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The WHO Framework Convention on Tobacco Control

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Tobacco is the biggest killer [1]
We need an international response
to an international problem [2]
Gro Harlem Brundtland
Former WHO Director-General

We must act now to reverse
the global tobacco epidemic
and save millions of lives [3]
Margaret Chan
WHO Director-General

Abstract

Tobacco is among the major preventable causes of death in the world today. The World Health Organization (WHO) estimates that tobacco kills about 6 million people yearly. The tobacco epidemic is devastating but preventable by strong political measures. This was the reason why in 1996 the World Health Assembly requested WHO to initiate the first treaty negotiated under the auspices of WHO in history: the WHO Framework Convention on Tobacco Control (WHO FCTC). In 2005, this Convention entered into force and changed the landscape of public health. Health was no longer the task of national health ministries, but also of the ministries of finance, economy, environment, consumer protection and many others. The WHO FCTC presents a blueprint for governments to reduce both the supply and the demand for tobacco. To support the Parties to the Convention to implement the WHO FCTC, guidelines on several articles have already been developed by the Parties and adopted by the Conference of the Parties, with others to follow. There is no doubt: the WHO FCTC is one of the most widely embraced treaties in the history of the United Nations, with 180 Parties involved (as of 15 January 2015), and many of them are implementing the WHO FCTC consistently. This success demonstrates sustained global political will to strengthen tobacco control and to reduce tobacco consumption.

The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) [4] is the first treaty negotiated under the auspices of WHO and a response to the globalization of the tobacco epidemic (see chapter 2). Since the establishment of WHO in 1948, its objective is 'the attainment by all peoples of the highest possible level of health' and Article 19 of its constitution gives the World Health Assembly (WHA), the WHO's governing body, the authority to adopt conventions with respect to any matter within the competence of WHO [5].

Two main reasons were responsible for using the instrument of a convention: First, the tobacco epidemic is a global public health threat with continuously increasing consumption of cigarettes and other tobacco products resulting in a raising avoidable tobacco-related death toll. The end of this epidemic is not yet in sight. Second, there was sufficient evidence that in most instances policy measures could stop this epidemic and could lead to a decline in tobacco use and related morbidity and mortality (see chapter 12). Only a convention was the appropriate means to establish manda-

tory measures for all member states, since previously developed and implemented recommendations and voluntary action plans were not effective enough.

The idea of using WHO's constitutional authority to develop an international regulatory mechanism for tobacco control first appeared in a report prepared by the WHO Expert Committee on Smoking Control in 1979 [6]. An article on the feasibility of such an international framework further explored this idea in 1989 [7]. A couple of years later, a successful process in setting up the agenda for the development of an international legal approach was conceptualized in the 1990s when US-based lawyers Ruth Roemer and Allyn Taylor [8] developed concrete proposals and worked together with the WHO Public Health Consultant Judith Mackay to eventually introduce a resolution during the 9th World Conference on Tobacco or Health held in Paris in 1994 'to achieve an International Convention on Tobacco Control adopted by the United Nations'.

Developing the Agenda of the WHO Framework Convention on Tobacco Control

It was an enormous effort of political will, creative work on policies and sustainable funding by many donors to finally establish an agenda for the convention [9]. Thanks to a careful conceptualization of an international legal approach and thanks to the Paris Resolution of the 9th World Conference on Tobacco or Health, the WHA requested the WHO Director-General in 1996 to initiate the preparation of the WHO FCTC. After her election as Director-General in 1998, Gro Harlem Brundtland made tobacco control one of her top priorities, created the WHO Tobacco Free Initiative (TFI) and started the preparations for the negotiations. In 1999, the WHA established an Intergovernmental Negotiating Body (INB) to draft and negotiate the convention and created a Technical Working Group open to all Member States to prepare for INB. Within only a few months, the Working Group presented a provisional text of potential parts of the WHO FCTC. The text elements were accepted by the WHA in 2000 to serve as a sound basis for initiating negotiations so that the first INB session could be realized in October 2000. During nearly 3 years, six sessions of negotiations were held in Geneva until the final WHO FCTC text was unanimously adopted by the WHA during its 56th Assembly on May 21, 2003. On June 16, the Convention was opened for signature and on the first day, 28 Member States and the European Union signed. By the end of the signing period 1 year later, 168 Member States had signed. The requirements for entry into force were met with the deposit of ratification, acceptance, approval, formal confirmation or accession by 40 Member States. And finally, 90 days after the deposition of the 40th instrument, the WHO FCTC entered into force on February 27, 2005 (fig. 1).

