World Health Organization
REGIONAL OFFICE FOR Europe

REGIONAL COMMITTEE FOR EUROPE
65TH SESSION

Vilnius, Lithuania, 14–17 September 2015

Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025: making tobacco a thing of the past

Working document

World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
65th session

EUR/RC65/10
+ EUR/RC65/Conf.Doc./6

Vilnius, Lithuania, 14–17 September 2015

16 July 2015
150475
ORIGINAL: ENGLISH

Provisional agenda item 5(e)

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Conceptual overview and main elements

Vision

Ultimately, the long-term vision is for a WHO European Region free of tobacco-related morbidity, mortality and addiction.

Target

The target is a minimum 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years or over by 2025 (baseline 2010).

Guiding principles

Gender sensitivity
Protection of children
Protection from threats to fundamental human rights and freedoms
Leave no one behind

Focus and supporting areas

Focus area 1 – Strengthening implementation of the WHO Framework Convention on Tobacco Control and supporting innovation
Focus area 2 – Responding to new challenges
Focus area 3 – Reshaping social norms

Supporting area 1 – Assessing progress, gaps, gradients, trends and impact
Supporting area 2 – Working together: partnerships and international cooperation

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Introduction

1. This roadmap envisions a WHO European Region that is free of tobacco-related morbidity, mortality and addiction – in short, a Region where tobacco is a thing of the past.

2. We know how to achieve it. The means are described in the WHO Framework Convention on Tobacco Control (FCTC) *(1)*, which entered into force a decade ago and to which 50 Member States of the WHO European Region are parties, its implementation guidelines, and the policy options and decisions adopted by the Conference of the Parties (COP). In addition, there is a new international treaty – the Protocol to Eliminate Illicit Trade in Tobacco Products *(2)* – which is open for ratification by the parties. These are powerful tools that are not being used to their full potential: while some of the European countries are global tobacco control leaders, there is still a relatively low level of FCTC implementation overall and very few parties have implemented the Convention comprehensively *(3)*. Furthermore, within the European Union (EU), a number of major directives related to tobacco control also bind 28 of the 53 Member States of the WHO European Region, including, most recently, the directive concerning the manufacture, presentation and sale of tobacco and related products *(4)*. Strengthening implementation of the FCTC in the WHO European Region through this roadmap would ensure that no Member State is left behind and that time-bound commitments are met while providing the opportunity for all States parties to gain from innovation, share experience and together face emerging (and cross-boundary) challenges.

3. We know what we would gain if we were successful. Tobacco use is the single most preventable cause of death and disease; it is also a leading contributor to the overall health inequities in Europe.[1] Effective tobacco control helps achieve the strategic objectives of Health 2020 – the WHO policy framework for health and well-being in Europe *(5)* to reduce health inequalities and improve leadership and participatory governance for health. In addition to the health gains, there are substantial returns on investment from effective tobacco control measures with significant productivity gains and savings to health and social care *(6)*.

4. We know what we stand to lose if we fail. Tobacco control is a primary entry point for achieving the global goal of a 25% reduction in premature mortality from noncommunicable diseases (NCDs) by 2025 agreed by the World Health Assembly. Yet there are serious concerns this may not be reached *(7)* and, based on present estimates, 36 countries within the WHO European Region are unlikely to meet the related voluntary target of a 30% relative reduction in current tobacco use if no stronger measures are undertaken.[2] Strengthening the implementation of the WHO FCTC is a key driver to achieve the health aims of the post-2015 development agenda *(8)*.

5. We have the mandate to act. In resolution EUR/RC64/R4 on the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the

[1] See the Appendix for further information on the context and impact of tobacco.
[2] Within the WHO European Region, a further 11 countries are expected to meet the target; sufficient data are not available for another six countries.

Context of Health 2020 *(9)*, endorsed at the 64th session of the Regional Committee for Europe in 2014, Member States of the Region affirmed their commitment to accelerating efforts to achieve the full implementation of the WHO FCTC. They pledged to work together to make the global target on NCDs related to tobacco use a reality, requesting this roadmap to support their efforts.

6. The roadmap aims to guide movement in the desired direction and to assist Member States and the WHO European Region in reaching the goal and in achieving its vision. It recognizes that the time and exact routes that countries take may differ, reflecting the diversity of the Region and the particular circumstances of Member States, but encourages all leaders to begin the journey, make progress at an appropriate speed, close the gap between countries and reach the common destination. The preparation of the roadmap benefits from a close working relationship with the Secretariat of the WHO FCTC and draws on the expertise of a senior advisory group, technical discussions with representatives of Member States, the advice of the Standing Committee of the WHO Regional Committee for Europe (SCRC), new evidence on the status of tobacco control in Europe, and current developments in the field.

Vision

7. Ultimately, the long-term vision is for a WHO European Region free of tobacco-related morbidity, mortality and addiction.

