HISTORY OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

FCTC

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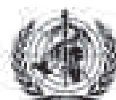

FCTC
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Foreword

The history of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) is public health history in the making. As the first global health treaty negotiated under the auspices of WHO, the FCTC has given a new legal dimension to international health cooperation. Following its adoption by the World Health Assembly in May 2003, it has become one of the most widely embraced treaties in United Nations history, with, by the end of 2009, 168 Parties.

This report recounts the story of the Framework Convention up to the beginning of 2010. Most of the information came from the individuals who kindly responded to a questionnaire and shared personal testimonies about this remarkable addition to the contemporary history of public health. A literature review and a search of WHO files and references provided additional valuable material. Dr Vera Luiza da Costa e Silva and Dr Annette David, international experts in tobacco control and participants in the negotiation of the Framework Convention, were the principal editors, at the request of the Convention Secretariat. A first draft was presented and discussed during a lunchtime seminar at the third session of the Conference of the Parties held in Durban, South Africa, November 2008, and comments, suggestions and additional input received during and after the seminar were considered and incorporated. The Secretariat provided overall support and guidance in the collection of information and writing the document. The report is the outcome of collaboration among country representatives, negotiators, intergovernmental and nongovernmental organizations, experts and WHO staff. The Convention Secretariat thanks all contributors to the report for their valuable input and support.

This publication should be considered a 'living document', an attempt to record the rich history of the Framework Convention systematically, from its conception to the negotiations, ratification and entry into force and to establishment of the machinery for its implementation. Its strength derives from the fact that it incorporates the diverse perspectives of the numerous stakeholders who participated in the process, and it reflects the personal commitment and dedication of the people who shared the vision and the challenge of harnessing international law to strengthen public health.

This publication was released in February 2010 on the fifth anniversary of the entry into force of the Convention. Comments and suggestions on this publication as well as further input into the history of the Convention will be highly appreciated.

Dr Haik Nikogosian
Head, Convention Secretariat

“Tobacco is the biggest killer.”

Dr Gro Harlem Brundtland
Former Director-General, World Health Organization

Confronting enormous odds: The tobacco epidemic

By the 1990s, the tobacco epidemic was a public health problem of epic proportions. It was a leading cause of premature death. The escalation of smoking and other forms of tobacco use worldwide had resulted in the loss of at least 3.5 million human lives in 1998 and was expected at that time to cause at least 10 million deaths a year by 2030 if the pandemic was not controlled, with 70% of these deaths occurring in developing countries (1).

Past efforts to stem the global tobacco epidemic had proved ineffective. Propelled by a multinational industry driven by the extremely profitable nature of tobacco manufacture and trade and fostered by the addictiveness of nicotine, the epidemic spread rapidly from the developed to the developing world. Globalization enfeebled the efforts of individual country to control tobacco use. Active promotion of tobacco use by the industry rendered the approach of the medical model inadequate. The traditional public health methods for reducing tobacco use were no match for the tobacco industry’s power, transnational reach and formidable resources.

Successful control of the tobacco epidemic seemed close to impossible. In the face of these enormous odds, it was time to change the rules of the game.

Changing the rules: Catalysing WHO to use its unused constitutional authority

Approved on 7 April 1948, WHO's Constitution mandates the Organization and its Member States to work for "the attainment by all peoples of the highest possible level of health". It also describes the extensive powers vested in the World Health Assembly, WHO's highest policy-making body, to protect and promote international public health, including the preparation and adoption of standards, legislation, conventions and agreements (Article 19) (2).

WHO had never wielded its treaty-making power, but the tobacco epidemic was a drastic public health challenge that called for radical, creative measures. The idea of using WHO's constitutional authority to establish an international regulatory mechanism for tobacco control first appeared in a report prepared by the WHO Expert Committee on Smoking Control in 1979 (3), chaired by Sir George Godber of the United Kingdom, with Dr Nigel Gray of Australia as the rapporteur and Dr Roberto Masironi of the WHO Cardiovascular Diseases Department as part of the WHO Secretariat. The report invoked Article 19 of the WHO Constitution and suggested that the Health Assembly consider using its treaty-making powers to control the tobacco epidemic if "the (tobacco control) programme outlined in its report did not produce results in a reasonable time". This idea was further explored by Professor V.S. Mihajlov of the former Union of Soviet Socialist Republics in 1989, who published an article on the feasibility of an international law framework for tobacco control (4).