Pivotal Elements of the Successful Negotiations

The first pivotal element was a strong leadership of Gro Harlem Brundtland who launched the TFI with Derek Yach as first Director, who steered the process and was followed by Vera da Costa e Silva, Yumiko Mochizuki and Douglas Bettcher, who became the TFI Directors in the years to come. Brundtland's goals were clearly expressed: 'to build a "vibrant alliance" between WHO, UNICEF, the World Bank, and "Partnership with a purpose" with nongovernmental organizations, the private sector, academic/research institutions and donors' [1]. These alliances were extremely successful (fig. 2).

The second pivotal element was the World Bank Report in 1999 (Curbing the Epidemic: Governments and the Economics of Tobacco Control [10]). It concluded that successful tobacco control brings unprecedented health benefits without harming national economies. WHO used this report to provide the economic justification for the WHO FCTC and to counter economic arguments made by the tobacco industry (see also chapters 3 and 11). The controversy for the truth of science started before and during the negotiations and continues until today [11].

Third, the strong nongovernmental community including distinguished academics and researchers united under the umbrella of the Framework Convention Alliance (FCA) played a substantial role in pushing the negotiations forward and in countering permanent attempts by the tobacco industry to interfere with the WHO FCTC process. FCA was formed in 2000 when British-based Action on Smoking and Health mobilized tobacco control civil society around the world for the support of a strong WHO FCTC. During the negotiations in INBs, FCA produced a daily newsletter, The Alliance Bulletin, for Member State delegates, which provided them with basic information on the negotiated subject. The Alliance Bulletin became a main source of information for many delegates, especially in small delegations. It praised positive contributions and also used the tactic of shaming to influence country delegates and bluntly denounced the tobacco industry's efforts to influence delegates. FCA assigned two awards daily: the *Orchid Award* for recognizing leadership in the negotiations for a strong WHO FCTC and the *Dirty Ashtray Award* for attempts try-

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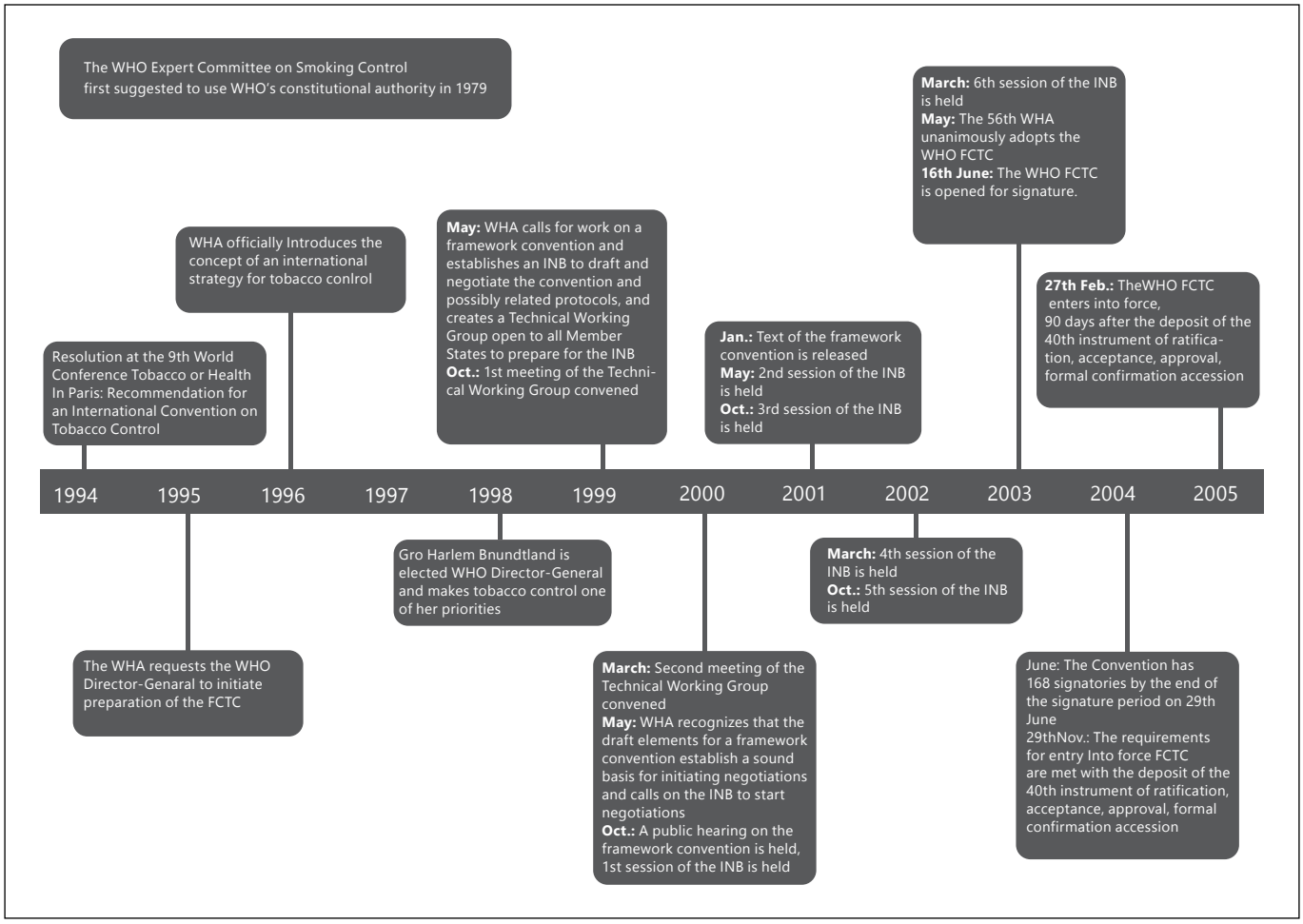