Targets

8. This roadmap charts the way to achieving the voluntary global target of a minimum 30% relative reduction in the prevalence of current tobacco use in persons aged 15 years and over by 2025 (baseline 2010).[3] This target was adopted by the World Health Assembly under the *Global action plan for the prevention and control of noncommunicable diseases 2013–2020 (10)*, its comprehensive global monitoring framework, endorsed in resolution WHA66.10 *(11)*, and the decision of the sixth session of the COP to the WHO FCTC *(12)*. In this decision, the Conference of the Parties, with the aim of strengthening its contribution towards achieving the noncommunicable disease global target on the reduction of tobacco use, calls on the parties to set a national target for 2025 for a relative reduction of current tobacco use in persons aged 15 and over.

9. Other more intermediary measures and milestones are being developed to track progress and to measure success, in line with those now in use *(3)*, on the basis of data already collected by the WHO and FCTC Secretariats to avoid any additional reporting burden for the parties.

[3] The achievement of the nine voluntary global NCD targets is set against a 2010 baseline year. In: WHO/Programmes/Noncommunicable diseases and mental health/NCD tools/About 9 voluntary targets [website]. Geneva: World Health Organization; 2015 (http://www.who.int/nmh/ncd-tools/definition-targets/en/, accessed 9 June 2015).

Guiding principles

10. The following guiding principles underpin this roadmap.

- Gender sensitivity – recognizing that, while the highest proportion of current smokers are male, the uptake among women is increasing; that biological, social, economic and cultural factors influence health risks; and that structures and environments may limit or determine exposure and behaviours.
- The protection of children – recognizing that exposure to tobacco smoke begins in utero, that children are being targeted by the tobacco industry and many become addicted to tobacco use before they are able to make informed adult decisions, and that, as smoking affects the health of smokers and those around them, we have an obligation to protect children from the risks of second-hand smoke.
- Protection from threats to fundamental human rights and freedoms – relating not only to the attainment of the highest possible level of health but also to protection from passive exposure to tobacco smoke and the protection of workers, including those in the tobacco industry.
- Leave no one behind – stressing the importance of ensuring that all countries in the Region are helped to achieve the goal, which is particularly important given the cross-boundary issues of tobacco control, and aligning with the guiding principles for sustainable development.

Scope

11. This roadmap draws on, and is aligned with, the articles of the WHO FCTC, as well as the guidelines for their implementation and COP policy options and decisions *(13)*. While recommending options for actions and without wishing to be directive, it therefore contains much that is already a commitment for the parties to the Convention, including the time-bound requirements of the treaty, such as those measures within Articles 11 (three-year deadline) and 13 (five-year deadline), and guidelines to Article 8 (five-year deadline).

12. There is scope within the WHO FCTC for even more to be achieved. Some articles are relatively neglected, while others could be implemented more creatively to maximize the possibilities within a legally binding framework. The roadmap intends that recommended actions be within the framework of the FCTC while still allowing for innovation.

13. The roadmap cannot contain all aspects. It seeks to strike a balance between recognizing the importance of a comprehensive approach and focusing on key actions for achieving the vision. Recognizing the specificity of the WHO European Region, as well as the diversity and circumstances of its Member States, and the gaps between the full potential of the WHO FCTC and current achievements within Europe, the roadmap highlights the actions for the greatest impact. These are organized into three main focus areas, underpinned by two cross-cutting supporting areas, as follows:

- *Focus area 1 – Strengthening implementation of the WHO FCTC and supporting innovation;*

- *Focus area 2 – Responding to new challenges;*
- *Focus area 3 – Reshaping social norms;*
- *Supporting area 1 – Assessing progress, gaps, gradients, trends and impact;*
- *Supporting area 2 – Working together: partnerships and international cooperation.*

Focus areas

Focus area 1 – Strengthening implementation of the WHO FCTC and supporting innovation

14. Countries should implement the WHO FCTC comprehensively, including all its minimum obligations, with the option of going further. However, in the European context some articles are likely to have a greater immediate impact than others. Article 6 *(1)* describes key measures for achieving the global tobacco target and for dealing with inequities: tobacco tax increases and high tobacco prices may significantly reduce tobacco consumption by encouraging cessation, stopping uptake by young people, preventing relapse and reducing the number of tobacco consumers. These are particularly significant for the protection of young people and low-income groups. It is important to recognize that implementation of Article 6 is not within the remit of ministries of health and requires close engagement with ministries of finance, as well as specific training in tobacco taxation. With the adoption of guidelines for the implementation of Article 6 *(1)* by the COP at its sixth session, the momentum exists for significant progress on tobacco taxation *(14)*. While acknowledging the sovereign right of Member States to define their tax policies, there is further opportunity for cross-boundary coherence within economic development areas. Where tax differentials between nearby jurisdictions are large and border crossing is easy, tax evasion (for example, through small-scale smuggling) can occur.

