Goal 1 refer to the implementation work carried out by the Parties, and to what extent the Parties benefited from assistance provided by the WHO FCTC Knowledge Hubs, or through South–South and Triangular cooperation projects. Number of Parties reporting having received or provided financial and/or technical support

This indicator reflects some questions from the International Cooperation and Assistance section of the reporting instrument of the WHO FCTC that were included in the reporting instrument of the Convention in its initial version. In the 2018 reporting cycle, 86 Parties reported having provided and 130 Parties reported having received financial and/or technical support. In the 2020 reporting cycle, the respective numbers were 86 and 134.

The successive global progress reports also give examples from the Parties on how they provide or receive assistance, and examples on how non-Party actors (for example, IGOs and NGOs) provided assistance to Parties. In case of the latter, the biennial reports submitted by the NGOs that are observers to the COP also describe additional examples of such assistance.[74]

There seem to be signs, however, of some under-reporting under this indicator by the Parties. For example, there are assistance mechanisms operated by the Convention Secretariat and its partners, such as needs assessments and related activities; some



73 Global Strategy to Accelerate Tobacco Control Advancing Sustainable Development Through the Implementation of the WHO FCTC 2019 – 2025: Indicator Compendium. January 2020. See: https://www.who.int/fctc/cop/g-s-2025/GS-2025_Indicator-Compendium.pdf

74 https://www.who.int/fctc/cop/observers_ngo/

Parties report on them but some others do not include a reference to them in their implementation reports. Efforts should be made to further encourage Parties to provide more complete and detailed information on the assistance they provided or received, as well as any financial or technical assistance that may be needed.

Number of Parties that have submitted a costed national tobacco control plan as part of their regular WHO FCTC reports

The WHO FCTC, and as a consequence its associated reporting instrument, does not reference the development of a "costed" national tobacco control plan. In the absence of such specific indicator, as outlined in the Indicator Compendium, the relevant questions of the reporting instrument that could be used as proxy indicators[75] refer to Parties having:

1. reported the development and implementation of comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the Convention; and
2. established or reinforced and financed a focal point for tobacco control and/or a tobacco control unit and/or a national coordinating mechanism for tobacco control.

Based on the reports of the Parties submitted in the 2018 reporting cycle, 120 Parties have reported having developed and implemented multisectoral national tobacco control strategies, plans and programmes and having established or reinforced and financed at least one type of tobacco control infrastructure – focal point, tobacco control unit or national coordinating mechanism as outlined above. By 2020, the respective number of Parties was 127. Details on the various mechanisms and types of infrastructure, disaggregated by indicators, for the 2018 and 2020 reporting cycles can be found in Annex 1.

Indirectly, another question in the reporting instrument might provide additional information on resources that might be available for tobacco control programmes. Parties are asked whether they earmark any percentage of taxation income derived from the sale of tobacco products for funding any national strategy, plan or programme in reference to Article 26 of the Convention. A brief additional study that also provides some examples of dedicating resources for tobacco control is available on the Convention Secretariat's webpage.[76]

Country data collected by WHO could also contain some relevant data; data reported to WHO by its Member States for the WHO Report on the Global Tobacco Epidemic, 2019 indicates that 34 Parties have allocated a budget to tobacco control strategies, plans and programmes.[77]

For the future, due to the fact that the reporting instrument of the WHO FCTC does not request information on "costed" strategies, consideration should be given to including this aspect in the reporting instrument, in relation to both Articles 5.1 and 26.2.

Number of Parties implementing price and tax measures

One of the indicators used in the reporting instrument of the WHO FCTC, in relation to Article 6, identifies Parties "that have adopted and implemented tax policies and, where appropriate, price policies on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption".

In the 2018 reporting cycle, 146 Parties reported having adopted such measures. In the 2020 reporting cycle, the figure was 153.[78]

75 Indirect measure or sign that approximates or represents a phenomenon in the absence of a direct measure or sign.
76 https://untobaccocontrol.org/impldb/wp-content/uploads/resources/Convention_Secretariat_Earmarking_Analysis_2015.pdf
77 Table 6.14 - National tobacco control programmes (https://www.who.int/tobacco/global_report/en/)
78 See additional details on tax measures in the section on Article 6 of this Global Progress Report for 2020 and in the 2018 Global Progress Report.

Moreover, the successive Global Progress Reports also provide examples of good practices in implementing price and tax measures; this is also the case for any indicators that are included in the reporting instrument of the WHO FCTC.

As this indicator is included in the current reporting instrument, the successive global progress reports will remain the most important source of information in relation to progress in this Global Strategy indicator. The completeness and accuracy of the information, also in view of the difficulties of collecting and reporting on such information, is an important element where further developments are needed. This consideration will be taken into account in any further revision of the WHO FCTC reporting instrument.

Number of Parties with strengthened national tobacco control measures

This is a complex indicator that requires a comparison in implementation between two reporting cycles for a number of individual indicators; moreover, and in accordance with the Indicator Compendium for the Global Strategy, the focus for analysing this indicator is focused on measures that have been implemented by the Parties on the time-bound requirements (related to Articles 8, 11 and 13) of the Convention. As a reminder, the time-bound measures under Article 8 are included in the related Guidelines for Implementation adopted at the Second Session of the conference of the Parties in Decision FCTC/COP2(7), while the time-bound requirements for Articles 11 and 13 are included in the Convention itself.

To assess this indicator, a comparison was made between the responses of the Parties in the 2016 (or the previous available report) and the 2018 (or the latest available report) reporting cycles. As the time allowed for an update in the analysis, the same procedure was repeated for the 2020 reporting cycle. “Voluntary agreements” were not considered as improvements.

Comparing information from the 2016 and 2018 reporting cycles, 124 Parties reported progress in implementing at least one measure under any of Articles 8, 11 and 13. Of these, 109 reported progress in one of the articles, and 15 Parties have reported progress in more than one article. When comparing the 2018 and 2020 reporting cycles’ data, progress can be observed in 91 Parties. Additional information on individual measures, by articles, appears in the sections below.

Article 8 (Protection from exposure to tobacco smoke)

In case of measures under this article, we considered an “improvement” if the response of the Party to “having adopted and implemented legislative, executive, administrative or other measures banning tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places” changed from “no” to “yes” or from “none” to “partial” or “complete”, or from “partial” to “complete”.

In 2018, some 65 Parties reported some level of “improvement” (as defined above) in banning tobacco smoking in any of the settings listed in the reporting instrument. In the 2020 reporting cycle, an increased number of improvements (77) was observed.

Article 11 (Packaging and labelling of tobacco products)

For Article 11, “improvement” in implementation refers to a response that changed from “no” to “yes” in any of the categories. In 2018, some 27 Parties reported progress under any specific indicators under Article 11. In the 2020 reporting cycle, the figure was only 13.

Article 13 (Tobacco advertising, promotion and sponsorship)

In 2018, compared to data from the 2016 reporting cycle for having a comprehensive ban on tobacco, advertising, promotion and sponsorship (TAPS), “improvement” (changing

from "no" to "yes") was detected in 10 Parties; an additional 37 Parties have made some progress under certain advertising mediums but not all. The same comparison between 2018 and 2020 data highlights seven Parties that have reported progress in making their advertising and promotion bans comprehensive, while 33 Parties reported some progress in any advertising mediums included in the reporting instrument.

Number of Parties that have identified WHO FCTC implementation as a development priority, including in their United Nations Development Assistance Framework (UNDAF)

The discussion paper titled *WHO Framework Convention on Tobacco Control: an Accelerator for Sustainable Development*,[79] jointly developed by the Convention Secretariat and UNDP, reiterates the fact that tobacco control, which is long-considered a priority for the health sector, can accelerate sustainable development across its social, economic and environmental dimensions. The paper documents how strengthened implementation of the WHO FCTC and progress towards SDG Target 3.a interacts with other SDG targets.

The Global Strategy seeks to meaningfully contribute to reaching the overall goal of SDG 3 (Good health and well-being) and, in particular, SDG Target 3.4 on NCDs. Also, strongly relevant for the progress in implementing Article 5 of the Convention, SDG 17 recognizes that the goals can only be realized with a strong commitment to global partnerships and cooperation.

The WHO FCTC is also referenced in the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development as a means to raise awareness and mobilize resources, stating that "price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and health-care costs, and represent a revenue stream for financing development in many countries". Tobacco control measures have consistently been identified as "best buys" for improving global health because they deliver large benefits for relatively small investments.

In accordance with the Indicator Compendium, this indicator refers to countries that have implemented the WHO FCTC as a development priority by indicating activities as part of their domestic engagement with the United Nations Development Assistance Framework (UNDAF).[80]

Searching the most recent UNDAFs extracted from the corresponding database (documents between 2012 and 2018), 47 hits were found for "tobacco" and 28 for "WHO FCTC", with four Parties' UNDAFs having made reference to both.

Number of Parties that have received assistance from the WHO FCTC Knowledge Hubs

This indicator is defined as the number of Parties who have received any form of assistance from at least one of the WHO FCTC Knowledge Hubs on matters under their expertise in relation to the Convention.[81] Each Knowledge Hub, in its yearly report submitted to the Convention Secretariat, describes the assistance it had provided to Parties. Such reports from the Knowledge Hubs serve, therefore, as the basis for measuring this indicator.

79 https://www.who.int/fctc/implementation/publications/who-fctc-accelerator-for-sustainable-development/

80 Core Data Source is represented by the UNDAF database: https://unsdg.un.org/resources/cooperation-framework . Cooperation Framework dashboard on UNSDG knowledge portal has given additional insight of the Cooperation Framework cycle of different countries: https://unitednations.sharepoint.com/sites/DCO-WG-UNSDG_CF/SitePages/Cooperation%20Framework%20Dashboard.aspx. Complementary Data Source represented by the Needs Assessments Reports carried out jointly by the Convention Secretariat, its partners and the involved Party stakeholders also collect information related to inclusion of WHO FCTC in the countries' health and development strategies, plans, and programmes through engaging with United Nations country teams.

81 Data Sources for this indicator included: Annual or biannual technical report on the operation of the Knowledge Hubs submitted to the Convention Secretariat, the Convention Secretariat's newsletters containing information on the work of the Knowledge Hubs and the Convention Secretariat's record of Party requests for assistance from Knowledge Hubs.

By the end of 2019, the WHO FCTC Knowledge Hubs provided assistance to 68 Parties in 116 instances. The regional breakdown of Parties that received assistance is the following: 15 Parties from the African Region; eight Parties from the Eastern Mediterranean Region; 15 Parties from the European Region; nine Parties from the Region of the Americas; eight Parties from the South-East Asian Region; and 13 Parties from the Western Pacific Region.

It is to be noted that all Knowledge Hubs are global in their scope, and provide technical assistance to any Party, irrespective of their geographical regions, upon request

Number of Parties involved in South–South and Triangular cooperation programmes, either as a provider or recipient

South–South and Triangular cooperation is a potential tool for promoting collaboration among Parties in accordance with Article 22 of the Convention. Parties might face similar challenges, and identifying and addressing them through peer support could serve as the basis of mutual assistance projects.

The COP has been promoting South–South and Triangular cooperation since its first session and requested the Convention Secretariat to carry out such projects. So far, 17 Parties (Brazil, Colombia, Ethiopia, Gabon, Georgia, Guatemala, the Islamic Republic of Iran, Jamaica, Malaysia, the Republic of Moldova, Mongolia, Panama, Peru, the Philippines, Senegal, Thailand and Uruguay) participated in formal South–South and Triangular projects, some of them in more than one project.[82] The six projects in which the above-mentioned Parties participated were organized in the following areas: addressing tobacco industry interference (Article 5.3, with 11 Parties participating in the project); national coordinating mechanisms (Article 5.2, with six Parties); tobacco taxation (Article 6; with three Parties); packaging and labelling (Article 11, with six Parties); tobacco cessation (Article 14, with five Parties); and promotion of alternative livelihoods (Article 17, with four Parties).

More bilateral assistance projects were organized afterwards; however, they were not under such a formal structure. As bilateral assistance projects could also be considered as South–South projects or even Triangular projects, if additional stakeholders are participating, it is important for the future monitoring of such instances that a platform is established in which such information can be shared by the Parties, not least for the sake of their analysis for the progress in the implementation of the Global Strategy.

82 https://www.who.int/fctc/implementation/cooperation/south-south/

Strategic Goal 2: Building international alliances and partnerships across sectors and civil society to contribute to WHO FCTC implementation

Indicators under Strategic Goal 2 highlight the ways Parties engage with partners while implementing the Convention. These include IGOs, as well as engagements under the 2030 Agenda for Sustainable Development.

Number of development agencies, intergovernmental organizations, international organizations or initiatives that include WHO FCTC implementation in their strategies or plans

The Indicator Compendium defined this indicator as the number of agencies or organizations within the United Nations System, and other relevant international agencies and initiatives that integrate WHO FCTC implementation in their strategies, plans and programmes.

Data for this indicator cannot be found in one well-defined circumscribed source; this information can collectively be extracted from working documents, communications and reports of country work carried out by the various Convention Secretariat teams, primarily those on Governance and International Cooperation and on Development Assistance. Furthermore, the Convention Secretariat carried out an additional information search to identify and review governing body decisions, policies, strategies, plans of development agencies, IGOs, international organizations, etc. Complimentary information was found on webpages of the United Nations Ad Hoc Interagency Task Force on Tobacco Control, which has been incorporated in the work of UNIATF,[83] and those of the UNDP.[84]

When collecting information for this indicator, in addition to desk research, an email was sent by the Convention Secretariat to relevant entities requesting them to report whether they have included WHO FCTC implementation in their strategies and plans. Based on the responses received (not all contacted agencies have replied), 10 entities (agencies and organizations) have been identified as including WHO FCTC in their strategies and plans. Details are included in the table overleaf.

83 https://www.who.int/tobacco/about/partners/un_taskforce/en/
84 https://www.undp.org/content/undp/en/home.html

Table 5. Agencies, organizations and initiatives that include WHO FCTC implementation (or any aspect of it) in their strategies or plans.