A vision for the future

Professor V.S. Mihajlov (former Union of Soviet Socialist Republics)

"Although this might be unrealistic at the present time, and indeed even ridiculous, I for my part am convinced that the day will come when international health law will contain rules at eliminating drunkenness, alcoholism and tobacco use, all of which cause enormous damage to health. Certain actions could indeed be carried out forthwith, examples being the development of conventions prohibiting advertising of tobacco products or strengthening international cooperation in efforts to combat the smuggling of alcohol beverages."

In 1993, a lawyer and law professor in the United States of America, Dr Ruth Roemer, embarked on a campaign to raise support for an international legal approach to the tobacco epidemic by the global tobacco control community (5).

Identifying the enemy

Dr Ruth Roemer (United States)

"You know this is a very nice fight to have because the enemy is very clear. The tobacco companies have been absolutely vicious in concealing what they knew about the addictiveness of tobacco and about pushing tobacco marketing on children and in the developing world so aggressively. But there are exciting developments in the field. I feel confident that tobacco will go the way of asbestos, and that some of the law suits that are now being brought may actually succeed and spell the demise of the tobacco industry."

Courtesy of John E. Roemer

Roemer introduced the idea of using international treaty law as a public health approach to the tobacco control unit in WHO. At that time, the unit was a modestly staffed programme under Mr Neil Collishaw, who joined WHO from Health Canada. Collishaw began to explore the possibility and a few years later invited Dr Allyn Taylor, a colleague of Dr Roemer's, to draft a background paper that would form the basis of a feasibility study (N. Collishaw, personal communication, 2008; 6). Dr Taylor eventually served as legal consultant to WHO during negotiation of the framework convention. Other early supporters included Dr Judith Mackay, a long-time WHO consultant and Director of the Asian Consultancy for Tobacco Control (7), and a group of African tobacco control advocates led by Dr Derek Yach, then chairperson of the 1993 All Africa Tobacco Control Conference (D. Yach, personal communication, 2008).

A hesitant start

Dr Judith Mackay (Hong Kong, China)

"On 26 October 1993, Ruth Roemer invited me for an unforgettable breakfast in San Francisco. Had WHO ever considered a convention on tobacco? She asked me. Ruth patiently explained that she meant a UN-style convention and asked me to convey this idea to WHO. I immediately passed on the suggestion to WHO in Geneva and to UNCTAD (UN Conference on Trade and Development and the then UN focal point for tobacco). The idea of a convention that utilized international law to further public health was new."

In October 1994, at the Ninth World Conference on Tobacco or Health in Paris, Mackay introduced a resolution drafted jointly by herself and Roemer, calling on national governments, ministers of health and WHO to "…immediately initiate action to prepare and achieve an International Convention on Tobacco Control to be adopted by the United Nations…." (7). Collishaw was a member of the Resolutions Committee. The resolution passed, with overwhelming support from tobacco control advocates and nongovernmental organizations. It was time to engage officially with and secure support from within WHO.

Promoting the idea of a framework convention within WHO

Mr Neil Collishaw (former WHO Secretariat)

"In 1994, the late Ruth Roemer proposed the idea of an international treaty on tobacco control to me. Initially, even though I thought it was a good idea, I was more cautious. I pointed out that a treaty would require a wide consensus of countries and at that time there were only about 10 countries that had comprehensive tobacco control policies. Moreover, it would face an uphill battle in WHO. Ruth persisted, reminding me of the idea's virtues throughout the year. Gradually, I warmed to the idea. During the 1990s in WHO, keeping the idea of the FCTC alive and growing to the point where it came to be 'owned' by the Member States—a point that was reached around 1999—was difficult and challenging. However, it was worth the effort and the risks."

Canadian participants at the 1994 world conference contacted Dr Jean Larivière, a senior medical adviser at Health Canada and a member of the Canadian delegation to the World Health Assembly, to convey the conference resolution to WHO. Through his efforts and those of like-minded colleagues between 1995 and 1996, working with WHO insiders like Collishaw, the mandate to develop an international framework convention for tobacco control was introduced and built into official WHO policies (J. Larivière, personal communication, 2008; 8). In May 1996, the World Health Assembly adopted resolution WHA49.17 (9), calling for an international framework convention on tobacco control. This was the first time that WHO had sought to wield its authority to use international law for a public health goal. For the first time in history, WHO sought to change the rules that determined how tobacco control would be played.