15. While the policy driver should be to reduce consumption (and to prevent substitution for cheaper products), effective tobacco taxes are also an important source of revenue. Tobacco taxation discussions are often linked with arguments related to illicit trade, which can undermine price and tax measures for tobacco control and increases the accessibility and affordability of cheap tobacco products [Article 15 *(1)*]. Approximately 9 to 11% of the global cigarette market, and even up to 50% in some countries, is illicit. In addition to undermining public health efforts, this represents a considerable loss of revenue for governments. The new FCTC Protocol adopted by the COP in 2012 seeks to eliminate all forms of illicit trade in tobacco products *(2)*. By February 2015, it had been signed globally by 53 States and the EU and ratified by six parties. Detailed guidelines for the implementation of several other articles, including Article 11 *(1)*, on the packaging and labelling of tobacco products, have also been adopted by the COP *(15)*. The new EU Tobacco Products Directive 2014/40/EU is also significant in this regard *(4)* since it regulates areas that fall under several articles of the WHO FCTC, including Article 11.

16. Countries are already being innovative within the framework of the FCTC. Some countries are paving the way towards a tobacco-free future, plain packaging and a

tobacco-free millennial generation: for example, within the WHO European Region, Finland, Ireland and the United Kingdom (Scotland) are setting themselves the bold goal of a prevalence of smoking of 5% or less. Point-of-sale display bans are a powerful tool for reducing the attractiveness of tobacco products to young people and, following their success, a number of countries are moving ahead with the introduction of plain packaging. In addition, social innovation to meet social need or purpose includes, in the area of tobacco control, the use of social media and new technology, with mCessation,[4] e-health and distance-learning opportunities.

17. Finally, implementation of the FCTC requires coordination and a whole-of-government approach and must be adequately resourced. Resources may come from a reallocation of existing health funds for prevention or from other sources; in either case, investment needs to be sufficient and monitored.

Recommendations for Member States

18. Ratify the WHO FCTC, if they have not already done so, and strengthen its implementation in a comprehensive way, ensuring policy coherence for tobacco control measures through whole-of-government and multistakeholder approaches [Article 5.1 *(1)*].

19. Consider setting, by 2015, a national target for 2025 for the relative reduction of current tobacco use in persons aged 15 and over, taking into account the voluntary global target provided by the World Health Organization, and developing or strengthening national multisectoral policies and plans to achieve that target.

20. Promote the full engagement of the Ministry of Health and all parts of government in order to promote a cross-government approach to tobacco control and to provide sufficient financial support for national activities to implement the FCTC. Establish or reinforce a national coordinating mechanism and/or focal point for tobacco control in order to promote national activities, capacity-building and advocacy to implement the Convention, linking all sectors and promoting the participation of citizens and civil society, and to provide sufficient financial support for such national activities [Article 5.2(a); Article 26 *(1)*].

21. Establish long-term, coherent taxation policies in order to contribute to the health objectives within a certain period of time, monitoring, increasing or adjusting tax rates on a regular basis to reduce tobacco use and to prevent negative border effects [Article 6 *(1)*].

22. Given the risk of substitution, tax all tobacco products in a comparable way, with a regular review, to minimize the incentive for users to change to cheaper products or product categories in response to tax or retail price increases [Article 6 *(1)*].

[4] Projects on mobile health (mHealth) for tobacco control. In: WHO/Health topics/Tobacco/More publications about tobacco/mHealth/Mobile health (mHealth) for tobacco control [website]. Geneva: World Health Organization; 2015 (http://www.who.int/tobacco/mhealth/projects/en/, accessed 9 June 2015).

23. In accordance with national circumstances, consider dedicating revenue or sustained funding to tobacco-control programmes, to include, for example, awareness raising, health promotion and disease prevention programmes, cessation services, economically viable alternative activities and the financing of appropriate structures for tobacco control [Article 6 *(1)*].

24. Ratify or accede to the Protocol to Eliminate Illicit Trade in Tobacco Products, if they have not already done so [Article 15 *(1)*].

25. Counteract the illicit trade in tobacco products, mark unit packets and packages of tobacco products, as well as any packaging, with unique identifiers and establish security features and systems to enable tracking and tracing, in accordance with the FCTC Protocol [Article 15 *(1)*].

26. Collect information on cross-border trade and monitor and exchange such information among customs, tax and other authorities [Article 15 *(1)*].

27. Ensure that unit packets and packaging of tobacco products carry large, clear, visible and legible health warnings and messages that describe the harmful effects of tobacco use and include pictures and pictograms in their warnings, as well as providing information on cessation, such as quit lines [Article 11 *(1)*].

28. Undertake, in accordance with its constitution or constitutional principles, a comprehensive ban on all tobacco advertising, promotion and sponsorship, including a display ban on tobacco products at points of sale and cross-border advertising, that covers traditional media (print, radio and television) and all media platforms, including the Internet, mobile telephones and other new technologies, as well as films [Article 13 *(1)*].

29. Consider restricting or prohibiting the use of logos, colours, brand images or promotional information on packaging other than brand names displayed in a standard format [Article 11 *(1)*].

Actions for the WHO Regional Office for Europe

30. Support the ministries of health in promoting an intersectoral approach for tobacco control and adopt a coherent whole-of-government approach to policy-making, in line with Health 2020.

31. Assist countries in identifying and overcoming barriers to full implementation of the FCTC, facilitating and promoting capacity-building, training and technical expertise and tailored approaches for countries with diverse circumstances within the WHO European Region.