Agencies, organizations and initiatives	Details of WHO FCTC implementation inclusion in strategies/plans
Cooperation Council for the Arab States of the Gulf (formerly known as Gulf Cooperation Council)	The Common Excise Tax Agreement of the States of the Council was adopted by the Council in Riyadh, Saudi Arabia, on 9–10 December 2015, and tobacco was explicitly singled out in the agreement.
Inter-agency and Expert Group on SDG indicators	The WHO and the Convention Secretariat work in partnership as co-custodians of SDG Target 3.a and on the monitoring of its indicator. They are both independently members of this group operating under the United Nations Statistical Commission.
International Labour Organization (ILO)	An ILO Governing Body document (GB.337/POL/5) containing the integrated strategy to address decent work deficits in the tobacco sector was endorsed by the 337th Session (October–November 2019) of the ILO Governing Body, and it refers to governments' commitments under the WHO FCTC, highlighting that 176 of the ILO's 187 Member States are Parties to the WHO FCTC. It also notes that the integrated strategy "takes into consideration the non-binding Model Policy for agencies of the United Nations System on preventing tobacco industry interference (Model Policy) developed by the United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases, of which the ILO is a member".
League of Arab States	Guidelines on combating smoking and tobacco and its products were adopted by the Arab Health Ministries' Council in 2018. Furthermore, in 2019, the Economic and Social Council also adopted it at the ministerial level.
United Nations Development Programme (UNDP)	UNDP's corporate strategy on health and development – *The HIV, Health and Development Strategy 2016-2021: Connecting the Dots* elaborates UNDP's work on HIV and health in the context of the 2030 Agenda for Sustainable Development[85] includes references to WHO FCTC, most prominently under Action Area 2 (Promoting effective and inclusive governance for health, and its Priority 2.2: Strengthening governance to address NCDs and accelerate tobacco control). UNDP's interest lies in scaling up its work with WHO and the Convention Secretariat, among other relevant partners, to support countries to analyse the costs and benefits of sugar, alcohol and tobacco taxes in terms of health, health equity, revenue raised and return on investment, building on work to develop national investment cases for NCDs/tobacco control. Working closely with the Convention Secretariat, UNDP is the lead agency in supporting countries to implement Article 5 of the Convention, specifically national planning, multisectoral governance, and protection against tobacco industry interference in policy-making.
United Nations Economic and Social Council (ECOSOC)	Member States of ECOSOC adopted a resolution (E/2017/L.21) by consensus that promotes implementation of the WHO FCTC by ensuring a consistent and effective separation between the activities of the United Nations System and those of the tobacco industry (developed under the auspices of the UNIATF using Article 5.3 of the WHO FCTC as the basis).
United Nations Educational, Scientific and Cultural Organization (UNESCO)	UNESCO supports preventing use of harmful substances including tobacco among children and young people, which is an expected outcome of its strategic priority for "all children and young people have access to safe, inclusive, health-promoting learning environments" in UNESCO's Strategy on Education for Health and Well-being,[86] implemented through providing guidance for Education sector responses to the use of alcohol, tobacco and drugs.[87]
United Nations Interagency Task Force on the Prevention and Control of NCDs (UNIATF)	Work is ongoing as part of the workplan of UNIATF in the area of promoting tobacco control among school-aged children involving UNIATF, UNICEF, the World Food Programme, the United Nations Office on Drugs and Crime, WHO and the Convention Secretariat. In addition, the Convention Secretariat is leading a joint project on promoting economically sustainable alternatives to tobacco growing involving UNIATF, WHO, UNDP, ILO, the Food and Agriculture Organization of the United Nations, UN Environment Programme and the United Nations Office on Drugs and Crime.
World Health Organization (WHO)	WHO has included WHO FCTC in its Thirteenth General Programme of Work (GPW13) 2019–2023 as its normative function (Promote Health, Keep the World Safe, Serve the Vulnerable), under Platform 2: Accelerating action on preventing noncommunicable diseases and promoting mental health:[88] "The Framework Convention on Tobacco Control shows how WHO's normative work leads to healthy lives. The Convention relies upon legally-binding commitments by the States Parties, multisectoral dialogue and collaboration with a range of stakeholders, excluding the tobacco industry. Achieving progress in tobacco control required political commitment by Member States, advocacy and technical expertise – provided by WHO – to support and monitor implementation, and the active engagement of civil society, including the monitoring of the activities of the tobacco industry at local level."

85 https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv--health-and-development-strategy-2016-2021.html
86 https://healtheducationresources.unesco.org/library/documents/unesco-strategy-education-health-and-well-being-contributing-sustainable
87 http://www.unesco.org/new/en/media-services/single-view/news/how_the_education_sector_should_respond_to_the_substance_use/
88 https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf

In the future, a mechanism should be established to improve recording of progress under this indicator, preferably in the Convention Secretariat, including for the information publicly available or the ones received through various channels by the Convention Secretariat.

Number of Parties where WHO country offices included WHO FCTC implementation in country cooperation strategies

WHO works with its Member States to support them in achieving their health objectives. WHO has six regional offices and also has 149 field offices in countries, territories or areas. All countries that have a WHO country office also have a Country Cooperation Strategy, covering a few years, laying out how WHO will cooperate with the governments and other partners in pursuing national health strategies and plans.

On the other hand, the Convention and the Convention Secretariat do not have a regional structure. This is the reason why the Convention Secretariat often collaborates with WHO, including its regional and country offices, especially on cases when providing assistance to a particular Party for their implementation of the WHO FCTC. For the occasion of the Eighth Global Meeting of Heads of WHO Country Offices, the Convention Secretariat issued an information note[89] describing the importance of such collaboration to help Parties' implementation of the WHO FCTC.

The collaboration between the Convention Secretariat and the WHO country offices, and the assistance that could be provided by WHO country offices to the Parties in their implementation of the WHO FCTC, might take different forms. One of them is the inclusion of support for WHO FCTC implementation in the Country Cooperation Strategies, the collaborative agreements between the host countries and the WHO country office.

To collect information on them, a search was done in WHO's "Country Cooperation Strategies and Briefs" database.[90] Overall, 84 full Country Cooperation Strategies and 86 briefs were reviewed (a total of 170) from the database at the time of the preparation of this report. Of those, 98 Parties made reference to either tobacco, WHO FCTC or SDG Target 3.a in their latest Country Cooperation Strategies or briefs.

Among the full Country Cooperation Strategies, 70 Parties included reference to WHO FCTC (21 in the African Region, four Parties in the Eastern Mediterranean Region, four Parties in the European Region, 13 Parties in the Region of the Americas, eight Parties in South-East Asian Region and 20 Parties in the Western Pacific Region). Additionally, there were 27 briefs that included WHO FCTC (11 in the African Region, five Parties in the Eastern Mediterranean Region, 10 Parties in the Region of the Americas and one Party in the Western Pacific Region), while there was one Party referencing WHO FCTC in both full Country Cooperation Strategy and the briefs.

Number of Parties that include WHO FCTC implementation in their voluntary reports on their domestic implementation of the SDGs, in relation to Target 3.a

Implementation of the WHO FCTC is included in the Sustainable Development Goals as one of 169 targets. Target 3.a calls for efforts to "strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate". Progress towards reaching the SDGs the countries are reported in voluntary national reviews (VNRs), a report that allows countries to describe their priority actions and the lessons they have learnt. The VNRs are available online.[91]

89 https://www.who.int/fctc/InformationForHeadsOfWHOCountryOffices.pdf?ua=1
90 https://www.who.int/country-cooperation/what-who-does/strategies-and-briefs/
91 https://sustainabledevelopment.un.org/vnrs/

In 2019, the Convention Secretariat commissioned a study on the inclusion of references to Target 3.a in Parties' VNRs submitted to the United Nations. Since the first VNRs, which were developed in 2016, and up until April 2020, some 158 VNRs have been prepared by the Parties, and of these, 57 reports included a reference to SDG Target 3.a.

To promote inclusion of a reference to SDG Target 3.a in WHO FCTC Parties' VNRs, the Convention Secretariat developed a guide for Parties that is available on the its website.[92]

Number of Parties that include civil society participation in the development and implementation of national tobacco control approaches

The Convention, in its Preamble and in Article 4.7, emphasizes the special contribution of NGOs and other civil society actors to national and international tobacco control efforts. The Guidelines for Implementation of Article 12 of the WHO FCTC and the Global Strategy provide further guidance for the involvement of the civil society in supporting the implementation of the Convention and the Global Strategy. As stated in the Indicator Compendium for the Global Strategy, some countries rely heavily on civil society involvement to advance the implementation of the Convention, particularly where tobacco control may not be considered as a public health priority. Effective tobacco control requires collective, multisectoral approaches that fall beyond the capacity, efficiencies and expertise of government agencies. This indicator demonstrates the prominent role of civil society in the development and implementation of national tobacco control approaches.

In their 2018 implementation reports, 152 Parties had reported that they promote awareness and participation of the NGOs not affiliated with the tobacco industry in the development and implementation of intersectoral programmes and strategies for tobacco control.[93] In the 2020 reporting cycle, the number was 148. This information is provided by the Parties in relation to their implementation of Article 12 of the Convention, and refers to programmes on education, communication, training and public awareness. Additional details are provided by the Parties on the assistance received and provided when reporting on their implementation of Article 22 of the Convention.[94]

Furthermore, the reports of NGOs that are observers to the COP, submitted regularly to the Convention Secretariat as part of reaccreditation procedures, also describe in more detail the areas where the civil society is involved in assisting the Parties in implementation of the Convention, and the projects they have conducted. The reports are available in the public domain on the Convention's website.[95]

Number of nongovernmental organizations that are accredited as observers to the Conference of the Parties participating in COP sessions

The WHO FCTC recognizes the need to catalyse and leverage the contributions of external stakeholders, particularly civil society, to achieve the aims of the Convention.

IGOs and regional NGOs whose aims and activities are in conformity with the spirit, purpose and principles of the WHO FCTC may apply for observer status which may be granted by the COP based on the report of the Convention Secretariat and taking into account the 17th and 18th preambular paragraphs of the Convention, as well as Article 5.3 of the Convention (Rules of Procedure of the WHO FCTC, Rule 31.2).23 Receiving observer status to the COP could pave the way for these organizations contributing to the

92 http://bit.ly/FCTCVNR
93 Question 3.2.6.5 of the WHO FCTC reporting instrument for this indicator is represented in WHO FCTC Implementation Database for the quantitative analysing the number of Parties whereby civil society has reported participating in the development and implementation of national tobacco control approaches. (https://untobaccocontrol.org/impldb/indicator-report/?wpdtvar=3.2.6.5.b)
94 https://untobaccocontrol.org/impldb/indicator-report/?wpdtvar=4.8
95 https://www.who.int/fctc/cop/observers_ngo/

discussions on tobacco control and, indirectly, to decision-making.

The number of NGOs that have been accredited observer status at COP8 was 21.[96] Out of these, up to 13 of the NGO observers actually participated – sent delegates – to the latest session of the COP (COP8 in 2018). The number and details of participating NGO observers can be found in the list of participants of the respective COP sessions; in this case COP8.[97]

Financial and technical support from civil society organizations to advance WHO FCTC implementation

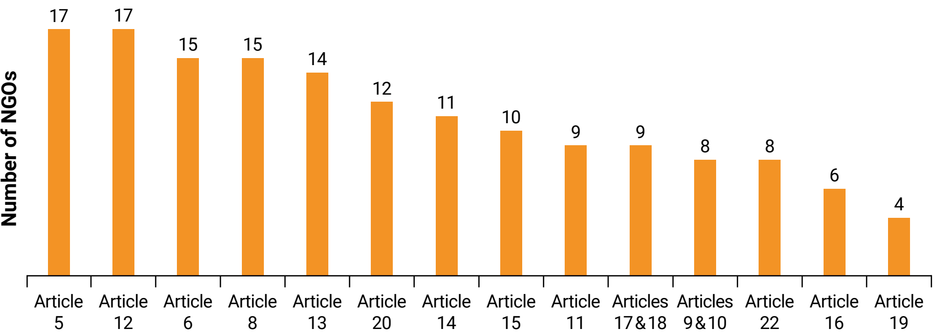
This qualitative indicator is essential to understand and monitor the role of civil society to promote the objectives of the Convention. In the Indicator Compendium for the Global Strategy, in the context of this indicator, "civil society organization" refers to NGO observers to the COP, whose organizational information is available through the biennial (reaccreditation) reports of NGO observers submitted to the COP. These reports are analysed by the Convention Secretariat, and a report is produced with the use of such information for each COP session. The most recent report on NGO contributions to implementation of the WHO FCTC is available in the public domain.[98]

These reports contain a broad range of qualitative information by articles to the Convention. In the reports, NGOs are requested to describe their contributions to the various articles, and this information includes, among others, the types (areas), forms (projects, programmes; technical or financial) and the targets (Parties) of the provision of such support.

The Convention Secretariat's report, based on the analysis of the information submitted by the NGOs as part of the process for their reaccreditation as observer to the COP, describes the level of contribution of NGOs to various articles of the WHO FCTC. Examples of projects of NGO observers in the support of the WHO FCTC implementation can be found in the relevant document prepared for COP8,[99] and similar future documents that will be prepared for each subsequent COP session. The number of NGOs that carried out activities on the various areas, as reported in their 2020 reports,[100] are provided in the figure below.

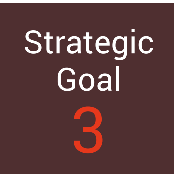
96 Decisions: (1) https://www.who.int/fctc/cop/sessions/cop8/FCTC__COP8(1).pdf?ua=1; (2) https://www.who.int/fctc/cop/sessions/cop8/FCTC__COP8(3).pdf?ua=1
97 https://www.who.int/fctc/cop/sessions/cop8/LOP_Final.pdf?ua=1
98 https://www.who.int/fctc/cop/sessions/cop8/FCTC_COP_8_19-en.pdf?ua=1
99 https://fctc.who.int/who-fctc/governance/conference-of-the-parties/eighth-session-of-the-conference-of-the-parties/main-documents/fctc-cop-8-19-review-of-accreditation-of-observers-to-the-conference-of-the-parties
100 NGOs reports 2020: https://fctc.who.int/who-fctc/governance/observers/nongovernmental-organizations/nongovernmental-organizations-reports

Fig. 32. Number of NGOs that carried out work on various WHO FCTC articles, as reported in 2020



In addition to the reports of NGO observers, it is worth analysing how Parties consider the assistance provided to them by NGOs that are active at national, regional or international levels (this information might overlap in some cases with the reports submitted by the NGO observers). In the reporting instrument, under the section on International Cooperation and Assistance, the Parties also me0ntion, in their responses to some open-ended questions, the contributions received from civil society organizations – see this analysis in the section on International Cooperation (Article 22) above.

In the future, to enable a more complete assessment of progress for this indicator, the reporting form for NGO observers should be completed with a question on the number of Parties to which they provided technical assistance, and the amount of financial support they provided for the implementation of the WHO FCTC at the national, regional and global levels.



Strategic Goal 3: Protecting the integrity and building on the achievements under the WHO FCTC

Indicators within Strategic Goal 3 focus on the effectiveness and the sustainability of WHO FCTC-related activities, while ensuring they are protected from tobacco industry interference.

An Implementation Review Mechanism has been established

This indicator is directly related to Specific Objective 3.1.2 of the Global Strategy, which states: "By 2020, create a peer-led WHO FCTC Implementation Review Mechanism to facilitate addressing gaps and challenges of individual Parties, share lessons learnt and contribute to the implementation of this Strategy."

At the time of collection of the baseline data, an Implementation Review Mechanism (IRM) has not yet been established.

As per decision FCTC/COP8(16),[101] an IRM pilot project exercise is currently being carried out among 12 volunteer Parties; the outcomes of this pilot exercise will be reported to COP9. The report, as required in the COP8 decision, shall include a costed strategy and the proposed terms of reference of the future IRM.

101 https://www.who.int/fctc/cop/sessions/cop8/FCTC__COP8(16).pdf?ua=1

Workplans and budget of the Convention Secretariat aligned with the Global Strategy

This indicator ensures that during the process of developing the successive workplans and budget of the Convention Secretariat for consideration by the COP, an alignment should be made with the Global Strategy, both the for the number of items and the adopted budget.

Such alignment will be ensured by the Convention Secretariat in the successive workplans and budgets, including the one that will be submitted to COP9.

An indicator that measures the gap in global funding for WHO FCTC implementation to be developed

The successive Global Progress Reports continuously underline that insufficient funding is one of the major constraints and barriers to implementation of the WHO FCTC.

In accordance with Article 26 of the Convention, "each Party shall provide financial support in respect of its national activities intended to achieve the objective of the Convention, in accordance with its national plans, priorities and programmes". Parties that have developed, implemented, and periodically updated and reviewed comprehensive national tobacco control strategies, plans and programmes in accordance with the Convention, as part of their fulfilment of their obligations with Article 5 of the Convention, should also have a budget associated with it. Such information on budgets – and subsequently on any possible gap – is not collected via the reporting instrument of the WHO FCTC. Additional information gathering is therefore needed to ensure that such information is available to the Parties to the Convention and, specifically, to support discussions and decision-making at the COPs.

International resource mobilization is a critical component of the Global Strategy which, in the context of the Convention Secretariat's fundraising strategy, has already been addressed by the COP.[102] Measuring the global funding gap is important in supporting the mobilization of resources for tobacco control globally.

To this end, the Framework Convention Alliance for Tobacco Control produced a report in 2018 that looked at the adequacy of funding for tobacco control measures.[103] In the report, a model to estimate the funding gap for WHO FCTC implementation was created using publicly available data, including the WHO NCD costing tool, the WHO Health Expenditure Database and other relevant sources. Costs of tobacco control measures were calculated by taking into account demand-reduction measures required under the WHO FCTC (the MPOWER measures), with special regard to those included in Article 6 (Price and tax measures to reduce the demand for tobacco), Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling), Article 13 (Tobacco advertising, promotion and sponsorship), Article 14 (Demand reduction measures concerning cessation of tobacco products) and Article 20 (Research, surveillance and exchange of information).

