**Forum:** Special Committee on Sustainable Development Goal 3  
**Issue:** Implementing the WHO framework on tobacco  
**Student Officer:** Anushka Jain  
**Position:** Deputy Chair

### Introduction

A treaty called the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) was adopted on 21st May 2003 by the World Health Assembly. It was signed by 168 countries. 15 countries are non-parties to the treaty, out of which nine countries have not signed and six countries have signed but not ratified. The FCTC aims to protect the current and future generation from the harmful consequences of smoking on health, economy, environment and society. This is true for both consumption of tobacco and exposure to tobacco smoke. Tobacco consumption has serious side effects such as heart and lung diseases, Chronic Obstructive Pulmonary Disease (COPD) that includes severe bronchitis and emphysema. Smoking has adverse effects on the immune system and makes the individual susceptible to tuberculosis. Even passive smoking leads to lung related diseases. To prevent these consequences, a set of universal guidelines have been set up that state the risks of tobacco consumption and limiting its use in all forms. The signatories of FCTC are encouraged to impose stricter rules in regulating tobacco. It is the first ever multinational agreement based on a chronic as well as a non-communicable disease. This treaty is also the first treaty to be signed under World Health Organization. The WHO FCTC was initiated as a response to the global tobacco epidemic. The tobacco epidemic was widely facilitated by the liberalization of its trade, foreign investment, global marketing, tobacco advertising, promotion and sponsorship. Also, cheap, counterfeit cigarettes have also resulted in the proliferation of tobacco use. The WHO FCTC provides legal basis for measures, justification of the measure, encouraging consensus, elaborating the purpose of these measures and demonstrating whether the measures being suggested are reasonable, effective or relevant.

### Definition of Key Terms

**Chronic Obstructive Pulmonary Disease (COPD)**
It is a pulmonary disease that has two symptoms either chronic bronchitis or chronic emphysema. This disease causes difficulty in breathing. It is caused mainly due to cigarette smoking or even passive smoking.

**Bronchitis**

Bronchitis either acute or chronic is the inflammation of bronchi which makes it difficult for the person to breathe. Its symptoms are shortness of breath, wheezing and chest pain.

**Passive smoking**

It is the involuntary inhalation of smoke or environmental tobacco smoke from the cigarettes or cigars of other people.

**Non communicable disease**

It is a type of disease that cannot be transferred from one person to another either directly or indirectly. For example, asthma, diabetes etc.

**Global tuberculosis epidemic**

It refers to the condition in which tuberculosis is becoming one of the main causes of death worldwide. Many drug resistant forms of tuberculosis have emerged making the disease more deadly and difficult to treat.

**Counterfeit cigarettes**

These are cigarettes that are manufactured and distributed without the permission of the manufacturing authority. Trademark infringement is used in this case of production mainly to deceive customers and avoid paying duty. Many counterfeit cigarettes even include rat poison, pesticides and arsenic.

**Background Information**

Approved on 7 April 1948, WHO constitution made it mandatory for the organization and its member states to work for “the realization of the highest possible level of health by all people”. It also describes the general powers conferred in the World Health Assembly, the highest policy-making body of WHO to safeguard and encourage international public health, including adoption and preparation of relevant standards, legislation, agreements and conventions as per (Article (19) (2).
The very idea for an international instrument for tobacco control was formally given in May 1995 at the 48th World Health Assembly. Next year, the 49th World Health Assembly adopted a resolution WHA49.17, which requested the Director-General to pledge the development of a WHO Framework Convention on Tobacco Control (WHO FCTC). With this, WHO's first treaty-making initiative was launched. Still, it was not until the year 1999 that negotiations on WHO FCTC began, one year later after the then WHO Director-General, Dr Gro Harlem Brundtland, had made global tobacco control a priority for WHO.

The WHO has been active for a long time in averting the innumerable health issues resulted from tobacco consumption. As the leading cause of avoidable death globally, tobacco has seen growth in both consumption and casualty rate globally with the increasing inter-connectivity of global economy. While tobacco related-diseases vary from communicable diseases traditionally been the concern of WHO, the effects of globalization have made tobacco much relevant for governmental authorities.