32. Promote, in collaboration with the Convention Secretariat, implementation of Article 15 of the FCTC and, in particular, the ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products by the parties in the European Region, and provide technical assistance to parties, upon request, to support their ratification work and technical work towards implementation of the specific requirements of Article 15.

33. Update the WHO “best buys” costing tool for minimum expenditure on tobacco control.

34. Continue to expose myths surrounding the illicit tobacco trade.

35. Support countries in developing and sharing innovative approaches and collaborating at national and subnational levels in trialling innovative policies and practices for tobacco control, thereby strengthening the evidence base for effective mechanisms.

Focus area 2 – Responding to new challenges

36. Since the adoption of the WHO FCTC by the World Health Assembly more than 10 years ago, new challenges have emerged. Electronic nicotine delivery systems (ENDS) are the subject of a public health dispute among genuine tobacco control advocates that has become more divisive as their use has increased. Whereas some experts welcome ENDS as a pathway to the reduction of tobacco smoking, others characterize them as a product that could undermine efforts to denormalize tobacco use. ENDS therefore represent an evolving innovation, with both promise and threat for tobacco control. Whether ENDS fulfil the promise or the threat depends on a complex and dynamic interplay among the industries that market them (independent manufacturers and tobacco companies), consumers, regulators, policy-makers, practitioners, scientists and advocates *(16)*.

37. The use of smokeless tobacco products and water pipes has also increased substantially and has become more widespread, with a growing interest among young people *(17,18)*. Waterpipe tobacco use has grown globally and appears to be reaching alarming levels among secondary school and university students. The sale of tobacco for oral use (snus) has long been prohibited in all EU countries except Sweden. While the WHO FCTC seeks to prevent and reduce the consumption of all tobacco products, the EU Tobacco Products Directive presents an example of how the manufacture, presentation and sale of different forms of tobacco can be regulated.

38. The implications of trade and investment agreements for the effective implementation of the WHO FCTC are currently highlighted *(19)*. Many governments in the Region have faced legal challenges by the tobacco industry in domestic courts in relation to tobacco control measures. Regarding the introduction of plain packaging legislation, Australia has been challenged under a bilateral investment treaty and is subject to a World Trade Organization dispute. Investor-State dispute settlement mechanisms make it possible for foreign investors to directly sue countries in private international tribunals for compensation, bypassing national and EU courts.

39. In order to make progress on the global tobacco target, a specific challenge for the WHO European Region will be to reduce the prevalence of current tobacco use in a way that seeks to close health inequalities. Meanwhile, the specific targeting of women and children by the tobacco industry, for example, by selling products in packaging likely to appeal to women or to children, adds to the challenge. Tobacco control policies must be adapted so that they work effectively for all population groups, particularly the most vulnerable and/or those with the highest tobacco use, including taking measures to address gender-specific risks when developing tobacco control strategies.

40. The use of ENDS and electronic non-nicotine delivery systems (ENNDS), most commonly in the form of electronic or e-cigarettes, appears to be increasing. While such products may offer a range of potential benefits for individual smokers, concerns have been raised over the potential health risks to users and non-users, their efficacy in helping smokers to stop smoking and overcome nicotine dependence, and implications for tobacco control efforts, such as smoke-free policies *(16)*.

Recommendations for Member States

41. Ensure that comprehensive tobacco control measures, such as taxation, warnings, protection from environmental tobacco smoke and cessation treatment, apply to all tobacco products [Article 4.4 *(1)*].

42. Develop appropriate policies that prevent and reduce tobacco consumption, exposure to tobacco smoke and nicotine addiction, with particular attention to young people, non-smokers and vulnerable groups [Article 5.2(b) *(1)*].

43. Establish regulations to prohibit or to restrict ingredients aimed at increasing the palatability and attractiveness of all tobacco products [Articles and partial guidelines 9 and 10 *(1)*].

44. Adopt and implement effective measures that prohibit the sale and supply of all tobacco and nicotine delivery products to persons under 18 years, including by prohibiting access of minors to self-service vending machines [Article 16 *(1)*].

45. Create sustainable, evidence-based, accredited tobacco cessation services and systems, with cost coverage, utilizing new or innovative approaches; provide a national quit line, if possible free of charge or at a subsidized rate; and incorporate brief advice on tobacco cessation at all points throughout the health-care system, including prior to surgery [Article 14 *(1)*].

46. Provide targeted tobacco cessation support for specific groups, including pregnant women, parents of young children, people with mental health conditions and patients with cardiac and respiratory disorders [Article 14 *(1)*].

47. Consider public health concerns regarding tobacco use in the negotiations on trade and investment agreements. Ensure that such agreements do not compromise the ability of a country to control its own tobacco epidemic, including through implementation of the WHO FCTC and its Guidelines.

Actions for the WHO Regional Office for Europe

48. Strengthen the knowledge base on the prevention and control of tobacco products such as water pipes and smokeless forms of tobacco, as well as on the use of ENDS/ENNDS, including monitoring patterns of use, collating, synthesizing and interpreting evidence, and exploring policy options and best practices.