The gap was measured by comparing available domestic and international funding to the estimated cost of implementation as indicated above. The report's calculations were based on a 16-country sample, capturing 30% of the world population, and scaled up to the global population to produce an estimated global funding gap. In 2018, the estimated global tobacco control funding gap stood at US$ 27.4 billion, considering both domestic and international funding.

102 Decision FCTC/COP7(25): Convention Secretariat's fundraising efforts and collaborative work. https://www.who.int/fctc/cop/cop7/FCTC_COP7_25_EN.pdf?ua=1
103 Framework Convention Alliance for Tobacco Control: Financing Gap to Implement Demand Reducing Tobacco Control Strategies in WHO FCTC Countries (https://www.fctc.org/wp-content/uploads/2019/02/FCTC-Funding-Gap-Report_9_18.pdf)

The above-mentioned study could be a starting point for the development of an indicator to measure such funding gaps for the entire WHO FCTC, as required under the Global Strategy. As an agreed indicator to measure this funding gap does not exist, the process of developing it should start.

Number of Parties that reported implementation of any measures relating to Article 5.3

Strategic Objective 3.2 supports and encourages Parties in their efforts to remove barriers to implementation of country-level tobacco control measures. Many countries have repeatedly identified interference by the tobacco industry to undermine or subvert national tobacco control efforts as a major barrier to implementing the Convention, including in the 2021 Global Progress Report. Article 5.3 states that Parties shall act to protect public health policies from commercial and other vested interests of the tobacco industry.

Implementation of Article 5.3 of the Convention is covered by the core questionnaire of the WHO FCTC, as well as in the additional questions of the reporting instrument of the WHO FCTC. Information on it is therefore provided regularly (every second year) by all reporting Parties, as part of their implementation reports, and analysed through the Global Progress Reports.

In the 2018 reporting cycle, 131 Parties reported that they have put in place measures under Article 5.3 of the Convention. In the 2020 reporting cycle, the number was 133. This does not mean, however, that this high number of Parties have addressed implementation of Article 5.3 in a comprehensive manner, for example, by utilizing all recommendations of the Guidelines for Implementation of Article 5.3 in their work and policies.

Number of Parties having an operational national multisectoral coordinating mechanism for tobacco control

Multisectoral coordination is central to the implementation of the WHO FCTC and to the SDGs, as WHO FCTC implementation is now part of that global agenda. On one hand, the requirements of the WHO FCTC fall within the portfolio of various government departments and, on the other hand, the range of determinants impacting people’s health, such as the social, environmental and commercial determinants, depend at least in part on policies emanating from non-health departments. As also highlighted in the Indicator Compendium for the Global Strategy, Parties could most effectively work towards the implementation of the WHO FCTC by engaging sectors beyond health and adopting a whole-of-government approach.

Based on data submitted in the 2018 reporting cycle, 134 Parties reported to have established or reinforced and financed a national coordinating mechanism for tobacco control. In the 2020 reporting cycle, the number was 131. An important assumption made here is that all reported national coordinating mechanisms are multisectoral and operational, information that is not always evident from the implementation reports. Overall, it could be admitted that more attention will be needed in a great number of Parties still not having a national coordinating mechanism to focus on strengthening their intersectoral cooperation by complying with Article 5.2(a) of the Convention.

Number of Parties that reported tobacco industry interference as the main barrier to WHO FCTC implementation

As described in the successive global progress reports, tobacco industry interference is the most frequently reported barrier to WHO FCTC implementation. To help Parties in implementing Article 5.3 of the Convention and Specific Objective 3.2.4 of the Global Strategy, the Convention Secretariat has established the WHO FCTC Knowledge Hub for Article 5.3, and has also developed, with the contribution from the Knowledge Hub, a series of tools and

materials to counter the tobacco industry's tactics. The COP also regularly addresses and takes decisions that could help Parties in their implementation of Article 5.3.

The information that supports monitoring of this indicator can be extracted from the responses of Parties to the section on Priorities and Comments of the reporting instrument. As this is an open-ended question, an additional search by key words was needed in reviewing the responses.

Based on data received in the 2018 reporting cycle, 39 Parties reported that they encountered and consider tobacco industry interference a constraint/barrier in implementing the Convention.

In the current Global Progress Report based on 2020 data, 46 Parties reported tobacco industry interference as a main barrier; additionally, more than 10 Parties referred to industries producing novel and emerging tobacco products and nicotine products, as industries that try to interfere with policy-making. Please, refer to Section 6 of the Global Progress Report for further details.

Number of Parties that fully fund their costed national tobacco control plans or strategies

This indicator relates to the indicator "Number of Parties that have submitted a costed national tobacco control plan as part of their regular WHO FCTC reports" under Strategic Objective 1.1 of the Global Strategy.

The development of costed national tobacco plans or strategies could be recognized as a significant contributing factor to the successful implementation of the WHO FCTC and the Global Strategy. In the spirit of Article 26 of the Convention and in accordance with strategic Objective 1.1 of the Global Strategy, Parties are expected to have costed national tobacco control plans. However, the existence of a costed plan does not infer that funds are indeed available for implementation, hence the necessity of this indicator that allows for monitoring the fact of whether or not Parties fully fund their tobacco control plans or strategies.[104]

The Indicator Compendium of the Global Strategy identifies WHO data as a source where information could be found on whether a particular country has declared a budget allocated for tobacco control. Again, the indicator used by WHO (Government's expenditures on tobacco control) does not fully correspond to the one in the Global Strategy, as allocation of funding for tobacco control does not directly mean that these resources have been used to support actions related to a plan or strategy. Overall, in the WHO database, 34 Parties in 2018 have allocated a budget for tobacco control.

The Indicator Compendium points to some data that are collected through the WHO FCTC reporting instrument as data that could help our understanding of the existence of funded national plans or strategies. Having established a focal point for tobacco control and/or having a comprehensive multinational tobacco programme (reported under the section on General Obligations of the WHO FCTC) might mean that the government devoted resources for sustaining the position of a focal point or for implementation of the tobacco control programme. On these bases, 121 Parties reported, in the 2018 reporting cycle, the development and implementation of comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the Convention, while 151 Parties reported having established or reinforced and financed a focal point for tobacco control. In the 2020 reporting cycle, the respective numbers were 128 and 153.

104 Source: Tobacco Control Country Profiles compiled by WHO: https://www.who.int/tobacco/surveillance/policy/country_profile/.

Key observations and lessons learnt

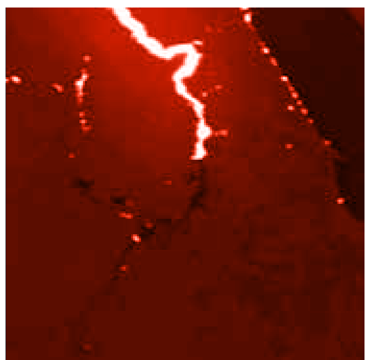
The first attempt to establish baseline data for the Global Strategy indicators have now been completed by using the Global Strategy Indicator Compendium as a guide.

The information presented in this section was collected from various sources. For a limited number of indicators, where the information could be extracted from the WHO FCTC reporting instrument, Parties' reports submitted in subsequent years were used as a primary source. Other sources included various information available with and collected by the Convention Secretariat, the organizations that are observers to the COP, the WHO FCTC Knowledge Hubs, WHO and other United Nations entities.

On some occasions, data collection still posed various challenges: data that was used to create this status report varied greatly in terms of their availability, accessibility, completeness and accuracy. For example, data were not available at all for particular indicators, or with the necessary level of detail, in which cases proxies were used. However, in the future, arrangements should be made to guarantee the accurate collection of such data. In other cases, especially data from international organizations that do not provide regular reports on their contributions to the implementation of the WHO FCTC, information was difficult to access. Further, on some occasions, data were not complete. For example, very few Parties submitted information through the additional questions on the use of implementation guidelines, which impedes the correct analysis of qualitative indicators, together with limited details provided on qualitative questions on the core questionnaire. Also, on other occasions, the successive data provided in the WHO FCTC reporting instrument lacked accuracy or consistency across the successive reporting cycles.

Monitoring the evolution of the indicators of the Global Strategy will certainly benefit from further development. On one hand, there is one indicator (on the global funding gap) that is still to be defined. In other cases, the proxy indicators that were still utilized – in the absence of other data – should be replaced with the ones referred to in the Global Strategy. The opportunity that arises with the further development of the WHO FCTC reporting instrument will be capitalized upon to evolve the process, improving the ability to gather the most accurate and comparable data to evaluate the implementation of the Global Strategy.

9 Conclusions



1 The 2021 *Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* is the ninth in the series of Global Progress Reports, and it is the most recently updated report of progress and achievements of the Parties in the implementation of the Convention. It also reports progress in priority areas established by the COP in the *Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025*. The Convention Secretariat has now added a further analysis of some of the prioritized articles, allowing for a more comprehensive picture.

2 Regarding implementation, two of the articles of the WHO FCTC prioritized in the Global Strategy (Articles 8 and 11) demonstrated the strongest implementation in 2020, while other priority articles (Articles 5, 6 and, especially, 13) remain somewhat less implemented. The COVID-19 pandemic and any post-COVID-19 recovery plan envisioned by the Parties provide a good opportunity to strengthen implementation of the WHO FCTC in general, and particularly Article 6 – as tobacco tax increases will result in higher revenues for the governments and could result in higher spending also for tobacco control – and Article 14, as the pandemic is an opportune time for smokers to quit tobacco use and health systems to assist them to do so.

3 With respect to global tobacco use prevalence, again, we have seen another decrease of the prevalence of current tobacco use in adults, since the issuance of the previous Global Progress Report. Unfortunately, in line with the observation made in the 2018 report, the escalating spread of novel and emerging tobacco products and nicotine products continues to be an area of concern. The most prevalent type of these products reported by the Parties are ENDS (available in 117 of 181 Parties), followed by ENNDS (63 Parties) and HTPs (in 62 Parties).

4 Some new implementation patterns became visible or more pronounced in this biennial report. A few examples of progress include an increasing number of Parties that announced the goal to achieve tobacco-free or smoke-free societies, addressing general obligations on a comprehensive manner, more Parties introducing plain packaging, and extending smoke-free environments to outdoor areas and cars where children are present.

5 Many Parties have received assistance in their implementation work from an increasing range of entities, including the Convention Secretariat, WHO, UNDP and the WHO FCTC Knowledge Hubs, which have increased their assistance work in line with Specific Objective 1.2.2 of the Global Strategy. It has also to be noted that in this reporting cycle, the Knowledge Hubs were given a more important role in the analysis of data received from the Parties in their specific work areas. Such contributions from most of the Knowledge Hubs have not only supported the analytical work in the Convention Secretariat, but also provide the opportunity for the Knowledge Hubs themselves to utilize the data they have analysed in their assistance work at the country, regional and global levels.

6 To support the recent downward trend in the global tobacco production reported by the United Nations Industrial Development Organization (UNIDO), which was more pronounced during the COVID-19 pandemic, Parties now have the opportunity to accelerate the implementation of Article 17 of the Convention. The progress in promoting viable alternatives to tobacco growers, workers and individual sellers has stagnated at a low level, despite the fact that, for example, still almost one half of Parties reported having tobacco growing in their jurisdiction. As a positive development, innovative measures to reduce the environmental consequences of tobacco packaging and filters were introduced in Europe, demonstrating a new opportunity in the implementation of Article 18. In July 2020, the Convention Secretariat launched a new Knowledge Hub to focus on Articles 17 and 18, with the Fundação Oswaldo Cruz in Rio de Janeiro, Brazil, taking up the role as the Knowledge Hub, and it is expected to support Parties in the implementation of these articles in the years to come.

7 Based on the feedback received from the Parties on the reporting process itself, it has become evident that the time has come for the next refreshment of the reporting instrument, of the reporting process and of the analysis of data. This also has been recommended by a 2019 external audit that focused on various aspects of the operation of the Convention Secretariat. In order to further improve them, a quality-assurance framework will be crafted and integrated in the reporting system and the reporting process.

8 Regarding the monitoring of the implementation of the Global Strategy, and based on initial experience, it would be advantageous to reflect in the existing WHO FCTC reporting instrument those Global Strategy indicators that concern Parties' implementation work, while other indicators will still require more attention and meticulous work to obtain the relevant information. Moreover, an indicator that measures the gap in global funding for WHO FCTC implementation will need to be developed.

9 Implementation gaps and challenges continue to be reported. The lack of financial resources available for Parties' implementation work has repeatedly been reported as a critical item, and, in the wake of the COVID-19 pandemic, this not only has not changed – it has worsened. Post-COVID-19 economic recovery packages should include measures that would also benefit tobacco control and provide financial resources to

governments, such as tobacco tax increases. Apart from the financial needs, the most frequently mentioned implementation barrier has also remained interference by the tobacco industry, including, increasingly, interference by the industries producing novel and emerging tobacco products and nicotine products – remembering that in most instances they are the same companies.

10 Efforts have been made to further raise awareness about the Convention internationally and to make it part of the global health policy narrative. The integration of the Convention with global NCD and tuberculosis control efforts has been strengthened, and its implementation in compliance with SDG Target 3.a has also been promoted. The Convention Secretariat's strong presence in the work of the United Nations Interagency Task Force on NCDs has contributed to the inclusion, in the agendas of organizations that are members of the Task Force, of the measures under the Convention that are relevant to the work of the respective agencies, even though there is space for further improvement in this area. This corresponds to Strategic Goal 2 of the Global Strategy, and it is critical to increasing the stakeholder base of the Convention ensuring that implementation of the Convention is truly intersectoral, and is viewed as an integral part of good governance in every country and organization.