Fig. 1. The process of realization of the WHO FCTC.

ing to undermine it. Finally, FCA used a *death clock*, a large digital counter that displayed the number of worldwide tobacco-related deaths since the beginning of the negotiations, located at the entrance to the plenary sessions [12].

Continuing the Momentum: New International Instruments and Support to National Implementation

When the treaty had entered into force in 2005, the main task was beforehand: the Parties' complete implementation of all its requirements.

The translation from theory (articles of the WHO FCTC) into practice (full implementation) has been a challenge. As governing body for the Convention, the Conference of the Parties (COP) was formed. It provides guidance for the implementation and establishes the administrative and political structures necessary for the Convention to achieve its goals. COP comprises all Parties to the WHO FCTC. Prepared by two sessions of an Intergovernmental Working Group in 2004 and 2005, the first COP session (COP1) took place in Geneva in 2006. Parties elected a Bureau of COP with six members, one representative from each WHO region. The Bureau elects its President from among its members. COP1 established a Convention Secretariat based at the WHO Headquarter in Geneva. The Secretariat supports the work of the Conference of the Parties and its subsidiary bodies, including the preparation of COP sessions, supports Parties in their implementation of WHO FCTC, coordinates the development of guidelines and elaborates global progress reports on the implementation of the Convention. COP1 adopted procedural and financial rules for COP and the Convention Secretariat. In summer 2007, Dr. Haik Nikogosian, former Health Minister of Armenia, was ap-