49. Document and publicize best practices in controlling new and emerging forms of tobacco.

50. Provide support on trade and investment issues so that countries are equipped to respond to the new challenges, building a network of individuals with relevant expertise for countries to draw on, and collating and disseminating experiences and best practices.

51. Promote evidence-based, accredited tobacco cessation practice and the training of health professionals in this and brief interventions, facilitating the exchange of best practices among countries.

52. Document and promote best practices on preventing tobacco sales to and by minors, including relevant research, thereby contributing towards the decrease of tobacco consumption among young people.

Focus area 3 – Reshaping social norms

53. Tobacco use is not standard and most people do not smoke. Changing the perception of the norm in a community, or reshaping the social norms, can influence current and potential tobacco users by creating a setting in which tobacco becomes less desirable, less acceptable and less accessible *(20)*. Providing enabling environments can protect against exposure to tobacco smoke, promote tobacco-free lifestyles, help tobacco users to quit and prevent other people from starting to use tobacco. For example, people with a high level of health literacy are more likely to quit, even when influenced by a socioeconomic group. The implementation of strong tobacco control measures influences public opinion, thereby contributing to changes in social norms. Such a comprehensive approach involves members of the public (non-smokers and smokers) and the media *(21)*. Scotland, United Kingdom, has the goal of creating a generation of young people who do not want to smoke through smoking "denormalization" measures aimed at children, such as smoke-free laws in places where children gather, peer-based prevention programmes for adolescents, targeting parents for cessation and encouraging families to have smoke-free homes.

54. Health professionals are key for reshaping social norms. They are drivers of behavioural change, serving as role models in society and pioneering progress in tobacco control, often based on organized health professionals advancing policy agenda.

55. A key element of reshaping social norms is to protect public health from commercial and other vested interests of the tobacco industry. In fully complying with the WHO FCTC, countries should, more than ever, make full use of Article 5.3 *(1)* and its Guidelines to protect public health policies from such interests of the tobacco industry.

Recommendations for Member States

56. Protect, across all branches of government, tobacco control policies and legislation from the interference of the tobacco industry. Where interactions with the tobacco industry are necessary, Member States should ensure that such interactions are conducted transparently. Whenever possible, they should be conducted in public, for example, through public hearings, public notice of interactions and the disclosure of records of such activities to the public [Article 5.3 *(1)*].

57. Minimize, or preferably put an end to, corporate social responsibility activities by tobacco companies, ban any publicity for such activities in accordance with the FCTC guidelines for the implementation of Article 5.3 and reject partnerships between government and the tobacco industry [Article 5.3 *(1)*].

58. Adopt, implement, monitor and actively enforce measures to provide protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places, and consider particular attention to places where children are present [Article 8 *(1)*].

59. Consider removing existing smoke-free exemptions, for example, in prisons, mental health institutions and nursing homes, which, while dwelling places for some individuals, are workplaces for others [Article 8 *(1)*].

60. Mobilize, engage and equip the community and civil society in designing, implementing, promoting and monitoring compliance with smoke-free legislation [Article 8 *(1)*].

61. Invest in communication, education and training measures, giving priority to evidence-based mass media quit-smoking and social marketing campaigns that warn of the dangers of tobacco and of the risks to children from exposure to second-hand smoke, and support the introduction and enforcement of regulations, including, but not limited to, those targeted at social groups with special needs [Article 12 *(1)*].

62. Advance health literacy and promote the integration of tobacco-related information in curricula at all levels of formal and informal education, including kindergartens, schools and colleges.

63. Promote the integration of tobacco cessation treatment and smoking prevention in the training of all health professionals in order to empower and encourage them to provide evidence-based advice to tobacco users.

64. Increase public awareness of the social, economic and environmental consequences of tobacco production and consumption, and of tobacco industry tactics and interference, as part of efforts to shape social norms [Article 12 *(1)*].

Actions for the WHO Regional Office for Europe

65. Document advanced practices by focusing on new tactics of the tobacco industry, including interference with international policy.

66. Support countries in their efforts to encourage health professionals to be role models and to provide evidence-based advice to tobacco users.

67. Promote the integration of tobacco cessation treatment and prevention of tobacco use in health professional training and prepare a sample health professional tobacco control curricula.

68. Provide more detailed and precise information on designing effective anti-smoking and quit-smoking campaigns, messages and approaches, facilitating direct cooperation between countries to exchange experiences and knowledge.

Supporting areas

Supporting area 1 – Assessing progress, gaps, gradients, trends and impact

69. Evidence is the foundation for effective policy and action. Surveillance of the use of all tobacco products reflects the outcomes of policies and indicates where new policies are required. The disaggregation of that data by factors such as gender, socioeconomic position and educational status will reveal social gradients and provide the basis for action to address the social determinants. Similarly, individual interventions and comprehensive tobacco control policies should be evaluated for their impact on different social groups. The standardization of data and the coordination of surveys within and among countries should be a focus. Tobacco surveillance is a separate issue; there should be a move towards more integrated and comprehensive monitoring not only of prevalence and risk factors but also of policy. The publication of key data and information sharing with civil society should be encouraged, particularly for equipping tobacco control advocates, decision-makers and the media. There is a need to better document advanced practices in sustainable funding for tobacco control programmes and for the broad dissemination of such practices.

