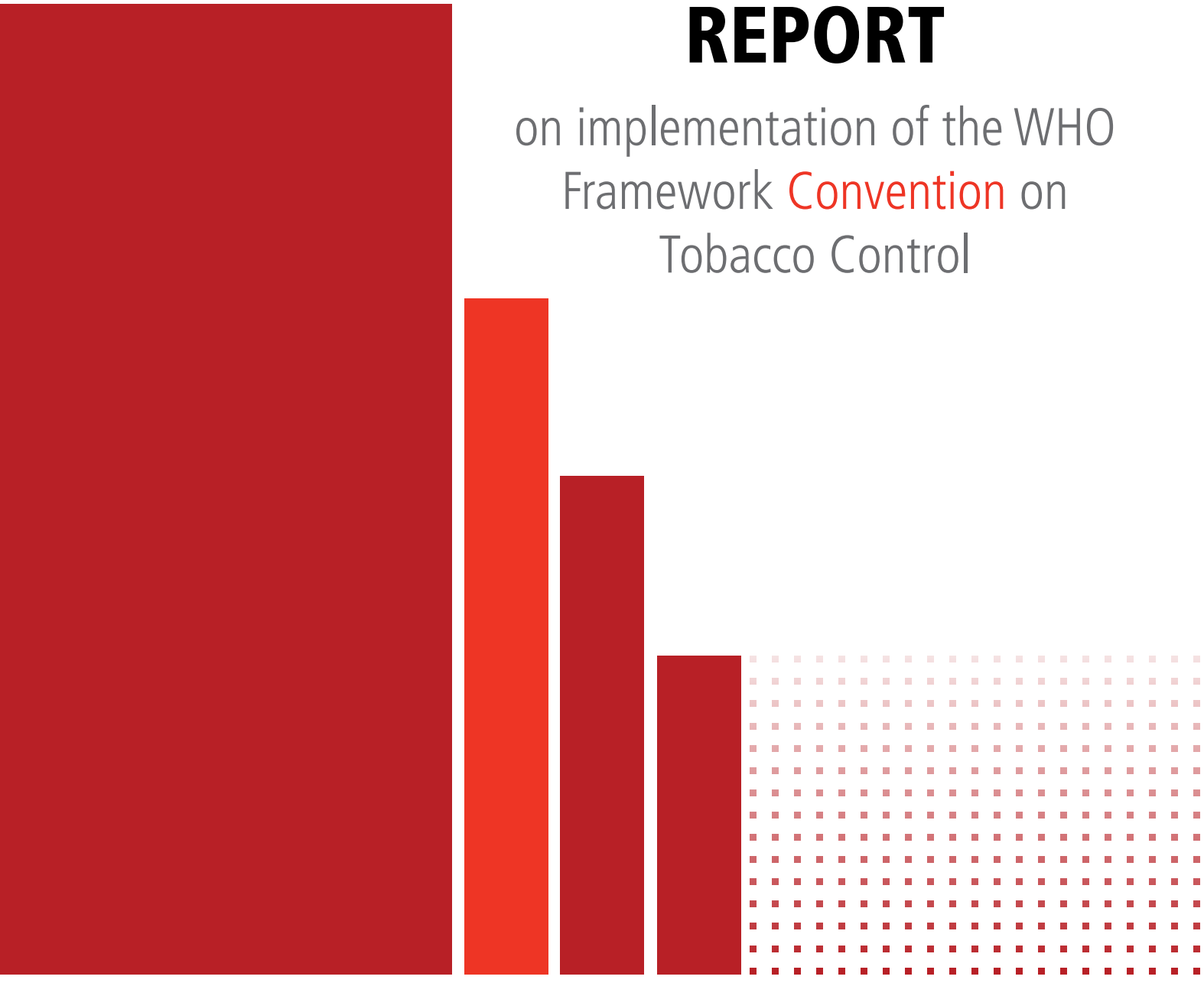
2016 GLOBAL PROGRESS REPORT

on implementation of the WHO Framework Convention on Tobacco Control



FCTC

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

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FOREWORD

The 180 Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC) celebrated the 10th anniversary of the world's first public health treaty in February 2015 and acknowledged the progress made, as well as the significant efforts undertaken by the Parties to fully and comprehensively implement the requirements of the Convention. This includes the recommendations of the implementation guidelines jointly developed by the Parties and approved by consensus at subsequent sessions of the Conference of the Parties (COP), and the decisions of the Convention's governing body. Progress so far has been extraordinary, and the Convention has made a difference within countries, regions and globally.

It is also important to note that a second public health treaty developed by the Parties to the Convention, the Protocol to Eliminate Illicit Trade in Tobacco Products, is coming ever closer to its entry into force, with 24 Parties to the Convention having already ratified or acceded to it. It is anticipated that the Protocol will take effect in the next two years, andwill make a significant contribution to curbing the illicit tobacco market among its Parties and beyond.

The 2016 report on worldwide progress in the WHO FCTC's implementation is the seventh consecutive report prepared by the Convention Secretariat with contributions from its partners and experts. These reports – produced biennially since 2012 – help shape the discussions at COP sessions, while in the case of reporting Parties, preparation of the reports contributes to the self-identification of needs and gaps, and of areas where more attention is needed to achieve full implementation of its obligations under the Convention. The analysis is based on the latest official reports of the Parties submitted in the 2016 reporting cycle.

The 2016 global progress report is timely, as it will greatly support renewed efforts by COP to reshape its country assistance framework, in line with decision FCTC/COP7(13). It is to be noted that assistance programmes, such as post-needs assessment projects, south-south and triangular cooperation agreements and other more invidualized initiatives targeted at Parties, use the information submitted through the Convention's reporting system. Reporting is thus a key element in providing information for subsequent country work.

The report describes progress by articles to the Convention, thus revealing advanced practice but also areas where more effort is needed. Although there has been clear progress, implementation of the Convention is uneven. It is encouraging that some advances are visible in areas where implementation had been lagging behind, such as controlling the illicit trade, tobacco taxation, the use of liability as a tobacco control measure and promotion of alternative livelihoods for tobacco growers. There has also been unprecedented progress in areas including plain packaging, smoking bans in outdoor areas, and measures to prevent tobacco industry interference with public policy in national tobacco control legislative and action plans, to name but a few.

More importantly, WHO analyses and the impact assessment group of the WHO FCTC have now observed the first signs of a general downward trend in tobacco use prevalence among Parties. The fact that the Convention has had an impact on Parties' tobacco control policies and subsequently, on tobacco use prevalence and related health consequences, is described in detail in the report of the impact assessment expert group, mandated by the sixth session of the COP (COP6) in 2014, which was asked to carry out an independent assessment of the Convention's effect.

This report for the first time contains a special section on new and emerging tobacco products. Subsequent to the decision of COP6, we strengthened the reporting system to focus on and detect changes in the evolution of the use of such products, including smokeless tobacco, water pipes, electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS). This section highlights one of the challenges the Convention faces in the second decade of its operation: how to best handle this changing landscape of the use of tobacco and nicotine products.

The Secretariat offers this new compilation of lessons learnt and observations to the COP, to serve as a resource and a catalyst, for its consideration and discussion. Its subsequent decisions will guide future work, especially in areas where the Parties face increasing difficulties or which are more difficult to implement.

EXECUTIVE SUMMARY

Reporting on their implementation of the WHO FCTC is not only an obligation for the Parties, as per Article 21 of the Convention, but is also the most important avenue for information exchange, with a view to sharing with other Parties information on progress, challenges, needs and barriers to implementation. The sharing of experience contributes to shared learning and may assist implementation among other Parties.

The 2016 reporting cycle was the third in which Parties were required to submit their implementation reports at the same time, in a designated reporting period. The designated timeframe for 2016 implementation reports was met by 133 Parties (74%), a slight increase over 2014. Overall, 173 Parties have submitted at least one implementation report since 2007. The number of Parties that have never submitted a report continued to decrease, from 15 in 2010 to six in 2016. Five new Parties reported for the first time in the 2016 reporting period.

Implementation of the Convention has progressed steadily since entry into force in 2005. However, progress appears uneven between different articles of the Convention, with average implementation rates varying from less than 20% to 88%. As was observed in the previous reporting cycle, Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products), and Article 16 (Sales to and by minors) achieved the highest implementation rates reported in 2016. Article 17 (Provision of support for economically viable alternative activities), Article 18 (Protection of the environment and the health of persons) and Article 19 (Liability), seem to have remained the three least implemented articles. However, their average implementation apparently improved as compared to 2014, which was also observed with Article 6 (Price and tax measures to reduce the demand for tobacco) and Article 15 (Illicit trade in tobacco products).

Some advanced trends were seemingly detectable, such as inclusion of reference to Article 5.3 in Parties' new tobacco control legislation, regulations and programmes; extending smoking bans in outdoor public areas; introducing plain packaging and large pictorial warnings; moving towards point-of-sale advertising bans and bans of tobacco product displays at points-of-sale; promoting alternative livelihoods and the utilization of liability as a tobacco control measure. It is also to be noted that while the tobacco industry became more aggressive in fighting new and progressive legislation, numerous industry-initiated court cases challenging Parties' tobacco control measures were defeated – at least those that have come to our attention – as courts in different jurisdictions ruled in favour of public health interests, and against the interests of the tobacco industry and its allies.

The reporting instrument used in 2016 has taken into account policies addressed to new and emerging tobacco products, including smokeless tobacco, water pipe tobacco and ENDS[1]. A number of Parties have taken measures, by regulating or even banning one or more of these product categories. In cases where the products were not banned, many Parties have extended regulations already in place for smoking tobacco products. However, the results indicate that for most Parties there remains a need to undertake measures to regulate these products.

Crucially, the first signs of a general downward trend in tobacco use prevalence among Parties now seem to be emerging, according to analyses by WHO and the impact assessment group of the WHO FCTC. These findings have also been supported by the latest prevalence data provided by the Parties in this reporting cycle. At the same time,

[1] Decisions FCTC/COP6(8), FCTC/COP6(10), FCTC/COP6(9).

WHO projections[2] show that most Parties need to accelerate tobacco control activities in order to achieve the global noncommunicable disease (NCD) target to reduce tobacco use by 30% between 2010 and 2025. Some Parties are expected to experience increases in smoking prevalence if effective policies are not urgently established. To enable more accurate trend analysis, as well as estimates and projections on tobacco use prevalence, Parties need to strengthen their surveillance and monitoring systems.

[2] http://www.who.int/fctc/cop/COP6_16_technical-paper.pdf?ua=1

1. INTRODUCTION

The 2016 global progress report is the seventh in the series. It has been prepared in accordance with the decisions taken by the Conference of the Parties (COP) at its first session (FCTC/COP1(14)), establishing reporting arrangements under the WHO Framework Convention on Tobacco Control (WHO FCTC), and at its fourth session (FCTC/COP4(16)), harmonizing the reporting cycle under the Convention with the regular sessions of the COP; in the same decision, the COP also requested the Convention Secretariat to submit global progress reports on implementation of the WHO FCTC for the consideration of the COP at each of its regular sessions, based on the reports submitted by the Parties in the respective reporting cycle.

The scope of this global progress report is twofold. Firstly, it provides an overview of the status of implementation of the Convention, on the basis of the information submitted by the Parties in the 2016 reporting cycle[3]. Secondly, it contains key observations on the progress made under the various articles of the Convention. Finally, it points to opportunities and challenges related to the Convention as a whole as well as to individual articles, providing the COP with information to be used when considering possible approaches to strengthening Convention implementation.

In the 2016 reporting cycle, two questionnaires were available for Parties' use: the core questionnaire, adopted by the COP in 2010 and subsequently amended for the 2014 and 2016 reporting cycles; and a set of "additional questions on the use of implementation guidelines adopted by the Conference of the Parties", available for the Parties' use since 2014, which was also updated for the 2016 reporting cycle. The questions on new and emerging products were added to both questionnaires, while new sections on the implementation guidelines concerning Article 6 and the policy options and recommendations on Articles 17 and 18 were added to additional questions. Both questionnaires can be viewed on the WHO FCTC website.[4]

In the 2016 reporting cycle the Secretariat received reports from 133 Parties (74%) out of 180, which is a slight increase over the previous 2014 reporting cycle, where 130 Parties (73%) submitted reports by the deadline. Five Parties (Dominica, El Salvador, Guinea, Nicaragua and Zimbabwe) reported for the first time, but there were still seven Parties that have never submitted an implementation report by the end of the 2016 reporting cycle (Angola, Cape Verde, Equatorial Guinea, Ethiopia[5], Guinea-Bissau, Liberia and Zambia).

The 2016 global progress report is based on the analysis of Parties' reports received by the deadline of 30 April 2016.[6] Throughout this report, unless otherwise mentioned, the information concerning the status of implementation of the Convention is based on the

[3] The designated reporting period in 2016 was from 1 January to 30 April 2016.

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

[5] Ethiopia submitted its 2016 implementation report after the deadline. Following the cut-off date for the incorporation of Parties' reports in the 2016 global progress report (30 April 2016), a further 11 Parties submitted reports by 28 October 2016: Barbados, Belarus, Lao People's Democratic Republic, Marshall Islands, Nauru, Peru, Qatar, Saint Lucia, Slovenia, Timor-Leste and Uzbekistan. These late reports were not included in the analysis of this global progress report.

[6] In the previous reporting cycle (2014), the Secretariat received 17 implementation reports after the closure of the reporting period. For the analyses in the current report, the results for 2014 (presented in the 2014 global progress report) were updated to include the data from these late submissions. For this reason, the results presented for year 2014 (n=147) in this global progress report may differ from the respective figures presented in the 2014 global progress report (n=130).

reports submitted by those 133 Parties[7]. In addition, three Parties[8] submitted information on their use of implementation guidelines adopted by the COP by completing the additional questions, and this information was also utilized in the report. The regularly updated status on the submission of reports can be viewed on the WHO FCTC website.[9]

The report follows as closely as possible the structure of the provisions of the Convention and that of the reporting instrument.

Methodological note

In this global progress report, implementation of the Convention is analysed on two levels: as a percentage of Parties implementing individual key measures and as an average of implementation rates across substantive articles. The calculation of the average implementation rates is provided in the footnotes to Chapter 2. The complete list of key indicators is provided in Annex 1. The conditional questions of the reporting instrument are detailed in Annex 2. Please note, implementation of Article 17 (Provision of support for economically viable alternative activities) and Article 18 (Protection of the environment and the health of persons) is considered only among the tobacco-growing Parties.

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

Some limitations need to be noted. Parties' implementation reports are not subject to systematic confirmation against laws, regulations and programmatic documents (such as national strategies or action plans), and do not always include enforcement and compliance aspects unless Parties provide this information in the open-ended questions (and except in the Article 8 section of the core questionnaire, where Parties are required to provide information on their enforcement activities). This may lead to some discrepancies between the information reflected in the implementation reports in different reporting cycles. When accepting the Parties' reports, the Secretariat provides feedback to all reporting Parties in line with the mandate given in decision FCTC/COP1(14). Such feedback concerns the completeness of the reports, placement of responses in the reports and, where appropriate, addressing discrepancies between responses from close-ended and

[7] Afghanistan, Algeria, Antigua and Barbuda, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Belgium, Belize, Benin, Bhutan, Bosnia and Herzegovina, Brazil, Burkina Faso, Burundi, Cameroon, Canada, Chile, China, Colombia, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Democratic Republic of the Congo, Denmark, Djibouti, Dominica, Ecuador, Egypt, El Salvador, Estonia, European Union, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Greece, Grenada, Guatemala, Guinea, Guyana, Honduras, Hungary, Iceland, India, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Latvia, Lebanon, Libya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Moldova (Republic of), Montenegro, Myanmar, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Philippines, Poland, Portugal, Republic of Korea, Russian Federation, Saint Lucia, Samoa, San Marino, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, South Africa, Spain, Sri Lanka, St. Kitts and Nevis, Suriname, Swaziland, Sweden, Syrian Arab Republic, Thailand, the former Yugoslav Republic of Macedonia, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Vanuatu, Viet Nam, Yemen and Zimbabwe. The reports of these Parties can be consulted in the WHO FCTC Implementation Database at: http://apps.who.int/fctc/implementation/database/.

[8] Japan, Panama and Turkey.

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

open-ended questions from the same report, or responses to the same questions from the other reports, should they be recognized by the Secretariat. For Parties providing new information based on this feedback, the respective information is corrected in their implementation reports. However, not all Parties reply to the feedback, which may result in some inaccurate information remaining. In addition, global progress reports provide a snapshot of the status of implementation in the latest reporting period among those Parties which report by the deadline. This may not fully reflect the situation among all Parties. For this reason, the Convention Secretariat has established the WHO FCTC Implementation Database, which presents the information among all Parties to the Convention across all reporting cycles, with changes applied on a regular basis as additional reports are being received from the Parties (outside the designated reporting cycles).

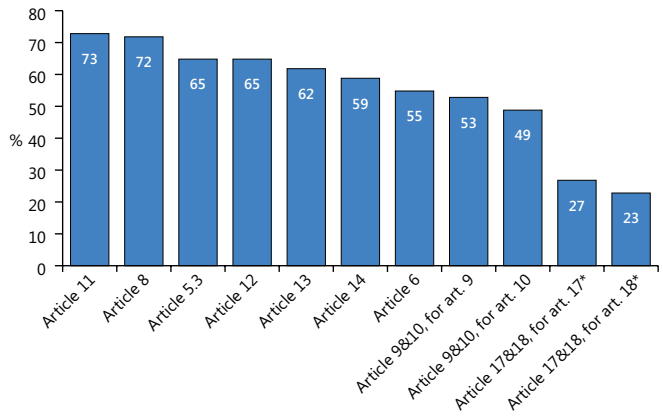
GUIDELINES TO SUPPORT PARTIES IN THE IMPLEMENTATION OF THE CONVENTION

The Conference of the Parties has adopted guidelines (and one set of policy options and recommendations in the case of Articles 17 and 18) for implementation of specific articles. There are nine such guidelines, which cover a wide range of provisions of the WHO FCTC: the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry (Article 5.3); price and tax measures to reduce the demand for tobacco (Article 6); protection from exposure to tobacco smoke (Article 8); regulation of the contents of tobacco products and of tobacco product disclosures (Articles 9 and 10); packaging and labelling of tobacco products (Article 11); education, communication, training and public awareness (Article 12); tobacco advertising, promotion and sponsorship (Article 13); demand reduction measures concerning tobacco dependence and cessation (Article 14), and the latest addition, provision of support for economically viable alternative activities and protection of the environment (Article 17 and 18).

The reporting instrument of the WHO FCTC provides Parties with the opportunity to give information on the use of these guidelines. In the 2016 reporting cycle, Parties most actively utilized the guidelines for Articles 11 and 8, with three quarters having used them **(Fig. 1)**. The least utilized were the newest guidelines, for Articles 17 and 18, with less than a third of tobacco-growing Parties reporting doing so.

The core questionnaire of the reporting instrument contains voluntary (non-mandatory) questions related to the use of implementation guidelines.

Figure 1. The use of guidelines for implementation of specific articles among reporting Parties in 2016



* The guidelines for Articles 17 & 18 concern tobacco-growing Parties, and the percentage has been calculated among this group.

2. OVERALL PROGRESS IN IMPLEMENTATION OF THE CONVENTION

Current status of implementation[10]

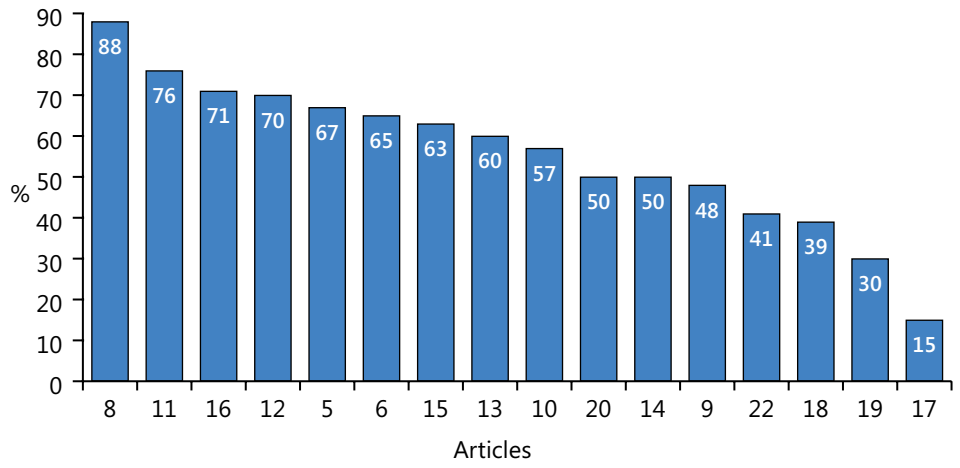
Implementation status was assessed on the basis of information contained in the Parties' 2016 implementation reports. A total of 148 key indicators were considered across 16 substantive articles[11] of the Convention. The indicators used are presented in **Annex 1**.

Fig. 2.1 presents the average implementation rate[12] of each substantive article as reported by the Parties in 2016. The figure shows that the implementation rates across the articles are very uneven, ranging from 15% to 88%. The articles with the highest rates, defined as having average implementation of 65% or more across the 133 Parties analysed, are, in descending order: Article 8 (Protection from exposure to tobacco smoke); Article 11 (Packaging and labelling of tobacco products); Article 16 (Sales to and by minors); Article 12 (Education, communication, training and public awareness); Article 5 (General obligations) and Article 6 (Price and tax measures to reduce the demand for tobacco).

They are followed by a group of articles for which the implementation rates are in the middle range of 41% to 64%, namely, and again in descending order: Article 15 (Illicit trade in tobacco products); Article 13 (Tobacco advertising, promotion and sponsorship); 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) and Article 22 (Cooperation in the scientific, technical and legal fields and provision of related expertise).

The articles with the lowest implementation rates, of 40% or less, are: Article 18[13] (Protection of the environment and the health of persons); Article 19 (Liability); and Article 17 (Provision of support for economically viable alternative activities).

Figure 2.1. **Average implementation of substantive articles of the Convention in 2016**



[10] The status of implementation was assessed as at 30 April 2016.

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

[12] Implementation rates for each indicator were calculated as the percentage of the reporting Parties that provided an affirmative answer in respect of implementation of the provision concerned.

[13] The average implementation rates for Articles 17 and 18 are calculated only among Parties which report tobacco growing in their jurisdiction in the reporting instrument.

When assessing the development in the overall implementation rates of the substantive articles in the reporting cycle 2014–2016, relatively few changes were observed. Five articles attracted positive changes of at least 5 percentage points over the past two reporting cycles: Article 6 (Price and tax measures to reduce the demand for tobacco), Article 15 (Illicit trade in tobacco products), Article 17[14] (Provision of support for economically viable alternative activities), Article 18 (Protection of the environment and the health of persons) and Article 19 (Liability).

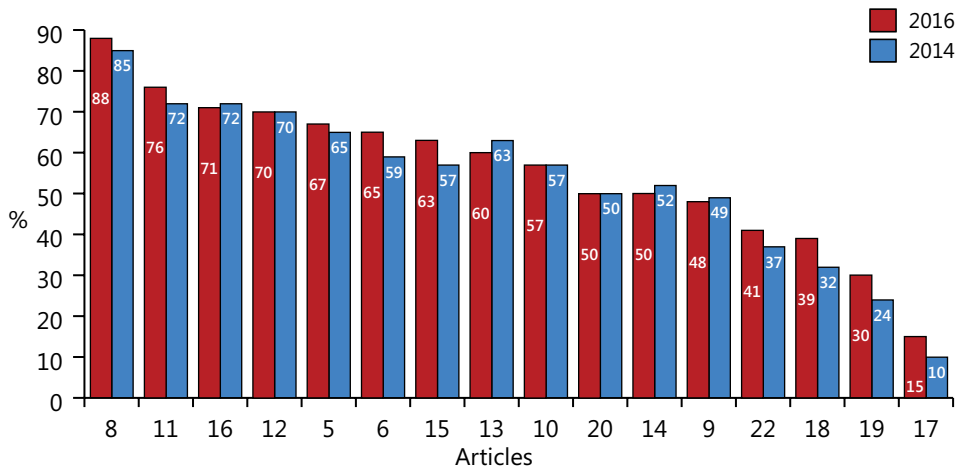
Time-bound measures

There are several indicators under Article 11 (concerning the size, rotation, content and legibility of health warnings, banning of misleading descriptors, etc.) and Article 13 (concerning adoption of a comprehensive ban and coverage of cross-border advertising, promotion and sponsorship) to which timelines of three and five years apply after entry into force of the Convention for each Party. In addition, in relation to Article 8 of the Convention, although there is no timeline imposed in the Convention itself, the guidelines for implementation of this article recommend that comprehensive smoke-free policies be put in place within five years of entry into force of the Convention for that Party.

Two out of the three articles mentioned in the paragraph above (Articles 8 and 11) are currently the two most widely implemented, thus sustaining their places in the top of all articles since 2014. By contrast, Article 13 still has a notably lower implementation rate in 2016. **(Fig. 2.2)**.

The time-bound measures were addressed in detail in the 2012 global progress report.[15] Since then, the three-year deadline for implementation of Article 11 has passed for most Parties, as have the five-year deadlines in relation to Articles 8 and 13. The figures on average implementation rates of these articles allow us also to conclude that a good number of Parties have apparently still not addressed the time-bound provisions of the Convention. It is therefore important that Parties which have not yet implemented the time-bound requirements of the Convention do so as early as possible.

Figure 2.2. Average implementation rates of substantive articles in 2014 and 2016.



Note: for Articles 17, 18 and 19 the method of calculation of the average implementation rates has changed from previous years.

[14] The average implementation rates for Articles 17 and 18 are calculated only among Parties which report tobacco growing in their jurisdiction in the reporting instrument.

[15] See pages 73–93 of the 2012 report (available at www.who.int/fctc/reporting/summary_analysis/en/).

3. IMPLEMENTATION OF THE CONVENTION BY PROVISION

Article 5 *General obligations*

Key observations:

- Positive approaches to multisectoral cooperation continue to be documented, although several Parties report challenges in working with non-health sectors.
- Greater synergies have been established by Parties, in particular, in response to prevention and control of all risk factors associated with noncommunicable diseases. For example, including tobacco as a risk factor in national health plans and strategies which have a broader health scope.
- Tobacco industry interference remains the most important barrier to effective implementation of the Convention.
- Parties' reports indicate that interference by the tobacco industry precludes the approval of legislation in a timely manner. This burdens Parties' time and resources.

Comprehensive, multisectoral tobacco-control strategies, plans and programmes (Article 5.1). In 2016, altogether 73% (97) of the reporting Parties indicated having such strategies, plans and programmes in place. It was more prevalent now as in 2014 (67%).

Several Parties reported the development and implementation of new or updated programmes or strategies since the previous reporting cycle (Australia, Azerbaijan, Bangladesh, Belarus, Burkina Faso, Canada, Cook Islands, Côte d'Ivoire, Costa Rica, Croatia, Cyprus, Ecuador, Georgia, Jamaica, Malaysia, Nepal, Norway, Palau, Portugal, Republic of Moldova, United Kingdom of Great Britain and Northern Ireland (Scotland), Thailand, Turkey, Turkmenistan and Viet Nam). An additional 13 Parties (Benin, Bulgaria, Colombia, Congo, Federated States of Micronesia, Gambia, Sao Tome and Principe, Spain, Tajikistan, Togo and Uzbekistan) reported that they have integrated tobacco-control programmes into either noncommunicable or cardiovascular disease prevention programmes/strategies or programmes/strategies covering addictions to tobacco, alcohol and other drugs (Gabon and Sweden).

Infrastructure for tobacco control (Article 5.2(a)). A majority of the reporting Parties, 87% (116), had a nationally designated focal point for tobacco control, and 65% (87) had a tobacco-control unit established. As in 2014, most focal points are based in either a health ministry or a public health agency under the direction of a health ministry. In some cases, the health and social ministries are combined. A national coordinating mechanism for tobacco control existed in 77% (102) of the reporting Parties. These mechanisms often involve government departments and agencies and other key stakeholders, as appropriate, and are established by law or by other executive and administrative measures.

A joint review of tobacco control infrastructure and governance in Sub-Saharan Africa was undertaken by the UN Development Programme (UNDP) and the Convention Secretariat.[16]

[16] http://www.who.int/fctc/FCTC-5.2A-NCM-Africa.pdf?ua=1

Several Parties provided additional details on their tobacco control infrastructure. For example, in Brazil, there are two mechanisms[17] in place whose work is relevant to implementation of the Convention: the National Commission for the Implementation of the WHO FCTC and the National Cancer Institute. In the Republic of Korea, the Division of Health Promotion in the Bureau of Health Policy at the Ministry of Health and Welfare is designated as the responsible entity for the development and implementation of national tobacco control policies. Six government officials, including two deputy directors and four officers, are fully involved in tobacco related policies and programmes. In Sri Lanka, a multisectoral plan for tobacco control required each sector to implement planned activities for tobacco control. In Micronesia, the Tobacco Control Advisory Council acts as the national coordinating mechanism. Its roles and responsibilities are included in the Terms of Reference approved by the President of the country.

An emerging trend within Parties' reports shows a strengthened synergy between prevention and control of the main risk factors for noncommunicable diseases. At a domestic level, several Parties reported that they are the focal point responsible for tobacco control or the tobacco control unit within the organizational structure dealing with the prevention of noncommunicable diseases within the responsible ministry.

Adopting and implementing effective legislative, executive, administrative and/or other measures. (Article 5.2(b)) Parties' reports show that most progress in implementation of the Convention is achieved through the adoption and application of new legislation or the strengthening of already existing tobacco-control legislation. Strengthening implementation also includes efforts to streamline enforcement of existing legislation.

Several Parties (Gabon, Georgia, Jamaica, Kuwait, Madagascar and Turkmenistan) reported new comprehensive tobacco-control legislation since the last reporting period in 2014, while others reported amendments to tobacco-control legislation to strengthen and improve its alignment with the requirements of the Convention.

One example of new regulation is the European Union's (EU) Tobacco Products Directive 2014/40/EU, which impacts tobacco control legislation in many European Parties.

Several other Parties are yet to adopt or strengthen their tobacco control legislation. Furthermore, several Parties (Antigua and Barbuda, Bahamas, Burundi, Gambia, Georgia, Guyana, Mauritania, Papua New Guinea and Saint Lucia) reported that there are delays, sometimes of more than five years, in passing tobacco control bills.[18]

[17] The National Commission for the Implementation of the WHO FCTC (CONICQ) was established by a federal decree and coordinates with national ministries the work related to implementation of the Convention, thus reflecting the multisectoral aspect of the treaty. The Commission works on areas related to several articles to the Convention, including Article 6 (price and tax measures), Articles 9 and 10 (regulation of contents, emissions and disclosures), Article 11 (packaging and labelling), Article 13 (tobacco advertising, promotion and sponsorship) and all supply reduction measures, including Articles 17 (alternatives to tobacco growing) and 18 (protection of the environment). Other articles of the Convention, such as Article 8 (smoke-free environments), Article 12 (education, communication) and Article 14 (tobacco cessation) are also dealt with by the National Commission, for instance by promoting national laws, communication campaigns and regulations and norms for smoking cessation support. Implementation of these articles is addressed at both state and municipal levels, as is the enforcement of measures under Articles 8 and 13 of the Convention. These mechanisms to implement tobacco control measures in the country through focal points at state level is more relevant for Articles 8, 12 and 14 (through state and municipal health bureaus and Article 14 also through the health system), while enforcement of Articles 8 and 13 falls under state and municipal competence (surveillance system under ANVISA's regulatory framework). The National Cancer Institute (INCA) is a body subordinated to the Ministry of Health, and is responsible for implementing the National Tobacco Control Policy, and also works together with focal points among state secretariats of 26 states and the Federal District.

[18] This might suggest potential tobacco industry interference, but other internal factors, such as lack of technical/financial resources, competing priorities and volatile socio-economic-political circumstances, might also play a role.