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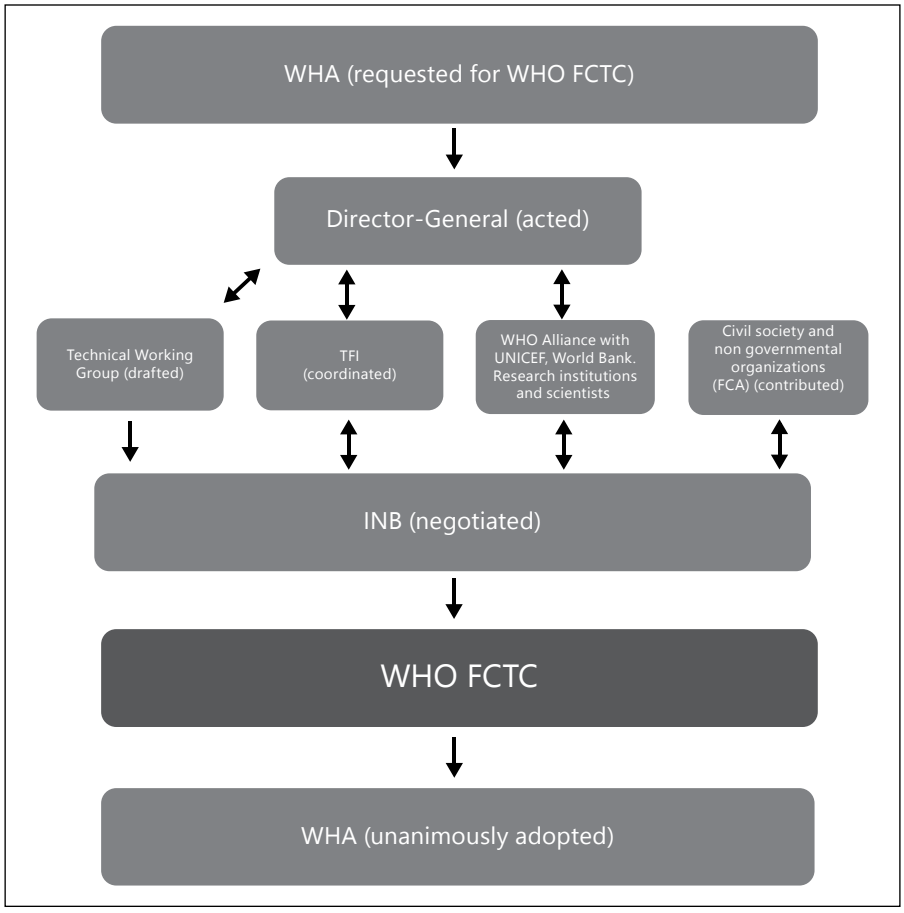

Fig. 2. The making of the WHO FCTC.

pointed as first head of the Convention Secretariat by the WHO Director-General [13].

During COP2 in Bangkok, Thailand, in 2007, Parties to the Convention decided to establish an INB to develop the first protocol to the convention, focusing on eliminating illicit trade in tobacco products. COP2 also adopted guidelines for the implementation of Article 8 (Protection from exposure to tobacco smoke) and decided to call for the elaboration of further guidelines in accordance with Article 7 of the treaty (Non-price measures to reduce the demand for tobacco).

COP3 took place in Durban, South Africa, in 2008, where Parties to the Convention adopted three other guidelines for implementation: on Article 5.3 (Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry), Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship).

COP4 was conducted in Punta del Este, Uruguay, in 2010, where the Parties to the Convention adopted guidelines for the implementation of Article 12 (Education, communication, training and public awareness), Article 14 (Demand reduction measures concerning tobacco dependence and cessation) and partial guidelines for implementation of Articles 9 (Regulation of the contents of tobacco products) and 10 (Regulation of tobacco product disclosures).

COP5 took place in Seoul, Republic of Korea, in 2012, where the Parties to the Convention adopted the Protocol to Eliminate Illicit Trade in Tobacco Products, following the negotiations that took place in Geneva between 2008 and 2012. COP5 also adopted a set of guiding principles and recommendations to support the implementation of Article 6 on price and tax measures to reduce the demand for tobacco, and established an open-ended intercessional drafting group to finalize the full guidelines in this area for consideration at COP6. The Conference also amended the partial guidelines on Articles 9 and 10, requesting the Working Group to continue its work, and established a process for