Under the auspices of tobacco activist and UCLA professor Ruth Roemer, WHO requested individual countries during the 1980s and 1990s to adopt national laws that are shown to reduce tobacco use. However, the FCTC marked first time when WHO went so far as to enact its international legal influences to address the issue. In fact, Roemer herself was among the main group of academics and tobacco activists who very well reinforced the idea of a framework-convention protocol approach.

The idea gained popularity for a multilateral treaty regarding tobacco control in 1994 at the ninth World Conference on Tobacco or Health in Paris, France, when Roemer and Taylor presented their strategy for global legal action. They were successful, and their proposal was adopted as one of the conference's first resolutions. The proposal outlined a way to have a global regulatory and supervisory framework on tobacco use, thereby helping to limit it. This framework looked at:

- Establishing the health implications of tobacco use, and an analysis of tobacco industry's penetration of new markets
- Establishing effective national tobacco regulation
- Establishing an international regulatory framework on tobacco

In 1995, the World Health Assembly (WHA), in Resolution 48.11, requested that the director general "report to the 49th World Health Assembly on the feasibility of developing an international instrument, such as guidelines, a declaration or an international convention on tobacco control to be adopted by the United Nations." In compliance with Resolution 48.11, the WHO employed Roemer and Taylor to draft a background paper on various mechanisms available to the WHO in effectively controlling tobacco use worldwide. This background paper provided a solid endorsement for a framework convention, as against alternative international legal action. According to its supporters, a framework convention would "promote global cooperation and national action for tobacco control."

With the support of Derek Yach, head of the Policy Coordination Committee at the WHO, the proposal gained momentum. Derek Yach became the first Director of the Tobacco Free Initiative in 1998.
and steered the development of the FCTC from then till its adoption in March 2003. Subsequently, Gro Harlem Brundtland was elected director general of the WHO in 1998. Alongside malaria treatment and prevention, the nascent Framework Convention rose to the top of her agenda at the WHO.

**Major Countries and Organizations Involved**

**Malawi**

One of the largest sources of income in Malawi comes from tobacco production. As per the 2015, Malawi is the 5\textsuperscript{th} largest producer of tobacco in the world. As of 2010, Malawi is the largest producer of burley leaf tobacco in the world. This country is highly dependent on tobacco for its financial needs. The number of teenage smokers is more than that of adult smokers. Malawi is not a signatory to the World Health Organization Framework Convention on tobacco control. A large proportion of citizens are engaged in tobacco production. This accounts for 75\% of the population of the country including children. Large scale farmers employ small scale farmers, especially those who can contribute to tobacco production along with their families. Malawi is known to engage children in the production of tobacco. It is the country with the highest percentage of child labor when compared to the other countries of South Africa. Around 80 thousand children aged five to fourteen are employed in tobacco fields. These children are more susceptible to Green Tobacco Sickness as compared to adults in the same occupation. This disease causes the transfer of nicotine to the body of harvesters due to rain or dew. It leads to the transfer of approximately 95 milligrams of nicotine in the child’s body that equals to smoking almost 50 cigarettes per day. Even though policies have been introduced in Malawi regarding the issue of production of tobacco, these policies have not been implemented effectively.

**Jamaica**

WHO’s FCTC Article 6 Guidelines do encourage all Parties to adopt simple tax structures. Uniform specific taxes, regularly adjusted to account for inflation and increases in per capita income, are generally recommended as the most appropriate, as they have desirable properties from both a public health and from an administrative point of view point. Jamaica provides a very interesting example of a country that migrated from a highly complex, multiple tax system to just a simple and uniform tax. It also adjusted the specific tax on a regular basis to avoid inflation and eroding the real value of tax. Until 2008, the tobacco excise tax in Jamaica consisted of two components, a specific tax; and an additional tax came into effect if the price exceeded a specific threshold.