Overall, 142 (82%) of the Parties strengthened existing legislation or adopted new tobacco control legislation after ratifying the Convention, of the 173 Parties that have submitted at least one implementation report since the Convention took effect.

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

As in 2014, a continuous trend towards more comprehensive national tobacco control legislation, where Parties continue to include new areas of the Convention in their legislation, for example Article 5.3 (preventing tobacco industry interference) and Article 12 (education and communication), amongst others.

REPUBLIC OF PALAU: TOBACCO CONTROL INFRASTRUCTURE CREATED AND PROGRAMMATIC ACTIVITIES STRENGTHENED

In accordance with Article 5.2(a), the Republic of Palau established a new national coordinating mechanism, which integrates tobacco control with the prevention of noncommunicable diseases. The coordinating committee includes representatives from different ministries and agencies, and co-operates closely with civil society and the private sector, where appropriate. The coordinating mechanism was established in May 2015 by Presidential order.

The first meeting of the Committee took place in June 2015.

In parallel, a national strategic plan fully complying with the Convention and aligned with WHO Global Targets for NCDs works towards a 30% reduction in the prevalence of tobacco use by 2025. Other short-term goals of the national plan include: improved capacity for tobacco dependence treatment, education and training activities, the introduction of monitoring and evaluation systems, and the earmarking of tobacco tax revenues for tobacco control purposes.

The Bureau of Public Health in the Ministry of Health is currently funded from external sources and both the focal point and the tobacco control units in Palau are set within this structure.

Photo: First meeting of the national coordinating mechanism on 10 June 2015.

Protection of public health policies from commercial and other vested interests of the tobacco industry (Article 5.3). In relation to Article 5.3, altogether 69% (92) of the reporting Parties had adopted or implemented measures to prevent tobacco industry interference. This was a similar proportion to the previous reporting period. It was now more common that the public had access to information on the activities of the tobacco industry. However, it remains a much-underutilized measure, implemented by 33% (44) of reporting Parties.

The trend for Parties to include implementation of Article 5.3 in national legislation (and other policy documents, such as strategy documents and action plans), has continued, with 11 Parties reporting such action. For example, in the comprehensive tobacco control legislation adopted in August 2013 in Gabon, a standalone section describes the measures to protect tobacco control policies from the commercial and other vested interests of the tobacco industry. Subsequently, the newly adopted tobacco control strategy for 2016–2020 foresees the development of additional regulations to prevent tobacco industry interference. The new tobacco control act of the Republic of Moldova, adopted in May 2015, also includes several requirements, as part of measures to "increase the efficiency of public policies related to tobacco", that are recommended by the guidelines for implementation of Article

5.3 adopted by the COP. Finally, Uganda's new tobacco control act, approved by Parliament in September 2015, addresses Article 5.3 of the Convention in a comprehensive manner; making it the duty of the government to protect tobacco control policies from tobacco industry interference and to ensure transparency of any interactions with the industry that still occur.

Additionally, more Parties reported the use of national workshops or other communication channels to inform government departments other than health on their obligations under Article 5.3 of the Convention. For example, in Turkey the Tobacco and Alcohol Market Regulatory Authority (TAPDK) in collaboration with the Ministry of Health and WHO organized two workshops to promote implementation of Article 5.3 and measures in line with its guidelines. In some cases, for example in Jordan, national consultations were followed by the elaboration of national guidelines on implementation of Article 5.3.

Pakistan developed standard operating procedures on government officials' interactions with the tobacco industry in line with the recommendations of Article 5.3 guidelines, while in India a code of conduct for government officials is currently being elaborated. In the Philippines, progress in further promoting the 2010 Joint Memorandum Circular on "Protection of the Bureaucracy Against Tobacco Industry Interference" resulted in 70 other agencies at national, regional and local government levels adopting the said policy. The mechanism established for the monitoring of the Joint Circular also includes an online form to complain about violations. The experience of the Philippines has been shared with other Parties as part of a joint Convention Secretariat/ UNDP south-south and triangular project focusing on implementation of Article 5.3.

JAMAICA: PROMOTING IMPLEMENTATION OF ARTICLE 5.3 AND THE IMPLEMENTATION GUIDELINES

Jamaica engaged in a comprehensive and multisectoral approach to implementation of Article 5.3 of the Convention. This work intensified after the joint assessment of the country's needs in implementing the WHO FCTC, an effort coordinated between the Convention Secretariat, the Government of Jamaica, PAHO/WHO and other partners.

The report of the mission[19] noted that "in meeting with representatives of various government ministries and agencies, the international team found that the tobacco industry still interferes with the development of public policies, and sponsors diverse activities and implements community-based projects described by the industry as 'Corporate Social Responsibility', often in direct or indirect partnership with government agencies. In many cases, government officials are not aware of these activities or do not perceive them to be a conflict of interest. In some cases, the tobacco industry is viewed as a legitimate stakeholder."

The country identified tackling tobacco industry interference as a priority in the post-needs assessment phase. In June 2015, a national workshop on tobacco industry interference was held with the participation of high level officials from a number of ministries, departments and agencies, the WHO country office, UNDP and civil society organizations. Awareness was raised and concerns were addressed regarding the implementation and enforcement of Article 5.3 of the Convention.

Following this workshop, the Ministry of Health further engaged with and hosted additional workshops regarding the implementation of Article 5.3 with the Ministry of Justice and other relevant stakeholders, in addition to the Jamaica Customs Agency. A session was also held with parish mayors. These discussions contributed to the elaboration of a separate section on Article 5.3 in the Draft Discussion Bill on tobacco control, which is to be reviewed by the current administration. The Draft takes into account the recommendations of COP guidelines on Article 5.3.

Learning from its experience, Jamaica is now participating in the joint Convention Secretariat/UNDP south-south and triangular cooperation project on "community of practice on tobacco industry interference", and is transferring its knowledge to other WHO regions at meetings.

Photo: Pictures taken at the national workshop on tobacco industry interference. On the left, the-then Jamaican Health Minister, Dr Fenton Ferguson, addressing the workshop.

Some Parties still report that progress is difficult in this area; this is reflected in the fact that interference from the tobacco industry is considered the most important barrier to implementing the Convention. Some reporting Parties provide specific examples of such

[19] http://www.who.int/fctc/implementation/needs/Jamaica_Needs_assessment_report_english.pdf?ua=1

THE CONVENTION SECRETARIAT ADVANCES THE ESTABLISHMENT OF A GLOBAL INFORMATION PLATFORM OF SENTINEL CENTRES TO MONITOR TOBACCO INDUSTRY INTERFERENCE (OBSERVATORIES) [20]

The project, initiated in the BRICS framework with political support from the BRICS health ministers, soon generated interest beyond this five-nation group, and has made some advances in the past two years.

The Observatories are expected to be hosted by academic, public health or similar (e.g., semi-autonomous government-based agencies) institutes among Parties with relevant expertise and capacity. They work to monitor tobacco industry activities and interference with public policy and to promote research and information exchange for the benefit of the country, the subregion and region. In addition – through their observations and training programmes – all Parties to the Convention should eventually benefit from their work.

The first Observatory was launched in Brazil in March 2016. Two further Observatories are being established in South Africa and Sri Lanka, with others to come.[21]

Photo: Dr Vera Luiza da Costa e Silva at the opening ceremony of the Brazilian Observatory on 31 March 2016.

interference. The fact that several Parties reported that there are delays, sometimes of more than five years, in passing tobacco control bills also suggests potential tobacco industry interference. Other internal factors might be involved e.g. lack of technical/financial capacity, changing priorities and volatile circumstances. To enable Parties' monitoring of tobacco industry activities, the Secretariat engaged with Parties which volunteered to establish tobacco industry monitoring centres, known as Observatories.

It is to be noted, that implementation of Article 5.3 by the Parties is extensively examined as part of other Convention Secretariat activities which are aimed at gathering knowledge and/or providing assistance to the Parties in their implementation work. The range of activities related to implementation of Article 5.3 is described in another document[22]. Such efforts result in the documentation and promotion of a series of tools[23] that Parties, in their turn, can use during implementation work.

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

[20] http://www.who.int/fctc/implementation/knowledge-management/

[21] The project is funded through extrabudgetary contributions from Brazil, European Union, Panama and Russian Federation. The Union, an Observer to COP, kindly contributes with technical and financial resources to the Observatories.

[22] http://www.who.int/fctc/cop/cop7/FCTC_COP_7_7_EN.pdf?ua=1

[23] http://apps.who.int/fctc/implementation/database/article/article-5/resources

Measures relating to the reduction of demand for tobacco

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

Key observations:

- Advanced practices in tobacco taxation, including effective collaboration with the finance sector, continue to increase, and include experiences in dedicating revenue for tobacco control Globally however, the reports received in 2016 show the simple average of Parties' tax shares in cigarette prices was lower.
- It is now more common for Parties to prohibit or restrict duty-free tobacco sales to international travellers and imports of non-taxed tobacco products by international travellers, than in 2014.
- The Addis Ababa Action Agenda identifies tobacco taxation as a mechanism to increase resources to fund implementation of the new sustainable development goals. This marks an important international development.
- Information on the tax regimes of tobacco products other than cigarettes is still inadequate and this lack of information prevents an assessment of the global status of such products. Data collection needs to be intensified for these products through, for example, a stronger involvement of relevant sectors in data collection at a national level, and promoting the exchange of taxation-related information at an international level between the UN agencies and intergovernmental organizations that collect and manage such data.

Taxation of tobacco, a highly effective element of the treaty if implemented fully and systematically as required in Article 6 of the Convention and related implementation guidelines, could contribute to the achievement of several Sustainable Development Goals (SDGs). Rising tobacco taxes make those products less affordable and induce smokers to quit or reduce consumption. Although in the short run smokers may experience budget restrictions to accommodate tobacco price increases, in the medium and long run, as they quit or reduce consumption, smokers will spend more on healthy choices such as education, and less as a result of tobacco-related diseases. Consequently, tobacco tax and price increases improve health (Goal 3), contribute to productive lives and household incomes, thus indirectly eradicating poverty (Goal 1), augmenting the consumption of other products and leading to less hunger (Goal 2). This may also lead to better education, which could, in turn, also help people to escape poverty (Goal 1).

Taxation of tobacco products. Sufficient information for analysis of tobacco taxation policies was provided by 126 out of 133 Parties[24]. Still, as in the case of previous reporting cycles, most of the available data refer to cigarettes. For other tobacco products, data were insufficient for the calculation of price and tax rate averages or for trend analysis.

Excise tax on cigarettes was levied in some form by 117 out of the 126 Parties included in the analysis, while the other nine Parties (none of which have local cigarette production), reported that they only apply import duties **(Table 1)**.

The overall distribution of types of excise taxes has not changed significantly since 2014 among the Parties that provided enough data. Among reporting Parties, 72% apply either

[24] The European Union, a Party to the WHO FCTC, provides a framework of action for its Member States in the area of tobacco taxation. Since the EU's guidance is eventually reflected in the Member States' policies, we included in this calculation those Member State Parties that reported in the 2016 reporting cycle.

Table 1. Cigarette excise regimes in 2016, by WHO region

WHO Region	TYPE OF EXCISE TAX						Import duty	%	Total
	Specific only	%	Ad Valorem only	%	Both Specific and ad valorem	%			
Africa	7	27	11	42	8	31	0	0	26
Americas	9	43	5	24	6	29	1	5	21
South-East Asia	2	33		0	2	33	2	33	6
Europe	3	8	4	10	33	83		0	40
Eastern Mediterranean	2	13	5	31	3	19	6	38	16
Western Pacific	14	82	1	6	2	12		0	17
Overall	**37**	**29**	**26**	**21**	**54**	**43**	**9**	**7**	**126**

a specific excise alone, or a combination of specific and ad valorem excise. The proportion of Parties applying ad valorem excise alone increased from 18% in 2014 to 21% in 2016.

The predominant taxation regime varies by region. Parties from Europe continue to favour the combination of specific and valorem rates, while Parties in the Western Pacific maintain a preference for specific tax only. A changing pattern is observed in Africa where compared to 2014 Parties seem to be moving towards a preference for a combination of specific and ad valorem tax. Compared to the last report, the South-East Asia region shows a reduction of countries with ad valorem rates, while Eastern Mediterranean countries are increasing the use of excise duties, with a parallel reduction in the number of Parties preferring import duties alone.

The worldwide simple average of total tax share on cigarette prices is 58% (minimum tax burden 5%; maximum tax burden 90%). This average is lower than in 2014, although tax burden indicators show significant differences among the Parties and WHO Regions.

Prices of tobacco products. **Table 2** presents maximum and minimum cigarette prices in US dollars per WHO region, and the ratio of maximum to minimum prices within the region is also calculated.[25] There are large differences in prices between Parties and regions. From an analytical point of view, a positive price trend within a region could be characterized by an increase of minimum prices and a reduction of the ratio of maximum to minimum prices, because smaller price differences between countries of a region reduce incentives for the illicit tobacco trade and cross–border shopping. The South-East Asia and Western Pacific regions present a favourable price trend, because minimum prices have increased and the ratios of maximum to minimum have decreased between reporting periods. The African and Americas regions show a similar price situation when 2014 and 2016 are compared. The European and Eastern Mediterranean regions present a negative price trend, as their calculated minimum prices are lower than in 2014, and their ratio of maximum to minimum price has increased. Two regions display a high ratio of maximum to minimum price: the African and European regions, but price distribution is different; in the case of Africa, prices are concentrated close to the minimum, while in the case of Europe, prices are close to the maximum.

[25] Data on cigarette prices presented in this table originate from the reports of the Parties submitted in 2014 and 2016, respectively.

Table 2. **Minimum and maximum prices for a pack of 20 cigarettes in US dollars by WHO region in 2014 and 2016**

WHO Region	2014			Number of countries in 2014	2016			Number of countries in 2016
	Minimum (country)	Maximum (country)	Ratio		Minimum (country)	Maximum (country)	Ratio	
African	0.4	5.3	15.1	20	0.5	8.4	17.1	16
Americas	1	7.8	7.8	17	1.0	7.5	7.7	20
South-East Asia	0.4	2.4	6.9	5	1.5	2.9	1.9	3
European	0.6	16.4	29.8	47	0.4	15.4	35.1	36
Eastern Mediterranean	0.8	2.4	3.1	10	0.6	3.3	5.6	13
Western Pacific	0.8	16.1	21.5	22	2.6	15.2	5.8	14

Changes in taxation across reporting cycles. In terms of changes in taxation policies adopted by the Parties to the Convention between reporting periods, the following trends could be observed: increasing specific or ad valorem rates; changing from a single type of rate to a combination of the two; changing from ad valorem to specific rate; and no policy change. It is to be noted that several Parties have not provided any tax information, which could be taken as a sign of no policy change or lack of data to be reported. The most frequent policy change was to increase the specific rate (53 Parties out of 132, or 40% of total reporting). There were 34 Parties (26%) reporting no change to taxation policies between the two reporting periods, and 29 Parties (22%) have entered no information on taxation in their reports. Besides that, a number of countries also implemented positive adjustments to their taxation regimes, i.e. imposing surcharge rates to their imports of tobacco products (two Parties), changes from specific or ad valorem rate to a combination of the two (four Parties), changing from multiple ad valorem rates to a single ad valorem rate or from ad valorem to specific rate (two Parties).

In relation to specific tax rates, it is also relevant to record the modalities of the increase and to see how active Parties in the different regions are increasing specific taxes **(Table 3)**. Options for policies concerning specific taxes include: increase of specific rates only (when Parties have a purely specific or a mixed–excise regime); increase of the specific rate and minimum tax (particularly in the European states applying a mixed excise system with minimum tax); and increase of the specific rate and altering the ad valorem rate (increase or decrease, where the Party has a mixed excise system). Some Parties increased their specific rate above inflation (Ireland and the United Kingdom in the European region; Australia and New Zealand in the Western Pacific region). **Table 3** displays the various options for amending specific rates by region. The table shows that Parties across the regions prefer to increase specific rates only. In this context, Parties in the European and Western Pacific regions and in the region of the Americas have been active in increasing specific rates. A few Parties in those regions (such as Colombia, Costa Rica and the Philippines) have predetermined rules for adjusting their applicable specific rates to account for inflation or other parameters; some others, e.g., those that are in the process to joining the European Union are making adjustments to match their tobacco tax policy to the EU excise duty regulations. In the South-East Asia, African and Eastern Mediterranean regions, a lower proportion of Parties (20% or fewer) increased specific rates and subsequently prices – Parties from these three regions have lower cigarette prices (expressed in US dollars) when compared to the other three regions **(Table 2)**.

Table 3. Reported modalities of and the regional distribution of increasing specific rates

WHO Region	Increase specific rates only		Increase specific rates and minimum tax level (countries with mix system) (C)	Increase specific rates above inflation (D)	Increase specific and ad valorem rates (E)	Increase specific rates and decrease ad valorem rates (F)	Number of countries with specific and mix system per region in this report (G)	Countries making an increase/ total number of countries with a specific component [(A) to (F)] / (G)
	Purely Specific System (A)	Mix system (B)						
AFRO	2	1					15	20%
AMRO	8	3			1		15	73%
EMRO	1						5	20%
EURO	3	10	7	2	2	2	36	72%
SEARO	1				1		4	0.5
WPRO	7			2			16	56%
Total number of countries	**22**	**14**	**7**	**4**	**4**	**2**	**91**	**58%**

Thirty-four countries reported that they have not implemented tobacco tax policy changes between the last two reporting periods **(Table 4)**. The South-East Asia, European and Western Pacific regions showed the lowest percentage of Parties with no tax policy change across these two reporting cycles; the highest proportions of no change and no information are found in the African and Eastern Mediterranean regions (both 71%).

In terms of tobacco tax policy and all other issues discussed so far, Africa seems to be in the most vulnerable position of all WHO regions. It has the largest proportion of countries with ad valorem rates (42% in Table 1), which is the less effective tax system to increase prices and reduce consumption. It also has one of the lowest minimum prices (0.4 US$ in Table 2) and the highest proportion of countries with no policy change and no information about policy change (71.4% in Table 4).

Earmarking tobacco taxes for funding tobacco control. Twenty-five countries have reported dedicating revenue stemming from tobacco taxation to fund health programmes, but only 10 Parties – Chile, Cook Islands, Costa Rica, Iceland, El Salvador, Honduras, Iran (Islamic Republic of), Panama, Poland and Viet Nam – directed resources to tobacco control. Other Parties also utilize resources stemming from tobacco taxation to health promotion and noncommunicable disease prevention programmes, or for health financing and cancer treatment. Additionally, Cote d'Ivoire dedicates 5% of tobacco taxes to funding sports activities and Iran (Islamic Republic of), according to its tobacco control act, dedicates up to 2% of all taxes collected through the sale of tobacco products for programmes of public associations and NGOs working in tobacco control. El Salvador has created a more complex solidarity health fund, which also includes revenues deriving from tobacco taxation.

In 2015, the Convention Secretariat conducted additional research on Parties' experience with the designation of tobacco taxes[26], providing a useful resource for Parties contemplating such measures. In July 2015, UN member states adopted the Addis Ababa Action Agenda at the Third International Conference on Financing for Development. The

[26] See the report of the study at : http://apps.who.int/fctc/implementation/database/groups/convention-secretariat-who-fctc-study-parties-experience-dedication-tobacco-taxes-2015

Table 4. Regional distribution of "no change" and "no information provided" options on tax policy

WHO Region	No Changes	Percentage over reporting countries in the region (%)	No Information	Percentage over reporting countries in the region (%)	Percentage of countries with no change and no information	Number of reporting countries
AFRO	6	21.4	14	50.0	71.4	28
AMRO	7	29.2	4	16.7	45.8	24
EMRO	9	52.9	3	17.6	70.6	17
EURO	8	20.0	3	7.5	27.5	40
SEARO	1	16.7	2	33.3	50.0	6
WPRO	3	17.6	3	17.6	35.3	17
Total	**34**	**26**	**29**	**22.0**	**47.7**	**132**

GAMBIA: TOBACCO TAX REFORM IN A LOW-INCOME SETTING

Gambia is a small, low-income country in West Africa, with fewer than 2 million people and GDP per capita of US$ 435. The country has raised cigarette taxes significantly in several increments since 2012 as part of its comprehensive tobacco control efforts, and also has increased the tax burden on other tobacco products to ensure consumers do not substitute with cheaper goods.

In 2013, following the recommendations of the needs assessment exercise conducted jointly by the Convention Secretariat and the Government of Gambia, the base tax for cigarettes was changed from kilograms to packs. Similarly, specific excise rates for cigarettes were increased by 51% and excise tax was introduced for other tobacco products. Subsequently, the WHO Regional Office for Africa and the Centre for Tobacco Control in Africa assisted the country in developing a new, three-year plan to greatly increase the tax rates of cigarettes and other tobacco products.[27] This included a more significant rise in the first year of the plan (2014), followed by tax rate increases of above the expected inflation rate and real GDP growth for 2015 and 2016. Additionally, the rate of environmental tax was considerably increased in 2014, and by around 10% in the following two years.

The following table presents the changes in tax rates on cigarettes and other tobacco products; the table also shows the so-called environmental tax which was simultaneously increased.

Cigarettes	**2012**	**2013**	**2014**	**2015**	**2016**
Excise tax (Gambian Dalasi (GMD)/pack, unless otherwise stated)	165/kg or 3.30	5	9	12	15
Environmental tax (GMD/pack, unless otherwise stated)	10/kg or 0.20	10/kg or 0.20	2.10	2.20	2.42
Variation of excise tax rate per pack (%)		51.5	80	33	25
Variation of excise tax + environmental tax per pack (%)		47.3	113.5	28	22.7
Other tobacco products	**2012**	**2013**	**2014**	**2015**	**2016**
Excise tax (GMD/kg)	NA	37.50	150	200	300
Environmental tax (GMD/kg)	75	75	100	110	120
Variation of excise tax + environmental tax per kg (%)		50	122.2	24	35.5
Expected growth of nominal GDP (%), according to World Economic Outlook - IMF			**6.4**	**11.1**	**10.5**

[27] http://bit.ly/2eClcuR

GAMBIA: TOBACCO TAX REFORM IN A LOW-INCOME SETTING *(continued)*

The next table shows the outcome of the tax reform. As a result of the changes in taxation, the price of the most popular cigarette brand increased in 2013 and 2014, but remained unchanged in 2015. Consequently, the ratio of cigarette price and GDP per capita (which is indicative of the affordability of cigarettes) rose by more than 50% between 2013 and 2014, meaning that cigarettes became less affordable.

Subsequently, imports of cigarettes and other tobacco products seem to have declined between 2012 and 2014 by almost 50% in the case of cigarettes, and around 85% in case of other tobacco products. In the same period, excise revenues almost tripled, whereas the share of tobacco excise revenues in GDP more than doubled.[28]

The example of Gambia indicates that it is possible to increase revenue through a significant change of tobacco excise tax rates, even in a low-income context and with declining government revenue/GDP ratio. This example also shows the need for Parties to the Convention to make use of the guidelines on Article 6 of the Convention, adopted in 2014.

Prices, imports, revenues	2012	2013	2014	2015
Average retail price of a pack of the top-selling cigarette brand (GMD/pack)	NA	25	40.6*	40.6**
Affordability index (100 packs of the top-selling brand/GDP per capita) (%)		14.5	22.8	21.0
USD price of the top-selling brand		0.75	1.78	0.85
Imports of cigarettes ('000kg)***	1048.94	597.94	540.36	
Imports of other tobacco products ('000kg)***	71.86	25.39	10.45	
Excise tax revenue (million GMD)* **	**89.9**	**169.97**	**261.82**	**284**
Cigarettes	88.62	166.91	257.69	
Other tobacco products	1.28	3.06	4.13	
Tobacco excise tax revenue/GDP (%)	**0.31**	**0.53**	**0.76**	**0.743**
Central Government Revenue/GDP (%), according to World Economic Outlook - IMF	25.3	18.5	22.5	21.7

Notes: * WHO Global Tobacco Control Report, 2015, ** 2016 Global Progress Report on the implementation of the WHO FCTC; *** Nargis N, Manneh Y, Krubally B, et al (2016); GDP per capita and GDP in local currency WEO-IMF

document represented an important global development, providing the foundations for the Sustainable Development Goals. In particular, signatories agreed to consider taxing harmful substances to deter consumption and to increase domestic resources, agreeing that taxes on tobacco reduce consumption and can provide significant revenue for many countries.[29]

Tax- and duty-free tobacco products. More than 65% of the Parties reported that they prohibited or restricted imports of tax- and duty-free tobacco products by international travellers, reflecting a notable increase compared with 2014 when 59% of the Parties reported such a policy.

[28] Unfortunately, there are no new prevalence data available for Gambia after the implementation of the tax reform. The impact of tax increases on tobacco consumption as well as related health consequences are still to be documented.

[29] See para 32 in https://sustainabledevelopment.un.org/frameworks/addisababaactionagenda.

Article 8 *Protection from exposure to tobacco smoke*

Key observations:

- New Parties have joined those introducing comprehensive bans on smoking in public places, through the adoption and enforcement of new tobacco control legislation. Parties need assistance to ensure that this encouraging trend continues by, for example, ensuring the elimination of existing voluntary agreements.
- There is a continuing trend to extend smoking bans to outdoor areas, and special attention seems to have been given to the rights of children to enjoy smoke-free air at outdoor playgrounds and in private cars.
- Banning the use of water pipes and electronic cigarettes in places where smoking is otherwise forbidden is becoming more common.

Measures to protect from environmental tobacco smoke. In 2016, a total of 92% of the reporting Parties had implemented measures to protect 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, where appropriate, other public places. In this group, most Parties (111) did this through national legislation, but 34 reported operating through subnational legislation. Encouragingly, Parties reporting the use of voluntary agreements to ensure protection from exposure to tobacco smoke is decreasing, with only 20 Parties declaring such accords.

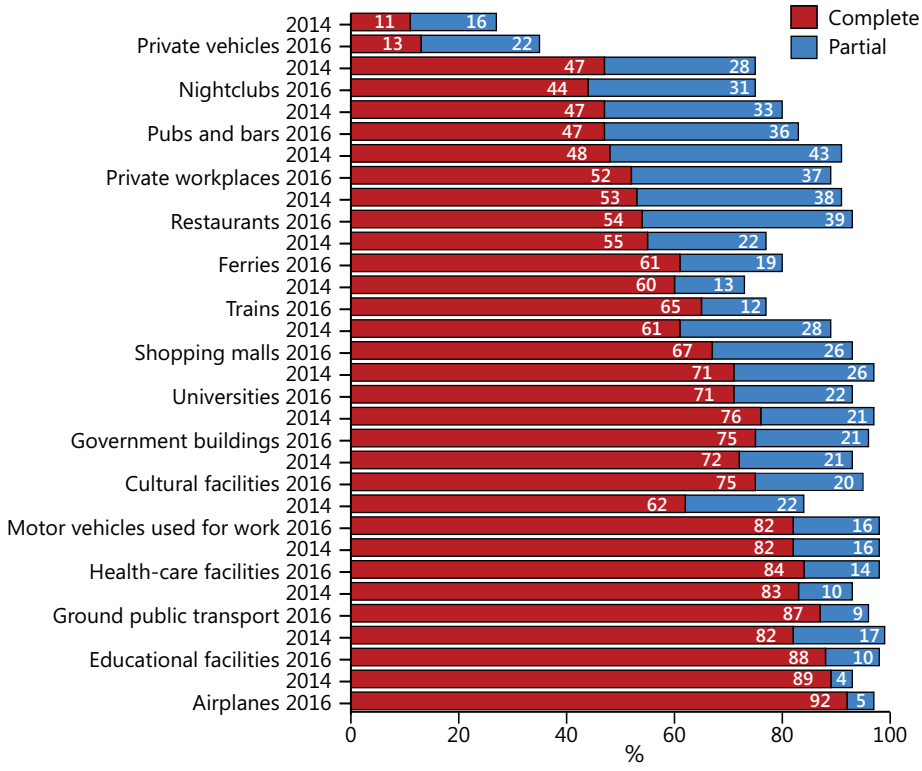
Although implementation rates of smoking bans in the studied settings showed generally small changes (see **Figure 3.1.**), it is worth reiterating that the most frequently covered areas, especially for complete bans, have remained aeroplanes, educational facilities, surface public transport, health and cultural facilities, and government buildings. This year, a very positive change was noted in relation to comprehensive smoking bans in motor vehicles used for work: the percentage of Parties enforcing this as part of their smoke-free policies rose from 62% in 2014 to 82% in 2016. Encouragingly, implementation rates also show slight increases for bans in private cars when children are present.

When identifying areas of progress, Parties focused on the need to implement existing laws and regulations, on monitoring and where appropriate extending smoke-free policies, while a few Parties adopted new legislation. It is worth mentioning that Parties have now started to ban smoking in settings previously considered too difficult, for example, in prisons. In 2016, smoking was banned in Welsh prisons, as well as four jails in England. The bans were soon overturned by the Court of Appeal, but the Ministry of Justice is still allowed to introduce its own voluntary, phased controls on smoking. In Australia, from 1 July 2015, smoking was banned in all areas at prisons in Victoria.

A few Parties (Australia, Canada, China, Malaysia and Mexico) reported progress at subnational level and five (France, Ireland, Italy, Slovakia and the United Kingdom) reported bans on smoking in private cars in the presence of children. In Italy, smoking in cars is also forbidden in the presence of a pregnant woman. Earlier trends extending smoking bans to outdoor areas, mostly beaches and playgrounds, continued. Three European Parties (Hungary, Latvia and Spain) reported that they had limited the use of ENDS/ENNDS in all places with smoking bans.

The trend continued of further extending existing smoking bans to outdoor areas or otherwise. For example, France introduced a smoking ban in playgrounds effective from 1 July 2015, with a 68 euro fine for infractions. This measure widened the 2007 smoking ban which covered cafés, hotels, bars, restaurants, discos and casinos. Estonia banned smoking on public beaches, following the example of Italy. In Canada, comprehensive

Figure 3.1. Settings covered by Parties' smoke-free bans in 2014–2016



smoke-free legislation has been passed in all subnational jurisdictions, and numerous municipalities have adopted bylaws or policies to prohibit smoking in public places such as patios, playgrounds and parks. For example, 2015 regulatory amendments in the province of Ontario prohibit the smoking of tobacco on and around children's playgrounds and publicly-owned sporting areas; the sale of tobacco on post-secondary campuses and in schools, childcare centres including those in private homes; and smoking on all restaurant and bar patios. In China, while the adoption of a nationwide ban of smoking is still to materialize, the number of cities which banned smoking has increased to 18 since the entry into force of the Convention. Seven cities (Beijing, Xining, Shenzhen, Lanzhou, Changchun, Tangshan and Fuzhou) joined those adopting their own smoke free laws and regulations since the previous reporting cycle.

Mechanisms/infrastructure for enforcement. The majority of reporting Parties, 86% (105), have established a mechanism/infrastructure for the enforcement of smoke-free measures. Overall, Parties seem to give more attention to the enforcement of smoke-free measures. For example, Panama has strengthened implementation of the smoking ban by providing more resources to its enforcement infrastructure. These include new equipment like SidePack instruments (to measure concentrations of PM 2.5 particles in the environment) and additional staff training to use the new machinery; new laptops to record the information collected during inspections; cameras to document the evidence found and to record the process of applying the appropriate sanctions. In 2015, Ecuador designated a new authority to enforce smoke-free regulations, thus increasing resources available for this work. Belgium also reported an increase in fines and other sanctions, and observed a diminishment of infractions detected in cafés. Among challenges faced by Parties, a few (Bosnia and Herzegovina, Cook Islands and Oman) reported weak enforcement and insufficient compliance with smoke-free rules.

ENFORCEMENT INFRASTRUCTURE OF THE SMOKING BAN IN COSTA RICA

In Costa Rica, the infrastructure for enforcement of the 2012 tobacco control act[30] is now well established and operational.