The first treaty planning meeting was held in Halifax, Canada, in June 1997 (10), but negotiation of a treaty on tobacco control by WHO Member States was still to be championed by the Organization.

An uphill effort: Securing an official mandate for WHO to start preparing a convention

Dr Jean Larivière (Canada)

"Once in Geneva, I found out that nobody on the 1995 WHO Executive Board had knowledge of the conclusions of the recently held 1994 Paris meeting. I nevertheless discussed the matter with colleagues on the Board, asking them to support a draft resolution on the issue. Mexico, Finland and Tanzania agreed to be co-sponsors. The resolution was tabled and adopted at the WHO Executive Board, and it led to the May 1995 WHA Resolution 48.11, requesting WHO… to study the feasibility of developing an international legal instrument on tobacco control to be adopted by the United Nations.

"When I arrived in Geneva to attend the session of the Executive Board in January 1996, I realized that the working paper developed by WHO on this matter merely asked the Board to note the results of the feasibility study. There was obvious opposition within the WHO Secretariat and among some members of the Board to the use of Article 19 of the Constitution for the first time in the history of WHO to draft and adopt a 'convention' on tobacco control. A resolution was proposed formally calling on the Director-General of WHO to begin drafting a framework convention on tobacco control. Drs Kimmo Leppo (Finland) and John Hurley (Ireland) introduced the resolution which was adopted by the Board. Subsequently, the 49th World Health Assembly endorsed a resolution calling for the development of an international framework convention on tobacco control in May 1996."

Champions, capacity and collecting the evidence: The transition from concept to reality

While resolution WHA49.17 established an official mandate to initiate a convention, it was not until 1998 that WHO seriously embarked on the transition from the concept of a framework convention to reality. Dr Gro Harlem Brundtland, the newly elected WHO Director-General, championed tobacco control as a priority for her term and established the Tobacco Free Initiative (TFI) as a special cabinet project under Dr Derek Yach, an early supporter of an international legal approach to tobacco control. Dr Brundtland was familiar with treaty-making, having been involved in environmental treaties as Norway's Minister of Environmental Affairs, and she was open to the idea of WHO undertaking an international framework convention to control tobacco use. The United Nations Foundation/United Nations Fund for International Partnerships provided significant resources to support TFI's work (11). These assured political support and created the basis for the organizational infrastructure necessary for preparing a framework convention.

Championing tobacco control and treaty negotiation

Dr Gro Harlem Brundtland (former WHO Director-General)

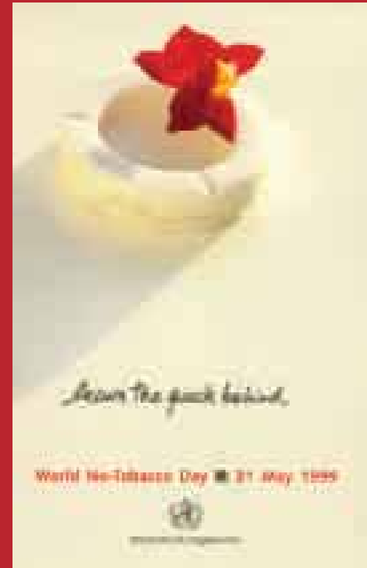
"The tobacco habit is extensively communicated! It is communicated through the media, the entertainment industry, and most directly through the marketing and promotion of specific products. Global trade in tobacco has increased markedly over the last few years. Direct foreign investment by multinationals in developing countries has also increased. New joint ventures are announced every few months between multinationals based in a few developed countries and the governments of emerging markets.

"Tobacco control cannot succeed solely through the efforts of individual governments, national nongovernmental organizations and media advocates. We need an international response to an international problem.

"I believe that the response will be well encapsulated in the development of an international framework convention that will cover key aspects of tobacco control that cross national boundaries. The framework convention will seek to address key areas of tobacco control such as: harmonization of taxes on tobacco products, smuggling, tax-free tobacco products, advertising and sponsorship, international trade, package design and labeling, and agricultural diversification." (12)

The launch of TFI was a global event. Dr Brundtland made her expectations clear to WHO's regional directors: they were to institute corresponding TFI teams in each of WHO's regional offices and allocate sufficient resources to support the protracted, complex work of preparing Member States for WHO's first foray into treaty-making. A media advocacy and social marketing campaign highlighting the tobacco epidemic as a WHO priority was launched to sensitize governments and civil society to the urgent need for a coordinated global response to control tobacco use. In December 1998, TFI convened a second preparatory meeting, sponsored by the British Columbia Provincial Government with input from Health Canada, to improve institutional capacity-building for preparation of the treaty. An advisory committee on policy and strategy and a scientific advisory committee on tobacco product regulation, composed of established tobacco control experts, were created to guide and support WHO TFI in its mission.