The 2nd type of Tax was reported to be very complicated to determine the net effect of any tax change. The tobacco industry used this confusion to increase the retail price by more than the increase in excise tax, so allowing itself to increase its profits at the expense of smokers and government. In 2005, the leading tobacco company in Jamaica terminated all domestic production and imported all its
cigarettes. Due to that, excise tax revenues especially the levy (23% of the base price) imposed to fund the National Health Fund fell sharply. The Government immediately responded by abolishing the complex tax structure and implemented a uniform system. It then raised the excise tax, increasing the retail price and tax revenue, and decreasing consumption. However, for five years subsequently, the nominal excise tax remained unchanged, and the real value of the excise tax dropped by 32% thus eroded by inflation. During that time, Jamaica’s tobacco industry increased the retail price of cigarettes for its own benefit. Since 2015, the Government has been consistently increasing excise taxes on tobacco products. Jamaican experience illustrates many important lessons for the designers of tax systems, including the need to keep its tax system simple. The tobacco industry has always exploited a complex tax system for its own benefit A uniform specific tax system is good from an administrative and public health perspective, with regular adjustments to palliate the effects of inflation. In 2017, Jamaica was recognized “for steady increases to tobacco taxes over many years to protect the health of all its citizens” at the 5th Latin American and Caribbean Conference on Tobacco or Health.

**Malaysia**

The guidelines for implementing WHO FCTC Article 8 emphasises the need for Parties to put in place protective measures not only in all “indoor” public places, but also in “other” outdoor or public places where they feel it is most “appropriate” to protect citizens from the hazards of passive smoking. On 1 February 2017, and in line with the definition of “other” public places, the Government of Malaysia officially designated all its public parks as non-smoking zones. This new regulation was put under the direct Control of Tobacco Regulations (CTPR 2004) of the Food Act of 1983. Under this new regulation, smoking is now banned in public parks, any open area for leisure and recreational purposes, such as pedestrian paths, playgrounds and game zones. The Government of Malaysia is fully committed to the implementation of Article 8. In Malaysia, it is estimated that seven out of every 10 adults (approx. 8.6 million adults) who visit restaurants are highly exposed to cigarette smoking in public places, while four out of every 10 adults (approx. 4.9 million adults), are exposed to it at home. With around 23% of Malaysian population estimated to be smokers, this law is targeting to help reduce morbidity and mortality attributable to tobacco use in Malaysia and contribute to the strong implementation of the WHO FCTC.

**Brazil**

Following a 5 year wait, the Brazilian Supreme Court has ruled that a regulatory agency has the complete power to ban additives in tobacco products, including flavors in cigarettes. In 2012, Anvisa, the Brazilian health regulatory agency, amended the Collegiate Board Resolution prohibiting the use of additives that confers flavor to cigarettes. In 2012, the National Confederation of Industry (CNI) filed a court case questioning Anvisa’s competence to amend the resolution and questioned the law that
created this agency. The injunction request by CNI was granted, and Anvisa Resolution was suspended in 2013. The judgement was challenged and the case reopened in November 2017. The Minister of Federal Attorney General's Office argued that the discussion involved only insertion of additives in the manufacturing of cigarettes, not the prohibition of their sale. Data of huge number of cases was presented on the damage to public health from smoking and argued about the need of prohibiting the addition of flavors to the product due to its potential appeal to young population and encouragement for kids to initiate cigarette consumption. It was argued that Anvisa acted within the regulatory limits assigned by the legislature, fulfilling its duty, in view of the recognized need to ban these additives, and in the correct spirit of agile response typical of regulatory agencies. The Direct Action of Unconstitutionality (ADI) judgement concluded in February 2018 and Court favored the constitutionality declaration of the law that created Anvisa. The regulatory power of the agency was maintained, which was a huge victory for Public Health and safety. However, regarding the specific aspect of the additives, Supreme Court considered application of resolution to have no binding effect throughout the national jurisdiction. This means the rule prohibiting the use of additives in cigarettes may be challenged in lower court environments. This ruling provides support for WHO FCTC Parties in passing measures supporting FCTC, including bans on tobacco flavors and additives.