Enforcement officers are based at a local level, in Regional Directorates of Health. There are around 225 such officers (for a population of less than 5 million people), but the number seems to be insufficient to perform the task. The officers of the authority provide the overall sanitary control for establishments, along with sewage problems, services, etc. and they also respond to complaints from the public. There are no pre-scheduled random checks. However, the checks must be carried out within a timeframe established by internal regulations.

The public can submit complaints about non-compliance with smoke-free rules by writing to the Ministry of Health at a dedicated email address (controldetabaco@misalud.go.cr), to an external module (National System of Infractions) on the website of the Ministry of Health or, more recently, through a new Facebook application.

Article 36 of the 2012 act sets out the fines applicable to any breach of Article 5, which lists the locations where smoking is prohibited. Fines are linked to base salaries, for example: a) 10% of base salary for smoking in places where it is prohibited; b) 15% of base salary for managers or persons responsible for the respective venue; c) 50% of base salary for those who sell tobacco products in smoke-free areas. According to Article 36 of the law, non-compliance with the regulations might also result in the closure of the premises or establishment.

The revenue from such fines are transferred to the Ministry of Health. The funds are used to build additional capacity for controlling implementation of the tobacco control act of 2012.

The needs assessment exercise, conducted jointly by the Convention Secretariat and the Government of Costa Rica, also reviewed implementation of Article 8 of the Convention and recommended strengthening the control and monitoring of compliance with smoke-free regulations, including an increase in the human resources dedicated for this task. Costa Rica reported that additional capacity will be added in 2017.

Photo: Information materials promoting the implementation of the tobacco act – the "law of life"

[30] http://www.tobaccocontrollaws.org/files/live/Costa%20Rica/Costa%20Rica%20-%20TC%20Law%20No.%209028.pdf

Article 9 *Regulation of the contents of tobacco products*

Article 10 *Regulation of tobacco product disclosures*

Key observations:

- Several Parties still lack legislation or other regulatory measures requiring the testing and measuring of the contents and emissions of tobacco products and the public disclosure of such information.
- Several other Parties reported the adoption of new or amended legislation, including requirements for reduced ignition propensity cigarettes, lowering the permissible standard of emissions and banning additives in tobacco products.
- Progress has been made in the sharing of knowledge and experience between the Parties in establishing testing laboratories.

Regulating contents and emissions of tobacco products. While progress has been made by the Parties in the implementation of requirements under Article 9, only around half of the reporting Parties regulate the contents and the emissions of tobacco products **(Fig. 3.2)**.

Under Article 9, several Parties reported new or updated laws, including requirements for reduced ignition propensity cigarettes, lowering the permissible standard of emissions and banning additives in tobacco products. In the Republic of Korea, all cigarettes have been fire-safe since 21 July 2015 due to an amendment to the Tobacco Business Act of January 2014. The revised Tobacco Products Directive of the European Union represents a significant policy development, including implementation of Articles 9 and 10 through a ban on products with characterizing flavours, prohibition of certain additives (vitamins, caffeine, etc.), strengthened reporting obligations for all ingredients, and enhanced reporting obligations for additives on a "priority list". Several European Parties have already reported progress in transposing the EU directive. For example, Estonia has banned cigarettes and roll-your-own tobacco with characterizing flavours. Additionally, the use of additives, stimulators, vitamins, mutagenic and reproductive toxic additives is prohibited. In Spain, [31] the prohibition of cigarettes with characterizing flavours is ongoing and the tobacco industry will also be obliged to report in detail on the ingredients used in their products under this new law.

In the case of menthol, the European Union's Tobacco Products Directive requires its ban from 20 May 2020. In 2015, Turkey also adopted a regulation banning menthol and its derivatives, including mint, as an additive in cigarettes and hand-rolled tobacco. The ban takes effect on 1 January 1 2019 at the manufacturer level, and 20 May 2020 at the retail level. (See Canada's experience in banning flavours in the text box.)

Published in May 2016, Vanuatu's amendment of its Tobacco Control Regulations Act regulates testing and measuring the contents and emissions of tobacco products. The law requires such tests to be carried out by the tobacco companies, and submitted to the relevant government authority. The costs of such tests will be borne by the tobacco industry.

Testing and measuring the contents and emissions of tobacco products. Fewer than half of the Parties require the testing of contents and measurement of emissions of tobacco products (Fig. 4.4). For example, United Republic of Tanzania, Sierra Leone

[31] The EU Tobacco Products Directive, which contains an EU-wide menthol ban, was adopted in 2014 and states that all EU member states are required to enforce it by 2020

and Afghanistan, amongst others, all reported that they do not require such testing and measurements. In addition, Papua New Guinea has never done any testing; nevertheless, efforts are being made to look at the testing and reporting of constituents and emissions. On the other hand, Parties such as Myanmar reported a lack of facilities and capacity for testing, measuring and regulating contents and emissions. In Pakistan, the Finance Act 2005 prescribed that no cigarette factory shall clear cigarettes unless they conform to the health standards prescribed by the federal government.

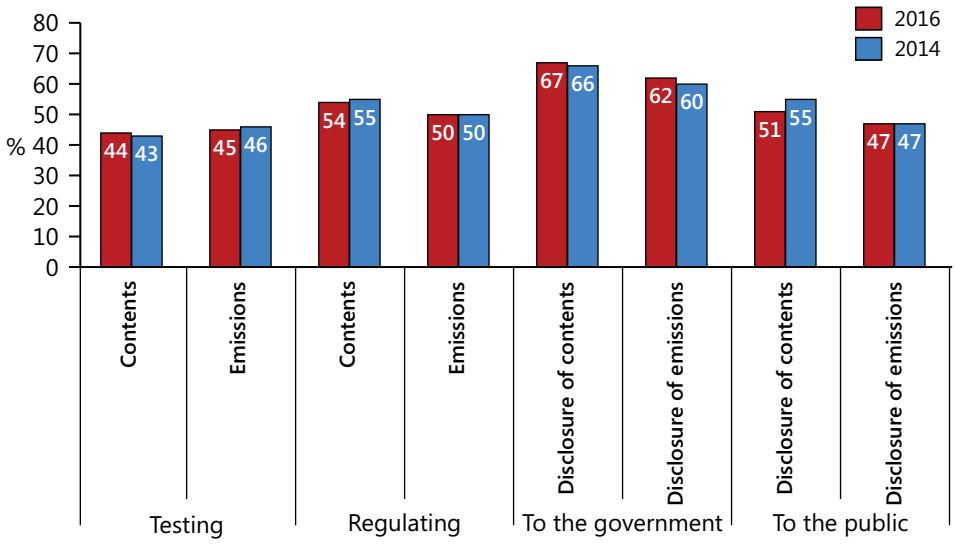
Although several Parties (Colombia, Croatia, Ecuador, Iran (Islamic Republic of) and Pakistan)) face challenges due to a lack of accredited testing facilities, the reports indicate good examples of international cooperation facilitated by the Convention Secretariat and WHO, such as the Iranian visit to Singapore to learn about the establishment and operation of testing facilities as part of the post-needs assessment assistance.

Disclosure to governmental authorities and the public. In 2016, over 60% of the reporting Parties required manufacturers or importers of tobacco products to disclose information on the contents and emissions of tobacco products to governmental authorities, and around half of the Parties required such disclosures to be made publicly available **(Fig. 3.2)**.

The most commonly mentioned area of progress was the development of legislation requiring the disclosure of information about tobacco contents and emissions. A few Parties reported displaying such information on websites for more comprehensive disclosure. Canada, in particular, has taken steps to make information easier to understand by replacing numerical data with clear, text-based statements about the toxic substances found in tobacco smoke.

In terms of challenges, Algeria and Iran (Islamic Republic of) reported a lack of media campaigns to promote public awareness on the constituents of tobacco smoke. Montenegro reported that there is a lack of adequate controls on disclosure and Tonga also reported inadequate enforcement of the existing legislation.

Figure 3.2. **Percentage of Parties implementing provisions under Articles 9 and 10 in 2014–2016**



CANADA: SALES OF ALL FLAVOURED CIGARETTES, BLUNT WRAPS AND LITTLE CIGARS[32] PROHIBITED

The first country to implement a nationwide cigarette safety standard was Canada in 2005. In July 2010, Bill C-32 prohibited the sale of all flavoured cigarettes, blunt wraps and little cigars, but exempted menthol cigarettes and flavours in all other categories of tobacco products, including water pipe tobacco (also known as shisha or hookah), smokeless tobacco and bidis. Amendments to national legislation will extend the flavour ban to cigars weighing 6g or less, with exemptions for menthol and some other constituents.

On 31 May 2015, Nova Scotia became the first jurisdiction in the world to implement a ban on menthol cigarettes, including all other menthol tobacco products. In Alberta, the flavours ban took effect on 1 June 2015, however, the ban on menthol tobacco products took effect on 30 September, 2015. In New Brunswick, the ban on flavours including menthol started on 1 January 2016. On 28 May 2015, Bill 45 received Royal Assent in Ontario and included a ban on flavours, including menthol, which will take effect on a date to be fixed by proclamation. In Quebec, Bill 44 received its second reading on 23 September 2015. The bill has all-party support. The prohibition on flavourings will come into force at retail outlets nine months after the bill is adopted.

[32] Case studies from Brazil and Canada in implementing Article 9 of the Convention, commissioned by the Convention Secretariat, were recently published at : http://www.who.int/fctc/publications/Best_practices_in_implementation_of_Article_9.pdf?ua=1

Article 11 *Packaging and labelling of tobacco products*

Key observations:

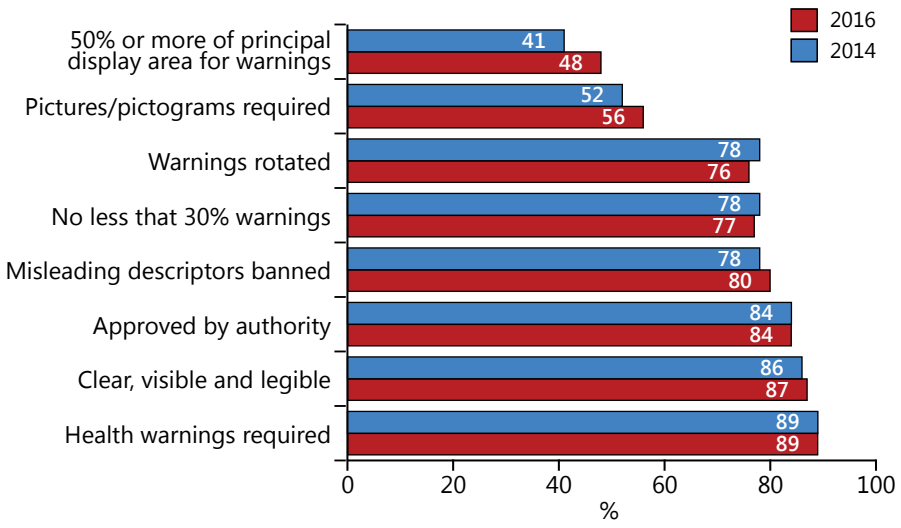
- There has been a domino effect as more Parties to the Convention adopt plain packaging legislation. France, Hungary, Ireland and the United Kingdom have adopted such legislation, subsequent to Australia.
- Many Parties have increased the size of pictorial warnings, with new records being set: Nepal and Vanuatu both require warnings covering 90% of the front and back of tobacco packages.
- Tobacco industry interference in this area remains intense, aiming both to weaken legislation and to delay its application. Importantly, some Parties won legal cases filed by the industry against tobacco package health warnings. Strengthened international information exchange and cooperation has been an important tool to counter the challenges posed by the tobacco industry.

Health warnings. Implementation rates of Article 11 measures for which the three-year deadline applies are presented in **Figure 3.3**. The reports show that close to 90% of reporting Parties now require health warnings. It should be noted that the percentage of Parties requiring health warnings covering 50% or more of the principal display area has increased since 2014.

Use of pictorial warnings. Slightly over half the reporting Parties require pictorial health warnings on tobacco product packaging. A number reported recent legislation introducing pictorial health warnings, or to enforce previously adopted legislation on this matter. Notably, Nepal implemented the world's largest graphic health warnings on tobacco packages in 2015, covering 90% of the front and back. In May 2016, Vanuatu adopted legislation requiring warnings to cover 90% (30% text and 60% image) of the principal display surface on the front and back of tobacco packages. This represents the biggest graphic health warning in the Pacific Islands.

The introduction of a new round of pictorial warnings was reported by a few Parties. In particular, Ecuador explained that its National Health Authority is responsible for

Figure 3.3. **Percentage of Parties implementing time-bound provisions under Article 11 in 2014–2016.**



developing such health warnings, based on perception surveys conducted to test their visual impact on the population. These include real pictures of people affected by tobacco use, e.g., those with cancer.

Plain packaging.[33] Australia adopted a law requiring plain (standardized) packaging of tobacco products in 2012. Research is now becoming available to show the impact of the legislation. According to a post-implementation review, between December 2012 and September 2015 there was an additional 0.55 percentage point decline in smoking prevalence among those aged 14 and above that can be attributed to the packaging changes. This equates to over 108,000 people who did not regress, did not start to smoke or who quit during that period.

Following the Australian decision, there was a domino effect as Parties adopted plain packaging standards. For example, France (April 2015), Hungary (August 2016), Ireland (March 2015) and the United Kingdom (March 2015) have since passed laws to require plain packaging and several other Parties, such as Belgium, Canada, Finland, New Zealand, Norway, Singapore, Slovenia, South Africa, Sweden, and the European Union (on a voluntary basis) have initiated processes with the same end. The latest such example is Hungary, where brands already on the market will receive a temporary exemption and can be produced in current packaging until the end of this year and sold until 20 May 2017.

THE CONVENTION SECRETARIAT AND WHO PROMOTE ACCESS TO PICTORIAL HEALTH WARNING LICENCES

WHO maintains a web-based **WHO FCTC Health Warnings Database**[34] designed to facilitate the sharing of pictorial health warnings and messages among the Parties, which was developed in accordance with decision FCTC/COP3(10). So far, 25 Parties – Australia, Brazil, Brunei Darussalam, Canada, China, Costa Rica, Djibouti, Egypt, European Union, India, Iran (Islamic Republic of), Jordan, Latvia, Malaysia, Mauritius, New Zealand, Pakistan, Russian Federation, Seychelles, Singapore, Thailand, Turkey, Ukraine, Uruguay and Venezuela (Bolivarian Republic of) – have made their pictorial warnings available through the database.

The Convention Secretariat and WHO have promoted the use of the database among the Parties. The Convention Secretariat also facilitates, upon request, the granting of licences to Parties, where a licence is required for the use of pictorial health warnings and messages. The Secretariat has facilitated the granting of licences to use pictorial health warnings to 22 Parties since 2010. Australia, Brazil, Brunei Darussalam, Canada, European Union, Mauritius, Peru, Thailand, and Venezuela (Bolivarian Republic of) have kindly granted licence permissions to other Parties. An African Tobacco Pack Warning Resource developed by the World Lung Foundation with assistance from the Convention Secretariat is now available.[35] The licence-free images in this database have been tested across Sub-Saharan Africa and are ready for use by the Parties to the Convention (mostly by the Parties from the African region, for reasons of relevance). The Convention Secretariat has initiated the development of additional, culturally appropriate pictorial health warning databases for Eastern Mediterranean and Pacific Island countries in collaboration with WHO.[36]

To capitalize on Parties' experiences and in an attempt to further promote plain packaging and bold packaging and labelling measures, a ministerial conference was held in Paris in July 2015, organized by the Government of France. This meeting brought together Parties interested in developing such legislation. Similarly, in June 2015, the Norwegian Ministry of Health and Care Services, the Norwegian Cancer Society and the McCabe Centre for Law and Cancer, a WHO FCTC Knowledge Hub, jointly conducted a workshop on legal issues relating to the implementation of plain (or standardized) tobacco packaging in Europe. The workshop included government officials, WHO FCTC Convention Secretariat and WHO representatives, and nongovernmental organizations (NGO) and academic experts from Australia, Belgium, Finland, France, Ireland, the Netherlands, Norway, Sweden, Turkey and the United Kingdom.

Challenges. Parties frequently reported an increased use of litigation to impede

[33] Plain packaging was also the topic of World No Tobacco Day 2016. http://www.who.int/campaigns/no-tobacco-day/2016/

[34] http://www.who.int/tobacco/healthwarningsdatabase/

[35] http://67.199.72.89/afropackwarnings/pw_index.html

[36] http://www.who.int/fctc/cop/cop7/FCTC_COP_7_19_EN.pdf?ua=1, paragraph 16.

implementation of Article 11. For example, in 2014, the Sri Lankan Ministry of Health adopted regulations which required tobacco product packaging to carry to 80% graphic pictorial health warnings. The Ceylon Tobacco Company sued the Ministry, claiming that such regulations exceeded the Ministry's authority and violated the company`s intellectual property rights.

Photo: The Norwegian Minister of Health and Care Services, Bent Høye, announced on 9 February 2015 that the Government will work to introduce plain packaging.

In addition to legal challenges, Parties also reported difficulties in coordinating cross-sectorial collaboration between governments. Despite the challenges posed to the implementation of the Convention, Parties continue to persevere. For example, in 2014 Kenya published new Tobacco Control Regulations that would shift towards standardized packaging. This was challenged in court by British American Tobacco Kenya Ltd., but in 2016 the court ruled against the tobacco company. The judgement specifically noted that the Tobacco Control Regulations, which are designed to implement the Tobacco Control Act, are intended to comply with the WHO FCTC which Kenya has ratified and is obligated to implement.

Article 12 *Education, communication, training and public awareness*

Key observations:

- Although nine out of 10 Parties implement some kind of awareness raising programme, the messages of such programmes still strongly focus on the health risks of tobacco use, exposure to tobacco smoke and the benefits of cessation. Parties may benefit from a greater emphasis on the economic and environmental consequences of tobacco consumption.
- There is a need to improve the use of research to guide the development and evaluation of awareness–raising programmes, for example, through improved pre-testing of the messages used.
- The emerging and positive trend of accounting for socioeconomic differences among the targeted groups needs to be strengthened.

Implementation of educational and public awareness programmes. In their 2016 reports, 89% (119) of Parties reported that they had implemented some kind of educational and public awareness programme. A number of Parties highlighted the continuation and further development of their previously established programmes or the launch of new campaigns. Several Parties (China, Kuwait, Mauritania, Seychelles, Turkey) highlighted that the launch or culmination of national campaigns or awareness programme activities was often timed to coincide with World No Tobacco Day.

A few Parties mentioned that a lack of resources had led to cutbacks in the planned awareness raising programmes. On a positive side, a few Parties also specifically highlighted that the resources for these activities had been increased. For example, Viet Nam emphasized the annual grant provided by Vietnam Tobacco Control Fund, as a result of which media coverage and other activities have now been expanded to all provinces, cities and state agencies. Bhutan and the United Kingdom reported that they had strengthened the presence of their educational and public awareness activities in social media, while other Parties (Colombia, Germany, Republic of Korea and the Russian Federation) reported better adapting their messages to mobile devices. For example, in the campaign by the Russian Federation, voice messages were aired on the Moscow metro network, combined with SMS-messages sent to the travellers.

Target groups and messages of educational and public awareness programmes. Almost all Parties reported having implemented educational and public awareness programmes targeted at children or young people, adults or the general public **(Fig. 3.4)**. It was now more common to target men (gender sensitive approach) and ethnic groups than it was in 2014.

In addition to the groups targeted through educational programmes set out in the reporting instrument, the following groups were also the focus of Parties' communication efforts: health professionals; customs and police officers; educators; decision-makers; community workers; NGO staff; officials of various ministries; military personnel; hospitality sector workers; parents; tourists; people with mental illnesses; the unemployed and law enforcement personnel.

Most reporting Parties considered age and gender differences (92% and 76%, respectively) in their programmes. Notably more Parties now reflected socioeconomic differences among targeted population groups in their educational programmes than in 2014 (44%). For example, Spain mentioned that regional plans, which guide local authorities in their

activities and programmes in tobacco control, address the socioeconomic differences in the target population. However, it was less commonly reported in this cycle that educational background (62%), cultural background (43%) and socioeconomic status (55%) were taken into consideration.

All Parties that reported implementing communication programmes covered the health risks of tobacco use in their messages **(Fig. 3.5)**, and most of them also covered exposure to tobacco smoke and the benefits of cessation. The economic and environmental consequences of tobacco production were least covered. Addressing the environmental consequences of tobacco production was now more common than in 2014 (40%).

A few Parties highlighted new developments in the topics covered in their programmes. In Finland, the SmokeFree-project, running annually since 1989, has now included a reference to electronic cigarettes in the class competition and project materials in the 2015–2016 season. ("Hooked on life – without nicotine").

Targeted training or sensitization programmes on tobacco control. The majority of the reporting Parties had implemented targeted training or sensitization programmes to at least one specific group in the reporting period. These were most often addressed to health workers and educators, followed by community workers and decision-makers **(Fig. 3.6)**. In addition to the categories set out in the reporting instrument, the following groups were also referred to by the Parties in their reports: religious, social, community and youth leaders; police and local authorities; trainees and their supervisors; military personnel; tobacco workers; and parents and foster-parents. In Jamaica, decision makers from various government departments were sensitised on the need to prevent tobacco industry interference when developing tobacco control programmes (see Article 5 chapter for more details).

Awareness and participation of agencies and organizations. Public agencies were involved by 88% (117) of reporting Parties and 86% (114) of Parties also involved

REPUBLIC OF KOREA: TAILORING CAMPAIGNS TO THE CHANGING MEDIA ENVIRONMENT

The Republic of Korea has been developing its anti-smoking campaigns systematically over the years. In 2014, the work was taken to a new level by developing the Korean Antismoking Campaign Evaluation Index (KACEI). In 2015, this was used to guide the development of new campaigns and communication strategies.

The country has also been constantly adapting its campaigns and public awareness activities to the changing media environment, to improve the reach beyond traditional media such as TV, radio, print and outdoor advertising. In 2015, it produced "web drama" (a series of scripted videos, generally in episodic form, released on the Internet), "webtoon" (comics published only online) and "viral video" (video clips that becomes popular through Internet sharing) for the anti-smoking campaign.

For example, a part of their campaign was a web drama called "Selection", aired through a local web-drama portal. The series featured a singer from a K-pop, a South Korean boy band, acting as a new employee of a tobacco company. His goal, however, was to take a revenge after his father lost a lawsuit filed against the company after he was diagnosed with lung cancer.

Photo: advert of the web drama. Courtesy of Ministry of Health and Welfare.

Figure 3.4. Target groups in educational and public awareness programmes 2014–2016

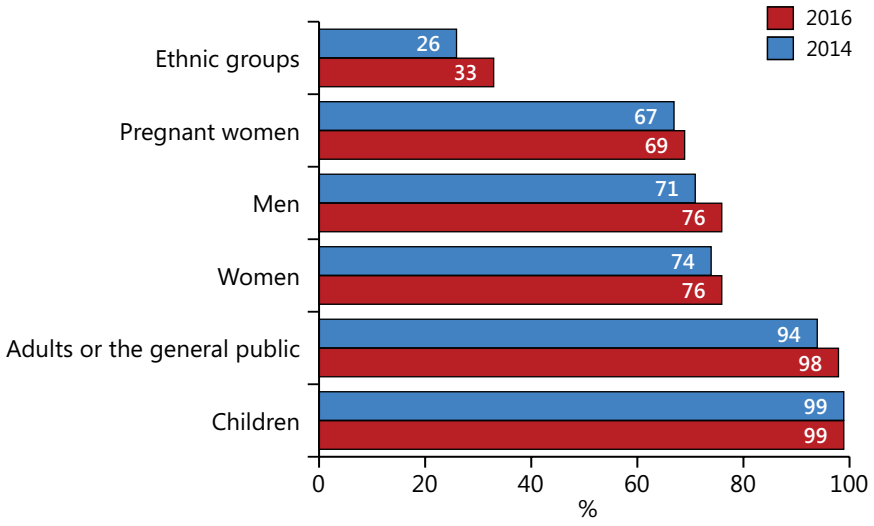
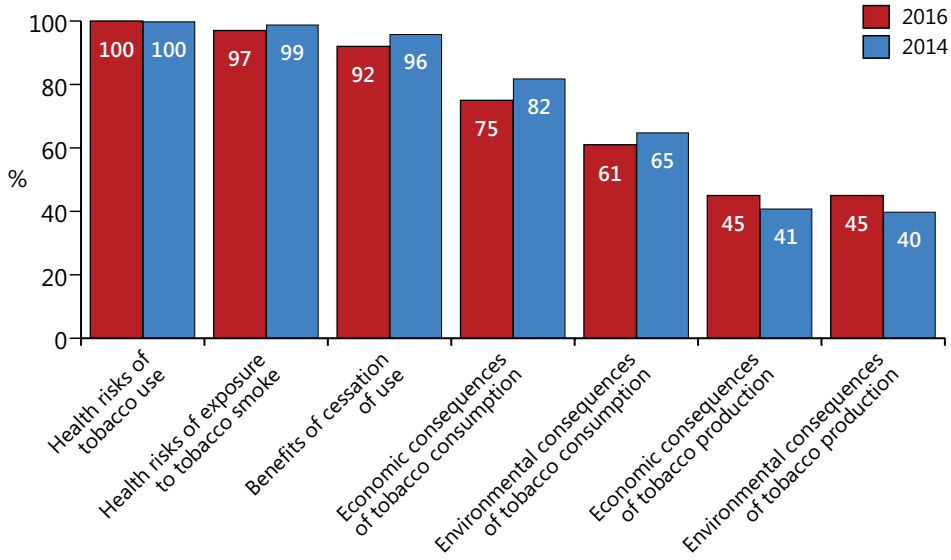


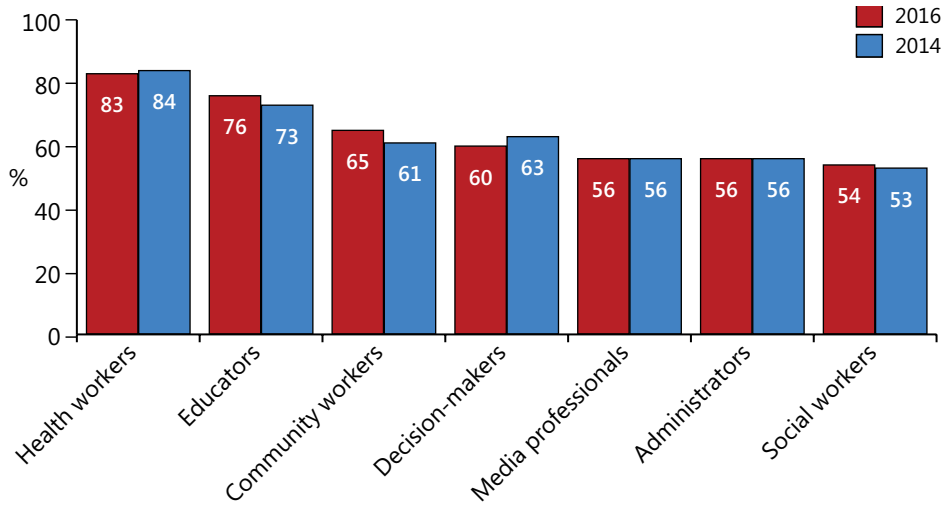
Figure 3.5. Areas covered in Parties' educational and public awareness programmes 2014–2016



non-governmental organizations in the development and implementation of intersectoral programmes and strategies for tobacco control. Slightly over half of reporting Parties, 56% (75), reported participation by private organizations. Other organizations mentioned by Parties were academic, higher educational institutions; community and scientific groups; professional colleges; municipalities; the media; and international organizations, including WHO.

In their progress notes, Parties continued to highlight advances in strategic planning for educational and public awareness programmes. Several Parties indicated that they had recently adopted or developed new or improved coordination structures for the activities in this field. A number of Parties reported that they either had established a comprehensive national tobacco control communication strategy or action plan or were in the process of developing one.

Figure 3.6. Targeting groups in specific training and sensitization programmes on tobacco control, in 2014–2016



Use of research to guide the development of programmes. Some 67% (89) of the reporting Parties utilized research to guide development, management and implementation of communication, education, training and public awareness programmes and required pre-testing, monitoring and evaluation, as suggested in the Article 12 guidelines. An encouraging example of monitoring and evaluation of the programmes was provided by the Czech Republic, which shared its national system of quality assessment of preventive school programmes, including tobacco use. The quality of all programmes is assessed as part of a certification procedure, thus providing an incentive for quality interventions.

Photo: 'Hooked on life – without nicotine' poster for the SmokeFree class competition by EHYT (Finnish Association for Substance Abuse Prevention).

Article 13 *Tobacco advertising, promotion and sponsorship*

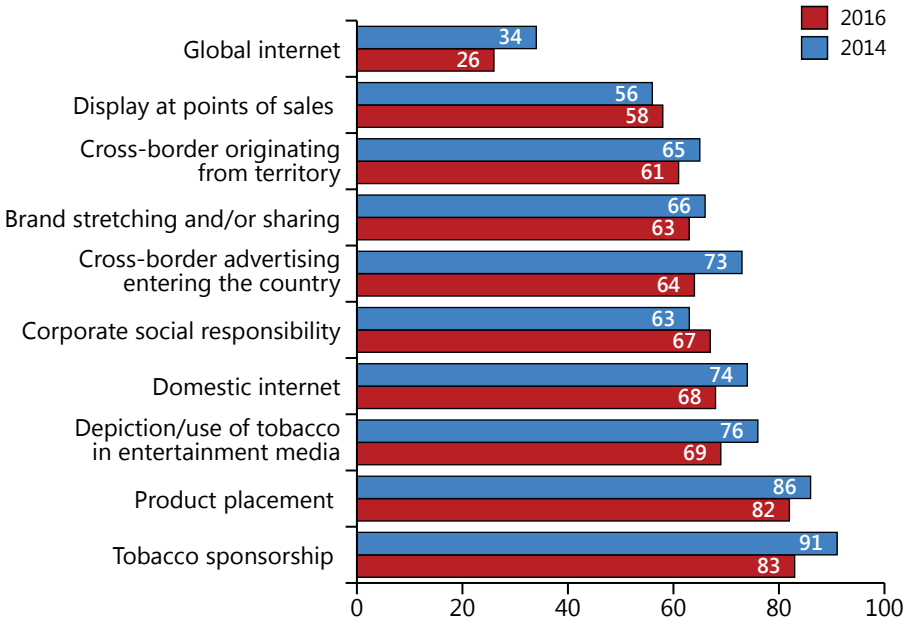
Key observations:

- Several Parties reported the introduction of new, comprehensive advertising bans, but only two-thirds of Parties also prohibit cross-border advertising.
- More Parties are including point-of-sale advertising bans as part of their comprehensive bans. Moreover, reports on the display of tobacco products at points-of-sale have now become more prevalent.
- Product placement and smoking scenes in movies, TV shows and entertainment media in general, remains an area of concern for many Parties.

Comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS). In the 2016 reporting cycle, a number of Parties adopted or strengthened TAPS bans, including Brazil, Cambodia, China, Gabon, Nigeria, Oman, the Republic of Moldova and Uganda. Overall, 72% (96) of the reporting Parties now have a comprehensive TAPS ban in place. However, Parties' definitions of a comprehensive ban on advertising, promotion and sponsorship vary, and do not always cover all of the measures stipulated by the guidelines for implementation of Article 13. In 2016, the most commonly covered areas in the Parties' comprehensive TAPS bans were tobacco sponsorship (83%), product placement (82%) and depiction of tobacco in entertainment media (69%) **(Fig. 3.7)**.

Cross-border advertising, promotion and sponsorship. In 2016, 61% (37) of Parties reported including cross-border advertising, promotion and sponsorship originating from the territory into their comprehensive bans. Only around third of the Parties reported imposing penalties for cross-border advertising (38%), or cooperated to eliminate it (29%).