70. Research needs to be coordinated and more closely tied to policy; the emphasis should be on impact analysis and the translation of findings to inform policy development and actions. Specific research gaps are evident in policy evaluation, impact assessment, implementation research and measuring progress and change, as well as regarding the supply and demand factors of tobacco in Europe. Despite the gap in information about the direct and indirect costs of tobacco use, bearing in mind that policy should be evidence based, research should be action oriented. A fuller use of the articles on surveillance and research [Article 20 *(1)*] and partnerships and international cooperation [Article 22 *(1)*], for example, could lead to better reporting of tobacco use and a sounder tracking of tobacco industries and their partners as they seek to influence WHO FCTC implementation. It could also enable more coordinated surveillance and evaluative strategies and information exchange among countries and networks *(22)*.

Recommendations for Member States

71. Establish and/or maintain sustainably funded tobacco consumption surveillance systems and regularly measure and report on the use of all tobacco products in adults and adolescents, disaggregated by age, sex and socioeconomic status, as appropriate [Article 20 *(1)*].

72. Continuously evaluate tobacco control measures to ascertain impact and outcomes, including differentially across population groups, as appropriate [Article 20 *(1)*].

73. Promote an active and multidisciplinary tobacco and ENDS research programme to address gaps in knowledge, inform policy and invest in translating research into practice [Article 20 *(1)*].

74. Enhance tobacco industry monitoring and surveillance programmes and identify and overcome barriers to gain better access to real-time sales data for analysis [Article 20 *(1)*].

75. Monitor current expenditure on tobacco control across government and at subnational levels, and compare with WHO recommended investment in "best buys".

76. Engage with tobacco control advocates, academics and civil society in codesigning, monitoring and evaluating tobacco control interventions, supporting efforts through appropriate training, capacity-building and the provision of information [Articles 4 and 22 *(1)*].

Actions for the WHO Regional Office for Europe

77. Develop more coordinated surveillance, research and evaluative strategies and encourage information exchange among countries and networks and the standardization of tools and approaches, where relevant.

78. Support policy evaluation, encourage research to reflect policy priorities and disseminate findings to further support countries in their efforts.

79. Support efforts for research and evidence to be applied and put into practice more quickly.

80. Document and promote advanced practices in sustainable funding for tobacco control programmes.

81. Support the parties to the WHO FCTC in complying, on time, with their reporting obligations under Article 21 of the treaty *(1)*.

Supporting area 2 – Working together: partnerships and international cooperation

82. In an interdependent world, given the global and regional forces challenging people's health, the need for countries to act together becomes increasingly important *(5)*. The efforts of countries risk being undermined by cross-border activities of the tobacco industry and its partners, including advertising, smuggling and pressure on trade policies. Governments can engage and equip civil society and academia to collaborate in collecting and using the necessary evidence for effective tobacco control in their countries and to counteract substantial lobbying by the tobacco industry. Partnerships that stimulate solidarity, collective learning and action assist in finding innovative and sustainable approaches that meet the needs of people at all levels of society.

83. Comprehensive multisectoral strategies and programmes are essential to reduce the consumption of all tobacco products. One of the strategic objectives of Health 2020 is to improve leadership and participatory governance for health. Effective tobacco control requires whole-of-government and whole-of-society approaches so that all sectors understand their roles and act on their responsibility for health and for accountability within all levels and systems. Supporting the achievement of the three

focus areas and the implementation of the WHO FCTC will require the involvement of multiple sectors, such as health, education, environment, trade, finance, social affairs and agriculture, as well as the wider stakeholders, such as citizens, civil society organizations and the media. Within countries, national and subnational governments have important and complementary roles to play.

Recommendations for Member States

84. Facilitate the participation of all relevant sectors, particularly health, finance, economy, education, environment and trade, and develop and sustain partnerships with broader stakeholders, such as civil society and researchers, in order to achieve the objectives of the WHO FCTC [Article 4 *(1)*].

85. Invest in international cooperation [Article 4 *(1)*].

86. Promote and facilitate the development, transfer and acquisition of technical, scientific, legal and other expertise [Article 22 *(1)*].

87. Support other Member States in the Region, for example, those with experience should share such knowledge with those most in need.

Actions for the WHO Regional Office for Europe

88. Continue to work closely with WHO and the Convention Secretariat to assist countries in translating the provisions of the WHO FCTC into national-level policies and programmes, and in interpreting implementation guidance to fit regional specificities.

89. Develop and sustain relevant partnerships at international and European levels, including with the EU and relevant United Nations partners, to support tobacco control in the WHO European Region, promoting the integration of FCTC implementation with health, development and other multisectoral programmes, including, as appropriate, within United Nations Development Assistance Frameworks.