Annex 1.
Progress in the implementation of the WHO FCTC in 2018–2020, as of 22 May 2020

Article/indicator name	2018*		2020**	
Article 5. General obligations	**Yes**		**Yes**	
	%	**Number (n)/181**	**%**	**Number (n)/181**
Comprehensive national tobacco control strategy	67	121	71	128
Focal point for tobacco control	83	151	85	153
Tobacco control unit	64	115	66	120
National coordinating mechanism for tobacco control	74	134	72	131
Article 5.3. Protection of public health policies from vested interests of the tobacco industry	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Measures to prevent tobacco industry interference	72	131	73	133
Public access to a wide range of information on the tobacco industry	38	68	39	71
Article 6. Price and tax measures to reduce the demand for tobacco	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Information on tobacco-related mortality in the population	44	80	50	91
Information on the economic burden of tobacco use in the population	34	61	40	72
Only specific tax levied	31	57	31	57
Only ad valorem tax levied	17	30	17	31
Combination of specific and ad valorem taxes levied	50	91	52	95
Tobacco tax earmarking	20	36	19	34
Tax policies to reduce tobacco consumption	81	146	85	153
Tobacco sales to international travellers prohibited/restricted	50	91	49	88
Tobacco imports by international travellers prohibited/restricted	64	115	64	115
Article 8. Protection from exposure to tobacco smoke	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Availability of data on exposure to tobacco smoke	85	154	84	152
Tobacco smoking banned in all public places	92	166	94	171

National law providing for the ban	84	152			89	161		
Subnational law(s) providing for the ban	24	44			27	48		
Administrative and executive orders providing for the ban	46	83			46	84		
Voluntary agreements providing for the ban	20	36			20	37		
Mechanism/ infrastructure for enforcement	80	145			82	149		
Article 8. Comprehensiveness of the smoking ban	**Complete**		**Partial**		**Complete**		**Partial**	
	%	**n/181**	**%**	**n/181**	**%**	**n/181**	**%**	**n/181**
In government buildings	75	135	15	27	77	139	16	29
In health-care facilities	79	143	10	19	82	148	11	20
In educational facilities	81	147	8	15	83	151	9	16
In universities	69	124	18	33	70	126	20	37
In private workplaces	52	95	31	57	51	93	35	64
In aeroplanes	89	161	3	6	91	165	3	5
In trains	62	112	10	19	66	119	9	17
In ferries	58	105	17	31	60	108	18	32
In ground public transport	81	147	9	16	83	151	10	18
In motor vehicles used for work	75	136	16	29	77	139	16	29
In private vehicles	15	28	22	40	17	30	20	37
In cultural facilities	69	125	20	37	72	131	19	35
In shopping malls	62	113	24	44	65	117	26	47
In pubs and bars	45	81	34	61	46	84	34	62
In nightclubs	44	79	30	54	45	82	32	58
In restaurants	51	92	37	67	54	97	37	67
Article 9. Regulation of the contents of tobacco products	**Yes**				**Yes**			
	%	**n/181**			**%**	**n/181**		
Testing and measuring the contents	46	84			48	87		
Testing and measuring the emissions	46	84			49	88		
Regulating the contents	55	100			57	104		
Regulating the emissions	48	86			49	88		
Article 10. Regulation of tobacco product disclosures	**Yes**				**Yes**			
	%	**n/181**			**%**	**n/181**		
Requiring disclosure on the contents to government authorities	67	122			69	124		
Requiring disclosure on the emissions to government authorities	59	106			61	110		
Requiring public disclosure on the contents	57	104			56	102		
Requiring public disclosure on the emissions	47	85			47	85		

Article 11. Packaging and labelling of tobacco products	Yes		Yes	
	%	n/181***	%	n/181***
No advertising or promotion on packaging	75	136	80	144
Misleading descriptors banned	81	147	83	150
Health warnings required	89	161	90	163
Health warnings approved by the competent national authority	84	152	86	155
Rotated health warnings	76	138	78	141
Large, clear, visible and legible health warnings required	87	157	89	161
law mandates, as a minimum, a style, size and colour of font[a]	90	142/157	91	146/161
Health warnings occupying no less than 30% required	78	141	82	148
Health warnings occupying 50% or more required	59	107	65	117
Health warnings in the form of pictures or pictograms required	65	118	70	126
copyright to pictures owned by the governmentb	48	57/118	48	61/126
granting of license for the use of health warnings[b]	53	62/118	50	63/126
Information on constituents required on packages	54	98	52	94
Information on emissions required on packages	45	81	40	73
Warning required in the principal language(s) of the country	84	152	85	154

Article 12. Education, communication, training and public awareness	Yes		Yes	
	%	n/181***	%	n/181***
Implemented educational and public awareness programmes	90	162	92	166
targeted to adults or the general public[c]	96	155/162	94	156/166
targeted to children and youth[c]	99	160/162	96	159/166
targeted to men[c]	76	123/162	77	127/166
targeted to women[c]	77	124/162	78	129/166
targeted to pregnant women[c]	73	118/162	73	122/166
targeted to ethnic groups[c]	30	49/162	29	48/166

reflecting age differences[c]	92	149/162	92	152/166
reflecting gender differences[c]	80	130/162	80	133/166
reflecting educational background differences[c]	62	101/162	64	106/166
reflecting cultural differences[c]	44	71/162	43	71/166
reflecting socioeconomic differences[c]	52	84/162	52	87/166
covering the health risks of tobacco consumption[c]	99	161/162	99	165/166
covering the risks of exposure to tobacco smoke[c]	98	158/162	98	162/166
covering the benefits of cessation of tobacco use[c]	96	155/162	93	155/166
covering economic consequences of tobacco production[c]	49	79/162	49	81/166
covering economic consequences of tobacco consumption[c]	79	128/162	80	132/166
covering environmental consequences of tobacco production[c]	48	78/162	49	82/166
covering environmental consequences of tobacco consumption[c]	63	102/162	64	107/166
Public agencies involved in programmes/ strategies for tobacco control[c]	97	157/162	96	159/166
NGOs involved in programmes/ strategies for tobacco control[c]	90	146/162	89	148/166
Private organizations involved in programmes/ strategies for tobacco control[c]	64	103/162	65	108/166
Programmes guided by research[c]	75	122/162	78	129/166
Training programmes addressed to health workers[c]	91	148/162	92	153/166
Training programmes addressed to community workers[c]	67	109/162	67	112/166
Training programmes addressed to social workers[c]	59	95/162	58	97/166
Training programmes addressed to media professionals[c]	63	102/162	63	105/166

Training programmes addressed to educators[c]	83	134/162	81	134/166
Training programmes addressed to decision-makers[c]	70	114/162	69	115/166
Training programmes addressed to administrators[c]	59	96/162	59	98/166
Article 13. Tobacco advertising, promotion and sponsorship	**Yes**		**Yes**	
	%	**n/181*** **	**%**	**n/181*** **
Comprehensive ban on all tobacco advertising, promotion and sponsorship instituted	73	133	75	136
Ban on display of tobacco products at points of sales	43	78	49	89
Ban covering the domestic Internet	49	88	51	93
Ban covering the global Internet	18	33	21	38
Ban covering brand stretching and/or sharing	46	84	49	89
Ban covering product placement	64	115	69	124
Ban covering the depiction/ use of tobacco in entertainment media	55	99	57	104
Ban covering tobacco sponsorship of international events/ activities	63	114	65	117
Ban covering corporate social responsibility	52	95	54	97
Ban covering cross-border advertising originating from the country	44	79	47	85
Ban covering cross-border advertising entering the country	49	89	51	92
precluded by constitution from undertaking a comprehensive ban[e]	11	5/47	7	3/45
restriction on all tobacco advertising, promotion and sponsorship[e]	34	16/47	36	16/45
restriction on cross-border advertising originating from the country[e]	15	7/47	18	8/45
prohibition of advertising by false and misleading means[e]	36	17/47	36	16/45
requiring the use of warnings to accompany all advertising[e]	34	16/47	31	14/45

restriction on the use of direct or indirect incentives[e]	40	19/47	42	19/45
requiring disclosure of advertising expenditures[e]	11	5/47	4	2/45
restriction on advertising, promotion and sponsorship on radio[e]	64	30/47	64	29/45
restriction on advertising, promotion and sponsorship on television[e]	62	29/47	60	27/45
restriction on advertising, promotion and sponsorship in print media[e]	49	23/47	47	21/45
restriction on advertising, promotion and sponsorship on the domestic Internet[e]	32	15/47	36	16/45
restriction on advertising, promotion and sponsorship advertising on the global Internet	21	10/47	22	10/45
restriction on sponsorship of international events and activities[e]	34	16/47	38	17/45
restriction on tobacco sponsorship of participants therein[e]	28	13/47	33	15/45
Cooperation on the elimination of cross-border advertising	31	56	30	54
Penalties imposed for cross-border advertising	36	66	41	74

Article 14. Demand reduction measures concerning tobacco dependence and cessation	**Yes**		**Yes**	
	%	**n/181*****	**%**	**n/181*****
Evidence-based comprehensive and integrated guidelines	61	111	64	116
Media campaigns on the importance of quitting	72	130	73	132
Programmes to promote cessation designed for girls and young women	33	59	31	56
Programmes to promote cessation designed for women	29	53	30	55

Programmes to promote cessation designed for pregnant women	38	68	39	70
Telephone quit lines	40	72	39	71
Local events to promote cessation	81	146	81	147
Programmes to promote cessation in educational institutions	57	104	59	106
Programmes to promote cessation in health-care facilities	79	143	78	142
Programmes to promote cessation in workplaces	54	98	54	98
Programmes to promote cessation in sporting environments	30	54	31	56
Diagnosis and treatment included in national tobacco control programmes	69	124	70	126
Diagnosis and treatment included in national health programmes	69	125	68	123
Diagnosis and treatment included in national educational programmes	40	72	38	69
Diagnosis and treatment included in the health-care system	69	125	69	125
in primary health care[f]	82	102/125	82	102/125
in secondary and tertiary health care[f]	62	78/125	66	83/125
in specialist health-care systems[f]	47	59/125	47	59/125
in specialized centres for cessation[f]	58	72/125	58	73/125
in rehabilitation centres[f]	28	35/125	30	37/125
physicians involved in programmes and counselling[f]	90	112/125	90	112/125
dentists involved in programmes and counselling[f]	53	66/125	56	70/125
family doctors involved in programmes and counselling[f]	67	84/125	67	84/125
practitioners of traditional medicine involved in programmes and counselling[f]	21	26/125	22	27/125
nurses involved in programmes and counselling[f]	81	101/125	81	101/125

midwives involved in programmes and counselling[f]	42	53/125			42	52/125		
pharmacists involved in programmes and counselling[f]	50	63/125			47	59/125		
community workers involved in programmes and counselling[f]	39	49/125			38	48/125		
social workers involved in programmes and counselling[f]	50	63/125			52	65/125		
Training on tobacco dependence treatment in the curricula of medical schools	55	99			56	101		
Training on tobacco dependence treatment in the curricula of dentist schools	27	49			30	54		
Training on tobacco dependence treatment in the curricula of nursing schools	40	72			39	71		
Training on tobacco dependence treatment in the curricula of pharmacy schools	24	44			27	48		
Accessibility and/or affordability of pharmaceutical products facilitated	60	109			61	111		
nicotine replacement therapy available[g]	92	100/109			90	100/111		
bupropion available[g]	67	73/109			64	71/111		
varenicline available[g]	66	72/109			64	71/111		
Article 14.2(b). and (c). Services and treatment costs provided covered by public funding or reimbursement schemes	**Fully**		**Partially**		**Fully**		**Partially**	
	%	**n/181*****	**%**	**n/181*****	**%**	**n/181*****	**%**	**n/181*****
Programmes in primary health care[f]	46	57/125	36	45/125	47	59/125	36	45/125
Programmes in secondary and tertiary health care[f]	34	43/125	32	40/125	37	46/125	33	41/125
Programmes in specialist health-care systems[f]	18	22/125	26	33/125	22	28/125	24	30/125
Programmes in specialized centres for cessation[f]	29	36/125	28	35/125	27	34/125	29	36/125
Programmes in rehabilitation centres[f]	11	14/125	18	22/125	16	20/125	20	25/125
Nicotine replacement therapy[g]	27	27/100	26	26/100	26	26/100	27	27/100
Buproprion[g]	23	17/73	32	23/73	24	17/71	32	23/71
Varenicline[g]	18	13/72	32	23/72	18	13/71	37	26/71

Article 15. Illicit trade in tobacco products	Yes		Yes	
	%	n/181	%	n/181
Information on the percentage of illicit tobacco products on the national market	18	32	21	38
Marking that assists in determining the origin of product required	65	118	68	123
Marking that assists in identifying legally sold products required	68	123	68	123
Statement on destination required on all packages	39	70	41	74
Tracking and tracing regime developed	36	65	43	77
Legible marking required	64	116	67	121
Monitoring of cross-border trade required	52	95	54	97
Information exchange facilitated	62	112	65	118
Legislation against illicit trade enacted or strengthened	73	132	76	137
Requiring that confiscated manufacturing equipment be destroyed	70	127	73	132
Measures to monitor, document and control the storage and distribution	67	122	69	124
Confiscation of proceeds derived from illicit trade enabled	70	126	73	132
Cooperation to eliminate illicit trade promoted	65	118	68	123
Licensing/other actions to control production and distribution required	69	124	71	128

Article 16. Sales to and by minors	Yes		Yes	
	%	n/181***	%	n/181***
Sales of tobacco products to minors prohibited	87	157	90	163
Clear and prominent indicator required	67	122	69	124
Required that sellers request for evidence of having reached full legal age	66	120	68	123
Ban of sale of tobacco in any directly accessible manner	55	100	59	106
Manufacture and sale of any objects in the form of tobacco products prohibited	60	109	63	114

Sale of tobacco products from vending machines prohibited	61	111	62	113
tobacco vending machines not accessible to minors[i]	38	26/68	42	28/66
Distribution of free tobacco products to the public prohibited	78	142	81	147
Distribution of free tobacco products to minors prohibited	85	153	86	156
Sale of cigarettes individually or in small packets prohibited	67	122	68	123
Penalties against sellers provided	78	141	81	146
Sale of tobacco products by minors prohibited	71	129	76	137
Article 17. Provision of support for economically viable alternative activities	**Yes**		**Yes**	
	%	**n/181*** **	**%**	**n/181*** **
Tobacco growing in jurisdiction	46	84	48	87
viable and sustainable alternatives for tobacco growers promoted[j]	29	24/84	28	24/87
viable and sustainable alternatives for tobacco workers promoted[j]	7	6/84	8	7/87
viable and sustainable alternatives for tobacco sellers promoted[j]	5	4/84	5	4/87
Article 18. Protection of the environment and the health of persons	**Yes**		**Yes**	
	%	**n/181*** **	**%**	**n/181*** **
Measures considering the protection of environment in respect to tobacco cultivation within territory[j]	32	27/84	33	29/87
Measures considering the health of persons in respect to tobacco cultivation within territory[j]	33	28/84	34	30/87
Measures considering the protection of the environment in respect to tobacco manufacturing within territory[j]	37	31/84	38	33/87
Measures considering the health of persons in respect to tobacco manufacturing within territory[j]	36	30/84	36	31/87

Article 19. Liability	Yes		Yes	
	%	n/181	%	n/181
Measures on criminal liability in the tobacco control legislation	52	95	58	105
Separate liability provisions on tobacco control outside of the tobacco control legislation	29	53	33	60
Civil liability measures that are specific to tobacco control	31	56	34	62
General civil liability measures that could apply to tobacco control	42	76	42	76
Civil or criminal liability provisions that provide for compensation	23	41	22	40
Criminal and/or civil liability action launched by any person	15	28	15	27
Actions taken against the tobacco industry on reimbursement of costs related to tobacco use	8	14	9	17

Article 20. Research, surveillance and exchange of information	Yes		Yes	
	%	n/181	%	n/181
Research on determinants of tobacco consumption promoted	68	123	71	129
Research on consequences of tobacco consumption promoted	67	121	66	119
Research on social and economic indicators promoted	64	116	64	116
Research on tobacco use among women, with special regard to pregnant women, promoted	48	86	46	83
Research on the determinants and consequences of exposure to tobacco smoke promoted	59	106	59	106
Research on identification of effective programmes for tobacco dependence treatment promoted	47	85	46	84
Research on identification of alternative livelihoods promoted	14	25	15	27
Training and support for those engaged in tobacco control activities	61	111	63	114
National system for surveillance of patterns of tobacco consumption	71	129	76	137

National system for surveillance of determinants of tobacco consumption	52	94	57	104
National system for surveillance of consequences of tobacco consumption	43	78	48	86
National system for surveillance on social, economic and health indicators	50	90	53	96
National system for surveillance of exposure to tobacco smoke	57	104	64	116
Regional and global exchange of national scientific, technical and legal information	63	114	67	122
Regional and global exchange of national information on tobacco industry practices	39	71	41	75
Regional and global exchange of national information on cultivation of tobacco	24	43	24	44
Updated database of laws and regulations on tobacco control	68	123	71	129
Updated database of information about the enforcement of laws	50	91	52	94
Updated database of the pertinent jurisprudence	25	46	25	45

Articles 22. and 26. **International cooperation and assistance**	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Assistance on transfer of skills and technology provided	39	70	41	75
Expertise for national tobacco control strategies, plans and programmes provided	38	69	40	73
Assistance on training and sensitisation of personnel in accordance with Article 12 provided	32	58	34	61
Assistance on equipment, supplies, logistics provided	25	45	26	47
Assistance on identification of methods for tobacco control, including treatment of nicotine addiction, provided	20	36	18	33
Assistance on research on affordability of nicotine addiction treatment provided	10	18	10	18

Assistance on transfer of skills and technology received	65	118	66	119
Expertise for national tobacco control strategies, plans and programmes received	64	115	66	120
Assistance on training and sensitization of personnel in accordance with Article 12 received	48	86	50	90
Assistance on equipment, supplies, logistics received	45	81	45	81
Assistance on identification of methods for tobacco control, including treatment of nicotine addiction received	31	56	32	58
Assistance on research on affordability of nicotine addiction treatment received	18	32	17	31
Regional and intergovernmental organizations and development institutions encouraged to provide financial assistance for developing country Parties	22	39	22	40
Specific gaps between available resources and needs assessed for the implementation of WHO FCTC	60	109	60	109

Novel and emerging tobacco products and nicotine products	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Smokeless tobacco available on national market	66	119	70	126
Adopted and implemented policy or regulation specific to smokeless tobacco	53	96	56	102
Water-pipe tobacco available on national market	69	125	74	134
Adopted and implemented policy or regulation specific to water-pipe tobacco	52	94	55	99
ENDS (ENDS/ENNDS in 2018) available on national market	57	103	65	117
Adopted and implemented policy or regulation specific to ENDS (ENDS/ENNDS in 2018)	45	82	55	99
ENNDS available on national market (new in 2020)			35	63

Adopted and implemented policy or regulation specific to ENNDS (new in 2020)			28	50
Heated tobacco products (HTPs) available on national market (new in 2020)			34	62
Adopted and implemented policy or regulation specific to HTPs (new in 2020)			30	55
Use of guidelines (voluntary questions)	**Yes**		**Yes**	
	%	**n/181**	**%**	**n/181**
Guidelines for Article 5.3	68	123	71	129
Guidelines for Article 6	57	104	61	110
Guidelines for Article 8	70	127	73	132
Guidelines for Articles 9 and 10, used for art. 9	51	92	52	95
Guidelines for Articles 9 and 10, used for art. 10	50	90	51	92
Guidelines for Article 11	67	121	69	124
Guidelines for Article 12	66	119	67	122
Guidelines for Article 13	60	109	65	118
Guidelines for Article 14	57	104	59	106
Guidelines for Article 17 and 18, used for Article 17 (among tobacco-growers)	24	20/84	26	23/87
Guidelines for Articles 17 and 18, used for Article 18 (among tobacco-growers)	18	15/84	28	17/87

*Among all 181 Parties, unless otherwise stated, 152 Parties formally submitted their questionnaire prior to opening of the 2020 reporting cycle. **Among all 181 Parties, unless otherwise stated, 139 Parties formally submitted their questionnaire by 25 April 2020. *** If the calculation is not among all Parties, the respective denominator is provided. For details on the respective subgroup analysis, see the name of the indicator and the footnote.