Figure 3.7. **Percentage of Parties reporting inclusion of selected provisions in comprehensive bans on tobacco advertising, promotion and sponsorship in 2014–2016**



Restrictions in the absence of comprehensive TAPS ban. Altogether 28% (35) of reporting Parties did not implement a comprehensive ban for TAPS. Of these, six (17%) Parties indicated that they were precluded by their constitution or constitutional principles from doing so. Of the Parties which only applied restrictions, around half, 49% (17), required restrictions for all TAPS. Advertising was most commonly restricted in radio, television and print media. Compared to 2014, it was now more common also to restrict TAPS in several different settings, especially with regard to the domestic and global Internet.

Recent progress highlighted by the Parties. A few Parties reported success in regulating TAPS in the entertainment media. The Republic of Korea reported that due to sustained strict regulation and co-operation between major broadcasters, tobacco scenes have virtually disappeared from television, and that viewers criticize companies which show smoking scenes. Other Parties such as Austria, Jamaica and the Philippines have also initiated regulatory restrictions to reduce or eliminate tobacco advertising in films, either in cinemas or in DVDs, the Internet, cable, satellite and other media. In Brazil[37] and Panama, surveys specifically concerning advertising on national and cable TV, movies, and the Internet are being conducted. A background paper from Egypt demonstrated excessive tobacco imagery both in movies and television series during the month of Ramadan[38]. Australia reported that in addition to national legislation, the state of Victoria had imposed subnational legislation since April 2014, by which the selling of films or videos containing a tobacco advertisement is prohibited. Panama's research initiative is presented in a text box.

A few countries reported progress in addressing sponsorship by the tobacco industry. India noted that in a circular from May 2014, the Central Board of Secondary Education advised all schools affiliated to it not to allow students to participate in events sponsored by any firms or by any subsidiary of a firm promoting the use of tobacco in any form, and further directed school students not to accept any prize or scholarship instituted by the tobacco industry. The Republic of Korea conducted a study on tobacco advertising and marketing especially in corporate social responsibility activities. In the Philippines, the Department of Education has initiated the development of a Comprehensive Policy and Guidelines on Tobacco Control to address not only the problem of smoking in schools and on Department premises, but also address tobacco industry interference in Departmental policies.

Reports also detailed new regulations for point-of-sale (POS) tobacco advertising

THEMATIC REGIONAL RESEARCH INITIATIVE IN THE REGION OF THE AMERICAS

Panama actively promotes national and regional research related to Article 13 of the Convention. In May 2014, it funded a workshop organized jointly with the WHO Regional Office for the Americas and NGOs, to discuss the country experiences and advances in relation to prohibiting tobacco advertising, promotion and sponsorship (TAPS), and to identify research needs and priorities in the area.

The workshop noted the importance of attracting resources from different governmental and non-governmental sources to continue generating scientific evidence in the area, and promoting the use of tobacco taxation and enforcement fees to allocate funds for research. It identified several research needs for the region, such as the impact of TAPS in retail outlets, the impact of package design, practices and impact of TAPS on the Internet, and research of the economic impact of public health policies. Further, it concluded that there is a need to conduct training workshops for researchers, and to identify or develop research protocols which allow comparisons between countries, but are adaptable to the country context. The workshop also addressed the issue of TAPS in the entertainment media, and the need to identify available protocols for monitoring the depiction of tobacco in entertainment media, and to facilitate relevant research in the countries.

In 2015, the Ministry of Health of Panama, together with the Instituto Conmemorativo Gorgas de Estudios de la Salud (ICGES), had initiated a study of tobacco advertising in national and cable television, movies, social networks, on the Internet and packaging and labelling in Panama. The goal of the study is to assess compliance with the current TAPS legislation.

[37] Research conducted by the Ministry of Health, Panama and Fundação Oswaldo Cruz Center for Studies on Tobacco and Health, Brazil.

[38] Report on the consultative meeting on tobacco advertising, promotion and sponsorship (TAPS) in drama (24–26 August 2014, Cairo, Egypt), available at: http://applications.emro.who.int/docs/IC_Meet_Rep_2014_EN_16244.pdf.

TOBACCO PRODUCT DISPLAY BANS AT POINTS-OF-SALE IN FOUR EUROPEAN COUNTRIES

Tobacco control advocates who have sought worldwide progress in implementing advanced tobacco control measures in the past two decades, might recall that bans of tobacco advertising at points-of-sale, let alone display bans, were considered the most difficult forms of tobacco product marketing to tackle. With the entry into force of the WHO FCTC in 2005, and especially after the adoption, by the Parties to the Convention, of the guidelines for implementation of Article 13 of the Convention in 2008, Parties have started venturing into new and previously untouched fields of tobacco control, like point-of-sale advertising. Bans have reached the inside of shops, the very place where the product is actually sold to the consumer, thus allowing for the elimination of one of the last forms of tobacco advertising. Today, advertising bans seen as the most advanced also include a ban of the display of tobacco products at the points-of-sale. Other than a price list, the products themselves became invisible to the customer, thus no longer attracting consumers with their sophisticated package designs, colours and imagery, and in particular making them invisible to children – the potential consumers of the future.

Four European Parties (Finland, Ireland, Norway and the United Kingdom) have undertaken, almost simultaneously, measures to ban tobacco product displays. Their experiences are presented in this recent publication commissioned by the Convention Secretariat.[39]

Photo: Tobacco products held in closed, non-transparent containers, Moscow, Domodedovo Airport. (Collection of Dr Tibor Szilagyi)

and display. The Russian Federation has enforced a POS display ban for tobacco products since June 2014. In addition, the Republic of Moldova and Tonga adopted new legislation to prohibit displays, and Costa Rica issued a removal request for the previous exemption, which allowed the display of tobacco products. In addition, El Salvador enforced restrictions on POS advertising and display. Australia had adopted new subnational, and Finland adopted new national, legislation to enforce the POS advertising and display ban also for electronic cigarettes.

Some Parties also reported on challenges to the implementation of Article 13. Panama mentioned that advertising in entertainment media, on the Internet and on social networks is the most difficult to control. Pakistan reported that their advertising legislation from 2013 was not enforced due to a legal challenge from Philip Morris Pakistan Limited, and the Ministry is still defending the case in the High Court of Sindh. Studies among Parties in the Eastern Mediterranean Region have shown a high frequency of tobacco use in entertainment media scenes. Egypt experienced excessive tobacco imagery both in movies and television series[40]. Another Party from the same WHO region, Tunisia, also reported that it continues to experience indirect advertising especially in filmed entertainment, showing people of all ages using a variety of tobacco products (cigarettes, cigars and water pipes).

[39] http://www.who.int/fctc/publications/best_practices_art13_whofctc.pdf?ua=1

[40] Report on the consultative meeting on tobacco advertising, promotion and sponsorship (TAPS) in drama (24–26 August 2014, Cairo, Egypt), available at: http://applications.emro.who.int/docs/IC_Meet_Rep_2014_EN_16244.pdf

Article 14 *Measures concerning tobacco dependence and cessation*

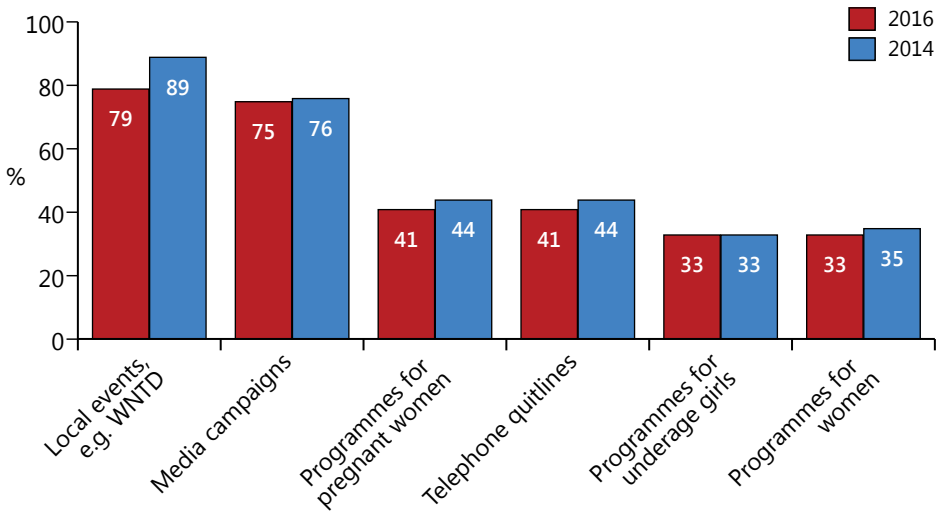
Key observations:

- Parties have taken positive steps to involve health professionals other than physicians in tobacco cessation counselling (dentists, nurses, midwives and community workers).
- More Parties reported covering the costs of smoking cessation treatment, or available pharmaceutical products for the purpose, fully or partially from public funding or reimbursement schemes.
- Improvement is still needed especially on evidence-based comprehensive and integrated guidelines for smoking cessation, which fewer than two thirds of the reporting Parties saying they have done so. In addition, no more than half of the reporting Parties include tobacco dependence treatment in the curricula of health professionals training.

Programmes to promote tobacco cessation. The majority (79%) of the Parties utilized the opportunities provided by events, such as the World No Tobacco Day, to promote tobacco cessation **(Fig. 3.8)**. The majority (75%) also had run media campaigns to promote smoking cessation.

A number of Parties highlighted in their progress notes that they were able to sustain and further develop previously established programmes, and several were doing so in a very systematic and coordinated manner. For example, the Smart Families programme in Finland, which has targeted pregnant women and families visiting maternity and child health clinics since 2006, has been expanded to support smoke-free domestic environments for children and their parents. The programme opened new websites in 2014 and has now strengthened the programme's presence in social media. In general, there is still much room for improvement in programmes for pregnant women, with no more than 41% (54) of the reporting Parties implementing these.

Figure 3.8. **Percentage of Parties reporting a specific programme to promote cessation of tobacco use in 2014–2016**



A few Parties had established completely new projects. In 2015, China National Health and Family Planning Commission, the Office of the Central Spiritual Civilization Development Steering Commission and other four departments jointly launched a promotion and education campaign with a smoke-free life theme. Singapore actively engaged non-smokers through the #StepUpForAQuitter campaign in 2015, recognizing that smokers are more likely to quit successfully when they are in a supportive environment. Luxembourg, Tonga and Viet Nam established new quitlines, and Maldives was piloting one. Overall, telephone quitlines were implemented by 41% (54) of reporting Parties, with no improvement since the last reporting cycle. Germany highlighted making their national quitline to toll-free in 2014, which had led to an increasing number of calls, and their online services were supplemented with new online-mentors.

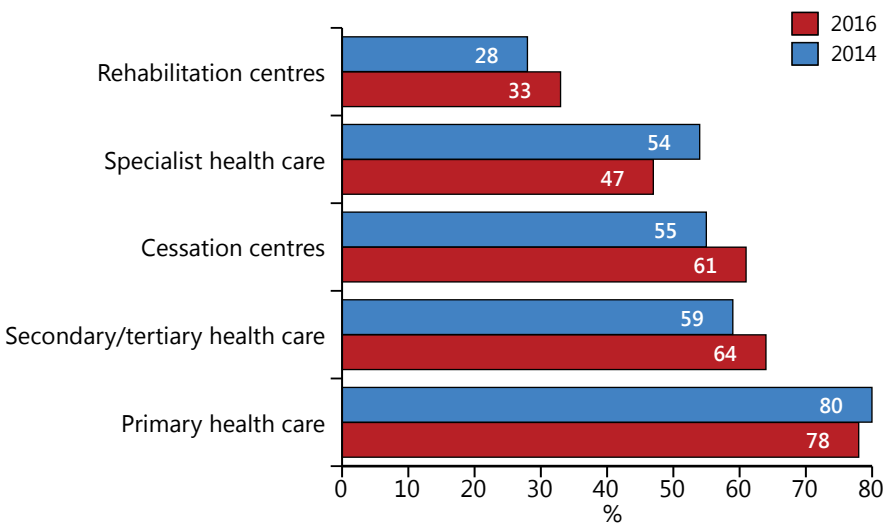
Settings. Of the reporting Parties, 73% (97) implemented cessation programmes in health-care institutions. Around half of the Parties implemented cessation programmes in educational institutions (53%) and workplaces (51%), and around a third (29%) in sporting environments. Other settings referred to by the Parties include: the military; government institutions; civil society organizations; prisons; cultural centres; and religious and workplace settings.

Integration of cessation into health-care systems. Altogether 69% (92) of the reporting Parties had integrated diagnosis and treatment into their health-care systems. Among this group, it was most common to integrate it into primary health care **(Fig. 3.9).** Compared to 2014, it was now more common to provide programmes on diagnosis and treatment in secondary and tertiary health care, specialized centres for smoking cessation and rehabilitation centres. Several Parties also mentioned that other structures within their existing health-care systems are participating in cessation initiatives, for example occupational health services and centres providing psychiatric care.

A number of Parties reported on the progress they have made in strengthening their cessation services and integration of cessation into a health-care system. Bahrain, Turkey, Republic of Korea, Saudi Arabia, Turkmenistan and Libya highlighted that they have established new cessation clinics. Republic of Korea had almost tripled the budget for national smoking cessation clinics in the reporting period. In 2016, Panama hosted a meeting under a Joint Convention Secretariat-UNDP south-south and triangular cooperation project, to share its experiences in implementing Article 14 of the Convention, including the operation of cessation clinics.

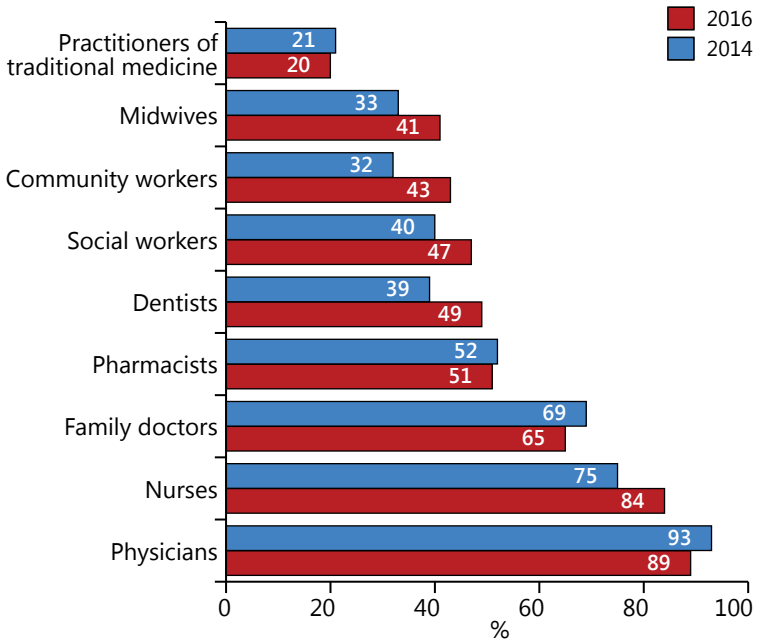
Photo: Dr Battalt, a cartoon character used to promote tobacco cessation in Saudi Arabia, as part of a comprehensive cessation strategy. Here, in a public event in a shopping centre in Riyadh. (Collection of Dr Tibor Szilagyi)

Figure 3.9. **Programmes on diagnosis and treatment of tobacco dependence within health-care systems in 2014–2016, by setting**



Involvement of health professionals. Physicians, nurses and family doctors are the health professionals most involved in cessation initiatives **(Fig. 3.10)**. Additionally, Parties involved more professionals from different settings in smoking cessation counselling as compared to 2014. Improvement was observed especially with dentists, nurses, midwives and community workers. A number of Parties also highlighted the implementation of training programmes targeted at health professionals in providing cessation advice, and several were doing so in very systematic manner. As mentioned in the Article 12 chapter, health workers are the most targeted group for specialized training or sensitization programmes, with 88% of reporting Parties having addressed this group in 2016.

Figure 3.10. **Percentage of Parties reporting the involvement of various health and other professionals in treatment and counselling services in 2014–2016**

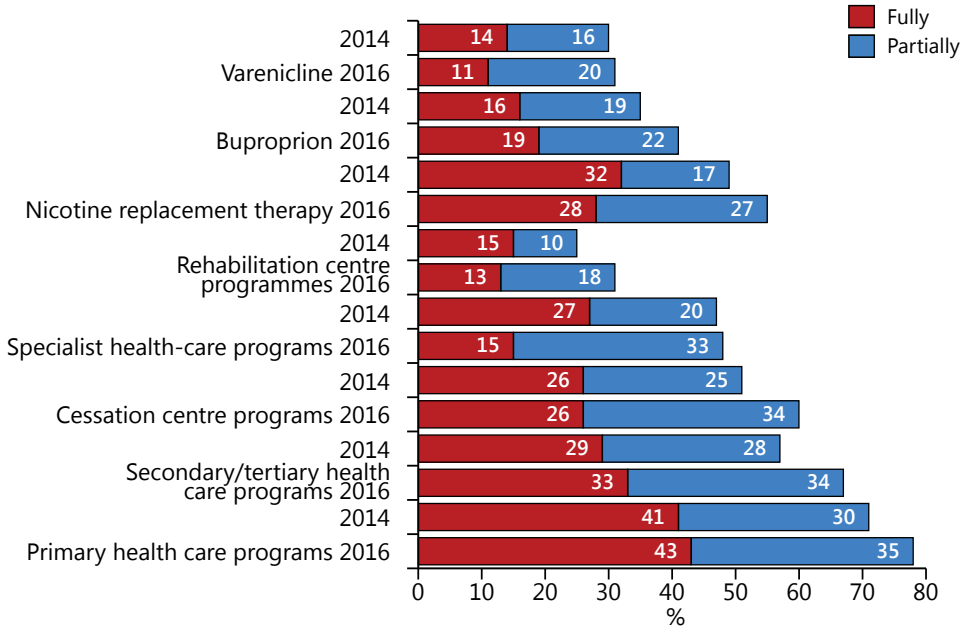


Curricula for health professionals. No more than half of the Parties reported that they include tobacco dependence treatment in the curricula of health professionals. Despite the increased involvement of different professionals in the provision of smoking cessation services and counselling, there were no reports of improvements in the inclusion of tobacco dependence treatment into the curricula for their professional training since the previous reporting cycle. In this cycle, around half of the Parties (66) reported including this matter in the training of medical professionals, 29% (38) in that of dentists, along with 33% (44) for nurses and 23% (31) for pharmacists.

Public funding or reimbursement schemes for treatment costs. Of the Parties that had included diagnosis and treatment in the health-care system, 78% covered the costs of services and treatment in primary health care fully or partially through public funding or reimbursement schemes **(Fig. 3.11)**. It was now more common to cover the costs fully or partially in all of these settings as compared to 2014.

Accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence. More than half, 59% (79), of the reporting Parties offered assistance to improve the accessibility and affordability of pharmaceutical tobacco dependence products. Over nine out of 10, 94% (74), of these Parties had nicotine replacement therapy (NRT) legally available in their jurisdiction, and the majority also had bupropion (72%) and varenicline (68%) available. Of the Parties facilitating accessibility of pharmaceutical products, around half (54%) were covering the costs of NRT fully or partially through public funding or reimbursement schemes, 41% did so for bupropion and 32% for varenicline **(Fig. 3.11)**. Covering the costs of NRT was now more common than in the previous reporting cycle. Canada was developing, with new funding, a provincial nicotine replacement therapy programme that will provide, free of charge, up to 8 weeks of NRT annually to eligible smokers looking to quit. France and the United Kingdom also highlighted measures to improve the affordability of NRT products.

Figure 3.11. Covering the costs of smoking cessation programmes and pharmaceutical products, in 2014–2016[41]



[41] For the programmes, the percentage is calculated among the reporting Parties, which include diagnosis and treatment in the health-care system. For pharmaceutical products, the percentage is among Parties which facilitate accessibility and affordability of pharmaceutical products in their jurisdiction.

Other pharmaceutical products available for tobacco dependence treatment were also reported by the Parties, including cytisine, clonidine, nortriptyline and escitalopram. In the United Kingdom, the Medicines and Healthcare Products Regulatory Agency (MHRA) licenced one electronic cigarette product as a smoking cessation medicine in November 2016. It is anticipated to be on the market next year, and available on prescription. The National Institute for Health Research is currently funding a randomized controlled trial to examine the efficacy of electronic cigarettes compared with nicotine replacement therapy, when used within the United Kingdom's stop smoking services.

National guidelines. Overall, 62% (83) of the reporting Parties had national cessation guidelines based on scientific evidence and best practices. In their progress notes, a number of Parties reported developing (or updating) these, and a few Parties indicated they were currently in the process of doing so. In a larger scale approach, the European Union reported that since 2015, the European Commission had provided funding for a project which develops evidence-based guidelines to high risk populations (those suffering from cardiovascular diseases, chronic obstructive pulmonary disease (COPD) and Type 2 diabetes, and also adolescents and pregnant women). The guidelines will contain strategies and recommendations designed to assist health professionals in delivering and supporting effective treatment for tobacco dependence. One of the implementing partners of this project is the European Network for Smoking and Tobacco Prevention (ENSP), an observer to the Conference of the Parties. This project capitalizes on the previous experience of ENSP, which focused on the development of a set of cessation guidelines for healthcare professionals.[42]

Inclusion in national programmes, plans and strategies. Almost three quarters, 69% (92) of the reporting Parties included tobacco dependence diagnosis and treatment and counselling services in their national tobacco-control strategies, plans and programmes. Altogether 65% (87) had included these in their health programmes. Over one third, 37% (49), had included it in educational programmes, plans and strategies. Several Parties highlighted progress in advancing a systematic approach, aligned with national strategies or plans, to the training of health professionals in smoking cessation methods, and promotion of cessation services. For example, in Spain, the training of health professionals in smoking cessation methods has been identified as one of the key elements in the national strategy of health promotion and health services. The country has developed online training directed at all primary health care professionals, and the training includes modules on behaviour change methodology and health education. The national strategy is accompanied by local implementation programmes, which map community resources and connects entities for intersectoral coordination – including a map format (see photo). The web-based application makes visible resources and activities that contribute to health and welfare in the municipalities adhering in the strategy. India also reported on its new cessation programme – Quit Tobacco for Life[43].

[42] http://www.ensp.org/escg

[43] http://www.nhp.gov.in/quit-tobacco

Photo: Search view of the web-based application 'LOCALIZA SALUD' of Spain.

IRELAND: SYSTEMATIC APPROACH TO THE TRAINING OF HEALTH PROFESSIONALS

Ireland has published national standards for intensive cessation services, including annual targets for the number of staff to be trained as intensive tobacco cessation specialists. The systematic approach was strengthened in 2014 through a coordination mechanism for nationwide smoking cessation services. Cessation training is provided online, and accompanied with face-to-face training courses in behavioural support. In 2014, an integrated "one-stop" model was developed, in addition to two new specialty online training modules – smoking in pregnancy, and smoking and mental health. In 2015, the Health and Quality Information Authority agreed to commence a health technology assessment of smoking cessation methodologies. Since 2014, Ireland has trained over 1000 primary care health professionals annually in smoking cessation methods. The total number in 2014 was 1303, and in 2015 it was 1185 plus an additional 452 undergraduate health professional students. The overall training target for 2016 has been set at 1350.

Measures relating to the reduction of the supply of tobacco

Article 15 *Illicit trade in tobacco products*

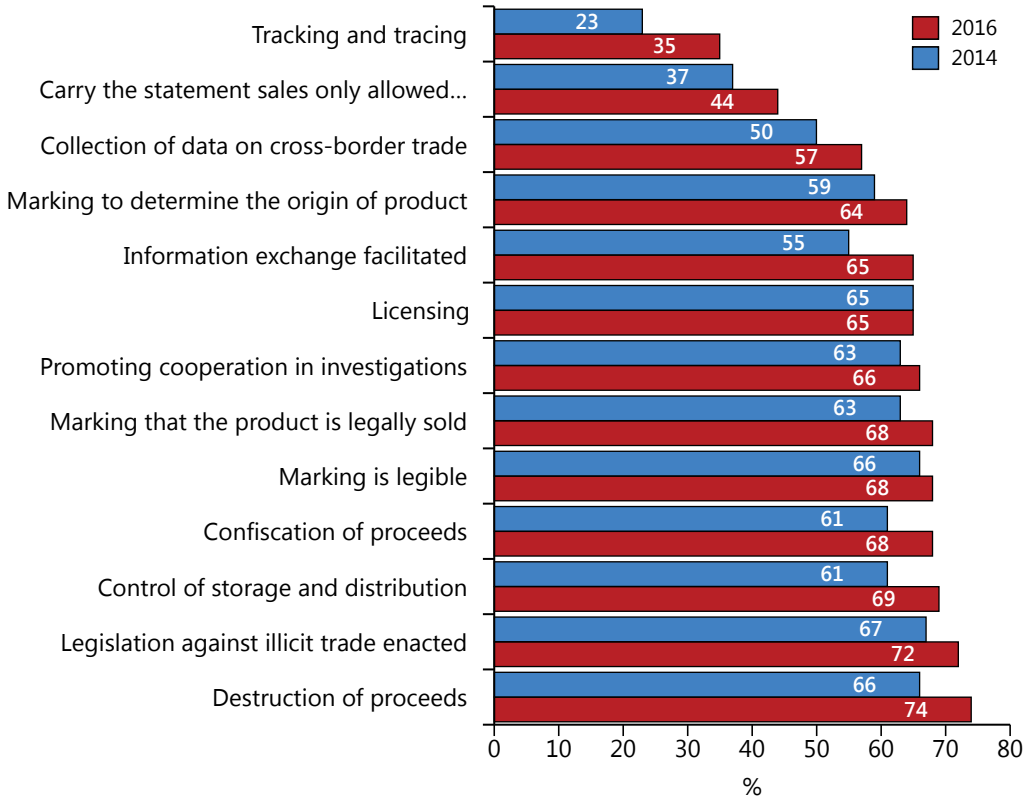
Key observations:

- An increasing proportion of reporting Parties, (almost three quarters), now have legislation in place to counter illicit trade in tobacco products.
- The implementation of most measures under this article has improved as compared to the previous reporting cycle, especially in relation to tracking and tracing systems and exchange of information.
- A number of Parties to the Convention have taken steps towards ratification/ accession to the Protocol to Eliminate Illicit Trade in Tobacco Products, or reported considering a making this a priority.

Enacting or strengthening legislation against illicit trade. Some 72% (96) of the reporting Parties have reported enacting or strengthening legislation against illicit trade in tobacco products **(Fig. 3.12)**. The implementation of all measures under this article (except licensing, promoting cooperation to eliminate illicit trade and the requirement for legible marking) improved as compared to the situation in 2014.

Marking of packaging. Reporting Parties most commonly require markings to determine whether the product is being legally sold on the domestic market (68%), and to assist in determining the origin of the product (64%) (Fig. 4.13). Altogether 68% of the reporting Parties also require markings to be legible and/or presented in the principal language

Figure 3.12. **Percentage of Parties reporting on implementation of provisions under Article 15 in 2016 and 2014**



or languages of the country and 44% require that unit packets and packages of tobacco products for retail and wholesale use carry the statement "Sales only allowed in..." or have any other effective marking indicating the final destination of the product.

Tracking and tracing. Over half, 57% (76) of the reporting Parties required monitoring and collection of data on cross-border trade in tobacco products, including illicit trade. One third, 35% (47) of the reporting Parties had developed or implemented a practical tracking and tracing regime to secure the distribution system and assist in the investigation of illicit trade (Fig. 4.13). This was notably more common than in the previous reporting cycle. Several Parties mentioned in their progress notes that they were transferring the new European Union Tobacco Products Directive (2014/40/EU) into their legislation. It introduces comprehensive rules on traceability for tobacco products, applied to cigarettes and roll-your-own tobacco from 20 May 2019, and for other tobacco products from 20 May 2024. Under the multiannual anti-fraud action Programme Hercule III, in October 2014 the European Anti-Fraud Office (OLAF) launched a new Tobacco Seizure Management Application ("ToSMA") and established an IT platform under the umbrella of the Anti-Fraud Information System (AFIS) which comprehensively analyses data on cigarette seizures reported by the EU member states. This was supported through the funding of a new laboratory in 2015, which is now becoming fully operational and aims to provide the member states and OLAF with opportunities to independently test cigarettes and other tobacco products in order to track their geographical origin, establish if they are counterfeit and build a database to share the results of analysis.

Confiscation and destruction. Almost two thirds of reporting Parties, 68% (91) enable the confiscation of proceeds derived from illicit trade in tobacco products, and a similar proportion, 69% (92) monitor, document and control the storage and distribution of tobacco products held or moving under suspension of taxes and duties. In addition, 74% (99) require the destruction of confiscated equipment, counterfeit and contraband cigarettes and other tobacco products derived from illicit trade, using environmentally friendly methods where possible, or their disposal in accordance with national law.

Licensing. Around two thirds, 65% (87) of the Parties require licensing or other action to control or regulate production and distribution in order to prevent illicit trade. In the progress notes by Parties, Ireland mentioned that in 2014 the government agreed on the need to draft new legislation to introduce a licensing system for the retail sale of tobacco products. The United Kingdom reported that the government will hold a public consultation on how to implement a licensing scheme for tobacco manufacturing equipment, and on whether to introduce a licensing system across the tobacco supply chain.

Photo: Customs and Health Enforcement Officers destroy illicit tobacco products seized in Vanuatu.

Promoting cooperation. Altogether 66% (88) of the reporting Parties promote cooperation between national agencies and relevant regional and IGOs with a view to eliminating illicit trade in tobacco products. France integrated enhanced measures to control illicit trade into its' National Plan for Tobacco Control for the years 2014–2019. In March 2015, the United Kingdom published an updated joint strategy entitled, "Tackling Illicit Tobacco: from leaf to light". The European Union published a comprehensive EU

strategy on "Stepping up the fight against cigarette smuggling and other forms of illicit trade in tobacco products". Gabon mentioned an awareness workshop for NGOs and civil servants in ministries involved in tobacco control. The Indian Ministry of Health and Family Welfare, in cooperation with the Ministry of Finance and WHO, marked World No Tobacco Day 2015 by holding a National Multisectoral Consultation on the Protocol to Eliminate Illicit Trade in Tobacco Products. In addition, several Parties referred to consultations or other steps towards acceding to the Protocol to Eliminate Illicit Trade in Tobacco Products.

PROTOCOL TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS: PROGRESS TOWARDS ENTRY INTO FORCE

Since adoption at COP5, the Protocol to Eliminate Illicit Trade in Tobacco Products[44], the first protocol to the WHO FCTC, many efforts have been undertaken to promote ratification and accession. The Protocol will enter into force after ratification by 40 Parties.

To raise awareness of the Protocol and promote its entry into force, the Convention Secretariat continues to organize multisectoral, subregional workshops for Parties to the WHO FCTC. These workshops bring together officials from different government sectors involved in the implementation of the Protocol, including health, customs, justice, finance and trade, with experts on Protocol matters, members of civil society and representatives of IGOs, including the World Customs Organization (WCO), the World Bank and WHO.

Since COP6, the following subregional Protocol workshops were held – in the South-East Asia Region: Nay Pyi Taw, Myanmar, 9–11 December 2014 and Colombo, Sri Lanka, 13–14 October 2015; in the Eastern Mediterranean Region: Kuwait City, Kuwait 23–24 March 2015; in the Americas Region: Panama City, Panama, 22–24 April 2015; and in the African Region: Gaborone, Botswana, 6–8 May 2015. A further workshop was organized by the WHO Regional Office for Africa in cooperation with the Convention Secretariat in Harare, Zimbabwe, from 20–22 April 2016. Most recently, Protocol workshops were conducted in the Americas Region: Brasilia, Brazil, 14–16 September 2016; and in the Western Pacific Region: Nadi, Fiji, 26–28 September 2016.

Findings of the subregional Protocol workshops indicate several common challenges faced by WHO FCTC Parties in ratifying the Protocol, which include: tobacco industry interference, specifically increasing attempts to encourage adoption of the "Codentify" system, and tobacco industry attempts to present itself as a partner in Protocol implementation; a lack of mutual ownership of the Protocol across government sectors; difficulties in engaging in interministerial collaboration and coordination during the implementation process; and the lack of capacity and resources for Protocol implementation.