90. Build cooperative relationships with non-United Nations and nongovernmental bodies, including civil society organizations, as well as institutions and economic development agencies that would help develop the economic case for tobacco control and support the development and implementation of tobacco taxes.

91. Encourage and facilitate mutual support among Member States, helping to match those most in need with those that can provide the most relevant experience.

92. Convene and facilitate groups of countries to work together on common themes of interest, such as emerging issues, and increase cross-country collaboration.

93. Enlist the support of professional associations of doctors, nurses and associated health professionals in reducing tobacco use among their membership and in equipping them to support tobacco cessation among patients.

References

(1) WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2003 (updated 2004, 2005; http://whqlibdoc.who.int/publications/2003/9241591013.pdf?ua=1, accessed 9 June 2015).

(2) Protocol to eliminate illicit trade in tobacco products, Seoul, 12 November 2012 (C.N.699.2012.TREATIES-IX.4.a). New York: United Nations; 2012 (https://treaties.un.org/doc/source/signature/2012/CN699E.pdf, accessed 9 June 2015).

(3) European tobacco control status report 2014. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0009/248418/European-Tobacco-Control-Status-Report-2014-Eng.pdf?ua=1, accessed 9 June 2015).

(4) Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC. O. J. E. U. 2014; L127:1–38 (http://ec.europa.eu/health/tobacco/docs/dir_201440_en.pdf, accessed 9 June 2015).

(5) Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf, accessed 9 June 2015).

(6) Tobacco return on investment tool. In: NICE/About/What we do/Into practice/Return on investment tools [website]. London: National Institute for Health and Care Excellence; 2014 (http://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/tobacco-return-on-investment-tool, accessed 9 June 2015).

(7) Kontis V, Mathers CD, Rehm J, Stevens GA, Shield KD, Bonita R et al. Contribution of six risk factors to achieving the 25×25 non-communicable disease mortality reduction target: a modelling study. Lancet. 2014;384(9941):427–437. doi:10.1016/S0140-6736(14)60616-4.

(8) Proposal for sustainable development goals. Open Working Group of the General Assembly on Sustainable Development Goals. New York: United Nations; 2014 (https://sustainabledevelopment.un.org/content/documents/1579SDGs%20Proposal.pdf, accessed 9 June 2015).

(9) WHO Regional Committee for Europe resolution EUR/RC64/R4 on the Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/64th-session/documentation/resolutions/eurrc64r4-ashgabat-declaration-

on-the-prevention-and-control-of-noncommunicable-diseases-in-the-context-of-health-2020, accessed 9 June 2015).

(10) Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1, accessed 9 June 2015).

(11) World Health Assembly resolution WHA66.10. Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Geneva: World Health Organization; 2013 (http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf, accessed 9 June 2015).

(12) Conference of the Parties to the WHO Framework Convention on Tobacco Control decision FCTC/COP6(16): towards a stronger contribution of the Conference of the Parties to achieving the noncommunicable disease global target on reduction of tobacco use. In: Report of the sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (Annex 7), Moscow, Russian Federation, 13–18 October 2014 (http://www.who.int/fctc/cop/sessions/COP6_report_FINAL_04122014.pdf, accessed 9 June 2015).

(13) WHO Framework Convention on Tobacco Control. Guidelines for implementation: Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, Article 14 (2013 edition). Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/80510/1/9789241505185_eng.pdf?ua=1, accessed 9 June 2015).

(14) Guidelines for implementation of Article 6 of the WHO FCTC: price and tax measures to reduce the demand for tobacco. In: WHO/FCTC/Guidelines/Adopted guidelines [website]. Geneva: World Health Organization; 2014 (http://www.who.int/fctc/guidelines/adopted/en/, accessed 9 June 2015).

(15) Guidelines for implementation of Article 11 of the WHO FCTC: packaging and labelling of tobacco products. In: WHO/FCTC/Guidelines/Adopted guidelines [website]. Geneva: World Health Organization; 2014 (http://www.who.int/fctc/guidelines/adopted/en/, accessed 9 June 2015).

(16) Electronic nicotine delivery systems: report by WHO (FCTC/COP/6/10 Rev.1). Sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Moscow, Russian Federation, 13–18 October 2014. Geneva: World Health Organization; 2014 (http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_10Rev1-en.pdf, accessed 9 June 2015).

(17) Control and prevention of smokeless tobacco products: report by WHO (FCTC/COP/6/9). Sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Moscow, Russian Federation, 13–18 October 2014. Geneva: World Health Organization; 2014

(http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_9-en.pdf, accessed 9 June 2015).

(18) Control and prevention of waterpipe tobacco products: report by the Convention Secretariat (FCTC/COP/6/11). Sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Moscow, Russian Federation, 13–18 October 2014. Geneva: World Health Organization; 2014 (http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_11-en.pdf, accessed 9 June 2015).

(19) Trade and investment issues relevant to implementation of the WHO FCTC: report by the Convention Secretariat (FCTC/COP/6/20). Sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, Moscow, Russian Federation, 13–18 October 2014. Geneva: World Health Organization; 2014 (http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_20-en.pdf, accessed 9 June 2015).