**Australia**

The National Tobacco Campaign largely contributes to the reduction of adult smoking rate in Australia. The recent campaign reads as – “Don’t Make Smokes Your Story” – and it was launched in the year 2016 intended to empower smokers aged 18–40 years to quit smoking. The campaign used the theme of family to focus on encouraging quit efforts through a positive and empowering message that speaks directly to Aboriginal and Torres Strait Islander people. The campaign works with communities to develop culturally relevant smoking termination resources and support community events to encounter the social customs around the acceptance of smoking. The TIS program for 2018–2019 to 2021–2022 comprises 37 organizations to provide funding through Regional Tobacco Control Grants (RTCG) to raise awareness and to draft and implement the smoking prevention and termination activities tailored to suit local needs. A National Best Practice Unit (NBPU) to be formed to fully support best practices in RTCG activities. Indigenous Quitline enhancement grants aimed to enhance the capacity of Quitline services and to provide accessible and useful services to people. The Quitskills training program, which provides training and motivational interviewing that target to rise the number of suitably trained and qualified professionals working with different communities, including young people, pregnant women and new mothers. A National Coordinator to be appointed to deliver high-level advice to Australian Government for designing policies, as well as providing leadership and required support to grantees. Enhancing activities which are to target priority groups particularly pregnant women and smokers in very remote areas. A national evaluation continued in 2018 and beyond by an external evaluator, looking at
this program’s appropriateness and effectiveness. An assessment of impacts and outcomes of the RTCG component that forms around 80% of funding for a Tackling Indigenous Smokers (TIS) program. Around 39% over the age of 15 are daily smokers. It is estimated that smoking results for one in five Aboriginal and Torres Strait Islander deaths.

**Thailand**

Thailand has been successfully establishing its tobacco control policies for the past thirty years and Article 13 of the WHO FCTC is no exemption to this. A ban on tobacco advertising was first implemented in 1989 in Thailand. The latest updates to the legislation on tobacco advertising, its promotion and the sponsorship came into force on in July 2017 under the Tobacco Products Control Act 2017 (BE 2560). Its article 35 specifies that business operators and related persons shall not be allowed to sponsor or in any way support individuals, groups or public as well as private agencies. This also includes promotion of image of any tobacco product, or its manufacturers or importers, advertising of tobacco products and promoting tobacco consumption, which may interfere with tobacco products control policies. An exemption was given for donations and humanitarian assistance just in case of severe natural disasters. But, this type of activities or news should not be promoted to the public. In addition to that, article 36 of the law also bans the retailers to display tobacco products at sale points. Display of names and prices of along with display of tobacco product retail places must fully comply with rules, procedures and conditions. Tobacco usage is one of the most serious public health issues in Thailand, given that it constitutes the single most critical risk factor for preventable deaths in the country, with over 51,000 deaths caused by smoking every year. Through the adoption of this law, which was elaborated on the basis of Guidelines for implementation of Article 13 of the WHO FCTC, Thailand continues to be a world leader in global tobacco controls, while fulfilling its obligations under the Convention.

**Global Partnerships for Tobacco Control (GPTC)**

The Global Partnerships for Tobacco Control (GPTC) was launched at the 11th World Conference on Tobacco or Health in 2000, to support and back international tobacco control activities at the grass roots level. There are currently over 360 groups in 100 countries involved in this program. It is said that no 2 organizations are same. Therefore, no 2 partnerships are alike. In the past 3 years, the Essential Action program has greatly assisted groups in building a wide array of global partnerships, each one suited to specific needs and the interests of the related groups. Essential Action partners groups are matched as per their type of organization, their current activities, interests and also their geographic location. Experience shows that similar interests, language skills, and the level of enthusiasm are essential "ingredients" for highly successful partnerships. There should be specific reason for need to work with a group in another country. Tobacco industry has no borders neither must tobacco control advocates if they should effectively address the global epidemic of tobacco-related deaths and diseases.
By developing robust bonds of cohesion between groups in different countries, the international tobacco control movement will be better able to challenge the tobacco industry at the local, national, and international levels. The Global Partnerships program gives mutual benefits to its partner groups. In addition to individual partnership projects, Essential Action enrolls various groups to take part in collective activities and action campaigns. Every month organizations do collect certain information from around the world on a particular tobacco control topic, for example tobacco industry's latest marketing strategies.