As mandated by the COP, the Convention Secretariat has established a panel of experts on the Protocol. It is composed of two experts per WHO region and is mandated to support the Secretariat in providing assistance and advice to Parties in core areas of the Protocol and to facilitate information exchange. Panel members will undertake relevant activities individually and as a group. Parties, through their WHO FCTC focal points, are invited to address requests for assistance to the Convention Secretariat. The Secretariat will assign each request to a panel member, within the limits of available funding and taking into account the specific expertise required for the assignment as well as the experts' availability, regional affiliation, familiarity with the situation of the requesting Party and language requirements.

As of 31 October 2016, the Protocol had 24 Parties[45]: Austria, Burkina Faso, Comoros, Congo, Côte d'Ivoire, Ecuador, European Union, France, Gabon, Gambia, Iraq, Latvia, Mali, Mongolia, Nicaragua, Panama, Portugal, Saudi Arabia, Senegal, Spain, Sri Lanka, Swaziland, Turkmenistan and Uruguay. An additional 17 Parties will have to ratify the Protocol to enable it to enter into force[46].

[44] For the text of the Protocol and more information see http://www.who.int/fctc/protocol/about/en/.

[45] See http://www.who.int/fctc/protocol/ratification/en/ for the status of ratification.

[46] In accordance with Article 45.3 of the Protocol, the instrument of formal confirmation of the European Union shall not be counted as additional to those instruments deposited by the Member States of the European Union for the purposes of the entry into force of the Protocol.

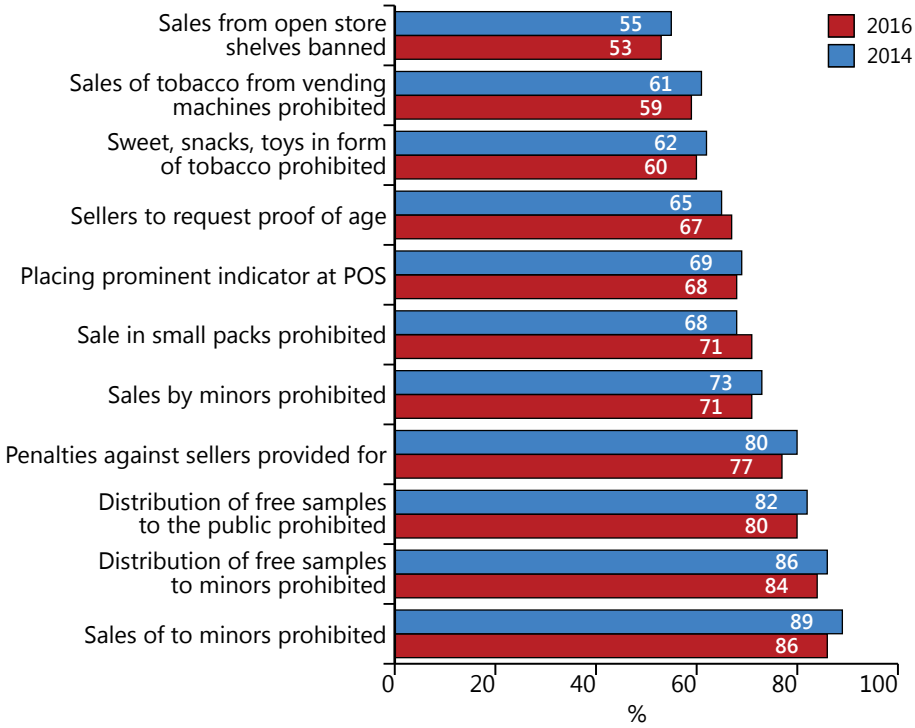
Article 16 *Sales to and by minors*

Key observations:

- Parties have continued introducing measures to ban sales to minors and to increase the legal age for purchasing tobacco products.
- There is room for improvement especially in prohibiting the sale of tobacco products in any manner by which they are directly accessible, such as open store shelves and from vending machines.
- The examples of Parties working to improve compliance through campaigns, systematic test purchases, providing guidance on the requirements of the law, simplifying administrative procedures for enforcement, and increasing penalties for tobacco sales to minors are beneficial to all other Parties that have yet to adopt this agenda.

Sales to and by minors. Most reporting Parties, 86% (115), prohibited sales of tobacco products to minors (Fig. 4.14). A smaller proportion (71%) also prohibited tobacco sales by minors. The legal age for tobacco purchases ranged from 14 to 22 years, the average being 19 years. In Australia, the Tasmanian State Government released the Healthy Tasmania Five Year Strategic Plan – Community Consultation Draft, which proposes raising the minimum legal smoking age in Tasmania from 18 to 21 (or 25) years of age. Over eight in 10 of the reporting Parties also prohibited the distribution of free samples to minors (84%), or to the public in general (80%). A few Parties, such as Hungary, the Czech Republic and the United Kingdom, mentioned that they were also introducing an age limit for electronic cigarettes.

Figure 3.13. Percentage of Parties reporting implementation of Article 16 provisions in 2014–2016



Requirements for tobacco retailers. 68% (90) of the reporting Parties required that all sellers of tobacco products place a clear and prominent indicator inside the point of sale about the prohibition of tobacco sales to minors. A similar proportion, 67%, required that sellers of tobacco products request that the purchaser provide evidence of legal age. Over half, 59% of the reporting Parties had prohibited tobacco sales from vending machines, and 53% in any manner by which they are directly accessible, such as open store shelves.

Among the Parties that have not yet prohibited vending machines, less than half (38%) require that vending machines are not accessible to minors. Some also noted progress in this area. The Czech Republic mentioned that in June 2015 the government approved a new draft act, which will impose stricter regulation of the sale of tobacco products from vending machines and in places where these products can be sold. In 2014 the Irish Government approved the drafting of legislation to introduce a licensing system and other measures in relation to the retail sale of tobacco products, including prohibition of the sale of tobacco products from self-service vending machines. In Norway, the ban on self-service of tobacco products entered into force in July 2014.

Prohibition of tobacco products with a specific appeal to minors. Some 71% (94) of reporting Parties prohibited the sale of cigarettes individually or in small packets. In addition, 60% prohibited the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products. Several Parties were in the process of transposing the European Union Tobacco Products Directive into their national legislation, which sets a minimum of 20 cigarettes for each unit packet, and a minimum of 30g for each unit packet of roll-your-own tobacco. In September 2016, Kenya enforced a ban on the sale of individual cigarettes. Pakistan was also considering banning such sales.

Enforcement and sanctions. Altogether 77% (103) of reporting Parties stipulated penalties for retailers and distributors in order to ensure compliance. Several Parties highlighted progress with new requirements and guidance for more active enforcement of age limits. Sweden amended its tobacco control legislation so that municipalities have the right to check retail outlets' compliance on purchases of tobacco and non-prescription medical nicotine products, to improve age control. The amendment was accompanied by detailed advice for the planning and execution of such test purchases. Samoa and Germany mentioned awareness and education programmes to support the enforcement of youth access laws. In India, the State Government launched a sensitization campaign, which also included talks and leaflet distribution at sales points, and compliance checks for tobacco sellers. Around 950 vendors were reached directly. On a special "Dry Day for Tobacco", 60 shops were raided for illegal advertising, and shops were provided with signs about the ban on sales to minors.

The Philippines has started to develop guidelines for enforcement of youth access restrictions, and the Department of Education has also issued policies to address tobacco sales to and by minors within school, including school premises, canteens and in school activities. Georgia reported that it was amending legislation to simplify administrative enforcement mechanisms, and the Czech Republic was broadening the range of control bodies. France also reported that the municipal police have now been designated to monitor the ban.

Montenegro and Italy adopted new or increased penalties for non-compliance with the regulations on sales to minors, while the Czech Republic and Kuwait were in the process of doing so. In Serbia, a new Law on Consumer Protection entered into force in 2014, also providing detailed instructions on fines for infringement of the prohibition on the sale and provision of tobacco products to under-18s.

Republic of Moldova: prohibition of tobacco sales from street vendors and in the proximity of educational facilities

In May 2015, the Moldovan Parliament adopted a series of amendments to various laws to strengthen tobacco control, including new provisions to prevent youth access to tobacco and related products. The sales of tobacco products to minors had been prohibited since 2009. The new legislation comprehensively banned the sale of tobacco and related products through street vendors, at improvised counters, vending machines and through the Internet. In addition, tobacco and related products cannot be sold anymore from small (less than 20 m^2) retail outlets located closer than 200 m from educational and medical facilities. All tobacco retail outlets are obliged to post in clear view information regarding the ban on sales of tobacco and related products to under-18s. Information on fines for violating this ban must now also be in a visible place. The young buyer must be asked for official photo ID proving the person's age, and sales must be refused without this. In addition, the new legislation includes many other provisions for youth protection. These include prohibition of packets containing fewer than 20 cigarettes, tobacco sales from open unit packets or individually, and "lipstick-style" packets that may create an association with cosmetic products, toys or food. Prohibition of the visible display of tobacco and related products in retail outlets will apply from May 2020.

Article 17 *Tobacco growing and support for economically viable alternatives*

Article 18 *Protection of the environment and the health of persons*

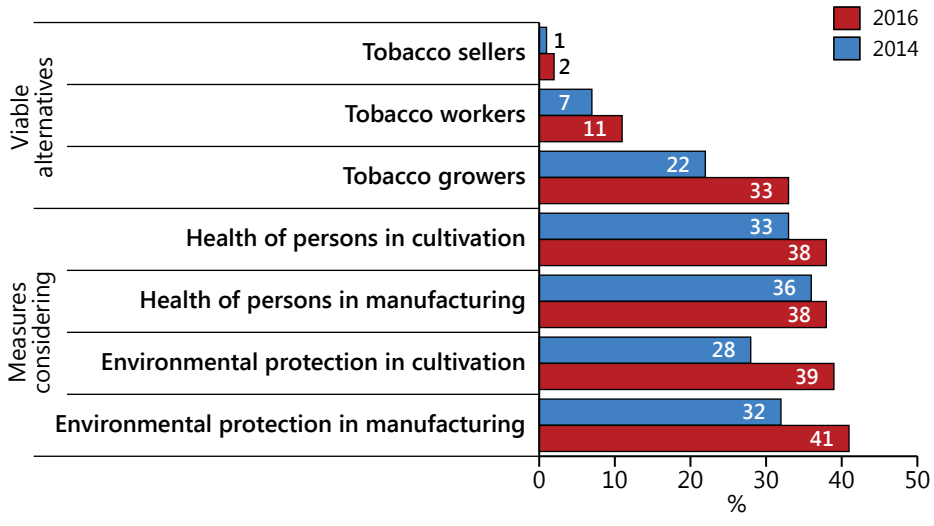
Key observations:

- Implementation rates of these articles have improved since the previous reporting cycle and there are more Parties that have identified mechanisms to promote alternatives to tobacco growing, such as providing incentives, including grants, for substitution programmes, and creating other employment opportunities for tobacco farmers.
- In the case of Article 18, Parties are striving to improve relevant health and safety legislation, regulations and policies, aiming to protect the environment and the health of the population.
- There are examples of Parties promoting the importance of the adoption of good practice in the cultivation and production of tobacco without the use of fertilizers, plant protection products, and through reduced water consumption.

Tobacco growing. Of the reporting Parties, 48% (64) registered tobacco growing within their jurisdiction. In this group, 84% (54) provided some information on the numbers of people working in tobacco cultivation. The numbers vary widely, from a few hundred in, for example, Azerbaijan, Panama, the Republic of Moldova and Jamaica, to several hundreds of thousands in Brazil and Turkey, and 1.5 million in China. In addition, 69% (44) of the Parties engaged in tobacco growing provided some information of the share of the value of tobacco leaf production in the national gross domestic product (GDP). The share was typically below or around 1%, for those providing a percentage figure.

Economically viable alternative activities. Among the tobacco-growing Parties, 33% (21) promoted viable alternatives for tobacco growers, a larger proportion than in 2014 (22%) **(Fig. 3.14)**. Several Parties provided details on their activities in this regard. For

Figure 3.14. **Implementation of different protective measures in tobacco cultivation and manufacturing, and promotion of viable alternatives among tobacco-growing Parties in 2014–2016**



example, Spain indicated that it has two types of support for tobacco crop diversification: one funded by the national budget (aid for diversification and economic revitalization of tobacco municipalities) and one based on financial grants provided by the European Agricultural Fund for Rural Development. Tunisia detailed an NGO-run project promoting alternatives for tobacco farming, which encourages switching to potato or other vegetable farming. China reported a 23% decline in tobacco acreage from 2013 to 2015 as a result of an increase in alternative measures for farmers.

Protection of the environment and the health of persons. In 2016, protective measures in tobacco cultivation and manufacturing were more common than in 2014 **(Fig. 3.14)**. Only the implementation of measures dealing with the health of persons in tobacco manufacturing showed a similar figure. Several Parties reported making recent progress in the implementation of Article 18. Improvements in safety legislation, regulations and policies to protect the environment and the health of populations were cited by Parties. In addition, adoption of good practice in the cultivation and production of tobacco without the use of fertilizers, plant protection products, and reductions in water consumption were mentioned in Parties' reports. Australia recently reported that commercial tobacco farming and manufacturing no longer occurs, however, this does not apply to Commonwealth, State and Territory governments. Nevertheless, they have environmental and occupational health and safety legislation, regulations and policies in place to protect the environment and the health of persons in relation to the environment. In India, the Ministry of Health and Welfare has supported a Public Interest Litigation filed by a civil society organization in the National Green Tribunal on the environmental impact of cigarettes and bidi butts, deforestation caused by tobacco curing and the adverse health impact of tobacco growing. In contrast, challenges remain, with Afghanistan reporting that its Ministry of Finance insists there are greater economic gains from raw tobacco exports and there is no willingness to take measures against it.

Brazil: visit of delegations from three Parties to learn from experience on promoting alternative livelihoods [47]

The Convention Secretariat has taken strides to strengthen implementation of Article 17 (*Provision of support for economically viable alternative activities*) and Article 18 (*Protection of the environment and the health of persons*) of the Convention, by establishing with UNDP a south-south and triangular cooperation project in this area. As part of the project, Brazil, as provider of know-how, promotes its experience in alternatives to tobacco farming to other Parties to the Convention (Jamaica, the Philippines and Uruguay).

The project involved the preparation of country-specific action plans in recipient countries establishing programmes for alternative livelihoods, informed by Brazil's experiences of over 15 years. This included the promotion of broad sustainability among growers; capacity-building for growing non-tobacco crops in more ecologically friendly ways; linking former tobacco farmers as sellers of food crops to government food programmes (school breakfasts and lunches); incorporating alternative livelihoods within existing social programmes; and building effective partnerships with non-governmental actors (e.g. civil society, academia) working toward successful alternative livelihoods.

Photo: study visit in the cities of Nova Trento, Leoberto Leal, Florianopolis/SC in Brazil, 28–30 March 2016.

[47] See details on the project at http://www.who.int/fctc/implementation/cooperation/project-Article-17-Brazil-alternative-livelihoods/ and a video prepared during the study visit in Brazil at https://www.youtube.com/watch?v=X3gLkFInoc4.

Other provisions *(liability, research and reporting)*

Article 19 *Liability*

Key observations:

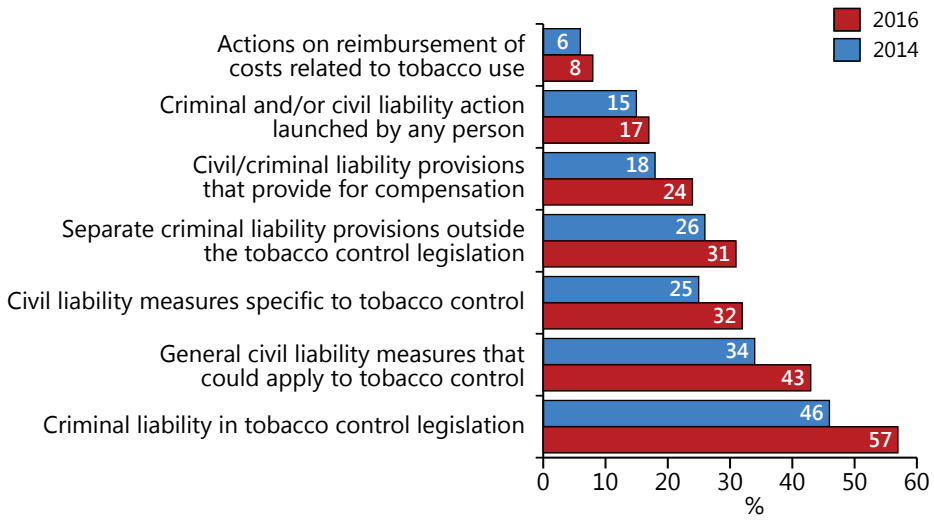
- There is progress in Parties' implementing measures that improve their compliance with Article 19 of the Convention, e.g., by including measures on liability in tobacco control legislation.
- Several Parties have extensively documented their experience on tobacco litigation, which are now available for other Parties' use.

First, it is important to mention that the evolution of the reporting instrument of the WHO FCTC, notably the introduction of several new indicators in 2014 and the comparative analysis of the responses to them in 2016, now provides the opportunity to better track Parties progress on specific measures under Article 19 of the Convention.

In 2016, altogether 57% (76) of Parties had provisions on criminal liability in their tobacco control legislation for the adverse health effects of tobacco and/or for reimbursement of medical, social or other relevant costs, and 31% had similar provisions beyond tobacco legislation **(Fig. 3.15)**. In addition, 43% had general civil liability measures that could apply to tobacco control, and 32% reported that there are civil liability measures specific to tobacco control. Civil or criminal liability provisions that provide for compensation exist in 24% of reporting Parties. In 2016, all these measures were now more common than in 2014.

For example, Brazil reported on general civil liability provisions that could apply to tobacco control. By using them, the Brazilian Government is working towards a lawsuit in order to recover the costs paid by the public health care system in relation to tobacco use. Similarly, Sweden reported that although it does not have special legislative provisions for adverse health effects and/or reimbursement of medical, social or other relevant costs related to tobacco, other general provisions may be applicable. In contrast, in Canada, all provinces and territories except Yukon passed legislation to enable the pursuit of health care cost recovery against tobacco companies. In general, launching criminal and/or civil

Figure 3.15. Existence of different provisions for liability, and actions taken against tobacco industry among Parties in 2016 and 2014



liability action against the tobacco industry, or taking action on reimbursement of costs related to tobacco use remained relatively rare, with less than fifth of the Parties reporting such actions **(Fig. 3.15)**.

In the Republic of Korea, the National Health Insurance Service filed a lawsuit against three domestic and foreign tobacco manufacturing companies — KT&G, British American Tobacco and Philip Morris — in April 2014, based on Article 19 of the Convention which seeks 53.7 billion Republic of Korea won in damages for compensation over tobacco-related disease, including lung cancer. As of April 2016, the time of submission the Party's report, the trial is continuing.

Canada: CAN$ 15.5 billion ruling against three tobacco companies in 2015

Following a 17-year lawsuit, Quebec Superior Court awarded 15.5 billion Canadian dollars against large tobacco companies in a landmark class action lawsuit. Quebec Superior Court Justice Brian Riodan's 276-page decision was published on 27 May 2015.

In this class action lawsuit, Imperial Tobacco, Rothmans, Benson & Hedges and JTI Macdonald were accused of deceiving public health authorities and the general public with regard to the health risks of smoking from 1950–1998. This action included more than one million Quebec smokers, including those who were either diagnosed with lung cancer/smoking related diseases and those who were addicted to nicotine and unable to stop. Individual cases were started in 1998 and were later united in 2005 in a class action lawsuit.

The ruling concluded that tobacco companies were aware of the risks of tobacco use and withheld this information, including failing to appropriately warn consumers of the side effects of their products. The judgement stated:

"Over the nearly fifty years of the Class Period, and in the seventeen years since, the Companies earned billions of dollars at the expense of the lungs, the throats and the general well-being of their customers. If the Companies are allowed to walk away unscathed now, what would be the message to other industries that today or tomorrow find themselves in a similar moral conflict?"

Article 20 *Research, surveillance and exchange of information*

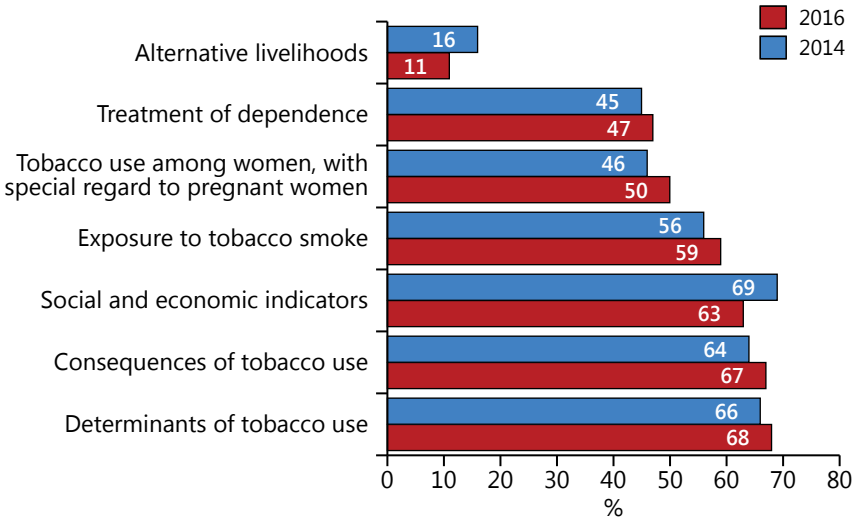
Key observations:

- Majority of Parties report on national systems for surveillance of patterns of tobacco consumption.
- Parties are making good progress in producing comparable data for monitoring youth smoking prevalence, however, for most of the Parties, the comparability of adult smoking prevalence data needs to be further improved.
- Data collection for smokeless tobacco and water pipes are yet to be strengthened.[48] Some Parties also show progress in addressing the new and emerging tobacco products in data collection.
- Availability of data on the economic burden of tobacco use, and share of illicit trade also remains poor.

National systems for epidemiological surveillance. In 2016, a majority of reporting Parties (71%) had a national system for surveillance of patterns of tobacco consumption. In addition, 56% of Parties had surveillance systems for exposure to tobacco smoke, 49% for determinants of tobacco consumption and on social, economic and health indicators, and 44% for the consequences of tobacco consumption. The proportions for all these remained at a similar level as compared to 2014.

Research topics. The reporting Parties most commonly addressed the determinants of tobacco use (68%), consequences of tobacco use (67%) and social and economic indicators related to tobacco consumption in their research activities **(Fig. 3.16)**. The last mentioned was now less common than in the previous reporting cycle. Only around half the reporting Parties developed or promoted research on tobacco use among women,

Figure 3.16. **Percentage of Parties developing and/or promoting research on various topics, 2014–2016**



[48] The reporting instrument requires Parties to provide information on smoking and smokeless tobacco use for adults, and water pipes (as "other tobacco products") is included in the questions about youth. The prevalence questions, including coverage of new and emerging forms of tobacco (ENDS/ENNDS), should be revised to allow for the collection of more reliable data on the use of various products.

especially pregnant women, and the treatment of tobacco dependence. Addressing alternative livelihoods in research remained very rare, with a tenth of reporting Parties doing so.

In their progress notes, Parties highlighted the production of new data on tobacco use, establishing new surveillance systems for tobacco monitoring, or improving current systems, for example by more frequent data collection or the inclusion of new products such as electronic cigarettes. Several Parties advanced research supporting the development or evaluation of tobacco control legislation, educational and communication efforts, and smoking cessation services. A few Parties still reported that they were unable to conduct new research or had to postpone surveys due to a lack of funding.

Availability of data on tobacco use. Of the reporting Parties, 91% (121) provided data on the prevalence of tobacco smoking among adults **(Annex 3)**, and 47% (62) did so for the use of smokeless tobacco among adults. There was a large variation in the survey methods utilized by the Parties, with emphasis on national monitoring systems rather than cross-national surveys with standardized methodology, such as the WHO STEPwise approach to Surveillance (STEPS) or the Global Adult Tobacco Survey (GATS).

Around 40% (53) of the reporting Parties were identified as having at least two comparable datasets across all reporting cycles for adult tobacco smoking. Altogether 53 Parties had new data on adult smoking collected in this reporting cycle. In this group, 39 Parties indicated that the new data was comparable to an earlier dataset. This number was slightly smaller than in 2014 (45). Collecting data on smokeless tobacco use in the adult population remained at a low level in 2016. Only 12% (16) Parties were identified as having comparable datasets across all reporting cycles for adult smokeless tobacco use. Altogether 26 Parties had new data on this topic from the reporting period, with 13 indicating that the new data was comparable to an earlier dataset.

In addition, 88% (117) of the reporting Parties provided data on the prevalence of tobacco smoking among youth, and 59% (78) provided it for the use of smokeless tobacco among youth. Most of the surveys were collected with standardized methodology enabling some cross-national comparisons, mostly as part of the Global Youth Tobacco Survey (GYTS), Health Behaviour in School-aged Children (HBSC) study or the European School Survey Project on Alcohol and Other Drugs (ESPAD).

A majority, (76%) 101 of the reporting Parties were identified as having at least two comparable datasets over all reporting cycles for youth tobacco smoking. Altogether 37% (49) Parties reported new data on youth tobacco smoking from this reporting period, and 34% (45) were identified as having this data comparable to an earlier dataset. This is an increase from the previous reporting cycle, where the respective number of Parties was 32. Comparable data on smokeless tobacco use was less common also with regards to youth, with only 20% (26) of the reporting Parties having it for all reporting cycles. Altogether 37% (23) of the Parties reported new data on youth smokeless tobacco use, but only 5% (6) had new data comparable to an earlier dataset.

In addition, 26% (34) of the reporting Parties indicated that they had data for tobacco use among ethnic groups.

Availability of data on exposure to tobacco smoke. In 2016, the majority, or 83% (110), of the Parties reported that they have data on exposure to tobacco smoke. Most of reported data originates from surveys implemented in 2010 or more recently, and 44 Parties reported surveys in the past three years. Unlike previous years, more Parties were able to report on exposure data among adults than among young people, with some of the Parties reporting on both adults and young people. Almost three quarters of Parties

reported having adult exposure data available and a little more than one third of Parties reported data focusing on youth age groups; in this latter category, the most frequently reported single source of information for exposure data is the Global Youth Tobacco Survey, which contains data only for 13–15 year olds.

Availability of data on tobacco-related mortality and economic burden. In 2016, around half the reporting Parties (47%) also indicated that they have information on tobacco-related mortality in their jurisdictions. The proportion remained similar when compared to 2014 (52%). Of the 62 parties that had data, 51 provided further information of the number of deaths attributable to tobacco use. The reported figures show broad variations depending on the size of the country. The highest figures were reported by Parties with large populations such as China, with 1.366 million tobacco-related deaths, the European Union (total tobacco-related mortality in its 28 Member States) with 706 000 deaths, and the Russian Federation, reporting 319 000 tobacco-related deaths.

For the economic burden of tobacco, almost half the reporting Parties (35%) indicated that they had information of this topic, with no notable changes from 2014 (33%). Of the 47 Parties which so indicated, 45 provided further details. A number of Parties had data from both direct and indirect costs. Despite the recent trend of conducting new studies in this area, most data which Parties referred to was relatively old (from 1997 onwards); only 11 Parties referenced data that had been collected after 2010.

Share of illicit tobacco products on the national tobacco market. 17% (23) of the reporting Parties had information on the percentage of illicit tobacco products on the national tobacco market, with no improvement since the last reporting cycle. Twenty Parties provided information of the percentage. Based on this information, the percentage was on average 15%.

Exchange of information and training and support for research. In 2016, 63% (84) recorded regional and global exchange of publicly available national scientific, technical, socioeconomic, commercial and legal information. Information exchange was less common regarding the practices of the tobacco industry (40%). Information relating to the cultivation of tobacco was exchanged by 20% of the reporting Parties. Over half (56%) the Parties had provided training for those engaged in tobacco control.

Database on laws and regulations. Altogether 67% (89) of Parties maintained a database of national laws and regulations on tobacco control. Less than half (47%) reported that the database also contained information on the enforcement of those laws and regulations. Less than a third (27%) had established a database of pertinent jurisprudence.

Article 21 *Reporting and exchange of information*

Key observations:

- A new Internet-based reporting tool was made available to Parties for compliance with their 2016 reporting obligations. Parties were divided on the user-friendliness of the core questionnaire and made several suggestions for future reporting cycles.
- More than 80% of the Parties submitted their 2016 implementation reports, mostly within the designated reporting period.
- The number of Parties that have never reported continued to decrease and currently stands at six.
- The seventh session of the COP was presented with recommendations made by the expert group on reporting arrangements, as mandated by COP6.

Under Article 21 of the Convention, each Party is required to submit to the Conference of the Parties periodic reports on its implementation of the WHO FCTC. The submitted reports are available in the public domain in the WHO FCTC Implementation Database.[49] The reporting process provides Parties with the opportunity of shared learning and contributes to the dissemination of best practice.

In 2014, in decision FCTC/COP6(15), Parties focused on establishing an expert group to review the reporting arrangements under the Convention, including the reporting process, the utilization of data collected and other relevant issues. Furthermore, the Parties also mandated the expert group to "examine various reporting mechanisms of other international treaties, including those that utilize an intergovernmental peer review process, and make recommendations on strengthening reporting arrangements and on the development of a reporting and implementation review mechanism under the WHO FCTC". The expert group completed its work and provided its report for consideration by COP7.[50]

In the meantime, the Convention Secretariat organized the 2016 reporting cycle much as in 2014, with only one major change: the format of the questionnaire was changed from an interactive Word document to an Internet-based questionnaire. The platform was provided by WHO and is a modified version of a Lyme-survey. This platform was selected for use since it runs well in the WHO computing environment, information is stored on the WHO server and data backup is available if needed.

The new reporting platform required the loading of the list of registered FCTC technical focal points into the system and handled invitations for the completion of the implementation reports automatically.

Additionally, the core questionnaire of the reporting instrument was also changed, to a limited extent, in terms of content[51]; a few new questions were added on the use of implementation guidelines as well as on policies related to new and emerging tobacco products. The outcome of the analysis of these new sections is included in the global progress report.

[49] http://apps.who.int/fctc/implementation/database/

[50] FCTC/COP/7/15, http://www.who.int/fctc/cop/cop7/FCTC_COP_7_15_EN.pdf?ua=1

[51] The content of the questionnaires was changed in response to various decisions of COP6 that mandated the Secretariat to collect new information on specific areas of implementation work.

The changes also involved additional questions (the optional module) of the reporting instrument. New sections were added to the optional module on Article 6 (Price and tax measures to reduce the demand for tobacco), on Article 17 (Provision of support for economically viable alternative activities) and Article 18 (Protection of the environment and the health of persons), and on new and emerging tobacco products. The additional questions were also available through the same reporting platform, requiring Parties to complete those questions online. Parties' experience with the new reporting platform and their feedback on the further development of the reporting instrument is presented in Annex 4.

Status of reporting by the Parties. Since 2012, Parties' reports are expected biennially, in designated reporting periods, with deadlines falling six months before the next regular session of the COP. In 2016, the third biennial reporting cycle was implemented, with 133 reports (out of the 180 expected, or 74%) received on time, and 12 other reports submitted following the cut-off date of 31 October 2016 for the incorporation of Parties' reports. This brought the total number of reports received in the 2016 cycle to 145 (or 81% of the total number expected). The number of non-reporting Parties has decreased cycle by cycle, down from nine in 2014 and 15 in 2012.

As mandated by the COP, the Secretariat provided feedback (in the June–August 2016 period) to all Parties that have submitted a report on time for 2016, including, inter alia, proposing corrections and requesting clarification, and submission of other relevant documents; almost 60% of Parties responded to the comments from the Secretariat in its feedback note, thus improving the quality and completeness of their reports.