Indicators in ***italics and bold*** under Articles 8, 11 and 13 constitute time-bound measures.

The conditional questions in the questionnaire are marked with increased indentation and superscript letters from a to i, and are calculated as follows: a The denominator is the number of Parties that answer Yes to C256: large, clear, visible and legible health warnings required. b The denominator is the number of Parties that answer Yes to C2510: pictorial health warnings. c The denominator is the number of Parties that answer Yes to C261: implementing educational and public awareness programmes. e The denominator is the number of Parties that answer No to C271: comprehensive ban on all tobacco advertising, promotion and sponsorship. f The denominator is the number of Parties that answer Yes to C285: including diagnosis and treatment in the health-care system. g The denominator is the number of Parties that answer Yes to C2810: facilitating accessibility and affordability of pharmaceutical products and that have the respective product category legally available in the jurisdiction, indicated in C2812. h The denominator is the number of Parties that answer No to C326: prohibition of sale of tobacco products from vending machines. The questions marked with superscript letter j are not conditional as such, but Articles 17 and 18 concern mainly the Parties that have tobacco growing in their jurisdiction. Therefore, for these questions, the denominator is the number of Parties that answer Yes to B71: tobacco growing in your jurisdiction.

Annex 2. Tobacco use prevalence reported by Parties

Fig. A2.1. Adult smoking and smokeless tobacco use prevalence. For definitions and additional information, see the bottom of the table

	Current tobacco smoking			Current smokeless tobacco use						
	Reported prevalence (%)			Reported prevalence (%)			Age range		Year	Survey/source (full survey and source names appear at the end of the figure)
Party	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**From**	**To**		
Afghanistan**	14.2	2.6	8.6	33.7	3.7	19.3	18	69	2018	STEPS
Albania										
Algeria**	32.2	0.4	16.5	17.3	0.4	8.9	18	69	2017	STEPS
Angola**	10.0	2.6	6.1	3.0	2.0	5.0	15	65	2013/14	CardioBengo -survey/ STEPS
Antigua and Barwbuda										
Armenia	51.5	1.8	27.9				18	69	2016	STEPS
Australia	18.3	12.1	15.1				18	100	2017/18	Australian Bureau of Statistics National Health Survey
Austria	30.2	24.0	27.0	2.7	0.4	1.6	15	99	2015	General Population Survey on substance use
Azerbaijan	31.9		15.3	0.2		0.1	15 (*18)	100 (*69)	2018 (*2017)	Statistical Yearbook of Azerbaijan 2019 (*STEPS)
Bahamas	26.9	6.4	16.7	0.9	0.1	0.5	25	64	2012	STEPS
Bahrain	33.4	7.0	19.9				20	64	2007	National Non-communicable Diseases Risk Factor Survey
Bangladesh	36.2	0.8	18.0	16.2	24.8	20.2	15	100	2017	GATS
Barbados	15.5	3.7	9.2				25	86	2012	Health of the Nation Survey
Belarus	43.2	10.1	23.7	0.2		0.1	16 (*18)	(*69)	2019 (*2016)	Household Living Standards Survey (*STEPS)
Belgium	24.5	14.6	19.4				15		2018	Belgian Health Interview Survey
Belize	16.4	2.1	0.0				15	49	2015	MICS
Benin	9.5	0.5	5.0	8.0	3.2	5.7	18	69	2015	STEPS
Bhutan	10.8	3.1	7.4	26.5	11.0	19.7	18	69	2014	STEPS
Bolivia (Plurinational State of)	21.9	9.1	14.8				14	64	2014	Consejo Nacional de Lucha Contra el Trafico Ilícito de Drogas
Bosnia and Herzegovina									2012	Subnational surveys reported: Study of the Health status of adult population (2012). Survey on health status of Republic of Srpska' citizens (2010).
Botswana	31.4	4.9	18.3				15	69	2014	STEPS
Brazil	18.9	11.0	14.7	0.5	0.2	0.3	18	100	2013	GATS/National Health Survey
Brunei Darussalam	36.3	3.7	19.9	1.7	2.1	1.9	18	69	2016	STEPS
Bulgaria	43.4	26.9	34.7				15	98	2014	EHIS
Burkina Faso										
Burundi	11.0	6.0	17.0						2000	Unknown
Cabo Verde			9.3	3.5	5.8	9.3	15	64	2007 (*2013)	STEPS
Cambodia	32.9	2.4	16.9	0.8	8.6	4.9	15	99	2014	National Adult Tobacco Survey

Cameroon	11.8	0.6	8.9	2.2	3.8	3.0	15	100	2013	GATS
Canada	16.7	13.5	15.1	1.5		0.7	15	100	2017	Canadian Tobacco. Alcohol and Drugs Survey (CTADS)
Central African Republic	22.8	0.1					22		2009	Unknown
Chad**	20.2	1.2	11.2				25	64	2008	STEPS
Chile	36.7	28.5	32.5				15	100	2016/17	Encuesta nacional de Salud
China	50.5	2.1	26.6				15	100	2018	GATS
Colombia	13.8	4.0	8.7				18	80	2018	Encuesta de Calidad de Vida (ECV)
Comoros	23.8	2.0	12.9	19.5	17.4	18.4	25	64	2011	STEPS
Congo	23.9	0.8	12.3				15	49	2014/15	MICS
Cook Islands	36.6	27.5	32.0				15	79	2011	Cook Islands Population Census
Costa Rica	13.0	4.0	8.9	0.1	0.0	0.0	15	100	2015	GATS
Côte d'Ivoire	17.1	0.6	8.5				15	49	2016	MICS
Croatia	35.3	27.1	31.1	0.8	0.4	0.6	15	100	2014/15	GATS
Cyprus	49.9	26.8	37.8				15	64	2019	Cyprus National Addictions Authority General Population Survey 2019
Czech Republic	34.7	22.7	28.5	3.4	1.5	2.4	15	100	2018	The use of tobacco and alcohol in the Czech Republic
Democratic People's Republic of Korea	46.1	0.0	22.0				15		2017	National Adult Tobacco Survey
Democratic Republic of the Congo	26.5	4.1	30.6	20.6	20.1		15	49	2013/14	Demographic and Health Survey
Denmark	24.0	22.2	23.1	6.0	2.0	4.0	15	99	2018	Monitorering af danskernes rygevaner
Djibouti										
Dominica	16.6	3.2	10.2	16.0		0.8	15	64	2008	STEPS
Ecuador	23.8	4.0	13.7				18	69	2018	STEPS
Egypt	43.6	0.6	20.0	5.5	0.6	3.0	15	65	2016 (*2010)	STEPS (*GATS)
El Salvador	16.9	2.2	8.8				18	100	2014	Encuesta Nacional de Alcohol y Tabaco (ENAT)
Equatorial Guinea**	24.0	2.0	26.0				15	49	2011	Encuesta Demografica y de Salud
Estonia	31.4	20.0	24.7	6.4	1.4	3.3	16	64	2018	Health Behaviour among Estonian Adult Population
Eswatini	11.7	2.5	6.0	2.7	1.8	2.2	15	69	2014	STEPS
Ethiopia	7.3	0.4	4.2			2.0	15	69	2015	STEPS
European Union	30.0	22.0	26.0	1.0	0.0	1.0	15		2017	Eurobarometer
Fiji	47.0	14.3	30.8				25	64	2011	STEPS
Finland	28.4	18.0	23.3	9.0	1.0	5.1	20	64	2018	National FinSote Survey
France	35.3	28.9	32.0				18	75	2017	Baromètre santé
Gabon										
Gambia	25.4	0.7	13.1	0.8	1.4	1.2	15 (*25)	100 (*64)	2018 (*2010)	Demographic Health Survey (*STEPS)
Georgia	55.5	7.8	30.7	0.0	0.0	0.0	18	69	2019	National tobacco survey
Germany	27.0	20.8	23.8				18	99	2014/15	German Health Update (GEDA Study)/EHIS
Ghana	4.8	0.1	1.7	1.9	0.3	0.8	15	49	2014	Ghana Demographic and Health Survey

Greece	24.6	29.6	27.1				18	74	2017	Kapa research
Grenada										
Guatemala	23.9	3.4	11.2				18		2003	World Health Survey
Guinea										
Guinea-Bissau	17.0	1.0					15	49	2014	MICS
Guyana	26.6	3.3	15.4	3.0	2.0	5.0	18 (*15)	69 (*49)	2016 (*2009)	STEPS (*Demographic Health Survey)
Honduras	37.3	33.3	35.3				12	18	2015	Prevalencia del Consumo de Drogas
Hungary	33.4	22.2	27.5	0.1	0.1	0.1	15		2014	EHIS
Iceland	10.9	11.6	11.3	11.5	3.0	7.3	18	79	2019	2020 Survey on determinants of health
India	19.0	2.0	10.7	29.6	12.8	21.4	15		2016/17	GATS
Iran (Islamic Republic of)	25.2	4.0	14.2				18	100	2016	STEPS
Iraq	38.0	1.9	20.7	0.4	0.0	0.2	18	100	2015	STEPS
Ireland	19.0	16.0	17.0				15	100	2019	Healthy Ireland Survey
Israel	24.7	15.1	19.8				21	64	2017	Kap (Knowledge, Attitude and Practice)
Italy	23.3	15.0	19.0				14	100	2018	Social Survey on Aspects of daily life
Jamaica	16.8	5.3	11.0				12	65	2016	National Drug Use Prevalence Survey
Japan	29.0	8.1	17.8				20		2018	National Health and Nutrition in Japan
Jordan	66.1	17.4	42.0	0.0	0.0	0.0	18	69	2019	STEPS
Kazakhstan	42.4	4.5	22.4	2.8	0.0	1.3	15		2014	GATS
Kenya	15.1	0.8	7.8	5.3	3.8	4.5	15		2014	GATS
Kiribati	68.2	34.5	49.9	7.6	1.4	4.2	18	69	2015/16	STEPS
Kuwait	39.2	3.3	20.5				18	69	2014	STEPS
Kyrgyzstan	48.0	3.0	26.0	10.0		5.0	25	64	2013	STEPS
Lao People's Democratic Republic	50.8	7.1	27.9	0.5	8.6	4.3	15		2015	National Adult Tobacco Survey
Latvia**	38.3	12.0	24.5	0.0	0.0	0.0	15	74	2018	Health Behaviour among Latvian Adult Population. 2018
Lebanon	39.4	31.9	35.7				18	100	2013	National tobacco control telephone survey
Lesotho	48.7	0.7	24.5	3.8	17.1	10.5	14	75	2012	STEPS
Liberia	17.2	2.8	9.9				25	64	2011	STEPS
Libya	49.6	0.7	25.1	2.2	0.1	0.7	25	64	2009	STEPS
Lithuania	48.4	18.9	33.2				15	64	2016	General population survey
Luxembourg	23.0	20.0	21.0				18		2018	Le abagisme au Luxembourg
Madagascar	28.5	0.8		24.6	9.6		15	59	2013	Recherche avancé sur le nicotine et le tabac
Malaysia	40.5	1.2	21.3	12.1	0.7	6.5	15	75	2019	National Health Morbidity Survey
Maldives	42.4	2.7	45.1	3.9	1.4	2.6	15	49 (*64)	2016/17 (*2011)	Maldives Demographic and Health Survey (*STEPS)
Mali	84.2	15.8	100.0	33.0	12.0	45.0	15	64	2013	STEPS
Malta	27.5	20.7					15	100	2014/15	EHIS
Marshall Islands	13.3	47.7	9.3	11.6	3.3	7.8	18		2014	RMI Behavioural Profile
Mauritania	34.1	5.7	17.3	5.7	28.3	9.0	15	64	2006	STEPS

Mauritius	38.0	3.9	19.3				18	65	2015	Mauritius Noncommunicable Disease Survey
Mexico	27.1	8.7	17.6	0.9	0.4	0.6	12	65	2016/17	Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco (ENCODAT)
Micronesia (Federated States of)	49.7	17.0	31.6	28.3	10.2	18.3	12	98	2012	National Outcome Measure Survey
Mongolia	49.1	5.3	27.1	0.5	0.5	0.5	15	64	2013	STEPS
Montenegro	36.2	34.5	35.4				15	64	2017	Research on the quality of life. Lifestyles and health risks of the inhabitants of Montenegro
Mozambique	21.9	2.9		2.5	7.9	5.6	15 (*25)	64	2011 (*2005)	Inquérito Demográfico e de Saúde de Moçambique (*STEPS)
Myanmar	43.8	8.4	26.1	62.2	24.1	43.2	25	64	2014	STEPS
Namibia	20.9	5.3		1.8	2.3		15	49	2006/07	2006/2007 Namibia Demographic and Health Survey
Nauru	49.7	56.0	52.9				15	64	2004	STEPS
Nepal	27.0	6.0	16.5	40.0	3.3	22.0	15	69	2016	Demographic and Health Survey
Netherlands	25.7	19.2	22.4				18	100	2018	Health survey life style monitor (CBS)
New Zealand	16.1	12.4	14.2				15	100	2018/19	New Zealand Health Survey
Nicaragua										
Niger	10.0	1.0	6.0				31	39	2016	Enquête Institut National de la Statistique Niger
Nigeria	7.3	0.4	3.9	2.9	0.9	1.9	15	100	2012	GATS
Niue	22.6	13.0	17.7				15	100	2012	STEPS
Norway	18.8	15.5	17.2	24.3	10.5	17.6	16	74	2019	The Norwegian Survey of Smoking Habits
Oman	14.7	0.0	7.7	1.7	0.0	0.9	15	100	2017	National Health Survey
Pakistan	22.2	2.1	12.4	11.4	3.7	7.7	15		2014	GATS
Palau	30.9	9.7	20.6	40.2	48.8	44.4	18	64	2016	Palau Hybrid Survey
Panama	9.4	2.8	6.1	1.0	0.5	0.8	15	100	2013	GATS
Papua New Guinea	60.3	27.0	44.0				15	64	2007	STEPS
Paraguay	22.8	6.1	14.5	3.0	1.6	2.3	15	74	2011	Primera Encuesta Nacional de Factores de Riesgo
Peru	30.8	7.7	18.9				15	100	2018	Encuesta Demográfica y de Salud Familiar
Philippines	40.3	5.1	22.7	2.7	0.7	1.7	15	100	2015	GATS
Poland	26.0	19.0	22.0			1.0	15		2019	Nation-wide survey
Portugal	27.8	13.2	20.0				15	100	2014	INE/INSA. Inquérito Nacional de Saúde
Qatar	20.2	3.1	12.1	1.3		0.7	15	65	2013	GATS
Republic of Korea	35.8	6.5	21.1				19		2018	Korea National Health and Nutrition Examination Survey
Republic of Moldova	43.6	5.6	23.3				18	69	2013	STEPS
Republic of North Macedonia	54.1	33.3	46.0				15	64	2017	Use of psychoactive substances among the general population in North Macedonia
Romania	39.2	12.4	25.3				15		2014	Health Status of Romanian Population