(20) Guidelines for implementation of Article 12 of the WHO FCTC: education, communication, training and public awareness (decision FCTC/COP4(7)). In: WHO/FCTC/Guidelines/Adopted guidelines [website]. Geneva: World Health Organization; 2010 (http://www.who.int/fctc/guidelines/adopted/en/, accessed 9 June 2015).

(21) Zhang X, Cowling DW, Tang H. The impact of social norm change strategies on smokers' quitting behaviours. Tob Control. 2010;19:i51–i55. doi:10.1136/tc.2008.029447.

(22) Giovino GA, Kulak JA, Kalsbeek WD, Leischow SJ. Research priorities for FCTC Articles 20, 21, and 22: surveillance/evaluation and information exchange. Nicotine Tob Res. 2013;15(4):847–861. doi:10.1093/ntr/nts336.

Appendix. Context and impact of tobacco

1. Tobacco use is the single most preventable cause of death and disease. Approximately 1.6 million people in the WHO European Region die of tobacco-related diseases every year and the Region has the highest proportion of deaths (16%) attributable to tobacco use. Globally, Europe also has the highest prevalence of tobacco smoking among adults (28%), including one of the highest smoking prevalence rates among women (19%) *(1)*.

2. Tobacco is a leading contributor to the overall health inequities in Europe: mortality from smoking-related conditions accounts for 22% of the overall inequities in the death rate from any cause among men and for 6% among women *(2)*. In some countries, the percentage can be higher *(3)*. Globally, being born male has been the highest predictor of tobacco use. However, the uptake of smoking among females has been rising *(4)*. The socioeconomic inequities in tobacco consumption are large and are widening *(5)*: even in countries where substantial reductions in smoking prevalence have been achieved, there may be an impact differential with, for example, greater reductions achieved among the higher-income or better educated groups. Some population groups may face particular challenges: for example, smoking is twice as common among those with mental health conditions compared to the general population; yet only a minority of people from this group receives effective smoking cessation interventions, and health-service settings may not be required to be smoke free *(6,7)*.

3. Exposure to tobacco can start early in life. Smoking during pregnancy means that tobacco-related harm begins in utero, and tobacco-related inequities can then increase over the life-course. Over 40% of children have at least one parent who smokes and almost one in two children regularly breathes air polluted by tobacco smoke in public places *(8)*. Children from disadvantaged groups are more likely to live with people who smoke. In this case, they are twice as likely to take up smoking themselves. Resolution EUR/RC64/R6 on the European child and adolescent health strategy 2015–2020 *(9)*, adopted by the WHO Regional Committee for Europe at its 64th session in 2014, contains the aspiration that all children born in or after 2000 will grow into non-smoking adults and reach middle age on a continent where tobacco is a rarity and where children grow up free of direct or indirect exposure to tobacco smoke. The fact that so many smokers start smoking before they are 18 years old suggests that the age-related restrictions on the sale of tobacco products have been circumvented in many countries.

References

(1) WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. In: World Health Organization/Programmes/Tobacco Free Initiative (TFI)/Publications/WHO report on the global tobacco epidemic [website]. Geneva: World Health Organization; 2013 (http://www.who.int/tobacco/global_report/2013/en/, accessed 9 June 2015).

(2) Mackenbach JP, Stirbu I, Roskam AJR, Schaap M, Menvielle G, Leinsalu M et al. Socioeconomic inequalities in health in 22 European countries. N Engl J Med. 2008;358(23):2468–2481. doi:10.1056/NEJMsa0707519.

(3) Jha P, Peto R, Zatonski W, Boreham J, Jarvis MJ, Lopez AD. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. Lancet. 2006;368(9533):367–370.

(4) Gender, health, tobacco and equity. Geneva: World Health Organization; 2010 (http://www.who.int/tobacco/publications/gender/gender_tobacco_2010.pdf?ua=1 accessed 9 June 2015).

(5) Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2013, updated reprint 2014 (http://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf?ua=1, accessed 9 June 2015.

(6) WHO Regional Committee for Europe resolution EUR/RC63/R10 on the European mental health action plan. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0009/217764/63rs10e_MentalHealth.pdf?ua=1, accessed 9 June 2015).

(7) Smoking and mental health: a joint report by the Royal College of Physicians and the Royal College of Psychiatrists. London: Royal College of Physicians, Royal College of Psychiatrists; 2013 (https://www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_full_report_web.pdf, accessed 9 June 2015).

(8) Tobacco fact sheet no 339. In: World Health Organization/Media centre/Fact sheets/Tobacco [website]. Geneva: World Health Organization; 2015 (http://www.who.int/mediacentre/factsheets/fs339/en/, accessed 9 June 2015).

(9) WHO Regional Committee for Europe resolution EUR/RC64/R6 on investing in children: the European child and adolescent health strategy 2015–2020 and the European child maltreatment prevention action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0019/259210/64rs06e_InvestChildren_140731.pdf?ua=1, accessed 9 June 2015).

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