Overall, since the start of the first reporting period in February 2007 to June 2016, when this document was finalized, the Secretariat had received at least one implementation report from 174 out of the 180 Parties (97%), a 3-percentage point increase since 2014.

On the other hand, in the case of additional questions (the optional module), the results are less clear. So far, only three Parties (Japan, Panama, Turkey) have completed the questionnaire focused on the utilization of implementation guidelines in the 2016 reporting cycle. To improve reporting rates for the additional questions, in October 2016 the Secretariat initiated a new effort to elicit responses from Parties to this questionnaire.

A regularly updated table presenting the status of Parties' reporting, including the number of core reports and additional questionnaires, and their submission dates, is available on the Convention Secretariat website[52].

Study on country practices concerning the preparation of WHO FCTC implementation reports. The workplan and budget for the Convention Secretariat in the financial period 2016–2017, adopted by COP6 in decision FCTC/COP6(27), mandates the Secretariat to "identify good practices in data collection and preparation/submission of reports". The Secretariat initiated this work in September 2016, and data collection is currently underway in 12 Parties to the Convention across various WHO regions. The lessons learned from Parties utilizing advanced practices in collecting data when preparing their implementation report is expected to become an important resource for other Parties to scale up their procedures and practices in addressing Article 21 of the Convention. This would also assist the Secretariat in promoting best practice and improve reporting capacities among the Parties to the Convention. A report containing observations and conclusions, as well as case studies from the different Parties on their reporting practices and experiences, will be made available on the website of the Secretariat in 2017.

[52] http://www.who.int/fctc/reporting/reporting_timeintro/

Broadening the resource base on Parties' implementation of the Convention

Other activities carried out under the COP workplan also assist our understanding of Parties' work and the outcomes of endeavours related to the implementation of various requirements. These include information gathered through joint needs assessments, the impact assessment exercise, Parties' self-communicated updates on implementation of the Convention, material on the south-south and triangular cooperation projects, the work of WHO FCTC Secretariat's Knowledge Hubs and tobacco industry Observatories, the FCTC implementation workshops in various regions and subregions around the world, regular media reviews on global tobacco control work and other activities. Furthermore, a new initiative by the Convention Secretariat aims to gain access to regularly collected tobacco-related data through engagement with the various agencies associated with the United Nations Interagency Taskforce on the Prevention and Control of NCDs (UNIATF).

The several joint needs assessment missions carried out in each biennium provide an in-depth analysis of a Parties' implementation of the Convention in all substantive areas. The needs assessment exercise starts with a review of the Party's latest implementation report, thus underlining the importance of the work submitted by the Parties. Additional information is also collected from other sources to update and supplement information from the Party's implementation reports. Furthermore, interviews conducted with key stakeholders of FCTC implementation result in a better understanding, as does information on progress since the preparation and submission of the last FCTC implementation report. This new information is collated in the report of the needs assessment mission, jointly produced by the mission team and the country experts/stakeholders. The missions therefore provide new and more in-depth information. The mission reports are publicly available at: http://www.who.int/fctc/implementation/needs/.

The impact assessment exercise was a special undertaking of the COP6-COP7 intersessional period. The exercise focused specifically on understanding whether any tobacco-control outcome observed in the Party's jurisdiction is related in any way to the fact that the country is Party to the Convention and whether this outcome can specifically be linked to the WHO FCTC. The key question to be answered during the impact assessment exercise is whether the specific outcome would have also happened in the absence of WHO FCTC. The impact assessment work provided an additional means of engagement with the Parties, which could contribute to the promotion of better implementation of the Convention at the national level (through the use of the arguments that surfaced during the impact assessment exercise in advocacy work) and at the global level (by learning from and better disseminating a Party's work).

Article 4.7 of the Convention recognizes that civil society participation in achieving the objectives of the Convention and its protocols is essential. NGOs that are accredited as observers to COP are obliged to report every second year on work carried out in the support of Convention implementation.[53] Much of this work is carried out at a national level and is detailed in NGO observer reports. The Convention Secretariat invited the 20 NGOs with observer status to submit reports via an online questionnaire in December 2015, with a deadline of 31 January 2016, and 19 subsequently responded. An analysis of this information, including NGO work in the Parties, is referred to in document FCTC/COP7/28, while the individual observers' reports will be made available on the website of the Secretariat. NGO reports might complement the official implementation reports of the Parties by highlighting, among other things, those areas where civil society can be counted on by governments in implementing the Convention.

Other activities, such as Parties' voluntary communication of achievements in the period between reporting cycles, discussions carried out during FCTC implementation workshops, south-south and triangular projects and the dissemination work carried out by knowledge networks (knowledge hubs and tobacco industry monitoring centres) could all contribute to broadening our resource base and knowledge on Parties' implementation work. Fostering the integration of activities linked to the COP workplan, with a view to improving the availability of data and information about Parties' implementation activities, should be pursued in future COP workplans.

[53] The Conference of the Parties, at its seventh session, in decision FCTC/COP7(17), requested that the Convention Secretariat also implement a survey on intergovernmental organizations with observer status to the COP.

International cooperation and financial resources *(Articles 22 and 26)*

Article 22 *International cooperation*

Key observations:

- There is more information now available on the provision and receipt of assistance as compared to previous reporting cycles.
- Several Parties received assistance to establish or strengthen capacity in national tobacco-control programmes.
- Increasingly, Parties are collaborating with each other and receiving assistance from other Parties, who champion best practices and disseminate their experience with neighbouring Parties.

Areas of assistance. In 2016, it remained more common to receive assistance than to provide it **(Fig. 3.17).** Assistance was typically given for tobacco control programmes, the transfer of skills and technology and the training and sensitization of personnel, all provided by around one third of the reporting Parties. On the other hand, assistance was typically received for the same three areas, but it was also relatively common to obtain equipment, supplies and logistics. The provision and receipt of assistance were now more common than in 2014, except for assistance in expertise for tobacco control programmes and the transfer of skills and technology.

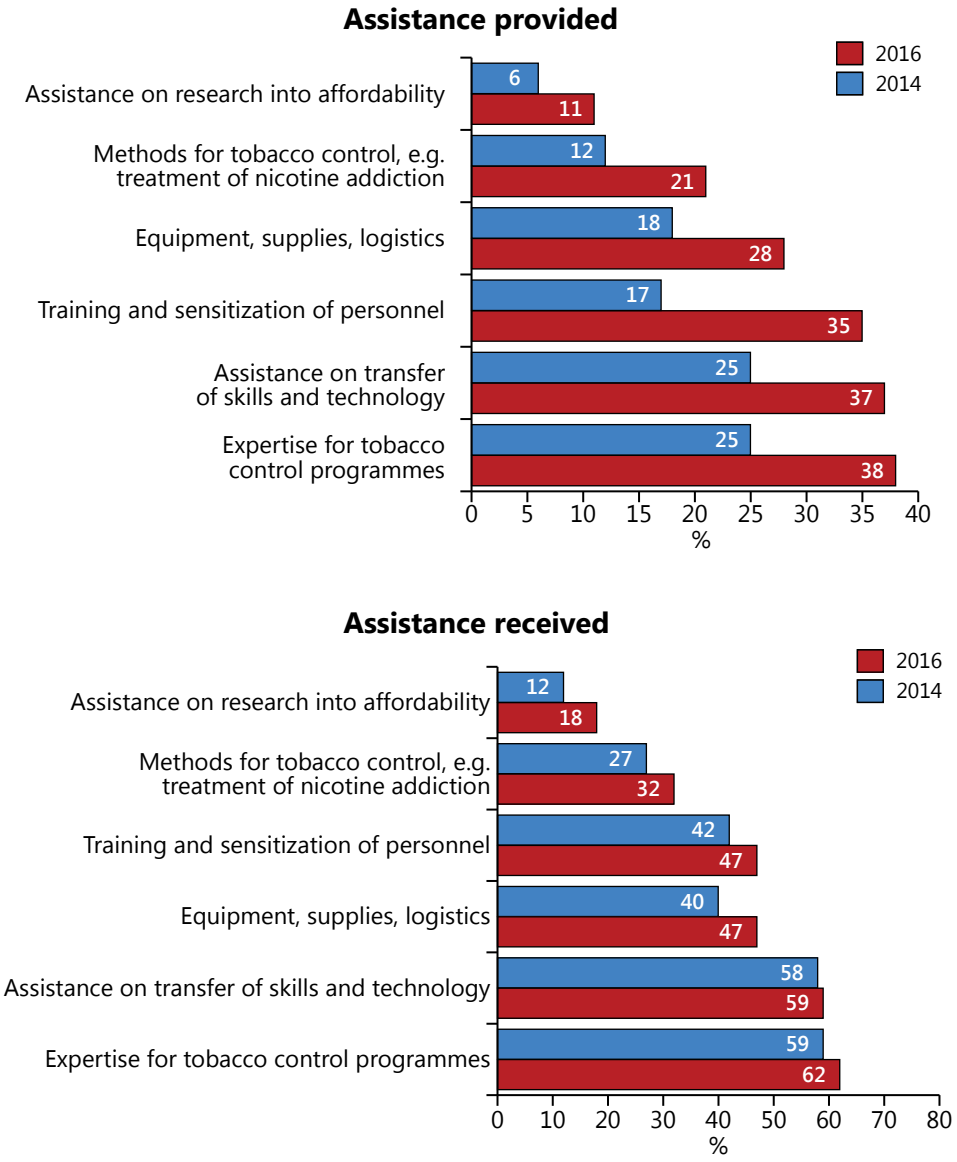
Provision and receipt of assistance was mostly related to establishing or strengthening capacity in national tobacco control programmes. Many Parties reported assistance from the World Health Organization. A few Parties mentioned assistance from philanthropist organizations such as the Bloomberg Initiative, while other Parties mentioned help from other Parties to the Convention. For example, Finland has encouraged assistance to other Parties through the Finnish Lung Health Association; Kyrgyzstan and Tajikistan benefitted from such projects.

Parties' reports revealed that areas of assistance received or provided remained similar to those reported in 2014: developing national tobacco-control legislation; conducting needs assessments; granting licences for pictorial health warnings; conducting smoking cessation programmes (for example, quitline); education and communication. Additionally, new areas of support were added in the 2016 reporting cycle: litigation; implementing tobacco taxation policies; smoke-free areas; and implementing tobacco product regulations.

Implementation assistance through membership in regional and international organizations. Altogether 20% (27) of the reporting Parties had encouraged regional and international intergovernmental organizations and financial and development institutions, in which they are represented, to provide financial assistance for developing country Parties and for Parties with economies in transition, to assist in meeting obligations under the Convention. For example, the Russian Federation reported assistance to ministries of health from the Eurasian Economic Union (Armenia, Belarus, Kazakhstan and Kyrgyzstan). Finland reported on its bilateral tobacco control project with the Republic of Serbia, under the auspices of the EU, whereby the two countries were paired for information exchange and the establishment of programmes to support implementation of the Convention and EU Directive 2014/40/EU. Similar collaborative multilateral projects have been established as a part of the south-south and triangular cooperation efforts of the Secretariat[54].

[54] Document FCTC/COP/7/17.

Figure 3.17. **Percentage of Parties reporting on assistance they provided or received, by areas of assistance, 2014–2016**



NGOs ARE IMPORTANT TO THE IMPLEMENTATION OF THE CONVENTION BY THE PARTIES

The reports of NGOs accredited as Observers to the Conference of the Parties, through regular reports provided during the biennial accreditation review process[55], contain important examples of NGO contributions to Parties' implementation of the Convention.

For example, Campaign for Tobacco Free Kids manages the Tobacco Control Laws website, which includes WHO FCTC-compliant comparisons of tobacco control legislation from many Parties. The International Union Against Tuberculosis and Lung Disease (the Union) joined the initiative of the Convention Secretariat in promoting the establishment of tobacco industry monitoring centres (Observatories) in Parties, providing financial assistance to centres such as those in Brazil and Sri Lanka. The Union for International Cancer Control's McCabe Centre for Law and Cancer, a WHO FCTC Knowledge Hub, has already forged links with many Parties to the Convention through its legal training programme and subregional legal workshops.

[55] The reports of NGOs accredited as Observers to COP are available on the website of the Convention at: http://www.who.int/fctc/cop/ngo-reports/

4. NEW AND EMERGING TOBACCO PRODUCTS

Key observations:

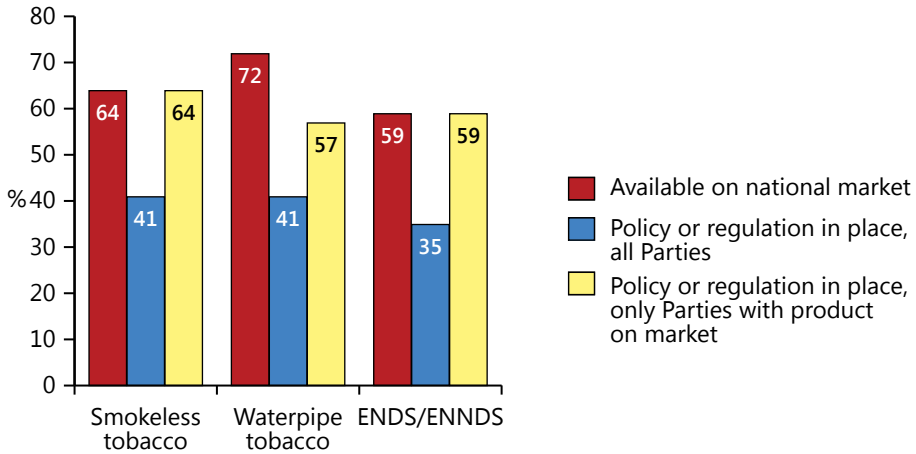
- The reporting system of the Convention is now tailored to gather data on new and emerging tobacco products, including policies and programmes for controlling their use.
- A majority of reporting Parties had either smokeless tobacco, water pipe tobacco or ENDS/ENNDS available on their national markets.
- There is an urgent need for Parties – with or without new and emerging tobacco products on the national market – to enact and enforce protective policies and regulations.

Smokeless tobacco and water pipes have traditionally been used in many Parties, but recently we see an expansion of the availability of such products in many parts of the world. Additionally, the use of ENDS, such as e-cigarettes, and other novel tobacco products is increasing in many countries as multinational tobacco companies and other manufacturers enter this new market. COP6 adopted decisions on all three product categories.

In order to strengthen data collection regarding these products, questions on new and emerging tobacco products were included in the 2016 reporting cycle; they are now referred to in both the core questionnaire and the additional questions (optional module) of the reporting instrument.[56]

As seen in **Figure 4.1**, over half the reporting Parties have the three products available in their markets. Most common was water pipe tobacco (72%), followed by smokeless tobacco (64%). The rapid growth of the e-cigarette industry is visible also in Parties' reports, as 59% had ENDS/ENNDS on the national market. Fewer than half of all reporting Parties had established policies or regulations for these products, the least common being

Figure 4.1. Availability of new and emerging tobacco products on the national market, and implementation of product specific policies and regulations in 2016



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

ENDS/ENNDS. Parties which already had these products on the national market were more active in implementing product-specific policies or regulations. For example, of the Parties with smokeless tobacco available on the national market, 64% also had policies or regulations for smokeless tobacco in place. On the other hand, these results indicate that around a third of the Parties with these products on the market are not enforcing product-specific policies.

A few Parties specifically mentioned that these products are not yet legally available in their national markets, but some of these indicated that such products are currently entering the market or are available on the illegal market, or through personal imports. The Eastern Mediterranean region, where the use of water pipes (under different names, such as hookah, nargile or shisha) is widespread, is experiencing a rapid expansion in the market for flavoured tobacco to be used in water pipes, the use of fruit water pipes (where the smoke passes through a layer of fruits) and floating water pipes (which float on water, allowing use while bathing), and of electronic shisha.

In terms of policies, several Parties reported banning the import and sale of smokeless tobacco products. Specifically, most Parties of the European Union, as well as Australia, Bahrain, Iran (Islamic Republic of) and New Zealand have reported such a ban. Norway and Mauritius reported banning water pipes. In the case of ENDS, 18 Parties reported bans on their importation and/or sale. Most of these Parties are Eastern Mediterranean states (Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Oman, Pakistan, United Arab Emirates), or from the Americas (Brazil, Chile, Mexico, Panama) and Europe (Norway, Russian Federation, Turkey). Mauritius (Africa) and New Zealand (Western Pacific) represent the other regions. Some of the Parties that have banned ENDS did so by deeming them "imitation" products; others (such as Norway) banned all new nicotine and tobacco products.

Photo: Water pipe tobacco on sale at Cairo airport. (Collection of Dr Tibor Szilagyi)

Another group of Parties reported regulations for these three product categories. Several indicated that their tobacco laws apply to all tobacco products, including these three categories (Congo, Costa Rica, Jamaica, Kyrgyzstan, Montenegro, Nigeria, Togo), and some others indicated that reference to these products is included in legislation or regulations that are being developed. Other Parties reported applying various restrictions on the use of such products, such as banning the marketing of one or more product categories; banning the use of such products in public places as with traditional smoking tobacco products; banning sales to minors; and requiring the appendage of health warnings to such apparatus. Responding to the expansion of such products to its market, Brazil reported a national campaign to prevent the use of water pipes.

Prohibition of advertising and promotion of electronic cigarettes in the European Union

COP6 urged Parties to consider banning or restricting the advertising, promotion and sponsorship of ENDS. Significant progress in this area was made with the new tobacco products directive (TPD) of the European Union (2014/40/EU).

The TPD noted that disparities between national laws and practices on advertising and sponsorship concerning electronic cigarettes present an obstacle to the free movement of goods and the freedom to provide services, and create an appreciable risk of competitive distortion. It was therefore necessary to approximate the national provisions on advertising and sponsorship of those products and to give them cross-border effect, ensuring a high level of protection for human health. This restrictive approach was adopted because of the potential risk of nicotine addiction as electronic cigarettes, like traditional cigarettes, normalized tobacco smoking.

Based on the new TPD, Member States must align national legislation to prohibit commercial communications with the direct or indirect effect of promoting electronic cigarettes and refill containers. Audiovisual commercial communications, for which the Audiovisual Media Services Directive (2010/13/EU) applies, are now prohibited for these products. Importantly, the TPD also clearly prohibits the cross-border advertising and promotion of e-cigarettes, and promotional elements on e-cigarette packaging.

5. PREVALENCE OF TOBACCO USE

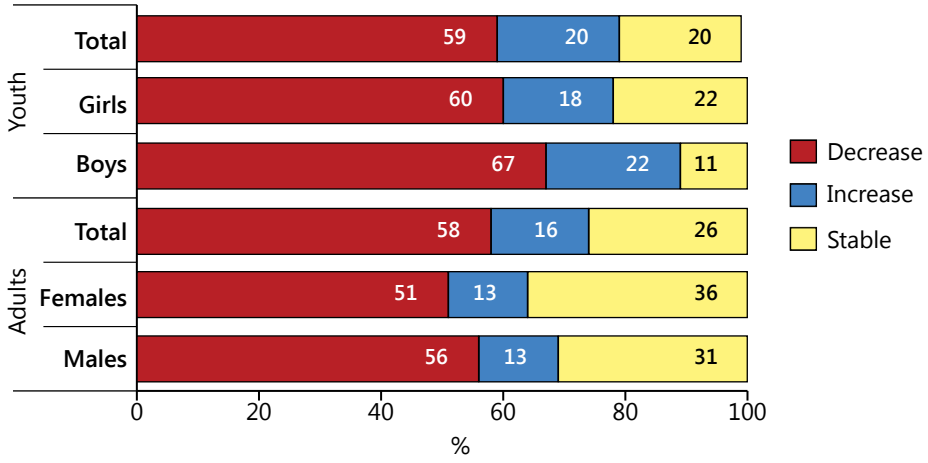
Key observations:

- Over half the Parties which reported in 2016 and held recent and comparable data, are experiencing a decrease in smoking among adults and young people.
- Projections to the year 2025 among a broader group of Parties show that most need to accelerate tobacco control activities in order to achieve the global NCD target of a 30% reduction in tobacco use by 2025. Of note, 21 Parties, including nine high-income Parties, are expected to experience increases in smoking prevalence if effective policies are not urgently put in place.
- To enable more accurate trend analysis, as well as estimates and projections, Parties to the Convention need to strengthen their surveillance and monitoring systems, and more generally, scale up their implementation of Article 20 of the Convention and exchange the collected data.

Recent development in tobacco use reported by the Parties. Most Parties, which had recent comparable national data, meaning that it was collected in 2014 or later with the same research methodology as an earlier dataset (see Annex 3 and the chapter on Article 20), were now observing a decrease in both adult smoking and youth smoking prevalence **(Fig. 5.1)**. With adults, a larger proportion (56%) were experiencing a decrease in male smoking than in female smoking (51%), and the same was identified for boys (67%) and girls (60%). For smokeless tobacco, no conclusions can be drawn due to the limited availability of recent comparable data among Parties[57].

Findings from the WHO FCTC impact assessment. The impact assessment exercise, mandated by COP6, revealed that since the FCTC came into force there have been significant gains in tobacco control action, notwithstanding variability across countries and policy domains, similar to that observed in the implementation reports. The report of the impact assessment expert group[58] refers to an analysis across 107 Parties

Figure 5.1. Trends in the prevalence of tobacco smoking among young people and adults, for Parties with new comparable national data 2014–2016[59]



[57] The prevalence of smokeless tobacco use among adults and youth, provided by the Parties, is presented in the Annex 3.

[58] http://www.who.int/fctc/cop/cop7/FCTC_COP_7_6_EN.pdf?ua=1

[59] For the list of Parties with two comparable datasets, with latest collected in the reporting period of 2014–2016, please refer to Annex 3.

examining the relationship between implementation of selected measures under the WHO FCTC (demand reduction measures) and changes in smoking prevalence in the period 2005–2015. It was found that generally, smoking prevalence decreased in the study period and in addition, Parties implementing a greater number of these key articles showed a significantly greater decline.

Comparable estimates for prevalence of smoking and smokeless tobacco use. Broader global and regional comparisons and trends were calculated by WHO's Department of Prevention of Noncommunicable Diseases. Its statistical model[60], which calculates these estimates, is designed to overcome issues concerning comparability between surveys and populations surveyed by both filling data gaps and by standardizing the results for a single age range and a select few indicators.

The data set includes all surveys previously reported by Parties, and surveys which WHO already have in records dating back as far as 1990. A statistical model was used to estimate trends in the prevalence of tobacco smoking for all Parties, with at least two surveys since 1990 (145 Parties). Parties with fewer than two surveys were assumed to be experiencing levels of smoking equivalent to the average seen in Parties of the same UN subregion. WHO estimates make it possible to compare smoking rates in 2014 with those in 2012, even though many Parties have not done national surveys in those particular years.

Among all Parties in 2012, an estimated 21.1% of people aged 15 or older were current smokers (35.6% of males and 6.6% of females). By 2014, smoking prevalence dropped slightly to 20.5% (34.6% of males and 6.2% of females). Smoked tobacco includes cigarettes and/or any other smoked tobacco product (e.g. pipes, cigars, cigarillos, bidis, kreteks, water pipes), according to the varieties surveyed by each Party. Current smoking means smoking either daily or occasionally at the time of the survey.

There are large data gaps regarding smokeless tobacco use because many Parties are not surveying for this type of tobacco, even though anecdotal evidence points to it being used worldwide. Consequently, there are insufficient data to measure changes over time at the global level. Using the most recent data about current smokeless tobacco use reported in surveys completed by Parties since 2006, the average prevalence among Parties globally in the period 2007–2014 was 7% (9% of males and 5.1% of females). As fewer Parties (89) have collected data on smokeless tobacco use since 2006, these averages are only indicative.

With respect to tobacco use among young people, the majority of Parties are beginning to consistently monitor 13–15 year-olds over time. It should soon be possible to calculate trend estimates of tobacco use among young people. Using the most recent data about current cigarette smoking reported in surveys completed by Parties in the period 2007–2014, the average prevalence among 147 Parties with surveys was 9.8% for boys and 4% for girls. On average, boys smoked at a rate more than double that of girls, however, in around one in 10 Parties, girls smoked at a higher rate than boys. In addition to using cigarettes, around 5% of boys and 3% of girls in Parties consume smokeless tobacco.

Projections on the development of tobacco smoking among Parties. In 2013, the Sixty-sixth World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (resolution WHA66.10). The global

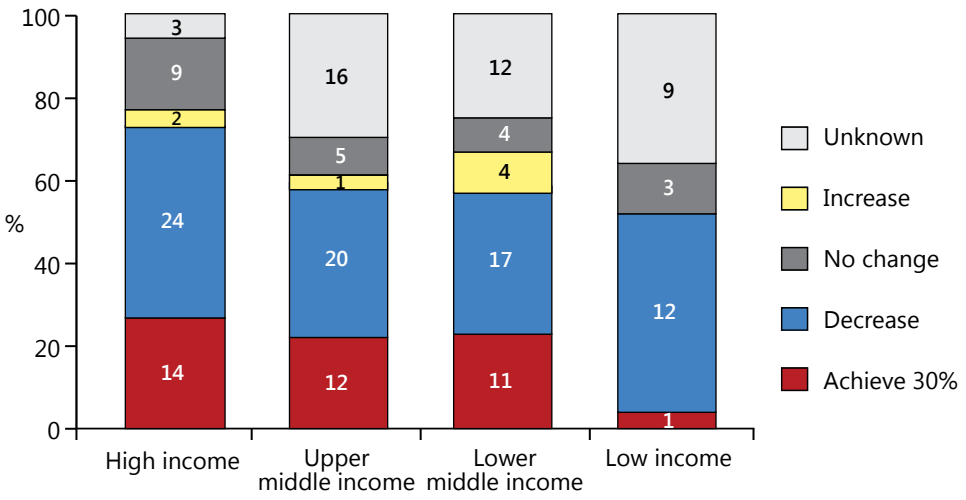
[60] WHO uses the data from surveys reported by Parties in their 2016 implementation reports to augment the WHO tobacco use prevalence data set, in order to calculate comparable trend estimates of smoking. The method for the estimation is described in the article, "Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control"; Bilano, Ver et al.; The Lancet, Volume 385 , Issue 9972 , 966–976; http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60264-1/abstract

action plan provides a road map to help countries reduce premature death from NCDs. It endorses nine voluntary targets addressing NCD premature death and the main risk factors, one of them being tobacco use. The tobacco target is to reduce the prevalence of tobacco use among persons aged 15-plus by 30% in relative terms between 2010 and 2025. Meeting this target is expected to greatly assist countries to achieve the related target of a 25% reduction in premature mortality from NCDs. Looking beyond 2025, the Sustainable Development Goals (SDGs) also include detailed action to reduce deaths from NCDs, one of which is to strengthen the implementation of the WHO FCTC in all countries.

In 2016, the Convention Secretariat and WHO produced a joint technical paper[61], requested by COP6 in decision FCTC/COP6(16), on the contribution and impact of WHO FCTC implementation in reducing the prevalence of current tobacco use, taking into account Parties' current situation. For this analysis, the smoking prevalence trends were used to estimate which Parties are likely to achieve the 30% relative reduction target. The results show that 38 Parties, or 21%, will probably achieve the target **(Fig. 5.2)**. An additional 73 Parties, or 41%, are decreasing and need only accelerate the declines they are already achieving. It is notable that 21 Parties, including nine high-income Parties, are expected to experience increases in smoking prevalence if effective policies are not urgently put in place. Most Parties need to accelerate tobacco control activities in order to achieve the NCD target.

It is important to remember that the trend estimates reflect measures implemented by Parties prior to the 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. 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.

Figure 5.2. Projections for WHO FCTC Parties to achieve the 30% relative reduction target in 2025, by World Bank income group[62]



[61] http://www.who.int/fctc/cop/COP6_16_technical-paper.pdf?ua=1

[62] Please note that in this figure, the numbers inside the columns represent the number of Parties in a respective category. The other figures in the report provide the exact proportion of the respective section as a number.

6. PRIORITIES, NEEDS AND GAPS, CHALLENGES

Priorities. Almost all Parties commented on their priorities and a majority assessed Article 14 (Demand reduction measures concerning tobacco dependence and cessation) as their highest priority. This was followed by Article 12 (Education, communication, training and public awareness), Article 15 (Illicit trade in tobacco products, as well as the Protocol to eliminate illicit trade in tobacco products) and, finally Article 8 (Protection from exposure to tobacco smoke). Many Parties also expressed the importance of full implementation of the FCTC.

Needs and gaps. A little over half the Parties reported gaps between the resources available and the needs assessed for implementation of the FCTC. Of these, the majority of Parties reported that they need both financial and human resources. The reasons for this varied. Some Parties had limited resources due to competing priorities, while others reported that their economic situation limited the resources available for implementation of the FCTC. For example, Greece explained that its economic crisis limited the resources available for implementation because most of their activities are supported by European project or donations from abroad.

Other gaps mentioned were the need for education and media campaigns to increase awareness of tobacco control issues, including raising the low level of public awareness of the effects of tobacco use, lack of a comprehensive and integrated tobacco programme and the influence of the tobacco industry.

Constraints and barriers. An overwhelming number of Parties described constraints or barriers encountered while implementing the Convention. In particular, interference by the tobacco industry was frequently mentioned, followed by a need for better legislative enforcement, insufficient political support and poor intersectoral coordination. Estonia described tobacco industry lobbies within other governmental and public institutions which prevented the passage of tobacco control policies, particularly when intersectoral coordination is required. Georgia also reported that the tobacco industry's influence within the country is a major barrier, as well as the desensitization of government officials outside the health sector. Information from several Parties referred to delays of up to five years in passing tobacco control bills and also suggested potential tobacco industry interference, alone or in combination with other internal factors. These include lack of technical capacity and of sufficient financial resources, competing priorities and volatile political circumstances.

Increasingly in recent decades, tobacco use has evolved. The 2016 reporting instrument included, for the first time, specific questions on policies related to new and emerging tobacco or nicotine products. Reports revealed that around two thirds of Parties have either smokeless tobacco products, water pipes and/or ENDS/ENNDS available in their markets. However, remarkably few Parties have adopted and implemented policies or regulations specific to those products.

7. CONCLUSIONS AND THE WAY FORWARD

1. In the 2016 reporting cycle, Parties' reports revealed an overall slowdown in implementation of the Convention, in spite of the advanced measures taken by several Parties. The 2016 reporting cycle showed no major changes in overall implementation rates of the Convention's requirements. These rates also show that a good number of Parties have not yet addressed even the time-bound provisions of the Convention. It is now evident that the pace of implementation needs to be accelerated.

2. The Parties to the Convention would benefit from the integration of various country assistance mechanisms to ensure that assistance is focused on the particular needs of the Parties and that the assistance framework is integrated, efficient and cost effective, thus providing a good return on investment. These mechanisms should capitalize on the experiences of the Parties and on a critical review of, and feedback from, such experiences.

3. Integration is also needed in data collection to allow more accurate assessments of the status of implementation by the Convention by the Parties. As a first step, it should be ensured that various initiatives of the Secretariat implemented under the COP work plan contribute to our knowledge base. This report also considers opportunities for integrating information from various programmes and projects under the COP work plan. As a first step, the report contains a special section listing other possible data sources that could be used to complement Parties' implementation reports. Several initiatives from the Convention Secretariat could also enrich and elucidate the information received through implementation reports.

4. The implementation guidelines (as well as policy options and recommendations) adopted by the Conference of the Parties, are based on scientific evidence and best practice, and represent the gold standard in implementation of the Convention. The guidelines need to be used more often and consistently as the primary roadmap in implementing Convention requirements, especially to strengthen legislation, regulation and the creation of national tobacco programmes.

5. Collaboration among the Parties, for example through south-south and triangular cooperation projects or bilateral assistance programmes, is necessary to share experiences from different sectors and to learn from best practice. This will unite Parties from different parts of the world and help assist those with similar economic, demographic and social landscapes in the fight against tobacco use.