Russian Federation	46.0	14.0	29.0	3.0	3.8	3.3	18	100	2019	Russian Public Opinion Research Centre (ВЦИОМ) survey
Rwanda	19.1	7.1	12.8				15	64	2013	STEPS
Saint Kitts and Nevis	16.2	1.1	8.7				25	64	2008	STEPS
Saint Lucia	25.3	4.0	14.5	1.3	0.2	0.8	25	64	2012	STEPS
Saint Vincent and the Grenadines										
Samoa	36.5	13.7	25.6				18	64	2013	STEPS
San Marino	16.1	14.4	15.2				15	100	2013	Sample survey
Sao Tome and Principe	9.7	1.7	5.5			3.5	25	64	2009	STEPS
Saudi Arabia	23.7	1.5	12.1	0.6	0.2	0.4	15	65	2014	The National Health Information Survey on Noncommunicable Diseases (SHIS)
Senegal	11.0	1.2	6.1	0.3	1.0	0.7	15	100	2015	GATS
Serbia	36.9	32.1	34.4				18	100	2019	Survey of the effects and attitudes related to the Law on Protection of the Citizens from Exposure to Tobacco Smoke
Seychelles	34.1	7.7	20.9	0.3	0.4	0.3	25	64	2013/14	STEPS
Sierra Leone	43.1	10.5	25.8	2.9	12.1	7.8	25	64	2009	STEPS
Singapore	21.1	3.4	12.0				18	69	2017	National Population Health Survey
Slovakia	40.0	32.0	36.0	2.0	1.0	1.0	18	100	2017 (*2013)	Eurobarometer (*TOHES Survey)
Slovenia	26.1	21.7	24.0	2.0	0.2	1.1	15	64	2018	National survey on tobacco, alcohol and other drugs
Solomon Islands	54.5	21.0	36.6	4.2	3.0	3.5	18	69	2015	STEPS
South Africa	37.0	6.8	21.9	6.4	1.3	3.9	15		2016	South African Demographic and Health Survey (SADHS)
Spain	28.3	20.8	24.4				15	100	2017	Encuesta Nacional de Salud en España
Sri Lanka	29.4	0.1	15.0	26.0	5.3	15.8	18	69	2015	STEPS
Sudan	17.1	0.7	9.6	14.3	0.2		18	69	2016	STEPS
Suriname	34.0	6.5	20.1				15	64	2013	STEPS
Sweden	14.0	13.0	13.0	22.0	6.0	14.0	16	84	2018	The National Survey of Public Health
Syrian Arab Republic	51.0	10.0	29.0				15	65	2000	National Survey on Tobacco Use
Tajikistan										
Thailand	37.7	1.7	19.1	1.5	2.7	2.1	15	100	2017	The smoking and drinking behaviour survey
Timor-Leste	53.3	4.1	48.6	16.1	26.8	19.8	15 (*18)	59 (*69)	2016 (*2014)	Demographic Health Survey (*STEPS)
Togo	12.4	1.8	6.8	5.1	2.2	3.6	15	64	2010	STEPS
Tonga	40.0	15.9	24.5				18	69	2017	STEPS
Trinidad and Tobago	33.5	9.4	21.1	0.5	0.3	0.4	15	64	2011	STEPS
Tunisia	48.3	2.6	25.1	3.0	0.7	1.8	15	100	2016	Enquête nationale “THES”
Turkey	44.1	19.2	31.6				15	80	2016	GATS
Turkmenistan	6.6	0.2	3.4	0.4	0.0	0.2	18	69	2018	STEPS
Tuvalu	48.6	22.4	35.0				18	69	2015	STEPS
Uganda										

Ukraine	39.7	8.8	22.8	0.4	0.0	0.2	15	100	2017	GATS
United Arab Emirates	15.7	2.4	9.1				18	50	2018	STEPS
United Kingdom of Great Britain and Northern Ireland	16.5	13.0	14.7				18	100	2018	ONS - Annual Population Survey/ONS - Opinions and Lifestyle Survey
United Republic of Tanzania	12.9	1.1	6.8	2.1	2.3	4.4	15	64	2018	GATS
Uruguay	23.2	15.9	19.4	0.3	0.0	0.1	15	100	2018 (*2017)	Encuesta Continua de Hogares (*GATS)
Uzbekistan	27.0	1.0	14.0	23.0		12.0	18	64	2014	STEPS
Vanuatu	45.8	4.0	23.7				25	64	2011	STEPS
Venezuela (Bolivarian Republic of)	21.6	12.7	17.1	5.7	0.9	3.3	12		2011	Estudio Nacional de Drogas en Poblacion General
Viet Nam	45.3	1.1	22.5	0.8	2.0	1.4	15	100	2015	GATS
Yemen	25.8	7.4	16.4	17.0	5.9	11.3	15	100	2013	Demographic Health Survey
Zambia	21.0	1.7		3.0	70.0	16.0	15	65 (*not defined)	2013/14 (*2014)	Demographic and Health Survey (*International Tobacco Control Survey (ITC))
Zimbabwe	20.4	2.4	22.8				15	54	2015	Demographic and Health Survey

The figures and survey information provided by the Parties are not subject to systematic verification against original survey reports or documents. In unclear cases, data can be cross-checked with other sources, and corrected in this annex table, and may therefore differ from the information available in the original reports submitted by the Parties. Survey name abbreviations: EHIS = European Health Interview Survey; Eurobarometer = Special Eurobarometer 458 on Attitudes of European Towards Tobacco and Cigarettes; GATS = Global Adult Tobacco Survey; MICS = Multiple Indicator Cluster Survey; STEPS = The WHO STEPwise approach to noncommunicable disease (NCD) risk factor surveillance. (*) Marks different age group, year or survey for the data reported for smokeless tobacco. **Indicates Parties in which the reported prevalence refers to daily use instead of current use. Current use is most often described by Parties as daily or occasional use, often past 30 days use, but can also entail other definitions. Detailed definitions should be verified against original survey documents of the respective Party.

Fig. A2.2. Youth smoking and smokeless tobacco use prevalence.
For definitions and additional information, see the bottom of the table

Party	Current tobacco smoking			Current smokeless tobacco use						
	Reported prevalence (%)			Reported prevalence (%)			Age range		Year	Survey/Source (full survey & source names appear at the end of the figure)
	Boys	Girls	Total	Boys	Girls	Total	From	To		
Afghanistan	8.0	3.7	8.3	4.8	3.3	4.1	13	15	2017	GYTS
Albania										
Algeria	16.0	3.1	8.8	7.0	0.8	3.5	13	15	2013	GYTS
Angola			19.0				8	12	2016	Encuesta de la Asociação Nacional de Luta Contra as Drogas
Antigua and Barbuda	6.3	5.9	6.1	2.6	1.6	2.1	13	15	2017	GYTS
Armenia	7.0	1.9	4.4				15	15	2017/18	HBSC
Australia	6.0	5.0	6.0				15	15	2017	Australian Secondary Students Alcohol and other Drug survey
Austria	20.6	22.7	21.6	15.7	4.6	10.2	15	15	2019	ESPAD
Azerbaijan	11.6	2.3	7.3	2.4	1.1	1.8	13	15	2016	GYTS
Bahamas	13.8	6.9	10.7	4.0	1.6	2.8	13	15	2013	GYTS
Bahrain	22.7	8.5	15.7	5.2	2.2	3.7	13	15	2015	GYTS
Bangladesh	4.0	1.1	2.9	5.9	2.0	4.5	13	15	2013	GYTS
Barbados	15.7	9.3	12.6	2.9	3.0	2.9	13	15	2013	GYTS
Belarus	8.9	9.9	9.4	0.9	0.2	0.6	13	15	2015	GYTS
Belgium	16.1	7.2					15	19	2018	Belgian Health Interview Survey
Belize	15.7	7.5	12.3	2.9	1.7	2.3	13	15	2014	GYTS
Benin	5.1	1.3	3.8	5.8	0.8	2.9	13 (*18)	15 (*21)	2016 (*2015)	GSHS (2016). STEPS (2015)
Bhutan	26.3	8.6	16.5	25.0	18.9	21.6	13	15	2013	GYTS
Bolivia (Plurinational State of)	13.6	8.1	10.9	3.6	2.0	2.8	13	15	2018	GYTS
Bosnia and Herzegovina									2018	Subnational results available: GYTS Republic of Srpska (2018); GYTS Federation of BiH (2018/2019)
Botswana	23.3	16.2	14.3				13	15	2008	GYTS
Brazil	7.1	6.0	6.6				13	17	2015	Pesquisa Nacional de Saúde do Escolar (PENSE)
Brunei Darussalam	13.9	4.3	8.9				13	15	2014	GSHS
Bulgaria										
Burkina Faso										
Burundi										
Cabo Verde	0.4	0.3					10	14	2013	Unknown
Cambodia	1.8		1.5	1.3		1.0	13	15	2016	GYTS
Cameroon	10.3	4.0	7.4	5.0	2.3	3.7	13	15	2014	GYTS
Canada	6.8	4.7	5.7	2.5	0.5	1.5	All grades 7-12		2017	Canadian Student Tobacco. Alcohol and Drugs Survey (CSTADS)
Central African Republic										
Chad	20.9	13.9	18.9				13	15	2008	GYTS
Chile**	3.9	4.8	4.3				13	17	2017	Décimo Segundo Estudio Nacional de Drogas en Población Escolar
China	5.8	2.3	4.2				Second grade		2019	China Youth Tobacco Survey
Colombia	9.2	8.6	9.0	4.2	3.5	3.9	13	15	2017	Estudio Nacional de Tabaquismo en Jóvenes en Colombia
Comoros	10.5	3.2	6.5				13	15	2015	GYTS

Congo	27.6		24.3	18.4		16.4	13	15	2009	GYTS
Cook Islands	19.9	19.4	19.7				13	15	2010	GSHS
Costa Rica	5.7	4.3	5.0	1.7	1.6	1.6	13	15	2013	GYTS
Côte d'Ivoire	2.5	0.2	1.2				15	19	2016	MICS
Croatia**	18.8	17.2	18.0				15	15	2014	HBSC
Cyprus							15	16	2015	(data available from ESPAD)
Czech Republic	18.4	20.0	19.2	6.4	2.8	4.7	13	15	2016	GYTS
Democratic People's Republic of Korea	1.3						13	15	2009	Central Bureau of Statistics
Democratic Republic of the Congo	11.5	3.7					14 boys. 17 girls	22 boys. 23 girls	2013/14	Demographic and Health Survey
Denmark	22.1	21.7	21.9	15.5	5.3	10.4	15	24	2019	Use of smokeless tobacco among youth
Djibouti	8.0	4.2		8.1	4.0		13	15	2013	GYTS
Dominica	30.4	19.8	25.3				13	15	2009	GYTS
Ecuador	1.3	0.5	0.9				10	17	2018	Indicadores Encuesta Nacional de Salud y Nutrición (ENSANUT)
Egypt	16.3	3.1	10.1	2.7	5.4	4.1	13	15	2014	GYTS
El Salvador	14.7	9.4	12.2	2.1	2.0	2.0	13	15	2015	GYTS
Equatorial Guinea										
Estonia	18.3	15.1	8.7	14.1	4.5	5.7	15 by gender. 11 total	15	2017/18	HBSC
Eswatini	15.8	8.6	11.5	6.0	5.0	5.4	13	15	2009	GYTS
Ethiopia	6.3	0.5	3.3				13	15	2003	GYTS
European Union	26.0	25.0	29.0				15	24	2017	Eurobarometer
Fiji	9.6	5.5	7.6				13	15	2016	GYTS
Finland	16.0	15.0	15.0	15.0	6.0	10.0	14	16	2019	National School Health Promotion Survey
France	6.6	8.1	7.3	1.0	0.0	0.5	14 (*18+)	15	2017	Enquête EnCLASS
Gabon	7.9	7.0	7.6	1.9	2.9	2.4	13	15	2014	GYTS
Gambia	15.9	4.2	9.2	2.3	0.9	1.5	13	15	2017	GYTS
Georgia	16.9	7.6	12.6	5.0	3.2	4.4	13	15	2017	GYTS
Germany	9.1	8.3	8.7				12	17	2018	Alkoholsurvey
Ghana	3.2	2.3	2.8	2.5	3.7	3.1	13	15	2017	GYTS
Greece	16.9	12.9	15.0	2.5	1.3	1.9	13	15	2014	Health Interview Survey
Grenada	12.5	7.1	9.7	2.0	1.6	1.8	13	15	2016	GYTS
Guatemala	18.0	13.2	15.7	3.0	1.8	2.4	13	15	2015	GYTS
Guinea										
Guinea-Bissau	7.7		5.4				13	15	2008	GYTS
Guyana	16.1	7.5	11.7	4.6	3.0	4.1	13	15	2015	GYTS
Honduras	9.6	6.4	7.9	2.2	1.9	2.2	13	15	2016	GYTS
Hungary	16.0	20.0	18.0	1.0	1.0	1.0	Grade 7–9 students		2016	GYTS
Iceland	3.0	3.0	3.0	6.0	5.0	6.0	15	16	2019	Ungt fólk
India	11.2	3.7	8.1	11.1	6.0	9.0	13	15	2009	GYTS
Iran (Islamic Republic of)	4.8	2.1	3.4	3.1	0.8	1.9	13	15	2016	GYTS
Iraq	18.7	10.4	14.8	1.6	2.1	1.9	13	15	2019	GYTS
Ireland	11.4	10.7	11.0				15	17	2014	HBSC
Israel	3.5	1.0	2.3				14	14	2011	HBSC
Italy	16.2	23.6	19.8				13	15	2018	GYTS
Jamaica	25.5	13.4	19.3				13	15	2017	GSHS