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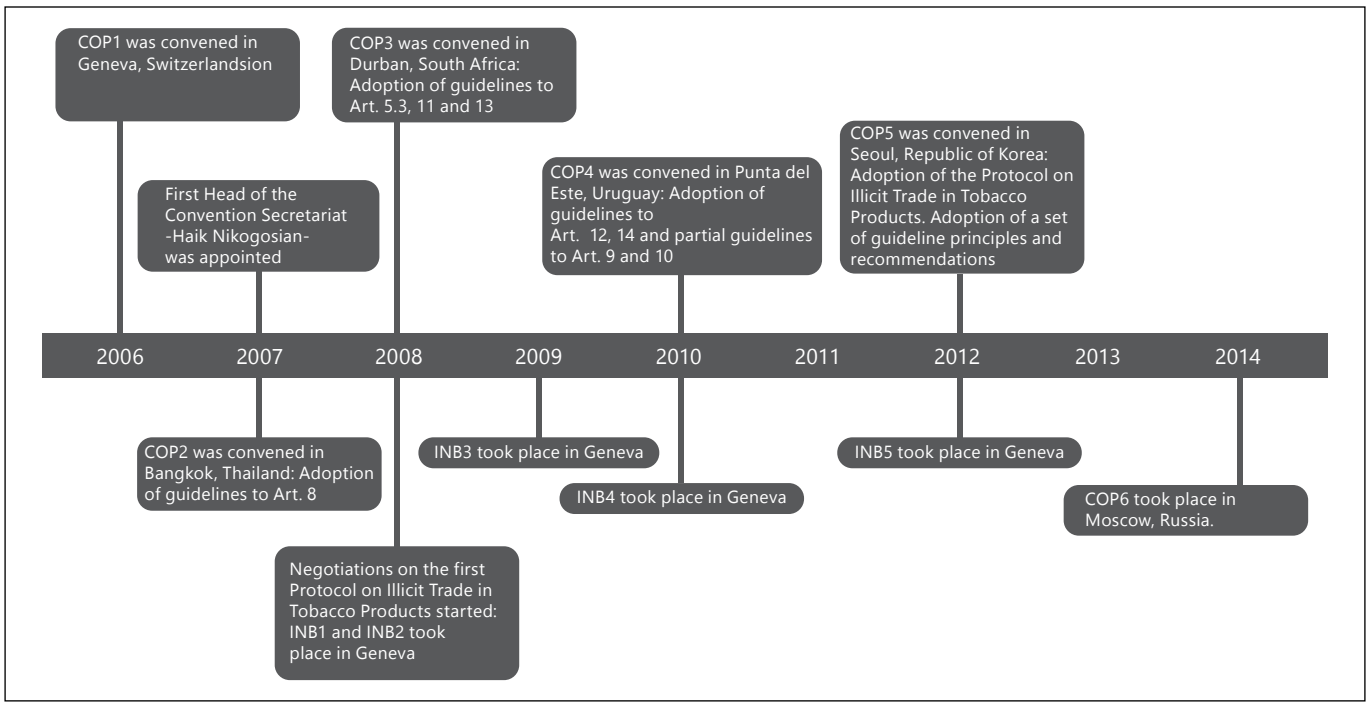

Fig. 3. Process of the implementation of the WHO FCTC.

further developing policy options and recommendations on Articles 17 and 18 regarding economically sustainable alternatives to tobacco growing for its next session.

COP6 took place in Moscow, Russia, in October 2014 (fig. 3). At this session, the Conference of the Parties adopted 29 decisions – the highest number of decisions at any session to date. These include several landmark decision on matters such as on Article 5.3 (to engage with international organizations on the matters of tobacco companies' influence); article 6 (to adopt guidelines on taxation of tobacco products); articles 17 and 18 (to adopt policy options and recommendations on economically sustainable alternatives to tobacco growing) and on electronic nicotine and non-nicotine delivery systems (ENDS), also known as electronic cigarettes. The latter acknowledges the need for regulations along the lines of policies concerning other tobacco products, including banning or restricting promotion, advertising and sponsorship of ENDS.

The WHO Framework Convention on Tobacco Control – A Milestone in International Public Health

The WHO FCTC contains 38 articles. The goal of the WHO FCTC is expressed in its objective: 'The objective of this Convention and its protocols is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke' [4].

The political will of the Parties is stated in the first preamble paragraph: 'Parties to this Convention (are) determined to give priority to their right to protect public health'.

The roadmap to fulfil this task is determined in Articles 6–17 requiring measures on both the demand and supply side of tobacco (fig. 4). In addition, three articles are to be implemented according to a specific timeline, set by Articles 11 and 13 of the Convention (packaging and labelling measures to be put in place within 3 years of entry into force of the Convention for the Party and measures to control advertising, promotion and sponsorship to be enacted within 5 years of entry into force of the treaty); in the case of Article 8 (Protection from exposure to tobacco smoke), the guidelines for implementation of this article adopted in 2008 recommend adoption of measures to ensure complete protection from exposure to tobacco smoke also within 5 years of entry into force of the Convention for the respective Party.