**World Health Organization**

Our current and future generations must be protected from shocking health, social, environmental and economic consequences of high tobacco consumption and exposure to tobacco smoking. Governments use tobacco control measures in WHO Framework Convention on Tobacco Control (WHO FCTC) to prevent tobacco usage and exposure to tobacco smoke. By implementing these measures, governments should reduce the burden of disease and death attributed to tobacco exposure.

The WHO Framework Convention on Tobacco Control (WHO FCTC) is a pre-eminent global tobacco control instrument and contains legally binding obligations for its Parties, setting global foundation for reducing both demand and the supply of tobacco products and provides a comprehensive direction for various tobacco control policies at different levels. To assist party countries in implementing effective strategies for selected demand reduction, WHO introduced a package of measures under the acronym of MPOWER. WHO recently reported about the progress that its Member States are making against the MPOWER measures. WHO global report on mortality attributable to tobacco and WHO global status report on NCDs. It highlights Tobacco's toll and says 6 people die from tobacco use and exposure to tobacco smoke (one death every six seconds). Prevalence of smoking is so significant that 22% of the world's population aged 15+ are smokers. 78% do not smoke. Non-smoking is becoming the norm. Tobacco control measures are essential because 10% of the world’s population live in countries that have sufficiently high tax rates on cigarettes.

**Timeline of Events**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of event</th>
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<tr>
<td>April 7th, 1948</td>
<td>World Health Organization was formed</td>
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<tr>
<td>1999</td>
<td>Framework Convention Alliance was founded</td>
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<tr>
<td>2007</td>
<td>Global Alliance for Chronic Diseases</td>
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<tr>
<td>February 27th, 2005</td>
<td>WHO framework on tobacco control was initiated</td>
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November 12th, 2018 Protocol to Eliminate Illicit Trade in Tobacco Products was introduced
December 12th, 2018 16th German Conference on Tobacco Control took place

Relevant UN Treaties and Events

- An international strategy for tobacco control 12th May 1995 *(WHA48.11)*
- Transparency in tobacco control, 21st May 2001 *(A54/52)*
- Tobacco control, 23rd July 2004 *(2004/62)*
- Smoke-free United Nations premises, 11th December 2008 *(A/RES/63/8)*
- Tobacco use and maternal and child health, 22nd July 2010 *(2010/8)*
- United Nations system-wide coherence on tobacco control, 10th August 2012 *(E/RES/2012/4)*
- Protocol to eliminate illicit trade in tobacco products, 12th November 2012 *(FCTC/COP5)*

Previous Attempts to solve the Issue

Smoking is an issue that is prevalent among the youth and adults of both genders in most countries. In US, smoking is prevalent among the native individuals. Despite the initiatives taken by the percentage of smokers in the US increased from 57% to 67%. There was a substantial decrease in the percentage of smokers but initiatives need to be undertaken for individuals with psychiatric disorders, financially unstable people and substance abuse victims. There are limited historic policies in European countries leading to the increased rate of smokers especially in Western Europe. There are 300 million smokers in China and about 750 million passive smokers that include approximately 200 million children. This is mainly due to large production of tobacco leaf and less education among individuals living in rural areas. Every year one third of the Chinese male population dies due to cigarette smoking. Policies have not been implied effectively by the government to reduce tobacco leaf production that would indeed reduce the rate of active smokers. Implementing anti-smoking legislation has led to huge reductions in exposure to secondhand smoke. In Scotland, the impact has been particularly very impressive for non-smokers who are living in non-smoking households with mean cotinine concentrations falling by approx. 49%. But unfortunately, non-smokers who are living in smoking households had a very negligible reduction. Smoke-free housing policies may be a very effective strategy in the reduction of secondhand exposure in these individuals. In European countries like Italy, despite legislative intervention, passive smoking remains as high as 55% among adolescents and young adults mainly due to smoke from automobiles. In US, self-initiative to report regular passive smoking is less. Hence, this has resulted in an increasing level of nicotine in almost 50% of non-smokers in such an environment. Children of smoking...
parents and 10 times more likely to experience passive smoking than the children of non-smoker parents. Governments have faced limitations while enacting policies regarding the issue of tobacco consumption. According to the Tobacco Control Legal Consortium at William Mitchell College of Law individuals criticize the implementation of smoking bans. In Canada, smoking in poor neighborhoods became prevalent and the rates increased after the ban on smoking in public places. In spite of the bans on smoking and steps taken by governments, children remain highly vulnerable to cigarette smoke.