Japan	0.8	0.6	0.7				13	15	2017	Survey on underage smoking and drinking
Jordan	32.8	13.4	23.2	3.9	1.1	2.5	13	15	2014	GYTS
Kazakhstan	3.5	1.9	2.8				13	15	2014	GYTS
Kenya	9.6	4.0	9.9	4.3	3.3	7.0	13	15	2013	GYTS
Kiribati	37.0	22.5	29.2	42.5	35.3		13	15	2018	GYTS
Kuwait	24.2	9.8	16.7	3.1	2.3	2.7	13	15	2016	GYTS
Kyrgyzstan	6.0	2.0	4.0	8.0	3.0	5.0	13	15	2014	GYTS
Lao People's Democratic Republic	10.7	2.1					13	15	2016	GYTS
Latvia	22.8	20.5	21.5	6.8	3.7	5.3	13	15	2018	GYTS
Lebanon	17.7	6.0	11.3				13	15	2011	GYTS
Lesotho	25.0	20.0					14	16	2008	Unknown
Liberia										
Libya	11.0	5.0	8.1				13	15	2010	GYTS
Lithuania	29.0	22.0	26.0				15	15	2018	HBSC
Luxembourg	15.0	15.0	NA				13	14	2018	Le tabagisme au Luxembourg
Madagascar	16.7	6.8	11.3	1.1	2.0	1.1	13	15	2019	GYTS
Malaysia	24.3	3.7	14.2	17.1	4.5	11.0	10	19	2016	Tobacco & E-Cigarette Survey among Malaysian Adolescents (TECMA)
Maldives	10.4	5.0	7.9	9.2	2.9	6.2	13	15	2011	GYTS
Mali	18.0	2.0	9.0				13	15	2008	GYTS
Malta	12.0	18.0	15.0				15	16	2015	ESPAD
Marshall Islands										
Mauritania	19.6	16.2	19.8	6.5	6.8	6.8	13	15	2018	GYTS
Mauritius	21.2	6.6	13.6				13	15	2016	GYTS
Mexico	6.7	3.0	4.9				12	17	2016/17	Encuesta Nacional de Consumo de Drogas. Alcohol y Tabaco (ENCODAT)
Micronesia (Federated States of)	43.0	24.4	33.0	26.4	21.7	23.8	13	15	2013	GYTS
Mongolia	20.3	8.3	14.3	13.0	5.7	9.5	13	15	2014	GYTS
Montenegro	18.0	12.0	15.0				16	16	2016	ESPAD
Mozambique	15.1	14.6	14.9	8.3	6.5	7.5	13	15	2013	GYTS
Myanmar	21.0	2.0	11.0	11.0	1.5	6.0	13	15	2016	GYTS
Namibia	12.3	11.3	11.9				13	15	2008	GYTS
Nauru	19.5	24.5	22.1				13	17	2011	GSHS
Nepal	5.5	0.8	3.1	24.6	16.4	20.4	13	15	2011	GYTS
Netherlands	8.6	7.0	7.8				12	16	2017	HBSC
New Zealand	2.9	4.8	3.8	-			15	17	2019	New Zealand Health Survey
Nicaragua	16.4	11.8		4.0	2.9		13	15	2014	GYTS
Niger	6.8	0.6	3.5	5.9	5.0	5.4	14	17	2009	Unknown
Nigeria	5.6	1.3	3.5				13	15	2008	GYTS
Niue										
Norway	6.0	3.0	5.0	12.0	6.0	9.0	15	15	2014	HBSC
Oman	5.1	2.5	3.7	4.2	1.8	2.9	13	15	2016	GYTS
Pakistan	9.2	4.1	7.2	6.4	3.7	5.3	13	15	2013	GYTS
Palau	42.3	28.8	35.4	12.2	16.8	14.7	13	15	2017	Palau Youth Tobacco Survey
Panama	6.2	5.4	5.9	2.2	2.4	2.3	13	15	2017	GYTS
Papua New Guinea	34.9	18.2	25.4	10.9	13.6	12.2	13	15	2016	GYTS
Paraguay	5.9	5.7	7.0	2.3	1.4	1.9	13	15	2014	GYTS
Peru	7.1	5.6	6.4	2.2	1.5	1.9	13	15	2019	GYTS
Philippines	20.5	9.1	14.5	2.9	2.1	2.5	13	15	2015	GYTS

Poland	21.9	18.2	20.0	7.9	3.3	5.6	13	15	2016	GYTS
Portugal	14.5	14.7	14.6				15	15	2015	ESPAD
Qatar	18.4	6.2	12.3	9.4	3.2	6.1	13	15	2013	GYTS
Republic of Korea	6.5	3.5	5.0				15	15	2019	Korea Youth Risk Behaviour Web-based Survey
Republic of Moldova	17.5	9.5	13.6	2.1	1.4	1.7	13	15	2019	GYTS
Republic of North Macedonia	56.3	42.0	40.2				15	34	2017	Use of psychoactive substances among the general population in North Macedonia (GPS)
Romania	12.2	10.1	11.2				13	15	2013	GYTS
Russian Federation	10.6	8.0	15.1	3.8	1.6	2.7	13	15	2015	GYTS
Rwanda	23.5	9.5	33.0				13	15	2008	GYTS
Saint Kitts and Nevis	10.4	7.8	9.2				13	15	2011	GYTS
Saint Lucia	9.4	6.4	7.9	4.5	2.4	3.5	13	15	2017	GYTS
Saint Vincent and the Grenadines	16.6	8.5	12.8				13	15	2011	GYTS
Samoa	42.2	25.3	33.8				13	15	2017	GYTS
San Marino	14.4	15.0	14.6	0.4	0.4	0.4	13	15	2014	GYTS
Sao Tome and Principe										
Saudi Arabia	13.0	5.0		15.0	7.1		13	15	2010	GYTS
Senegal	9.7	4.9		6.6	1.8		13	15	2013	GYTS
Serbia	15.5	15.2	15.3	2.4	1.2	1.8	13	15	2017	GYTS
Seychelles	19.6	10.3	14.7	2.8	0.6	1.7	13	15	2015	GYTS
Sierra Leone	14.5 20.3	9.7	12.1				13	15	2017	GYTS
Singapore			4.3				13	20	2016	Students Health Survey 2014-16
Slovakia	25.0	26.0					15	15	2014	HBSC
Slovenia	14.3	17.1	15.6	3.1	1.6	2.4	15	15	2018	HBSC
Solomon Islands	24.3	23.4	24.2				13	15	2008	GYTS
South Africa	16.9	13.1	14.8	8.9	8.1	8.5	15	15	2011	GYTS
Spain	31.4	38.5	35.0				14	18	2018	Encuesta sobre Uso de Drogas en Estudiantes de Enseñanzas Secundarias
Sri Lanka	2.9	0.0	1.5	4.2	0.5	2.4	13	15	2015	GYTS
Sudan										
Suriname	16.1	7.0	11.1	1.7	0.6	1.1	13	15	2016	GYTS
Sweden	8.0	12.0	10.0	13.0	3.0	9.0	15	16	2019	Alcohol and drug use among students (Skolelevers drogvanor)
Syrian Arab Republic	45.0	26.0	36.0				13	15	2007	GYTS
Tajikistan	6.8	2.8	5.9				13	15	2004	GYTS
Thailand	17.2	5.2	11.3	4.1	1.3	2.7	13	15	2015	GYTS
Timor-Leste	39.6	7.0	15.6	7.7	9.3	8.4	13	17	2015	GSHS
Togo	14.4	6.6	11.2	4.9	3.5	4.3	13	15	2013	GYTS
Tonga	22.1	6.8	14.6				13	15	2017	GSHS
Trinidad and Tobago	13.6	8.6	11.0	5.0	3.2	4.1	13	15	2017	GYTS
Tunisia	14.2	1.4	7.7	3.8	2.0	2.9	13	15	2017	GYTS
Turkey	23.2	12.1	17.9				13	15	2017	GYTS
Turkmenistan									2015	(GYTS available)
Tuvalu	30.4	11.2	19.8				13	15	2018	GYTS
Uganda	4.3	5.2	4.9	11.5	9.9	10.5	13	13	2011	GYTS
Ukraine	3.3	0.8	2.0				14	17	2017	Household survey of the National Statistic Service
United Arab Emirates	16.4	8.4	16.4	5.6	4.4	5.6	13	15	2013	GYTS

United Kingdom of Great Britain and Northern Ireland	5.0	5.0	5.0				15	15	2018	Smoking, drinking and drug use among young people in England
United Republic of Tanzania	4.8	1.8		2.9	0.9		13	15	2016	GYTS
Uruguay	9.3	11.4	10.4				13	17	2018	8ª Encuesta Nacional sobre Consumo de Drogas en Estudiantes de Enseñanza Media
Uzbekistan										
Vanuatu	16.7	11.7	14.1				13	15	2011	GYTS
Venezuela (Bolivarian Republic of)	5.8	4.2	5.5	2.3	0.3	1.6	12	14	2011	Estudio Nacional de Drogas en Población General
Viet Nam	4.6	1.2	2.8				13	17	2019	GSHS
Yemen	19.4	7.9	15.1	6.7	2.6	5.1	13	15	2014	GYTS
Zambia	24.9	25.8	25.6				13	15	2011	GYTS
Zimbabwe	17.3	12.8	16.2	6.5	4.6	5.6	13	15	2014	GYTS

The figures and survey information provided by the Parties are not subject to systematic verification against original survey reports or documents. In unclear cases data can be cross-checked with other sources, and corrected in this annex table, and may therefore differ from the information available in the original reports submitted by the Parties. (*) Marks different age group, year or survey for the data reported for smokeless tobacco. **Indicates Parties where the reported prevalence refers to daily use instead of current use. Current use is most often described by Parties as daily or occasional use, often past 30 days use, but can also entail other definitions. Detailed definitions should be verified against original survey documents of the respective Party. Survey name abbreviations: ESPAD = European School Survey Project on Alcohol and Other Drugs; Eurobarometer = Special Eurobarometer 458 on Attitudes of European Towards Tobacco and Cigarettes; GSHS = Global School-Based Student Health Survey; HBSC = Health Behaviour in School-aged Children Survey; MICS = Multiple Indicator Cluster Survey; STEPS = The WHO STEPwise approach to noncommunicable disease (NCD) risk factor surveillance.

Annex 3.
The count of the implemented measures reported under respective WHO FCTC articles, by each Party, in the 2020 reporting cycle

Party	Article number															
	5	5.3	6	8*	9	10	11**	12	13***	14	15	16	17****	18****	10	20
Afghanistan	4	2	1	5	0	0	2	9	0	11	0	2	1	0	5	10
Albania	4	2	3	12	3	3	7	12	5	10	8	10	0	3	1	15
Algeria	4	1	2	6	2	2	5	7	6	10	10	4	0	2	1	7
Angola	3	1	1	10	4	4	5	12	0	11	6	4	0	0	0	7
Antigua and Barbuda	3	1	0	8	0	4	8	4	0	8	0	9	–	–	0	2
Armenia	3	0	3	7	4	2	6	12	0	12	9	11	0	0	3	14
Australia	4	2	3	12	0	0	8	12	8	18	10	9	–	–	6	13
Austria	2	1	2	7	4	4	8	11	8	15	12	9	–	–	1	14
Azerbaijan	1	1	2	7	2	4	5	8	0	5	12	8	0	4	2	6
Bahamas	0	0	3	1	0	0	3	0	0	4	11	1	–	–	0	3
Bahrain	4	2	3	9	4	4	8	12	8	20	12	11	–	–	6	16
Bangladesh	3	0	0	3	0	0	8	6	7	0	4	6	0	0	2	13
Barbados	1	1	3	12	0	0	6	8	0	11	0	8	–	–	3	2
Belarus	3	2	3	8	4	4	7	10	6	16	12	11	–	–	2	14
Belgium	3	0	3	12	4	4	8	6	6	20	11	7	0	0	2	13
Belize	3	0	3	10	0	0	7	12	0	11	12	11	–	–	7	0
Benin	2	1	1	10	2	1	5	12	8	4	12	10	0	0	4	12
Bhutan	4	2	3	12	2	2	8	12	10	11	9	0	–	–	0	14
Bolivia (Plurinational State of)	1	0	0	7	2	3	8	4	5	2	8	5	0	2	0	7
Bosnia and Herzegovina	1	0	1	4	3	4	6	7	9	7	10	11	0	0	2	13
Botswana	0	2	1	12	3	4	6	11	9	17	11	10	–	–	2	18
Brazil	4	2	1	12	4	2	7	7	4	11	11	7	1	2	4	19
Brunei Darussalam	3	1	3	11	1	2	7	4	8	12	7	11	–	–	2	6
Bulgaria	3	2	3	12	4	4	8	12	0	18	12	10	1	4	3	15
Burkina Faso	4	2	1	12	2	4	8	11	9	9	10	9	–	–	3	15
Burundi	2	0	1	3	0	0	0	10	5	2	5	0	–	–	5	3
Cabo Verde	4	1	3	10	0	3	2	11	2	9	9	8	–	–	4	11
Cambodia	4	2	2	12	0	0	8	10	9	10	4	8	0	4	7	19
Cameroon	4	0	0	7	0	0	8	12	6	15	1	2	1	0	0	14
Canada	4	2	3	12	3	2	8	12	0	20	11	9	0	4	7	17
Central African Republic	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chad	2	2	1	12	0	0	8	11	7	7	13	10	0	0	4	12
Chile	3	2	1	11	0	3	8	5	6	6	3	8	0	2	2	12
China	4	2	3	7	4	2	6	12	4	17	12	10	1	4	0	19
Colombia	2	1	1	12	0	0	7	8	10	12	11	11	1	1	1	15
Comoros	3	2	1	12	0	4	8	11	8	14	10	10	–	–	2	2
Congo	3	1	3	7	2	2	8	7	7	7	9	2	–	–	1	0
Cook Islands	3	2	3	8	4	4	8	12	8	18	2	10	–	–	0	18
Costa Rica	2	2	2	12	4	3	8	11	9	12	12	11	0	0	1	15
Côte d'Ivoire	3	0	1	12	0	2	8	12	8	11	12	11	–	–	5	10
Croatia	3	2	1	11	4	4	8	10	10	13	10	11	0	0	2	11
Cyprus	4	1	0	12	2	4	8	9	5	12	13	7	–	–	1	3
Czech Republic	3	1	3	7	4	4	8	6	0	13	10	9	–	–	2	11
Democratic People's Republic of Korea	3	1	3	11	4	4	5	7	6	12	11	8	–	–	4	9
Democratic Republic of the Congo	3	2	1	3	4	4	7	0	6	3	8	6	0	0	2	0
Denmark	4	1	2	3	4	4	8	0	5	11	12	7	–	–	2	7
Djibouti	3	1	3	10	0	4	8	3	10	0	13	11	–	–	3	3

Dominica	1	0	1	0	0	0	0	10	0	1	0	0	–	–	0	1
Ecuador	3	1	3	11	0	4	8	7	0	11	10	8	3	4	0	15
Egypt	3	1	1	1	2	0	8	11	7	11	8	6	–	–	3	10
El Salvador	1	0	2	12	0	2	8	5	0	14	8	11	–	–	1	15
Equatorial Guinea	0	0	0	0	0	0	0	11	0	0	0	2	–	–	0	0
Estonia	4	0	3	4	4	4	7	6	2	12	10	10	–	–	2	6
Eswatini	2	2	1	8	0	1	0	12	0	5	13	5	–	–	1	2
Ethiopia	3	1	1	12	4	2	7	9	10	4	6	10	0	0	2	7
European Union	4	2	2	0	4	4	8	4	5	6	11	6	1	2	0	17
Fiji	3	0	3	8	1	2	8	12	7	14	9	11	0	0	0	14
Finland	3	1	3	2	4	4	8	7	9	20	13	10	–	–	4	14
France	2	2	2	7	4	4	8	5	6	13	13	10	1	0	4	15
Gabon	3	1	1	2	0	0	8	6	7	1	8	3	–	–	1	1
Gambia	4	2	3	10	0	0	3	12	8	13	11	2	–	–	3	3
Georgia	4	1	3	11	4	2	8	11	10	8	7	10	0	0	1	8
Germany	4	1	2	5	4	4	8	9	0	11	9	9	0	0	1	15
Ghana	4	2	3	11	1	1	8	11	7	8	13	11	–	–	3	12
Greece	2	0	3	10	3	2	6	10	0	15	8	11	1	4	2	9
Grenada	2	0	3	6	0	2	3	0	0	0	4	0	–	–	0	1
Guatemala	0	1	1	12	0	0	3	0	0	0	3	7	0	0	0	3
Guinea	3	1	0	2	0	2	0	7	4	0	3	1	0	2	3	9
Guinea-Bissau	1	0	0	0	0	2	0	2	0	1	0	0	–	–	0	0
Guyana	4	2	2	12	4	4	8	11	10	11	10	10	–	–	3	17
Honduras	2	2	3	12	4	4	8	12	5	18	12	11	1	4	5	19
Hungary	3	1	3	10	4	4	8	5	7	14	12	10	1	1	1	12
Iceland	3	1	3	9	3	2	6	2	7	14	1	11	–	–	0	9
India	4	1	3	11	4	3	8	12	5	17	8	8	2	3	2	17
Iran (Islamic Republic of)	4	1	3	11	4	4	8	11	10	18	13	11	0	4	2	17
Iraq	4	1	1	3	4	3	7	11	6	15	12	7	–	–	4	15
Ireland	4	1	3	12	4	4	8	12	6	19	12	9	0	0	3	16
Israel	4	1	3	4	0	0	6	7	0	11	8	7	–	–	1	10
Italy	3	0	3	4	4	4	8	5	6	17	13	9	0	3	1	17
Jamaica	3	1	2	12	0	4	8	11	0	16	13	4	2	0	2	17
Japan	4	1	2	6	2	2	7	11	0	13	12	6	0	4	3	12
Jordan	4	1	3	3	4	2	6	12	8	15	5	8	–	–	0	12
Kazakhstan	1	1	0	8	4	2	8	8	0	12	1	11	–	–	2	11
Kenya	4	2	3	12	4	4	7	10	9	8	13	11	–	–	6	15
Kiribati	3	1	2	7	4	4	8	12	6	15	13	11	–	–	1	5
Kuwait	2	1	2	11	2	2	7	7	6	15	7	8	–	–	2	12
Kyrgyzstan	4	2	3	11	2	4	8	11	7	18	11	10	1	3	6	14
Lao People's Democratic Republic	3	1	3	12	0	4	8	10	7	0	2	8	0	0	0	13
Latvia	3	0	1	10	3	4	8	7	9	8	13	11	–	–	5	13
Lebanon	3	1	0	12	1	2	6	3	8	5	5	10	–	–	6	0
Lesotho	3	0	0	0	0	0	0	7	0	15	0	0	–	–	0	11
Liberia	4	2	1	0	0	0	0	0	0	1	0	0	–	–	4	0
Libya	4	1	1	8	0	0	5	11	10	10	5	8	–	–	1	10
Lithuania	4	1	2	9	2	1	8	4	8	0	13	10	–	–	4	10
Luxembourg	2	2	0	11	2	2	8	5	8	15	12	10	–	–	1	7
Madagascar	4	1	3	12	0	0	8	9	8	3	12	8	0	0	2	6