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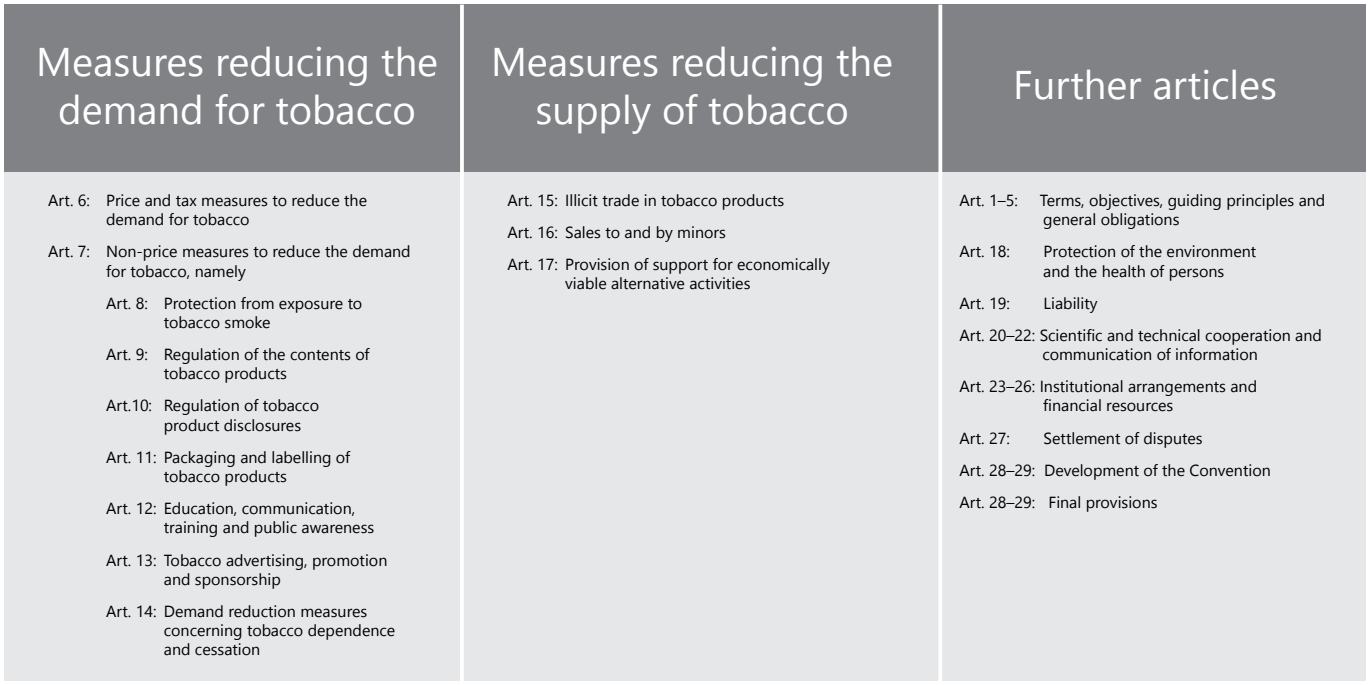

Fig. 4. WHO FCTC: core provisions.

Further articles address liability (Article 19), mechanisms for scientific and technical cooperation and exchange of information (Articles 20–22), institutional arrangements and financial resources (Articles 23–26), settlement of disputes (Article 27) and the further development of the Convention and final provisions (Articles 28–38).

Implementation of the Treaty in Member States

Each Party periodically submits reports on its implementation of the Convention to COP, as required by Article 21.1 of the WHO FCTC. These reports enable Parties to learn from each other's experience in implementing the WHO FCTC and are also the basis for reviews by COP on the progress of the international implementation of the Convention. The Secretariat of the WHO FCTC publishes global progress reports on the implementation on a regular basis.

The latest of these reports was published in 2014 [14] and summarized the submissions from 130 Parties (73% of all Parties that were due to report). The report showed that there are certain Articles with quite high implementation rates and articles with a relatively low reported implementation rate, with the remaining articles falling in between the above two groups (fig. 5).

Likewise, a substantial difference was reported in the progress Parties had made in implementing the respective Articles since their previous submission.

Parties report on their implementation of the WHO FCTC by using a standard questionnaire adopted and further refined by COP, but there is not yet a mechanism for the validation and assessment of compliance of the Parties with all requirements of the treaty in place. The Convention Secretariat reviews the reports for completeness and consistency, but no systematic 'correction' of the submitted reports takes place, for example on the basis of adopted tobacco control legislation, since this falls beyond the mandate of the Convention Secretariat. COP, using the experience of other international treaties, is currently considering the establishment of a mechanism to assist with the review of the reports submitted by the Parties, in accordance with Articles 23.5(d) and (f) of the Convention.