6. New and emerging tobacco products continue to spread and become essential elements of the tobacco-use landscape. This will have adverse consequences on tobacco control if policies do not progressively reflect their presence. Comprehensive and concerted actions are needed with the participation of all concerned stakeholders to address such products, including through the development of specific policies to curb their use.

ANNEX 1

LIST OF KEY INDICATORS (152) DERIVING FROM THE REPORTING INSTRUMENT USED IN ASSESSING THE CURRENT STATUS OF IMPLEMENTATION

Article 5

- development and implementation of comprehensive, multisectoral, national tobacco-control strategies, plans and programmes
- existence of a focal point for tobacco control
- existence of a tobacco-control unit
- existence of a national coordinating mechanism for tobacco control
- protection of public health policies from commercial and other vested interests of the tobacco industry
- public access to a wide range of information on tobacco industry activities required

Article 6

- tax policies to reduce tobacco consumption implemented
- sales to international travellers of tobacco products prohibited or restricted
- tobacco imports by international travellers prohibited or restricted

Article 8

- tobacco smoking banned in indoor workplaces, public transport and indoor public places *
- ***comprehensiveness of protection in government buildings***[63]
- ***comprehensiveness of protection in health-care facilities***
- ***comprehensiveness of protection in educational facilities***
- ***comprehensiveness of protection in universities***
- ***comprehensiveness of protection in private workplaces***
- ***comprehensiveness of protection in aeroplanes***
- ***comprehensiveness of protection in trains***
- ***comprehensiveness of protection in ground public transport***
- ***comprehensiveness of protection in ferries***
- ***comprehensiveness of protection in motor vehicles used as places of work***
- ***comprehensiveness of protection in private vehicles***
- ***comprehensiveness of protection in cultural facilities***
- ***comprehensiveness of protection in shopping malls***
- ***comprehensiveness of protection in pubs and bars***
- ***comprehensiveness of protection in nightclubs***
- ***comprehensiveness of protection in restaurants***

[63] The indicators in ***italics and bold*** constitute the time-bound measures.

Article 9

- testing and measuring the contents of tobacco products required
- testing and measuring the emissions of tobacco products required
- regulating the contents of tobacco products required
- regulating the emissions of tobacco products required

Article 10

- disclosure of information to government authorities about the contents of tobacco products required
- disclosure of information to government authorities about the emissions of tobacco products required
- public disclosure of the contents of tobacco products required
- public disclosure of the emissions of tobacco products required

Article 11

- requiring that packaging of tobacco products does not carry advertisement or promotion
- ***misleading descriptors required***
- ***health warnings required***
- ***requiring that health warnings be approved by the competent national authority***
- ***rotated health warnings***
- ***large, clear, visible and legible health warnings required***
- ***health warnings occupying no less than 30% of the principal display areas required***
- ***health warnings occupying 50% or more of the principal display areas required***
- ***health warnings in the form of pictures or pictograms required***
- warning required in the principal language(s) of the country*

Article 12

- educational and public awareness programmes implemented
- public agencies involved in programmes and strategies
- nongovernmental organizations involved in programmes and strategies
- private organizations involved in programmes and strategies
- programmes are guided by research
- training programmes addressed to health workers implemented
- training programmes addressed to community workers implemented
- training programmes addressed to social workers implemented
- training programmes addressed to media professionals implemented
- training programmes addressed to educators implemented

- training programmes addressed to decision-makers implemented
- training programmes addressed to administrators implemented

Article 13

- ***comprehensive ban on all tobacco advertising promotion and sponsorship required***
- ban on display of tobacco products at points of sale required
- ban covering the domestic Internet required
- ban covering the global Internet required
- ban covering brand stretching and/or sharing required
- ban covering product placement required
- ban covering the depiction/use of tobacco in entertainment media required
- ban covering tobacco sponsorship of international events or activities required
- ban covering corporate social responsibility required
- ***ban covering cross-border advertising, promotion and sponsorship originating from the country's territory required***
- ban covering cross-border advertising promotion and sponsorship entering the country's territory required
- cooperation on the elimination of cross-border advertising
- penalties imposed for cross-border advertising

Article 14

- evidence-based comprehensive and integrated guidelines developed
- media campaigns to promote tobacco cessation implemented
- programmes designed for underage girls and young women implemented
- programmes designed for women implemented
- programmes designed for pregnant women implemented
- telephone quitlines introduced
- local events to promote cessation of tobacco use implemented
- programmes to promote cessation in educational institutions designed
- programmes to promote cessation in health-care facilities designed
- programmes to promote cessation in workplaces designed
- programmes to promote cessation in sporting environments designed
- diagnosis and treatment included in national tobacco-control programmes
- diagnosis and treatment included in national health programmes
- diagnosis and treatment included in national education programmes
- diagnosis and treatment included in the health-care system
- tobacco dependence treatment incorporated in the curricula of medical schools
- tobacco dependence treatment incorporated in the curricula of dental schools
- tobacco dependence treatment incorporated in the curricula of nursing schools

- tobacco dependence treatment incorporated in the curricula of pharmacy schools
- accessibility and affordability of pharmaceutical products facilitated

Article 15

- marking that assists in determining the origin of product required
- marking that assists in identifying legally sold products required
- statement on destination on all packages of tobacco products required
- tracking regime to further secure the distribution system developed
- legible marking required
- monitoring of cross-border trade required
- information exchange facilitated
- legislation against illicit trade enacted
- destruction of confiscated manufacturing equipment required
- storage and distribution of tobacco products regulated
- confiscation of proceeds derived from illicit trade enabled
- cooperation to eliminate illicit trade promoted
- licensing actions to control production and distribution required

Article 16

- sales of tobacco products to minors prohibited
- clear and prominent indicators required
- requirement that sellers request evidence of full legal age
- ban on sale of tobacco in any directly accessible manner
- manufacture and sale of any objects in the form of tobacco products prohibited
- sale of tobacco products from vending machines prohibited
- distribution of free tobacco products to the public prohibited
- distribution of free tobacco products to minors prohibited
- sale of cigarettes individually or in small packets prohibited
- penalties against sellers provided for
- sales of tobacco products by minors prohibited

Article 17

- viable alternatives for tobacco growers promoted
- viable alternatives for tobacco workers promoted
- viable alternatives for tobacco sellers promoted

Article 18

- measures in respect of tobacco cultivation considering the protection of the environment implemented
- measures in respect of tobacco cultivation considering the health of persons implemented

- measures in respect of tobacco manufacturing for the protection of the environment implemented
- measures in respect of tobacco manufacturing considering the health of persons implemented

Article 19

- measures on criminal liability contained in the tobacco control legislation
- separate liability provisions on tobacco control outside of the tobacco control legislation exist
- civil liability measures that are specific to tobacco control exist
- civil liability measures that could apply to tobacco control exist
- civil or criminal liability provisions that provide for compensation exist
- any recorded launch of criminal and/or civil liability action
- legislative action taken against the tobacco industry for reimbursement of various costs

Article 20

- research on determinants of tobacco consumption promoted
- research on consequences of tobacco consumption promoted
- research on social and economic indicators promoted
- research on tobacco use among women promoted
- research on exposure to tobacco smoke promoted
- research on identification of tobacco dependence treatment promoted
- research on alternative livelihoods promoted
- training for those engaged in tobacco control provided
- national system for surveillance of patterns of tobacco consumption established
- national system for surveillance of determinants of tobacco consumption established
- national system for surveillance of consequences of tobacco consumption established
- national system for surveillance of indicators related to tobacco consumption established
- national system for surveillance of exposure to tobacco smoke established
- scientific and technical information exchanged
- information on tobacco industry practices exchanged
- information on cultivation of tobacco exchanged
- database of laws and regulations on tobacco control established
- database of information about the enforcement of laws established
- database of the pertinent jurisprudence established

Article 22

- assistance received on transfer of skills and technology
- assistance received on expertise for tobacco-control programmes
- assistance received in training and sensitization of personnel
- assistance received in equipment, supplies and logistics
- assistance received in tobacco control methods, e.g. treatment of nicotine addiction
- assistance received in research on affordability of addiction treatment
- international organizations encourage to provide support to developing country Parties

ANNEX 2

PROGRESS IN IMPLEMENTATION BETWEEN THE 2012 AND 2014 REPORTING PERIODS

Article/Indicator name[1]	2016		2014	
Article 5. General obligations	**Yes (%)**		**Yes (%)**	
comprehensive multisectoral national tobacco control strategy developed	73		67	
focal point for tobacco control exists	87		86	
tobacco control unit exists	65		66	
national coordinating mechanism for tobacco control exists	77		75	
interference by the tobacco industry	69		68	
public access to a wide range of information on the tobacco industry	33		27	
Article 6 Price and tax measures to reduce the demand for tobacco	**Yes (%)**		**Yes (%)**	
existence of information on tobacco-related mortality	47		52	
existence of information on the economic burden of tobacco use	35		33	
only specific tax levied	25		20	
only ad valorem tax levied	14		10	
combination of specific and ad valorem taxes levied	51		59	
tobacco tax earmarking	20		20	
tax policies to reduce tobacco consumption	79		79	
tobacco sales to international travellers prohibited	51		42	
tobacco imports by international travellers prohibited	66		56	
Article 8 Protection from exposure to tobacco smoke	**Yes (%)**		**Yes (%)**	
availability of data on exposure to tobacco smoke	83		74	
tobacco smoking banned in all public places	92		96	
national law providing for the ban[a]	91		88	
subnational law(s) providing for the ban[a]	28		25	
administrative and executive orders providing for the ban[a]	45		49	
voluntary agreements providing for the ban[a]	16		21	
mechanism/infrastructure for enforcement provided[a]	86		82	
Article 8 — Comprehensiveness of measures applied	**Complete (%)**	**Partial (%)**	**Complete (%)**	**Partial (%)**
comprehensiveness of protection in government buildings[a]	75	21	76	21
comprehensiveness of protection in health-care facilities[a]	84	14	82	16
comprehensiveness of protection in educational facilities[a]	88	10	82	17

Article/Indicator name[1]	2016		2014	
comprehensiveness of protection in universities [a]	71	22	71	26
comprehensiveness of protection in private workplaces[a]	52	37	48	43
comprehensiveness of protection in airplanes[a]	92	5	89	4
comprehensiveness of protection in trains[a]	65	12	60	13
comprehensiveness of protection in ferries[a]	61	19	55	22
comprehensiveness of protection in ground public transport	87	9	83	10
comprehensiveness of protection in motor vehicles used for work[a]	82	16	62	22
comprehensiveness of protection in private vehicles[a]	13	22	11	16
comprehensiveness of protection in cultural facilities[a]	75	20	72	21
comprehensiveness of protection in shopping malls[a]	67	26	61	28
comprehensiveness of protection in pubs and bars[a]	47	36	47	33
comprehensiveness of protection in nightclubs[a]	44	31	47	28
comprehensiveness of protection in restaurants[a]	54	39	53	38
Article 9 Regulation of the contents of tobacco products	**Yes (%)**		**Yes (%)**	
testing and measuring the contents of tobacco products	44		43	
testing and measuring the emissions of tobacco products	45		46	
regulating the contents of tobacco products	54		55	
regulating the emissions of tobacco products	50		50	
Article 10 Regulation of tobacco product disclosures	**Yes (%)**		**Yes (%)**	
requiring disclosure of information about the contents of tobacco products	67		66	
requiring disclosure of information about the emissions of tobacco products	62		60	
requiring public disclosure on the contents of tobacco products	51		55	
requiring public disclosure on the emissions of tobacco products	47		47	
Article 11 Packaging and labelling of tobacco products	**Yes (%)**		**Yes (%)**	
packaging of tobacco products does not carry advertising or promotion	74		71	
misleading descriptors banned	80		78	
health warnings required	89		89	
health warnings approved by the competent national authority	84		84	
rotated health warnings	76		78	
large, clear, visible and legible health warnings required	87		86	
law mandate, as a minimum, a style, size and colour of font[b]	91		91	
health warnings occupying no less than 30% required	77		78	

Article/Indicator name[1]	2016		2014	
health warnings occupying 50% or more required	48		41	
health warnings in the form of pictures or pictograms required	56		52	
copyright to pictures owned by the Government[c]	53		36	
granting of license for the use of health warnings[c]	55		57	
information on constituents required on packages	57		51	
information on emissions required on packages	51		51	
warning required in the principal language(s) of the country	87		61	
Article 12 Education, communication, training and public awareness	**Yes (%)**		**Yes (%)**	
implemented educational and public awareness programmes	89		96	
implemented educational programmes targeted to adults or the general public[d]	98		94	
implemented educational programmes targeted to children and youth[d]	99		99	
implemented educational programmes targeted to men[d]	76		71	
implemented educational programmes targeted to women[d]	76		74	
implemented educational programmes targeted to pregnant women[d]	69		67	
implemented educational programmes targeted to ethnic groups[d]	33		26	
age differences reflected in educational programmes[d]	92		91	
gender differences reflected in educational programmes[d]	76		72	
educational background differences reflected in educational programmes[d]	62		62	
cultural differences reflected in educational programmes[d]	43		40	
socioeconomic differences reflected in educational programmes[d]	55		44	
programmes covering the health risks of tobacco consumption[d]	100		100	
programmes covering the risks of exposure to tobacco smoke[d]	97		99	
programmes covering the benefits of cessation of tobacco use[d]	92		96	
programmes covering economic consequences of tobacco production[d]	45		41	
programmes covering economic consequences of tobacco consumption[d]	75		82	
programmes covering environmental consequences of tobacco production[d]	45		40	

Article/Indicator name[1]	2016		2014	
programmes covering environmental consequences of tobacco consumption[d]	61		65	
public agencies involved in programmes/strategies for tobacco control	88		91	
NGOs involved in programmes/strategies for tobacco control	86		88	
private organizations involved in programmes/strategies for tobacco control	56		56	
programmes guided by research	67		64	
training programmes addressed to health workers	83		84	
training programmes addressed to community workers	65		61	
training programmes addressed to social workers	54		53	
training programmes addressed to media professionals	56		56	
training programmes addressed to educators	76		73	
training programmes addressed to decision-makers	60		63	
training programmes addressed to administrators	56		56	
Article 13 Tobacco advertising, promotion and sponsorship	**Yes (%)**		**Yes (%)**	
comprehensive ban on all tobacco advertising, promotion and sponsorship instituted	72		71	
ban on display of tobacco products at points of sales [e]	58		56	
ban covering the domestic Internet[e]	68		74	
ban covering the global Internet[e]	26		34	
ban covering brand stretching and/or sharing[e]	63		66	
ban covering product placement [e]	82		86	
ban covering the depiction/use of tobacco in entertainment media [e]	69		76	
ban covering tobacco sponsorship [e]	83		91	
ban covering corporate social responsibility[e]	67		63	
ban covering cross-border advertising originating from the country[e]	61		65	
ban covering cross-border advertising entering the country[e]	64		73	
precluded by constitution from undertaking a comprehensive ban[f]	17		12	
all tobacco advertising, promotion and sponsorship restricted[f]	49		43	
cross-border advertising originating from the country restricted[f]	20		24	
advertising by false and misleading means prohibited[f]	34		43	
use of warnings to accompany all advertising required[f]	34		33	
use of direct or indirect incentives restricted[f]	40		36	
disclosure of advertising expenditure required[f]	17		10	

Article/Indicator name[1]	2016		2014	
advertising restricted on radio[f]	66		60	
advertising restricted on television[f]	63		57	
advertising restricted in print media[f]	54		52	
advertising restricted on the domestic Internet[f]	43		31	
advertising restricted on the global Internet[f]	23		10	
sponsorship of international events and activities restricted[f]	31		38	
tobacco sponsorship of participants therein restricted[f]	26		36	
cooperation on the elimination of cross-border advertising	29		31	
penalties imposed for cross-border advertising	38		34	
Article 14 Demand reduction measures concerning tobacco dependence and cessation	**Yes (%)**		**Yes (%)**	
evidence-based comprehensive and integrated guidelines developed	62		59	
implemented media campaigns on the importance of quitting	75		76	
implemented programmes specially designed for underage girls and young women	33		33	
implemented programmes specially designed for women	33		35	
implemented programmes specially designed for pregnant women	41		44	
implemented telephone quitlines	41		44	
implemented local events to promote cessation of tobacco use	79		89	
designed programmes to promote cessation in educational institutions	53		53	
designed programmes to promote cessation in health-care facilities	73		76	
designed programmes to promote cessation in workplaces	51		50	
designed programmes to promote cessation in sporting environments	29		33	
included diagnosis and treatment in national tobacco control programmes	69		71	
included diagnosis and treatment in national health programmes	65		72	
included diagnosis and treatment in national educational programmes	37		44	
included diagnosis and treatment in the health-care system	69		74	
primary health care providing programmes on diagnosis and treatment [g]	78		80	
secondary and tertiary health care providing programmes on diagnosis and treatment[g]	64		59	
specialist health-care systems providing programmes on diagnosis and treatment [g]	47		54	

Article/Indicator name[1]	2016		2014	
specialized centres for cessation providing programmes on diagnosis and treatment [g]	61		55	
rehabilitation centres providing programmes on diagnosis and treatment [g]	33		28	
physicians offering counselling services[g]	89		93	
dentists offering counselling services [g]	49		39	
family doctors offering counselling services[g]	65		69	
practitioners of traditional medicine offering counselling services[g]	20		21	
nurses offering counselling services[g]	84		75	
midwives offering counselling services[g]	41		33	
pharmacists offering counselling services[g]	51		52	
community workers offering counselling services[g]	43		32	
social workers offering counselling services[g]	47		40	
tobacco dependence treatment incorporated into the curricula of medical schools	50		46	
tobacco dependence treatment incorporated into the curricula of dentistry schools	29		25	
tobacco dependence treatment incorporated into the curricula of nursing schools	33		31	
tobacco dependence treatment incorporated into the curricula of pharmacy schools	23		22	
accessibility and affordability of pharmaceutical products facilitated	59		60	
nicotine replacement therapy available[h]	94		98	
treatment with bupropion available [h]	72		72	
treatment with varenicline available[h]	68		75	
Article 14.2(b) and (c) services and treatment costs provided covered by public funding or reimbursement schemes	**Fully (%)**	**Partially (%)**	**Fully (%)**	**Partially (%)**
programmes in primary health care covered by public funding[g]	43	35	41	30
programmes in secondary and tertiary health care covered by public funding[g]	33	34	29	28
programmes in specialist health-care systems covered by public funding[g]	15	33	27	20
programmes in specialized centres for cessation covered by public funding[g]	26	34	26	25
programmes in rehabilitation centres covered by public funding[g]	13	18	15	10
nicotine replacement therapy costs covered by public funding[h]	28	27	32	17
buproprion costs covered by public funding[h]	19	22	16	19
varenicline costs covered by public funding[h]	11	20	14	16

Article/Indicator name[1]	2016		2014	
Article 15 Illicit trade in tobacco products	**Yes (%)**		**Yes (%)**	
data on the percentage of smuggled tobacco products	17		16	
marking that assists in determining the origin of product required	64		59	
marking that assists in identifying legally sold products required	68		63	
statement on destination required on all packages of tobacco products	44		37	
tracking regime to further secure the distribution system developed	35		23	
legible marking required	68		66	
monitoring of cross-border trade required	57		50	
information exchange facilitated	65		55	
legislation against illicit trade enacted	72		67	
requiring that confiscated manufacturing equipment be destroyed	74		66	
storage and distribution of tobacco products monitored	69		61	
confiscation of proceeds derived from illicit trade enabled	68		61	
cooperation to eliminate illicit trade promoted	66		63	
licensing required	65		65	
Article 16 Sales to and by minors	**Yes (%)**		**Yes (%)**	
sales of tobacco products to minors prohibited	86		89	
clear and prominent indicator required	68		69	
required that sellers request for evidence of having reached full legal age	67		65	
ban of sale of tobacco in any directly accessible manner	53		55	
manufacture and sale of any objects in the form of tobacco products prohibited	60		62	
sale of tobacco products from vending machines prohibited	59		61	
tobacco vending machines not accessible to minors[i]	38		55	
distribution of free tobacco products to the public prohibited	80		82	
distribution of free tobacco products to minors prohibited	84		86	
sale of cigarettes individually or in small packets prohibited	71		68	
penalties against sellers provided	77		80	
sale of tobacco products by minors prohibited	71		73	

Article/Indicator name[1]	2016		2014	
Article 17 Provision of support for economically viable alternative activities	**Yes (%)**		**Yes (%)**	
tobacco growing in your jurisdiction	48		55	
viable alternatives for tobacco growers promoted[j]	33		22	
viable alternatives for tobacco workers promoted[j]	11		7	
viable alternatives for tobacco sellers promoted[j]	2		1	
Article 18 Protection of the environment and the health of persons	**Yes (%)**		**Yes (%)**	
measures implemented in respect to tobacco cultivation considering the protection of the environment[j]	39		28	
measures implemented in respect to tobacco cultivation considering the health of persons[j]	38		33	
measures implemented in respect to tobacco manufacturing for the protection of the environment[j]	41		32	
measures implemented in respect to tobacco manufacturing considering the health of persons[j]	38		36	
Article 19 Liability	**Yes (%)**		**Yes (%)**	
measures on criminal liability contained in tobacco control legislation	57		46	
separate liability provisions on tobacco control outside of tobacco control legislation exist	31		26	
civil liability measures that are specific to tobacco control exist	32		25	
civil liability measures that could apply to tobacco control exist	43		34	
civil or criminal liability provisions that provide for compensation exist	24		18	
criminal and/or civil liability action launched by any person	17		15	
actions taken against the tobacco industry on reimbursement of costs related to tobacco use	8		6	
Article 20. Research, surveillance and exchange of information	**Yes (%)**		**Yes (%)**	
research on determinants of tobacco consumption promoted	68		66	
research on consequences of tobacco consumption promoted	67		64	
research on social and economic indicators promoted	63		69	
research on tobacco use among women promoted	50		46	
research on exposure to tobacco smoke promoted	59		56	
research on identification of tobacco dependence treatment promoted	47		45	
research on alternative livelihoods promoted	11		16	
training for those engaged in tobacco control provided	56		54	
national system for surveillance of patterns of tobacco consumption established	71		67	
national system for surveillance of determinants of tobacco consumption established	49		47	

Article/Indicator name[1]	2016		2014	
national system for surveillance of consequences of tobacco consumption established	44		43	
national system for surveillance on social, economic and health indicators established	49		48	
national system for surveillance of exposure to tobacco smoke established	56		56	
scientific and technical information exchanged	63		60	
information on tobacco industry practices exchanged	40		41	
information on cultivation of tobacco exchanged	25		27	
database of laws and regulations on tobacco control established	67		67	
database of information about the enforcement of laws established	47		54	
database of pertinent jurisprudence established	27		28	
Articles 22 & 26. International cooperation and assistance	**Yes (%)**		**Yes (%)**	
assistance provided on transfer of skills and technology	37		25	
expertise for tobacco control programmes provided	38		25	
training and sensitization of personnel provided	35		17	
equipment, supplies, logistics provided	28		18	
methods for tobacco control, e.g. treatment of nicotine addiction provided	21		12	
assistance on research on affordability provided	11		6	
assistance received on transfer of skills and technology	59		58	
expertise for tobacco control programmes received	62		59	
training and sensitization of personnel received	47		42	
equipment, supplies, logistics received	47		40	
methods for tobacco control, e.g. treatment of nicotine addiction received	32		27	
assistance on research on affordability received	18		12	
development institutions encouraged to provide financial assistance for developing country Parties	20		20	
specific gaps	59		54	

[1] 133 reports were included in the analysis for the 2016 reporting cycle. The 2014 analysis consists of 147 reports, including the 17 late submissions not included in the 2014 Global Progress Report. This table presents the percentages for affirmative answers.

The conditional questions in the questionnaire are marked with increased indent and superscript letters from [a] to [i], and are calculated as follows: [a] The denominator is the number of Parties which answer Yes to tobacco smoking banned in all public spaces. [b] The denominator is the number of Parties which answer Yes to large, clear, visible and legible health warnings required. [c] The denominator is the number of Parties which answer Yes to pictorial health warnings. [d] The denominator is the number of Parties which answer Yes to implementing educational and public awareness programmes. [e] The denominator is the number of Parties which answer Yes to comprehensive bans on all tobacco advertising, promotion and sponsorship. [f] The denominator is the number of Parties which answer No to the comprehensive ban on all tobacco advertising, promotion and sponsorship. [g] The denominator is the number of Parties which answer Yes to including diagnosis and treatment in the health-care system. [h] The denominator is the number of Parties which answer Yes to facilitating accessibility and affordability of pharmaceutical products. [i] The denominator is the number of Parties which answer No to the prohibition of sale of tobacco products from vending machines. The question marked with superscript letter [j] is not conditional as such, but Articles 17 and 18 concern mainly the Parties which have tobacco-growing in their jurisdiction. Therefore, for these questions, the denominator is the number of Parties which answer Yes to tobacco-growing in their jurisdiction.

ANNEX 3

TOBACCO USE PREVALENCE REPORTED BY THE PARTIES

ADULT SMOKING PREVALENCE[1] REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Afghanistan	2011	35.20%	NR	NR				CS
Algeria	2010	27.00%	2.50%	15.00%				CS
Australia	**2010, 2013**	14.50%	11.20%	12.80%				DS
Austria	**2008, 2015**	30.20%	24.00%	27.00%	↘	↘	↘	CS
Azerbaijan	**2012, 2014**	35.90%	0.00%	18.20%	↔	↔	↗	CS
Bahamas	2012	26.90%	6.40%	16.70%				CS
Bahrain	2007	33.40%	7.00%	19.90%				CS
Belgium	**2008, 2013**	26.80%	19.90%	23.00%				CS
Belize	2006	17.70%	1.40%	10.20%				CS
Benin	**2008, 2015**	10.80%	0.60%	5.20%	↘	↘	↘	CS
Bhutan	2012, 2014	10.80%	3.10%	7.40%				CS
Bosnia and Herzegovina	2002, 2012	46.90%	34.50%	40.70%				CS
Brazil	**2008, 2013**	18.90%	11.00%	14.70%				CS
Cameroon	2011, 2013	11.80%	0.60%	8.90%				CS
Canada	**2012, 2013**	16.00%	13.30%	14.60%				CS
Chile	2003, 2010	44.20%	37.10%	40.60%				DS
China	**2010, 2015**	52.10%	2.70%	27.70%	↔	↔	↔	CS
Colombia	**2008, 2013**	18.80%	7.40%	12.95%				CS
Congo	2008, 2012	13.00%	1.30%	6.60%				CS
Cook Islands	2004, 2011	24.26%	16.36%	20.27%				CS
Costa Rica	2010, 2015	13.00%	4.00%	9.00%				CS
Cote D'Ivoire	2005, 2011/2012	25.10%	1.80%	14.60%				CS
Croatia	2011, 2014	35.30%	27.10%	31.10%				CS
Czech Republic	**2012, 2014**	37.40%	25.80%	31.40%	↔	↔	↔	CS
Cyprus	**2012, 2014**	44.00%	19.00%	31.00%	↗	↔	↗	CS
Democratic Republic of the Congo	2010, 2013/2014	38.00%	9.00%	6.40%				CS
Denmark	**2013, 2015**	22.80%	22.20%	22.50%	↘	↗	↔	CS
Djibouti	2006, 2012	18.00%	2.00%	25.40%				CS
Dominica	2008	16.60%	3.20%	10.20%				CS
Ecuador	2010, 2011/2013	38.20%	15.00%	31.50%				CS

ADULT SMOKING PREVALENCE[1] REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Egypt	2005, 2009	38.00%	0.50%	20.00%				CS
El Salvador	2014	16.90%	2.20%	8.80%				CS
Estonia	**2012, 2014**	39.40%	22.70%	29.40%	↘	↘	↘	CS
European Union	**2012, 2014**	31.00%	22.00%	26.00%	↘	↘	↘	CS
Federated States of Micronesia	2002, 2012	39.80%	25.40%	35.00%				DS
Finland	**2013, 2014**	24.80%	18.70%	21.40%	↔	↔	↔	CS
France	**2010, 2014**	38.40%	30.00%	34.10%	↗	↗	↗	CS
Gambia	2010	31.30%	1.00%	15.60%				CS
Georgia	2011	55.50%	4.80%	30.30%				CS
Germany	**2009, 2012**	31.40%	23.90%	27.60%				CS
Ghana	2008, 2014	4.10%	0.10%	NR				CS
Greece	**2009, 2014**	39.00%	26.50%	32.50%	↘	↘	↘	CS
Guatemala	2003	23.90%	3.40%	11.20%				CS
Guyana	2009	31.00%	3.00%	34.00%				CS
Honduras	2015	37.30%	33.30%	35.30%				CS
Hungary	**2009, 2014**	33.40%	22.20%	27.50%	↘	↘	↘	CS
Iceland	**2013, 2015**	15.30%	15.00%	15.20%	↔	↘	↘	CS
India	2010	24.30%	2.90%	14.00%				CS
Iran (Islamic Republic of)	**2009, 2011**	20.84%	0.90%	10.91%				CS
Iraq	2006	41.50%	6.90%	21.90%				CS
Ireland	**2007, 2015**	24.00%	21.00%	23.00%	↘	↘	↘	CS
Italy	**2013, 2014**	24.80%	15.10%	19.80%	↘	↔	↘	CS
Jamaica	2000, 2007/2008	22.10%	7.20%	14.50%				CS
Japan	2011, 2014	32.20%	8.50%	19.60%				CS
Jordan	2007	49.60%	5.70%	29.00%				CS
Kenya	2008/2009, 2014	15.10%	0.80%	7.80%				CS
Kiribati	2004/2006	37.70%	22.30%	29.20%				CS
Kuwait	**2006, 2014**	39.20%	3.30%	20.50%	↘	↘	↘	CS
Kyrgyz Republic	2012, 2013	42.00%	2.00%	22.00%				DS
Latvia	**2012, 2014**	51.80%	21.00%	36.10%	↔	↗	↗	DS
Lebanon	2007, 2013	39.40%	31.90%	35.70%				CS
Libya	2009	49.60%	0.70%	25.10%				CS
Lithuania	**2012, 2014**	42.20%	17.20%	27.20%	↗	↔	↗	CS

ADULT SMOKING PREVALENCE[1] REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Luxembourg	**2013, 2015**	23.00%	18.00%	21.00%	↘	↘	↔	CS
Madagascar	2013	28.50%	0.80%	NR				CS
Malaysia	**2011, 2015**	43.00%	1.40%	22.80%	↔	↔	↔	CS
Maldives	2011	34.70%	3.40%	18.80%				CS
Mali	**2007, 2013**	24.52%	2.72%	10.84%				DS
Malta	2008	31.00%	21.40%	25.70%				CS
Mauritania	2006	34.10%	5.70%	18.90%				CS
Mauritius	**2009, 2015**	38.00%	3.90%	19.30%	↘	↔	↘	CS
Mexico	**2009, 2015**	25.20%	8.20%	16.40%	↔	↔	↔	CS
Montenegro	**2008, 2012**	35.00%	27.00%	31.00%				CS
Myanmar	**2009, 2014**	43.80%	8.40%	26.10%	↔	↔	↗	CS
Netherlands	**2013, 2015**	27.60%	20.80%	24.20%	↗	↘	↔	CS
New Zealand	**2012/2013, 2014/2015**	18.20%	15.00%	16.60%	↔	↘	↘	CS
Nigeria	2012	7.30%	0.40%	3.90%				CS
Norway	**2013, 2015**	21.50%	19.10%	20.30%	↘	↘	↘	CS
Oman	**2004, 2008**	16.60%	0.70%	7.00%				CS
Pakistan	2012/2013, 2014	22.20%	2.10%	12.40%				CS
Palau	2011/2013	24.00%	8.40%	16.60%				CS
Panama	2010, 2013	9.40%	2.80%	6.10%				CS
Papua New Guinea	2007	60.30%	27.00%	44.00%				CS
Paraguay	2003, 2011	22.80%	6.10%	14.50%				CS
Philippines	2009	47.70%	9.00%	28.30%				CS
Poland	**2013, 2015**	32.00%	19.00%	25.00%	↘	↔	↘	CS
Portugal	**2005, 2014**	27.80%	13.20%	20.00%	↘	↗	↔	CS
Republic of Korea	**2012, 2014**	42.30%	5.10%	23.30%	↘	↘	↘	CS
Republic of Moldova	2005, 2012	48.20%	8.20%	27.20%				CS
Republic of Serbia	**2006, 2013**	37.90%	31.60%	34.70%				CS
Russian Federation	**2012, 2014**	53.00%	16.00%	33.00%	↘	↘	↘	CS
Samoa	**2002, 2014**	33.40%	12.20%	23.30%	↘	↘	↘	DS
San Marino	2013	16.10%	14.40%	15.20%				CS
Saudi Arabia	2006, 2014	23.70%	1.50%	12.20%				CS
Senegal	2003, 2015	10.70%	0.40%	5.40%				CS
Seychelles	**2004, 2013/2014**	34.10%	7.70%	20.90%	↘	↗	↘	CS

ADULT SMOKING PREVALENCE[1] REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Sierra Leone	2009	43.10%	10.50%	25.80%				CS
Singapore	2010, 2013	23.10%	3.80%	13.30%				DS
Slovakia	2006, 2015	40.00%	32.00%	36.00%				CS
South Africa	2003, 2012 (for total)	35.10%	10.20%	18.20%				CS
Spain	**2011/2012, 2014**	30.40%	20.50%	25.40%	↔	↘	↘	CS
Sri Lanka	2006	22.80%	0.30%	11.50%				DS
Suriname	2007, 2012	34.00%	6.60%	20.00%				CS
Syrian Arab Republic	2001	51.00%	10.00%	29.00%				CS
Swaziland	**2007, 2014**	11.70%	1.20%	6.00%	↘	↘	↘	CS
Sweden	**2013, 2015**	20.00%	19.00%	20.00%	↘	↘	↘	CS
Thailand	**2013, 2014**	40.50%	2.20%	20.70%	↗	↔	↔	CS
Togo	**2007, 2010**	12.40%	1.80%	6.80%				CS
Tonga	2011, 2012	46.40%	13.40%	29.30%				CS
Trinidad and Tobago	2011	33.50%	9.40%	21.10%				CS
Tunisia	2005	48.40%	8.20%	24.90%				CS
Turkey	**2010, 2012**	41.40%	13.10%	27.10%				CS
Turkmenistan	2014	15.50%	0.60%	8.30%				CS
Ukraine	**2014, 2015**	45.00%	10.60%	NR	↔	↔	NR	DS
United Arab Emirates	2003, 2010	31.00%	1.80%	32.80%				CS
United Kingdom	**2012/2013, 2015**	20.70%	15.90%	18.30%	↘	↘	↘	CS
United Republic of Tanzania	1992, 2012	26.00%	2.90%	14.10%				CS
Vanuatu	2011	62.30%	20.20%	52.50%				CS
Viet Nam	2001/2002, 2010	47.40%	1.40%	23.80%				CS
Yemen	**2003, 2013**	25.80%	7.40%	16.40%				CS
Zimbabwe	2010/2011	22.90%	1.00%	10.40%				DS

[1] This table combines information provided by the Parties in 2016 under the Current smoking tobacco section, or Daily smoking tobacco section, in the reporting instrument. The definitions of what is considered smoking tobacco may differ between countries. Detailed descriptions of individual country definitions of smoking tobacco products included is outside the scope of this report. Whenever reported by the Parties, current or daily smoking prevalence is included in the table. The methodology of the surveys, and the definitions of smoking or tobacco use differ, and the figures and changes over time are presented here not comparable as such between the Parties.