Malaysia	3	1	2	10	2	0	8	12	0	20	9	10	3	0	0	12
Maldives	4	1	2	9	0	0	6	9	7	10	7	7	–	–	4	6
Mali	3	2	1	7	0	2	5	12	6	11	11	7	–	–	1	11
Malta	3	2	0	12	2	4	8	10	10	14	12	10	–	–	3	13
Marshall Islands	3	0	2	9	0	0	3	4	3	4	1	9	–	–	2	13
Mauritania	2	2	1	11	3	2	7	11	4	7	4	7	–	–	2	0
Mauritius	4	2	3	11	0	0	8	12	5	15	13	11	–	–	3	10
Mexico	2	1	3	3	2	4	8	6	0	12	12	11	0	0	5	11
Micronesia (Federated States of)	4	1	3	7	0	0	0	11	5	18	0	9	–	–	0	16
Mongolia	2	2	1	8	0	2	7	5	10	7	11	10	–	–	3	9
Montenegro	3	1	0	12	4	2	7	7	7	10	11	11	0	4	4	14
Mozambique	1	0	1	6	2	4	5	6	3	9	11	6	–	–	1	6
Myanmar	4	1	3	12	0	0	8	9	8	10	3	9	0	0	1	12
Namibia	1	1	1	12	4	1	8	12	5	10	13	10	–	–	1	9
Nauru	2	0	2	7	3	2	4	2	1	1	5	8	–	–	0	4
Nepal	3	1	2	9	2	2	8	12	9	9	8	10	–	–	1	9
Netherlands	4	2	1	11	4	4	8	9	6	17	13	8	–	–	6	17
New Zealand	4	1	3	11	2	4	8	9	6	19	9	9	–	–	3	15
Nicaragua	3	1	3	10	3	4	8	5	0	4	12	10	0	4	3	7
Niger	2	0	1	1	2	2	8	11	9	0	9	10	0	0	5	2
Nigeria	3	2	1	10	4	4	8	12	8	14	8	11	1	2	7	11
Niue	2	1	3	7	2	4	7	6	4	6	0	11	–	–	0	2
Norway	3	0	3	12	1	4	7	7	9	12	9	10	–	–	4	13
Oman	4	2	2	12	1	0	8	12	0	6	7	8	0	1	0	14
Pakistan	4	1	2	11	0	0	8	12	5	5	7	9	0	4	1	2
Palau	4	0	3	6	0	0	0	10	3	10	8	11	–	–	5	4
Panama	3	2	3	12	0	0	8	11	10	13	11	11	0	2	2	17
Papua New Guinea	2	0	1	8	0	0	3	4	7	0	0	3	0	0	0	7
Paraguay	4	1	1	10	0	4	7	11	9	14	7	11	0	4	3	13
Peru	1	0	1	12	0	0	8	5	0	9	6	8	0	0	0	4
Philippines	4	2	3	8	4	4	8	12	0	15	13	7	2	2	4	13
Poland	3	1	0	5	4	4	0	6	0	14	8	0	1	0	0	15
Portugal	4	1	2	9	4	4	8	8	7	14	13	10	0	0	2	13
Qatar	4	1	3	12	4	4	8	12	9	16	12	11	–	–	3	11
Republic of Korea	4	1	3	8	2	2	8	10	1	20	4	9	0	1	4	16
Republic of Moldova	4	2	3	12	4	4	7	7	7	9	11	11	1	4	5	14
Republic of North Macedonia	2	1	3	12	4	4	7	12	7	12	12	11	0	4	5	14
Romania	1	2	3	2	3	4	6	3	5	10	9	8	0	0	0	4
Russian Federation	2	1	1	12	4	3	8	5	9	7	8	10	0	0	6	10
Rwanda	2	2	2	12	0	0	6	8	4	4	12	5	–	–	5	12
Saint Kitts and Nevis	1	0	0	0	0	0	0	0	0	0	0	2	–	–	0	0
Saint Lucia	2	1	1	12	0	2	8	10	0	13	7	2	–	–	1	14
Saint Vincent and the Grenadines	1	0	0	0	0	0	0	4	0	1	0	0	0	0	0	3
Samoa	4	1	2	12	4	4	8	12	7	10	8	10	–	–	2	9
San Marino	2	2	0	9	0	0	0	8	2	2	0	9	–	–	0	2
Sao Tome and Principe	2	2	0	8	0	2	7	2	3	0	0	4	–	–	0	0
Saudi Arabia	4	1	3	10	4	4	8	12	9	16	12	11	–	–	0	16
Senegal	4	2	3	12	2	4	8	12	8	11	11	7	–	–	3	16
Serbia	3	1	3	9	2	0	6	6	5	10	12	10	0	0	3	13

Seychelles	4	1	3	12	0	4	8	12	9	11	13	11	–	–	1	7
Sierra Leone	3	0	2	0	0	0	0	0	0	0	8	0	–	–	0	5
Singapore	4	1	2	10	2	2	8	12	8	20	9	11	–	–	1	13
Slovakia	3	1	3	10	4	0	8	5	5	12	11	11	0	0	1	7
Slovenia	3	2	2	12	4	4	8	9	10	14	13	11	–	–	3	14
Solomon Islands	3	2	3	11	4	2	8	10	4	9	12	8	0	2	1	7
South Africa	1	2	2	2	1	2	4	12	3	5	4	7	0	0	1	7
Spain	4	2	3	12	4	4	8	12	8	18	12	8	0	3	5	18
Sri Lanka	4	2	3	10	2	0	8	11	6	13	0	10	–	–	4	9
Sudan	3	2	2	5	2	3	8	11	9	13	12	7	0	0	1	9
Suriname	2	1	2	12	0	0	8	0	6	3	7	10	–	–	0	10
Sweden	4	0	3	2	4	3	7	12	7	12	12	8	–	–	3	14
Syrian Arab Republic	4	2	0	8	4	4	5	12	7	9	12	11	0	0	0	3
Tajikistan	0	2	3	2	0	0	8	11	2	12	9	4	–	–	1	0
Thailand	4	2	3	12	4	4	8	12	9	20	11	11	0	0	4	18
Timor-Leste	2	2	3	4	2	4	8	12	7	20	10	9	–	–	1	8
Togo	3	1	3	12	0	0	7	11	10	0	8	11	–	–	2	15
Tonga	4	0	3	11	4	4	8	12	8	20	7	11	0	0	1	17
Trinidad and Tobago	4	2	3	12	2	3	8	12	8	19	12	10	–	–	2	16
Tunisia	4	2	3	6	4	4	6	11	6	20	8	6	0	4	1	11
Turkey	4	1	3	12	3	4	8	12	7	17	12	11	3	4	3	14
Turkmenistan	3	2	3	12	4	3	7	11	9	14	10	11	–	–	5	15
Tuvalu	1	0	3	6	1	1	0	4	0	1	0	9	–	–	0	2
Uganda	3	0	1	8	4	4	5	12	0	2	3	0	1	0	6	14
Ukraine	0	1	1	9	2	4	7	2	0	3	8	9	0	0	0	7
United Arab Emirates	4	1	1	10	4	4	8	9	6	18	5	11	0	4	4	14
United Kingdom of Great Britain and Northern Ireland	4	2	2	12	4	2	8	9	8	16	13	9	–	–	2	16
United Republic of Tanzania	4	1	0	8	0	4	4	3	0	0	7	5	–	–	1	3
Uruguay	3	1	3	12	1	2	8	5	8	12	7	9	2	0	0	10
Uzbekistan	3	1	1	5	1	2	5	10	3	7	5	9	0	4	3	10
Vanuatu	2	1	2	12	4	4	8	12	7	4	5	11	0	0	0	0
Venezuela (Bolivarian Republic of)	4	1	3	12	4	4	8	12	9	19	8	10	–	–	0	16
Viet Nam	4	0	3	12	2	2	7	12	6	8	8	9	–	–	2	14
Yemen	3	1	3	6	4	4	8	8	6	9	4	8	1	0	0	10
Zambia	4	2	0	10	1	1	4	11	0	12	13	3	1	0	0	5
Zimbabwe	3	0	3	7	0	0	5	12	0	17	7	8	0	4	1	17
Maximum count by article	**4**	**2**	**3**	**12**	**4**	**4**	**8**	**12**	**10**	**20**	**13**	**11**	**3**	**4**	**7**	**19**

Methodological notes:

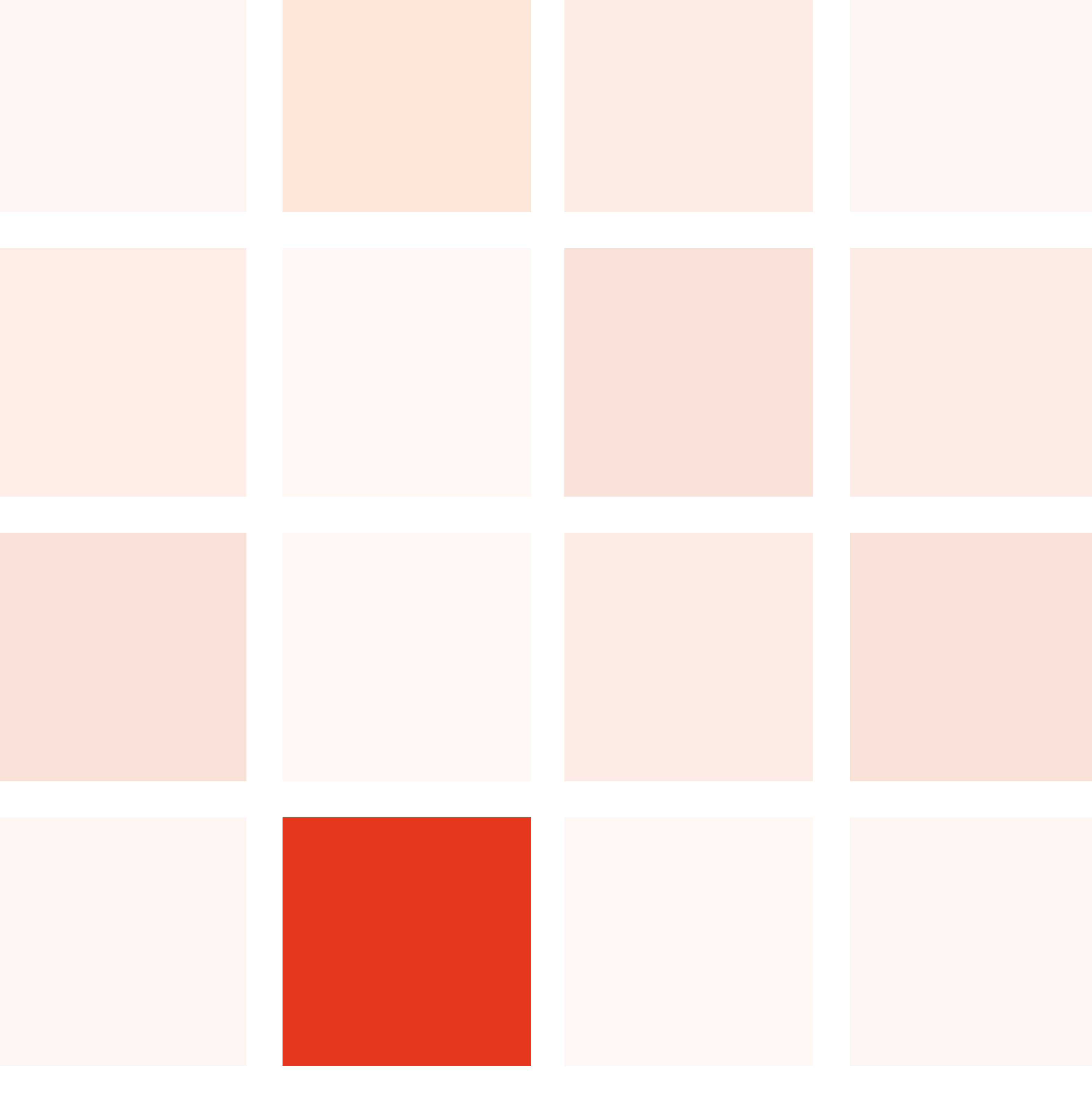
Unless otherwise stated, the indicators selected for this analysis under each WHO FCTC article correspond to the list of key indicators6. For each Party, the count of "Yes" responses to the key indicators was calculated using the latest available data as of 22 May 2020. The first row of the table presents the maximum count available for each article.

* For Article 8, the analysis covers the complete bans in: 1) aeroplanes; 2) ground public transport (buses, trolleybuses, trams); 3) government buildings; 4) health-care facilities; 5) educational facilities; 6) universities; 7) private workplaces; 8) motor vehicles used as places of work (for example, taxis, ambulances or delivery vehicles); 9) cultural facilities; 10) shopping malls; 11) pubs and bars; and 12) restaurants. This corresponds to the list of indicators used for the analysis on the universal protection from the exposure to tobacco smoke in chapter 3.

** For Article 11, the analysis covers the "Yes" responses to the following list of measures: 1) prohibition of misleading descriptors; 2) health warnings required; 3) health warnings approved by the competent national authority; 4) rotating health warnings; 5) large, clear, visible and legible health warnings; 6) health warnings occupying no less than 30% of the principal display areas; 7) health warnings occupying 50% or more of the principal display areas; and 8) health warnings in the form of pictures or pictograms. This corresponds to the list of indicators used for the analysis on the prominent health warnings in chapter 3.

*** For Article 13, the analysis covers the "Yes" responses to the following list of measures: 1) display of tobacco products at points of sales; 2) domestic Internet; 3) global Internet; 4) brand stretching and/or sharing; 5) product placement; 6) the depiction/use of tobacco in entertainment media; 7) tobacco sponsorship of international events/activities; 8) corporate social responsibility; 9) cross-border advertising originating from the country; and 10) cross-border advertising entering the country. This corresponds to the list of indicators used for the analysis on the means under a comprehensive TAPS ban in chapter 3.

**** For Articles 17 and 18, the count has been calculated only among those Parties that respond Yes to tobacco growing in B71.



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