Orchids for ashtrays



The first image that emerged from TFI's social marketing campaign was 'Orchids for ashtrays', created by photographer Ashvin Gatha for World No Tobacco Day 1999. Gatha, a former smoker, conceived a white marble ashtray on which was posed a bright red orchid. The flower represents life, instead of ashes and death. "In today's society we are bombarded by the media, not given time to think for ourselves. Cigarettes are like a drug and are a defiance of individual freedom. We purchase the dreams that the cigarette companies churn out. Never mind that we are killing ourselves in the process," explained Gatha. During the negotiations for the framework convention, this image was the inspiration for the 'Orchid' and 'Dirty Ashtray' awards given out by observers from nongovernmental organizations to pinpoint participants whose contributions to the negotiations were perceived to boost or impede the progress of the convention, respectively.

The Director-General's championing of tobacco control extended beyond WHO into the United Nations system. The United Nations Ad Hoc Interagency Task Force on Tobacco Control was established by the Secretary-General of the United Nations in 1999 to coordinate the work in tobacco control being carried out by different United Nations agencies. It shifted the responsibility for serving as the tobacco control focal point from UNCTAD to WHO, which thus coordinated the work of 17 agencies of the United Nations system and two outside organizations (13). The Task Force provided a mechanism for interagency collaboration in tobacco control, in recognition of the importance of multiagency cooperation for implementing the framework convention and also for addressing the link between tobacco and poverty and exposure to second-hand tobacco smoke. Partnerships with agencies in sectors other than health, such as the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organization (ILO), the United Nations Children's Fund (UNICEF) and the World Bank, ensured that related aspects of tobacco control were addressed. World Bank research on the economic aspects of tobacco control augmented the evidence base on cost–effective measures. Its publication *Curbing the epidemic* (14) made an important contribution to the treaty negotiations by providing compelling economic arguments for effective tobacco control.

WHO also sought other partnerships, such as with the United States Centers for Disease Control and Prevention and the Canadian Public Health Association, to set up a system for tracking progress in tobacco control. The Global Youth Tobacco Survey was the first system to emerge and was the cornerstone for the Global Tobacco Surveillance System (15).

In recognition of the pivotal role of civil society in tobacco control, WHO TFI began discussions with nongovernmental organizations, which led to creation of the Framework Convention Alliance in October 1998 (16). Some of the nongovernmental organizations that did pioneering work in tobacco control, such as Corporate Accountability International (formerly INFACT) and the International Nongovernmental Coalition against Tobacco, entered into official relations with WHO during the same period. A major portion of the funds provided by the United Nations Foundation/United Nations Fund for International Partnerships were channeled into grants for capacity-building for nongovernmental organizations (17).

In 1998, litigation brought by the Association of Attorneys General in the United States against the tobacco industry resulted in the Master Settlement Agreement, by which previously confidential industry documents providing evidence of the industry's long history of deception and deceit became available. These internal documents emphasized the urgency of mounting a concerted, comprehensive, global response to the tobacco epidemic and also demonstrated the importance of preventing the tobacco industry from influencing negotiation of the framework convention. The documents were used by an external committee of experts established by Dr Brundtland in 1999, chaired by Dr Thomas Zeltner, director of the Swiss Federal Office of Public Health, to investigate the possibility of tobacco industry interference in WHO's work on tobacco control (18).

The tobacco industry: a threat to the framework convention

Dr Thomas Zeltner (Switzerland)

"…tobacco companies have operated for many years with the deliberate purpose of subverting the efforts of the World Health Organization to control tobacco use. The attempted subversion has been elaborate, well-financed, sophisticated and usually invisible… The tobacco companies…viewed WHO... as one of their foremost enemies… (and) instigated global strategies to discredit and impede WHO's ability to carry out its mission."