Possible Solutions

Doctors can encourage their patients to stop smoking in particular where behavior change is being sought. They can design and implement specific programs to stop smoking by applying core principles of behavioral science teaching. There are two reasons to believe antidepressants might help in smoking cessation. First, depression may be a symptom of nicotine withdrawal, and smoking cessation sometimes flare up depression. Second, smoking appears to be due, in part, to deficits in dopamine etc., all of which are increased by antidepressants. Allied with these reasons, some smokers interested in medical treatment prefer not to use alternative sources of nicotine when quitting smoking. A very interesting aspect of intervention, which is useful to understand and to be able to apply, is the concept of “motivational interviewing”. This strategy is based on the idea that most patients are not prepared to change their habits, although might feel better if they do.

There are few communication campaigns that use multiple-media formats; include hard-hitting or graphic images; are intended to change knowledge, beliefs, attitudes, and behaviors which may impact tobacco use; and provide tobacco users with information on resources on how to quit. Increases in the sale price for tobacco products will decrease the number of people using tobacco, reduce the amount of tobacco consumed, and prevent young people from starting to use tobacco. Comprehensive smoke-free policies prohibit smoking in all indoor areas of workplaces and public places, including restaurants and bars, to prevent involuntary exposure to secondhand smoke. The public sector has traditionally regulated smoking in one of three ways. The first, and most important, is excise taxation, at both the state and federal levels (some localities tax cigarettes as well). Taxes were then roughly constant in real terms until federal excise taxes increased in 1991 and 1993 and since have risen in real terms, largely as a result of state actions. The important second public regulation is restriction of smoking in public places. Both states and localities have placed a variety of restrictions on smoking in sites such as workplaces, restaurants, and public transportation. A number of additional ordinances are in place at the county and local levels, and many sites have voluntarily become smoke-free as well. The set of smoking regulations involves restrictions on youths’ access to tobacco products. This was traditionally the purview of state governments, which passed a variety of restrictions on the purchase of tobacco products. States were expected to enforce these laws by various methods, including conducting random, unannounced
inspections, and to develop a strategy and timetable for achieving an inspection failure rate of less than 20 percent.

**Guiding Questions**

- What steps can be taken to reduce the rate of passive smokers?
- Apart from putting a ban on smoking in public, what can governments do to reduce the rate of active smokers?
- What can be done to lower the harmful effects of smoking parents on their children?
- How can counterfeit cigarettes be identified and its retail be reduced?
- Is self-reporting an effective method of reducing second hand smoking? If yes, how can it be encouraged?
- What limitations do governments face while implementing anti-smoking policies?

**Bibliography**


Appendix or Appendices

I. https://tobaccocontrol.bmj.com/content/28/Suppl_2/s119

This website gives a brief explanation on the working of FCTC. It explains the important history of this treaty by giving an overview of its history.

II. https://www.who.int/tobacco/framework/WHO_FCTC_english.pdf

This website gives a detailed answer to the importance of FCTC, its layout, its working and the policies that have been initiated till date.


This website gives an insight to the reasons for tobacco epidemic and its consequences.

IV. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6589457/

This website explains the ways in which the policies of FCTC were implemented and how they were strengthened to meet the needs of the present.

V. https://journals.sagepub.com/doi/pdf/10.1177/1757975909358252

This is useful in the way that it explains how the FCTC treaty can be helpful in the Mediterranean region.

VI. https://journals.sagepub.com/doi/pdf/10.1177/1757975909358252
This website gives a detailed explanation of the background history of WHO FCTC.