The reporting system of the Convention has evolved significantly over the years [15]. It currently comprises not only standardized instruments to assist Parties to provide information on their implementation efforts, but also promotes, among the Parties, the use of specific WHO FCTC indicators and terms/definitions to allow for better comparability of reported data in the future. This will ensure that

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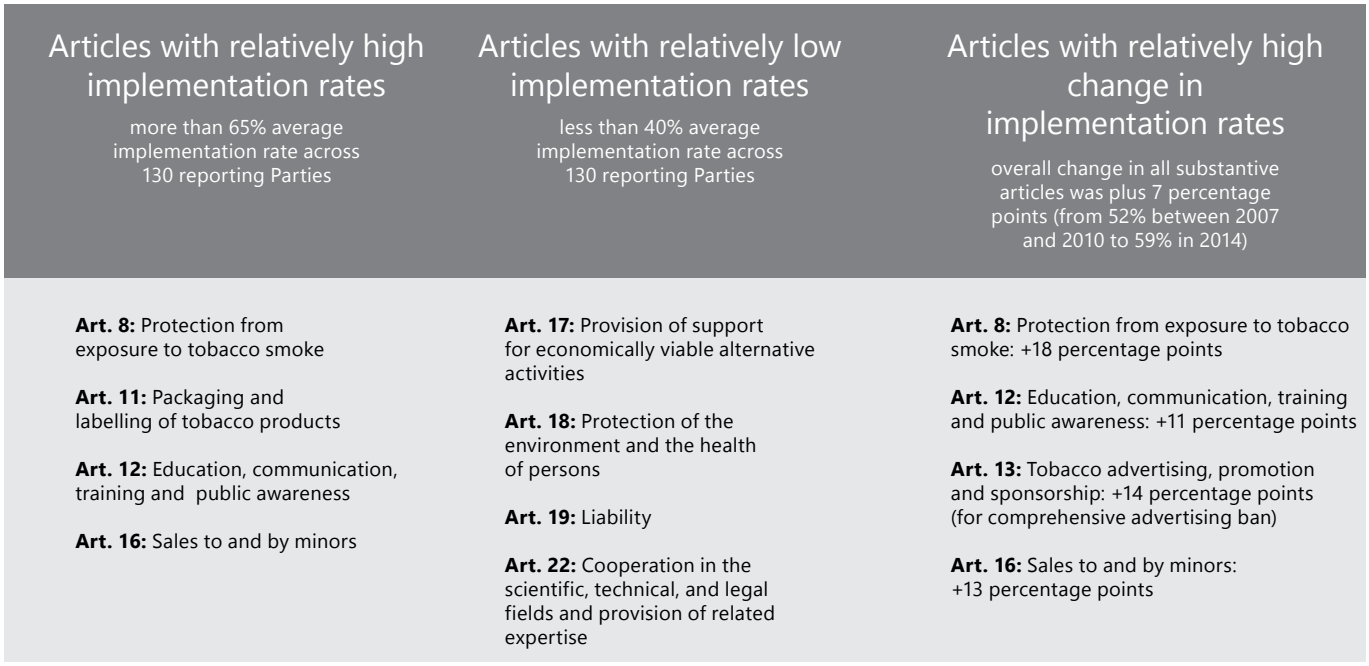

Fig. 5. Implementation of WHO FCTC.

the reporting system of the WHO FCTC is suited to track progress within a Party, but will also contribute to better comparability of data across the Parties.

Effects and Lives Saved by the WHO Framework Convention on Tobacco Control

As the implementation of the WHO FCTC progresses globally, the need has emerged to conduct an impact assessment of the WHO FCTC. At its 5th session, COP initiated the establishment of such process [16]. In some areas, and groups of interventions, literature is already available to indicate the significant impact the Convention has on shaping countries' tobacco control policies, as well as on tobacco use and its health, and economic, social and environmental consequences, as foreseen in Article 3 of the Convention.

One significant comprehensive work was published in July 2013 [17]. The paper examined the effect of selected tobacco control demand reduction measures on lives saved since the WHO FCTC went into force in 2005. The authors of the study projected that 7.4 million premature deaths will be averted by 2050 through the implementation of one or more of the 'MPOWER measures' (see chapters 2 and 12) (the MPOWER measures correspond to one or more of the demand reduction provisions included in the WHO FCTC [18]). The study focused on the 41 countries (2 of which are not Parties to the WHO FCTC) that had implemented the MPOWER measures at 'the highest level of achievement', that is at a level proven to attain the greatest impact. These countries represented nearly 1 billion people or one seventh of the world's population of 6.9 billion in 2008. Of the 41 countries, 33 had put in place one MPOWER measure and the remaining 8 had implemented more than one. Given that 1 in every 2 smokers dies prematurely from smoking-related diseases, the authors calculated that the MPOWER measures put in place in the 41 countries would prevent the premature deaths of half of the 14.8 million smokers who quit – that is 7.4 million people – by 2050. The study showed that almost half of the averted deaths would be attributable to increased cigarette taxes (3.5 million).