[2] The list contains Parties that have submitted a report in the 2016 reporting cycle.

[3] For Parties where there are at least two comparable datasets, and the latest data is from reporting period 2014-2016, the arrow indicates the change between the last two comparable datasets. The arrow ↔ is used when there is less than 1 percentage point change between the two respective measurement occasions.

[4] Abreviations: CS = Current use of smoking tobacco; DS = Daily use of smoking tobacco

PREVALENCE[1] OF SMOKELESS TOBACCO USE AMONG ADULTS, REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Afghanistan	2011	20.00%						CST
Algeria	2010	9.80%	0.80%	5.30%				CST
Austria	2015	2.70%	0.40%	1.60%				CST
Bahamas	2012	0.90%	0.10%	0.50%				CST
Benin	**2008, 2015**	9.00%	3.00%	5.00%	↘	↘	↘	CST
Bhutan	2014	26.50%	11.00%	19.70%				CST
Brazil	**2008, 2013**	0.50%	0.20%	0.30%				CST
Cameroon	2013	2.20%	3.80%	3.00%				CST
Canada	**2012, 2013**	1.20%	NR	0.60%				CST
Costa Rica	2010, 2015	0.10%	0.00%	NR				CST
Croatia	2014	0.80%	0.40%	0.60%				CST
Czech Republic	**2012, 2014**	3.10%	1.70%	2.40%	↔	↔	↔	CST
Democratic Republic of the Congo	2013/2014	13.00%	29.00%	42.00%				CST
Denmark	**2013, 2015**	2.30%	0.90%	1.60%	↗	↔	↔	CST
Dominica	2008	16.00%	NR	0.80%				CST
Egypt	2009	5.50%	0.60%	3.00%				CST
Estonia	**2012, 2014**	5.70%	0.80%	2.80%	↘	↘	↘	CST
Finland	**2013, 2014**	5.60%	0.40%	2.60%	↘	↔	↔	CST
Gambia	2010	0.80%	1.40%	1.10%				CST
Georgia	2011	1.00%	0.20%	0.60%				CST
Ghana	2014	1.70%	0.20%	0.87%				CST
Guyana	2009	3.00%	2.00%	5.00%				CST
Hungary	2014	0.08%	0.09%	0.09%				CST
Iceland	**2013, 2015**	13.00%	3.00%	5.00%	↗	↗	↗	CST
India	2010	33.90%	18.40%	25.90%				CST
Kenya	2014	5.30%	3.80%	4.50%				CST
Kyrgyz Republic	2013	10.00%	0.00%	5.00%				CST
Libya	2009	2.20%	0.10%	0.70%				CST
Madagascar	2013	24.60%	9.60%	34.20%				CST
Malaysia	**2011, 2015**	20.40%	0.80%	10.90%	↗	↔	↗	CST
Maldives	2011	3.90%	1.40%	2.60%				CST
Mali	2013	33.00%	12.00%	45.00%				CST
Mauritania	2006	5.70%	28.30%	9.00%				CST
Mexico	**2009, 2015**	0.40%	0.00%	0.20%	↔	↔	↔	CST

PREVALENCE[1] OF SMOKELESS TOBACCO USE AMONG ADULTS, REPORTED BY THE PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Myanmar	**2009, 2014**	62.20%	24.10%	43.20%	↗	↗	↗	CST
Nigeria	2012	2.90%	0.90%	1.90%				CST
Norway	**2013, 2015**	20.00%	6.30%	13.30%	↔	↔	↔	CST
Oman	2008	7.00%	0.40%	3.90%				CST
Pakistan	2014	11.40%	3.70%	7.70%				CST
Palau	2011/2013	49.30%	59.60%	54.20%				CST
Panama	2010, 2013	1.00%	0.50%	0.80%				CST
Paraguay	2011	3.00%	1.60%	2.30%				CST
Philippines	2009	2.80%	1.20%	2.00%				CST
Poland	2013	2.00%	1.00%	1.00%				CST
Saudi Arabia	2014	0.60%	0.20%	0.40%				CST
Seychelles	**2004, 2013/2014**	0.30%	0.40%	0.30%	↔	↔	↔	CST
Sierra Leone	2009	43.10%	10.50%	25.80%				CST
Slovakia	2015	2.00%	1.00%	1.00%				CST
South Africa	2007	1.40%	8.40%	6.50%				CST
Sri Lanka	2006	24.90%	6.90%	15.80%				CST
Swaziland	2014	2.70%	1.80%	2.20%				CST
Sweden	**2013, 2015**	25.00%	7.00%	16.00%	↗	↔	↗	CST
Thailand	**2011, 2014**	2.53%	3.94%	3.26%	↗	↘	↔	CST
Togo	2010	5.10%	2.20%	3.60%				CST
Trinidad and Tobago	2011	0.50%	0.30%	0.40%				CST
Tunisia	2005	1.00%	1.00%	1.00%				CST
Turkmenistan	2014	2.70%	0.00%	1.40%				CST
Ukraine	2010	0.50%	0.00%	0.20%				CST
United Republic of Tanzania	2012	2.90%	2.20%	2.50%				CST
Viet Nam	2001/2002, 2010	0.30%	2.30%	1.30%				CST
Yemen	**2003, 2013**	17.00%	5.90%	11.30%				CST
Zimbabwe	2010/2011	5.00%	1.00%	2.00%				CST

[1] This table combines information provided by the Parties in 2016 under the Current smoking tobacco section, or Daily smoking tobacco section, in the reporting instrument. The definitions of what is considered smoking tobacco may differ between countries. Detailed descriptions of individual country definitions of smoking tobacco products included is outside the scope of this report. Whenever reported by the Parties, current or daily smoking prevalence is included in the table. The methodology of the surveys, and the definitions of smoking or tobacco use differ, and the figures and changes over time are presented here not comparable as such between the Parties.

[2] The list contains Parties that have submitted a report in the 2016 reporting cycle.

[3] For Parties where there are at least two comparable datasets, and the latest data is from reporting period 2014-2016, the arrow indicates the change between the last two comparable datasets. The arrow ↔ is used when there is less than 1 percentage point change between the two respective measurement occasions.

[4] Abreviations: CS = Current use of smoking tobacco; DS = Daily use of smoking tobacco

YOUTH SMOKING PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Afghanistan	**2004, 2010**	3.70%	0.80%	2.50%				CSC
Algeria	**2007, 2013**	12.20%	0.80%	5.70%				CSC
Australia	**2011, 2014**	5.40%	4.90%	5.10%	↘	↘	↘	CSC
Austria	**2009/10, 2013/2014**	10.00%	9.00%	10.00%	↘	↘	↘	DSC (here for 15-year-olds, from int. report)
Azerbaijan	2011	1.80%	0.40%	1.10%				DSC
Bahamas	**2009, 2013**	16.00%	10.70%	13.70%				CSC
Bahrain	**2002, 2015**	15.30%	4.10%	9.70%	↘	↔	↔	CSC
Belgium	**2008, 2013**	21.10%	22.50%	21.80%				CS
Benin	2003	19.70%	2.90%	14.40%				
Bhutan	**2009, 2013**	23.10%	6.60%	14.00%				CSC
Bosnia and Herzegovina	**2008, 2013**	15.50%	9.70%	12.70%				CSC
Brazil	2002/2005, 2012	5.10%	5.00%	5.10%				CS
Cameroon	**2008, 2014**	8.30%	2.50%	5.70%	↔	↔	↔	CSC
Canada	**2010/2011, 2012/2013**	13.50%	9.80%	11.70%				CS
Chile	**2011, 2013**	7.10%	7.50%	7.30%				DSC
China	2014	9.90%	1.60%	5.90%				CSC
Colombia	**2004, 2011**	14.70%	9.00%	11.70%				CST
Cook Islands	**2008, 2011**	19.90%	19.40%	19.70%				CSC
Costa Rica	**2008, 2013**	5.70%	4.30%	5.00%				CSC
Cote D'Ivoire	**2003, 2009**	20.90%	5.70%	13.70%				CSC
Croatia	**2009/2010, 2013/2014**	19.00%	17.00%	18.00%	↘	↘	↘	DSC
Czech Republic	**2009/2010, 2013/2014**	8.00%	10.00%	9.00%	↘	↘	↘	DSC
Cyprus	**2011, 2015**	22.00%	13.00%	18.00%	↘	↘	↘	CS
Democratic Republic of the Congo	2008	11.70%	3.60%	8.20%				CSC
Denmark	**2010, 2013**	26.60%	23.50%	25.10%				CS
Djibouti	**2009, 2013**	8.00%	4.20%	6.60%				CSC
Dominica	**2004, 2009**	13.80%	8.90%	11.60%				CSC
Ecuador	2011/2013	37.50%	14.60%	30.60%				CS
Egypt	**2009, 2014**	8.30%	0.80%	4.80%	↘	↘	↘	CSC
El Salvador	**2003, 2009**	11.20%	7.10%	9.10%				CSC

YOUTH SMOKING PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Estonia	**2009/2010, 2013/2014**	9.00%	7.00%	8.00%	↘	↘	↘	DSC
European Union	**2012, 2014**	26.00%	25.00%	25.00%	↘	↗	↘	CS
Federated States of Micronesia	2007, 2013	37.60%	18.60%	27.20%				CSC
Finland	**2013, 2015**	10.00%	10.00%	10.00%	↘	↘	↘	DSC
France	**2011, 2015**	24.00%	28.00%	26.00%	↘	↘	↘	CSC
Gabon	2014	6.10%	4.00%	5.20%				CSC
Georgia	**2008, 2014**	9.90%	3.80%	7.00%	↘	↗	↘	CSC
Germany	**2011, 2014**	10.50%	8.90%	9.70%	↔	↘	↘	CSC
Ghana	**2006, 2009**	4.30%	2.90%	3.60%				CSC
Greece	**2005, 2013**	10.30%	9.90%	10.10%				CSC
Grenada	**2004, 2009**	9.90%	6.20%	8.10%				CSC
Guatemala	**2006, 2008**	13.70%	9.10%	11.40%				CSC
Guyana	**2004, 2010**	13.30%	5.60%	9.50%				CSC
Honduras	2012, 2015	NR	NR	8.30%				CS
Hungary	**2012, 2013**	24.00%	24.00%	24.00%				CSC
Iceland	**2013, 2015**			3.00%			↔	DS
India	**2006, 2009**	5.80%	2.40%	4.40%				CSC
Iran (Islamic Republic of)	**2003, 2007**	5.10%	0.90%	3.00%	↗	↔	↗	CSC
Iraq	**2008, 2014**	7.80%	3.60%	5.70%	↗	↔	↗	CSC
Ireland	**2009/2010, 2013/2014**	7.00%	6.00%	6.00%	↘	↘	↘	DSC
Italy	**2010, 2014**	20.60%	26.30%	23.40%	↗	↗	↗	CSC
Jamaica	**2006, 2010**	22.50%	17.70%	20.20%				CSC
Japan	**2012, 2014**	1.30%	0.50%		↔	↔	NR	CSC
Jordan	**2009, 2014**	17.30%	5.40%	11.40%	↔	↘	↔	CSC
Kenya	**2007, 2013**	7.40%	2.60%	4.90%				CSC
Kiribati	2011	34.30%	19.50%	26.10%				CSC
Kuwait	**2009, 2016**	19.40%	4.60%	11.60%	↔	↘	↔	CSC
Kyrgyz Republic	**2008, 2014**	4.00%	0.90%	2.40%	↘	↘	↘	CSC
Latvia	**2011, 2014**	25.30%	23.90%	24.70%	↘	↘	↘	CSC
Lebanon	**2005, 2011**	17.70%	6.00%	11.30%				CSC
Libya	**2007, 2010**	6.10%	2.00%	4.30%				CSC
Lithuania	**2009/2010, 2013/2014**	14.00%	7.00%	11.00%	↘	↘	↘	DSC

YOUTH SMOKING PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Luxembourg	2014, 2015	30.00%	7.00%	19.00%	↗	↘	↗	CSC
Madagascar	2008	30.70%	10.20%	19.30%				CSC
Maldives	**2007, 2011**	6.20%	2.40%	4.30%				CSC
Mali	**2001, 2008**	17.40%	2.50%	10.40%				CSC
Malta	**2007, 2011**	12.00%	18.00%	15.00%				CSC
Mauritania	**2006, 2009**	14.60%	9.00%	11.60%				CSC
Mauritius	**2007, 2011**	23.30%	9.40%	16.30%				CSC
Montenegro	**2008, 2014**	15.00%	4.80%	9.70%	↗	↔	↗	CSC
Myanmar	**2007, 2011**	13.00%	0.50%	6.80%				CSC
Netherlands	**2009/2010, 2013/2014**	8.00%	7.00%	7.00%	↘	↘	↘	DSC
New Zealand	**2013/2014, 2014/2015**	6.80%	5.40%	6.10%	↘	↔	↘	CSC
Nigeria	**2000, 2008**	11.40%	5.50%	6.20%				CSC
Norway	**2009/2010, 2013/2014**	2.00%	1.00%	1.00%	↘	↘	↘	DSC
Oman	**2007, 2010**	3.10%	0.60%	1.80%				CSC
Pakistan	2008/2009, 2013	4.80%	0.90%	3.30%				CSC
Palau	2013	42.70%	22.10%	32.30%				CSC
Panama	**2008, 2012**	7.00%	3.20%	5.00%				CSC
Papua New Guinea	2007	52.10%	35.80%	43.80%				CSC
Paraguay	**2008, 2014**	3.90%	3.80%	3.90%	↘	↘	↘	CSC
Philippines	**2011, 2015**	20.50%	9.10%	14.50%	↗	↗	↗	CSC
Poland	**2009/2010, 2013/2014**	10.00%	10.00%	10.00%	↘	↗	↔	DSC
Portugal	**2011, 2015**	18.00%	21.00%	19.00%	↘	↘	↘	CSC
Republic of Korea	**2014, 2015**	11.90%	3.20%	7.80%	↘	↔	↘	CSC
Republic of Moldova	**2008, 2013**	11.00%	3.20%	7.20%				CSC
Republic of Serbia	**2008, 2013**	12.70%	13.30%	13.00%				CSC
Russian Federation	**2009/2010, 2013/2014**	13.00%	7.00%	10.00%	↘	↘	↘	DSC
Samoa	**2007, 2011**	42.20%	25.30%	33.80%				CSC
San Marino	**2010, 2014**	14.40%	15.00%	14.60%	↗	↗	↗	CSC
Saudi Arabia	**2007, 2010**	13.00%	5.00%	8.90%				CSC
Senegal	2015	5.20%	0.40%	2.80%				CSC
Seychelles	**2007, 2015**	19.60%	10.30%	14.70%	↘	↘	↘	CSC

YOUTH SMOKING PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Sierra Leone	2008	6.60%	5.00%	5.80%				CSC
Singapore	**2009, 2012**	9.00%	4.00%	6.00%				CSC
Slovakia	**2009/2010, 2013/2014**	11.00%	12.00%	12.00%	↘	↗	↔	DSC
South Africa	**2008, 2011**	15.00%	10.80%	12.70%				CSC
Spain	**2012, 2014**	29.60%	33.20%	31.40%	↗	↘	↘	CS
Sri Lanka	**2007, 2011**	2.80%	0.30%	1.50%				CSC
Suriname	2013	18.00%	3.00%	NR				CS
Syrian Arab Republic	**2007, 2010**	10.70%	3.10%	6.80%				CSC
Swaziland	**2005, 2009**	9.20%	4.50%	6.40%				CSC
Sweden	**2014, 2015**	10.00%	14.00%	NR	↘	↘	NR	CS
Thailand	**2011, 2013**	25.50%	1.40%	13.50%				CSC
Togo	**2007, 2013**	7.40%	1.20%	4.80%				CSC
Tonga	2010	37.50%	18.90%	27.10%				CSC
Trinidad and Tobago	**2007, 2011**	13.60%	6.90%	10.20%				CSC
Tunisia	**2007, 2010**	12.40%	1.60%	6.60%				CSC
Uganda	**2007, 2011**	5.00%	4.70%	4.80%				CSC
Ukraine	**2009/2010, 2013/2014**	11.00%	6.00%	8.00%	↘	↘	↘	DSC
United Arab Emirates	2005, 2013	9.70%	2.70%	6.20%				CSC
United Kingdom	2013, 2014	4.00%	7.00%	6.00%	↘	↔	↔	CSC
United Republic of Tanzania	2003, 2008	2.20%	1.10%	1.70%				CSC
Vanuatu	2007, 2011	19.40%	8.30%	13.60%				CSC
Viet Nam	2007, 2014	4.90%	0.20%	2.50%	↘	↘	↔	CSC
Yemen	2008, 2014	9.20%	2.50%	6.80%	↗	↔	↗	CSC
Zimbabwe	2008, 2014	17.30%	12.80%	16.20%	↗	↗	↗	CSC

[1] This table combines information provided by the Parties in 2016 under the Smoking among the young section in the reporting instrument. The definitions of what is considered smoking tobacco may differ between countries. Detailed descriptions of individual country definitions of smoking tobacco products included is outside the scope of this report. Whenever reported by the Parties, current or daily smoking prevalence is included in the table. The methodology of the surveys, and the definitions of smoking or tobacco use differ, and the figures and changes presented here are not comparable as such between the Parties.

[2] The list contains Parties that have submitted a report in the 2016 reporting cycle, and provided data of prevalence for the respective section.

[3] For Parties where there are at least two comparable datasets, the arrow indicates the change between the last two comparable datasets. For Parties, which do not have comparable data available, the arrow indicates the observed tendency between last two measurement occasions. The arrow ↔ is used when there is less than a 0.5 percentage point change between the two respective occasions.

[4] Abreviations: CS = Current smoking CSC = Current smoking of cigarettes DS = Daily smoking DSC = Daily smoking of cigarettes NR = Not reported by the Party

YOUTH SMOKELESS TOBACCO USE PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Afghanistan	2004, 2010	7.60%	7.30%	7.60%				COT
Algeria	2007, 2013	6.90%	0.80%	3.50%				CST (2013), COT (2007)
Bahamas	2009, 2013	5.30%	3.10%	4.30%				COT
Bahrain	2002, 2015	5.20%	2.20%	3.70%				COT, CST (2015)
Benin	2003	21.30%	10.10%	17.90%				COT
Bhutan	2009, 2013	25.00%	18.90%	21.60%				CST, COT (2009)
Bosnia and Herzegovina	2008, 2013	2.80%	1.40%	2.10%				CST, COT (2008)
Brazil	2002/2005, 2012	5.40%	4.30%	4.80%				COT
Cameroon	2008, 2014	5.00%	2.30%	3.70%				CST, COT (2008)
Canada	2010/2011, 2012/2013	3.50%	0.50%	2.10%				CST
China	2014	1.30%	0.60%	1.00%				CST
Cook Islands	2008	10.50%	7.30%	8.70%				CST
Costa Rica	2013	1.70%	1.60%	1.60%				CST
Cote D'Ivoire	2003, 2009	10.00%	6.50%	8.30%				COT
Democratic Republic of the Congo	2008	29.30%	27.60%	28.90%				COT
Djibouti	2009, 2013	8.10%	4.00%	6.20%				CST, COT (2009)
Dominica	2004, 2009	21.60%	13.30%	17.70%				COT
Egypt	2009, 2014	2.70%	5.40%	4.10%				CST, COT (2009)
El Salvador	2003, 2009	10.70%	6.40%	8.50%				COT
Federated States of Micronesia	2007, 2013	26.50%	21.70%	23.80%				CST, COT (2007)
Finland	2013, 2015	10.90%	2.60%	6.70%	↔	↔	↔	CST
Gabon	2014	1.90%	2.90%	2.40%				CST
Georgia	2014	4.00%	2.80%	3.40%				CST
Ghana	2006, 2009	11.70%	9.20%	10.60%				COT
Greece	2013	2.50%	1.30%	1.90%				CST

YOUTH SMOKELESS TOBACCO USE PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Grenada	2004, 2009	19.10%	12.70%	15.80%				COT
Guatemala	2006, 2008	9.50%	6.20%	7.90%				COT
Guyana	2004, 2010	16.70%	12.30%	14.80%				COT
Hungary	2012, 2013	3.00%	1.00%	2.00%				CST
Iceland	2013, 2015	5.00%	4.00%	NR	↘	↗	NR	CST
India	2006, 2009	16.20%	7.20%	12.50%				COT
Iran (Islamic Republic of)	2003, 2007	31.90%	19.50%	26.10%				COT
Iraq	2008, 2014	4.30%	2.90%	3.70%				CST, COT (2008)
Jamaica	2006, 2010	20.50%	16.00%	19.50%				COT
Jordan	2009, 2014	3.90%	1.10%	2.50%				CST, COT (2009)
Kenya	2007, 2013	4.30%	3.30%	3.90%				CST, COT (2007)
Kuwait	2009, 2016	3.10%	2.30%	2.70%				CST, COT (2009)
Kyrgyz Republic	2008, 2014	7.60%	2.90%	5.10%				CST, COT (2008)
Latvia	2011, 2014	4.30%	2.00%	3.10%	↘	↘	↘	CST
Lebanon	2005	44.70%	35.70%	40.00%				COT (2005)
Libya	2007, 2010	7.50%	4.10%	5.80%				COT
Madagascar	2008	8.50%	5.80%	7.00%				COT
Maldives	2007, 2011	9.20%	2.90%	6.20%				CST, COT (2007)
Mali	2001, 2008	10.70%	7.20%	9.00%				COT
Mauritania	2006, 2009	15.90%	10.20%	13.10%				COT
Mauritius	2007	8.10%	2.70%	5.30%				COT (2007)
Montenegro	2008, 2014	2.00%	1.00%	1.40%				CST, COT (2008)
Myanmar	2007, 2011	15.20%	4.00%	9.80%				CST, COT (2007)
Norway	2009/2010, 2013/2014	17.00%	11.00%	14.00%	↗	↗	↗	CST
Oman	2007, 2010	2.50%	0.90%	1.60%				CST, COT (2007)

YOUTH SMOKELESS TOBACCO USE PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Pakistan	2008/2009, 2013	6.40%	3.70%	5.30%				CST, COT (2008/09)
Palau	2013	21.70%	17.00%	19.50%				CST
Panama	2008, 2012	4.80%	4.20%	4.60%				CST, COT 2008
Papua New Guinea	2007	20.10%	14.20%	17.60%				CST
Paraguay	2008, 2014	2.30%	1.40%	1.90%				CST, COT (2008)
Philippines	2011, 2015	2.90%	2.10%	2.50%				CST, COT (2011)
Republic of Moldova	2013	2.40%	2.00%	2.20%				CST
Republic of Serbia	2008, 2013	1.70%	1.40%	1.60%				CST, COT (2008)
San Marino	2010, 2014	0.40%	0.40%	0.40%				CST
Saudi Arabia	2007, 2010	15.30%	7.10%	11.00%				COT
Seychelles	2007, 2015	2.80%	0.60%	1.70%				CST, COT (2007)
Sierra Leone	2008	16.70%	21.80%	20.70%				COT
South Africa	2011	9.10%	6.90%	7.90%				CST
Sri Lanka	2011	13.00%	4.10%	8.50%				CST
Syrian Arab Republic	2007, 2010	29.40%	16.60%	23.00%				COT
Swaziland	2005, 2009	6.00%	5.00%	5.40%				CST, COT (2005)
Sweden	2014, 2015	10.00%	2.00%	NR	↔	↔		CST
Togo	2007, 2013	2.40%	1.80%	2.10%				CST, COT (2007)
Tonga	2010	17.20%	12.30%	14.20%				
Trinidad and Tobago	2007, 2011	12.70%	11.30%	12.00%				COT
Tunisia	2007, 2010	3.90%	0.90%	2.30%				CST, COT (2007)
Uganda	2011	17.80%	14.10%	15.60%				COT
United Arab Emirates	2005, 2013	4.10%	2.60%	3.40%				CST, COT (2005)
United Republic of Tanzania	2008	6.90%	5.50%	6.20%				CST
Vanuatu	2007	17.50%	11.30%	13.80%				COT (2007)

YOUTH SMOKELESS TOBACCO USE PREVALENCE[1] REPORTED BY PARTIES								
PARTIES[2]	LAST TWO SURVEYS (COMPARABLE DATASETS IN BOLD)	LATEST REPORTED PREVALENCE			CHANGE BETWEEN LAST COMPARABLE DATASETS / OBSERVED TENDENCY BETWEEN LAST MEASUREMENTS[3]			INDICATOR[4]
		MALE	FEMALE	COMBINED	MALE	FEMALE	COMBINED	
Viet Nam	2007, 2014	1.00%	0.40%	0.70%				CST, COT (2007)
Yemen	2008, 2014	6.70%	2.60%	5.10%				CST, COT (2008)
Zimbabwe	2008, 2014	6.50%	4.60%	5.60%	↔	↔	↔	CST

[1] Whenever reported by the Parties, current or daily smoking prevalence is included in the table. The methodology of the surveys, and the definitions of smoking or tobacco use differ, which is why the figures and changes over time are not directly comparable between the Parties. The indicators used by the Parties are listed in a separate column. NR = Not reported by the Party; n.a. = Not applicable in the respective section.

[2] The list contains Parties that have submitted a report in the 2016 reporting cycle.

[3] For Parties where there are at least two comparable datasets, the arrow indicates the change between the last two comparable datasets. For Parties which do not have comparable data available, the arrow indicates the observed tendency between last two measurement occasions. The arrow ↔is used when there is less than a 0.5 percentage point change between the two respective occasions.

[4] Abbreviations: CT = Current use of any tobacco (indicated in the current smoking section of the reporting instrument, hence, consists mostly of smoking tobacco products); CS = Current use of smoking tobacco; DT = Daily use of any tobacco; DS = Daily use of smoking tobacco

ANNEX 4

PARTIES' FEEDBACK ON THE USE OF AND FURTHER DEVELOPMENT OF THE REPORTING INSTRUMENT

The reporting system of the WHO FCTC, the biennial reporting cycle and the content of the questionnaire should already be well known to all Parties to the Convention. This year, with the transition to the Internet-based reporting instrument, Parties' feelings were mixed and the Convention Secretariat has also faced some challenges.

One was related to the need for an updated list of FCTC technical focal points for the Secretariat. This list, including up-to-date contact details (i.e., email addresses), was fed into the reporting system and proved of central importance in routing invitations to complete the survey and the many reminders sent out automatically by the system. It transpired that about 30% of the FCTC technical focal points in the Secretariat's records were outdated, and had to be changed during the reporting cycle. In some cases, this might have prevented access to the appropriate person and thus prevented their use of the reporting platform. Parties should be mindful of the need to alert the Secretariat to any changes in the recorded name and contact details for technical focal points so that we can keep our records up-to-date.

In some countries, where reliable Internet connections were a challenge, Parties had difficulties in completing the questionnaire and saving their data. In such cases, the Secretariat advised that the WHO country office be contacted to discuss the possible use of its Internet connection. Eventually, as a last resort, the Secretariat accepted hard copies of the documents, and resources within the Secretariat were used to include the reported data in the reporting platform.

This year, most of the assistance to Parties was offered electronically in response to Parties' queries. Due to the utilization of a new system, the Secretariat had sought IT assistance when necessary. The assistance provided to a large number of Parties assisted the timely submission of reports and their compliance with reporting requirements. Moreover, the Secretariat has provided feedback to Party counterparts upon submission of their reports, further promoting a common understanding.

The reporting system allows Parties to comment and offer suggestions for the future development of the questionnaire and the platform. Almost one third of reporting Parties provided comments on the new system, and some described their experience in its use. Some of the comments underlined the need to further improve the user-friendliness of the system; some Parties felt the questionnaire was too long and called for its streamlining and simplification. Others missed the possibility of downloading the questionnaire in a Word-program format, which would have enabled them to share the form across the various government sectors. A few Parties underlined the need to make available data already reported for amendments in any subsequent reporting cycle. The Secretariat will analyse these comments, along with its own experience. It will draw together the lessons learnt from the 2016 reporting cycle and the proposals of the reporting expert group mandated by the COP[64], with a view to making further improvements under the guidance of the COP, as appropriate.

[64] Document FCTC/COP7/15 at http://www.who.int/fctc/cop/cop7/FCTC_COP_7_15_EN.pdf?ua=1

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