Outlook

The WHO FCTC is one of the most widely embraced treaties in the history of the United Nations (UN), with 180 Parties participating (as of 15 January 2015) and cov-

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ering more than 88% of the world population. This success demonstrates sustained global political will to strengthen tobacco control and save lives. The last couple of years have brought about an increased awareness of the importance and harm caused by tobacco specifically and by noncommunicable diseases (NCDs) in general: not only in high-income countries but also globally. This has been reflected by a high-level meeting of the UN General Assembly on the prevention and control of NCDs that took place in New York City in September 2011 [19]. This high-level meeting was the second health-related high-level meeting in the history of the UN and addressed the prevention and control of NCDs worldwide, with a particular focus on developmental and other challenges, and social and economic impacts, particularly for developing countries.

World leaders agreed in this meeting that the global burden and threat of NCDs constitutes one of the major challenges for development in the 21st century and that business as usual was no longer an option. Countries committed to take action by setting national targets, developing national plans and implementing proven interventions to prevent, control and monitor NCDs. To support the development of national targets, in May 2013, the WHA adopted the WHO global action plan for the prevention and control of NCDs 2013–2020 [20], in which reducing tobacco use is identified as one of the critical elements of effective NCD control. The global action plan comprises a set of actions which – when performed collectively by Member States, WHO and international partners – will set the world on a new course to achieve nine globally agreed targets for NCDs; these include a reduction in premature mortality from NCDs by 25% in 2025 and a 30% relative reduction in prevalence of current tobacco use in persons aged 15 years and older. It is proposed that WHO Member States undertake the following actions to achieve this target:

- Accelerate full implementation of the WHO FCTC; Member States that have not yet become a Party should consider action to accede to the treaty at the earliest opportunity
- Protect tobacco control policies from commercial and other vested interests of the tobacco industry
- Putting in place a set of tobacco control measures, including the MPOWER measures
- Regulate the contents and emissions of tobacco products, and manufacturers and importers of tobacco products are required to disclose information about their contents and emissions to governmental authorities

Similarly to this global action plan, the UN Economic and Social Council adopted a resolution to support UN system-wide coherence on tobacco control. The resolution calls upon UN agencies to contribute and assist countries in meeting their obligations under the WHO FCTC.

Examples from countries that have put in place strong tobacco control measures in line with the WHO FCTC show that premature tobacco-related death can be prevented. Turkey or Uruguay are examples of countries that have had a long tradition of tobacco use and high smoking prevalence. However, after implementing a set of tobacco control measures at the highest level of achievement, smoking prevalence has been declining at unprecedented rates. Turkey, for example, has seen a relative decline in smoking of 13.4% in just 4 years [21, 22]. The successes demonstrated by many countries in using demand reduction measures to build capacity to implement the WHO FCTC show that it is possible to effectively address the tobacco epidemic and save lives, regardless of size or income. However, efforts to incorporate all provisions of the WHO FCTC into national tobacco control programs must be accelerated in all countries to save even more lives.

To make this a reality, WHO FCTC knowledge hubs are being established in several WHO regions. Three hubs either have been or are in the process of being established (Australia: McCabe Center for Cancer Control, focusing on trade and tobacco matters; Finland: National Institute for Public Health, focusing on surveillance, and Uruguay: Center for International Cooperation in Tobacco Control), with other hubs to follow.

Key Points

- The WHO FCTC is the first international treaty negotiated under the auspices of WHO.
- The WHO FCTC was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health.
- Adopted by the World Health Assembly in 2003 and entered into force in 2005, the WHO FCTC has since become one of the most rapidly and widely embraced treaties in United Nations history.
- The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation.
- Substantial progress has been made in implementing the WHO FCTC. However, efforts to incorporate all provisions of the WHO FCTC into national tobacco control programmes must be accelerated in all countries to save even more lives.

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