At the Fifty-second World Health Assembly in May 1999, resolution WHA52.18 (1) established a working group to prepare the proposed draft elements of a treaty and an intergovernmental negotiating body (INB) to draft and negotiate the proposed framework convention and possible related protocols. A report commissioned by WHO from Mr Luk Joossens (Belgium) served as the technical paper for the working group meetings. Dr Kimmo Leppo (Finland) chaired the two meetings, which produced a draft text that was subsequently accepted as the basis for the negotiations. Dr Margaret Chan (China), current WHO Director-General, and Dr Vera Luiza da Costa e Silva (Brazil) were the co-chairs

Preview of the framework convention

Mr Luk Joossens (Belgium)

"I was contacted by Neil Collishaw in June 1998 to write a paper entitled 'Improving public health through an international framework convention on tobacco control'. He told me that there were many lawyers who can describe the process of adopting a convention, but that he needed someone who would describe what should be the content of such convention from a public health perspective. I was not really familiar with conventions, but I felt that it was interesting to write a report on global tobacco control."

By this time, the elements essential to the success of the framework convention—high-level champions, an organizational infrastructure and capacity-building, multiagency, multisectoral partnerships, an expanding evidence base on effective interventions and on the industry's tactics to promote tobacco use, a system to track progress and a strategy for media advocacy and social marketing—were in place. Finally, the real work of treaty development could begin.

Consensus or compromise: The art of negotiation

Between October 1999 and March 2000, the intergovernmental technical working group produced provisional texts of proposed draft elements for the framework convention (19, 20). In May 2000, the Fifty-third World Health Assembly accepted the provisional texts and, in resolution WHA53.16 (21), called on the INB to start negotiating the framework convention. The process was finally under way.

Mapping out the territory

Dr Kimmo Leppo (Finland)

“I was approached by Derek Yach on behalf of Director-General in early 1999 regarding the possibility of chairing the first preparatory intergovernmental working group (IGWG) meeting to develop the WHO FCTC. This was based, I gather, on Finland´s role as a forerunner on the WHO initiative at the Executive Board, and perhaps also the forthcoming Finnish EU [European Union] Presidency, which might help with some of resistance from some of the rich countries.

“Drs Margaret Chan and Vera da Costa e Silva were vice-chairs, and I thoroughly enjoyed working with them over several meetings during the preparatory IGWG phase to map out the territory that had to be covered in the negotiation phase.

“In the later phases, I was no longer involved but many of my staff participated. I consider the FCTC one of the landmarks in the history of international (global) health, a new type of an instrument whose time had finally come to tackle global issues which national governments find hard or impossible to fight alone.”

The negotiations took 2.5 years: the first INB session was convened in October 2000 and the sixth session ended on 1 March 2003.

A public hearing on issues related to the proposed framework convention was held immediately before the first INB session. Over 160 organizations representing various stakeholders in tobacco control, including the public health community and most of the major tobacco multinational and state-owned tobacco companies, provided written and oral testimonies, which were made available to the INB participants and to the general public (22).

Different agendas, opposing perspectives: Quotes from the public hearing

A. Abrunhosa, (Chief Executive, International Tobacco Growers' Association): "…tobacco growing regions have a higher density of private and public services, namely in health, education, trade and banking…benefitting the whole society... A sudden and enforced decrease in tobacco production would mean an immediate increase in unemployment and… sudden poverty."

Litha Musyimi-Ogana, (African Centre for Empowerment, Gender and Advocacy, Kenya): "I come from a tobacco growing community in Mbeere District in Kenya. In the past, I can recall seeing in every homestead dwellings, a livestock shed and a granary for storing agricultural produce for domestic consumption. But all that has changed with the introduction of tobacco as a cash crop… Tobacco, the cash crop, has replaced the food crops and livestock and threatens the food security of every family. Yet tobacco is not yielding enough money for these people to buy food for subsistence and viable livelihoods... Governments, the United Nations and the WHO should listen to the farmers who have suffered under the hands of the tobacco industry."

British American Tobacco: "The WHO's proposed 'Framework Convention on Tobacco Control' is fundamentally flawed and will not achieve its objectives… The number of cultural, sectoral and geographic interests with a stake in the future of tobacco is very diverse. Consequently an agreed set of (nonregulatory) principles, freed from the constraints of the binding format proposed by the WHO, represents the only workable basis for the worldwide development of policies… British American Tobacco's framework would... leave national governments free to develop the most appropriate policies for the specific circumstances of their country [and] put in place the necessary checks and balances to ensure tobacco companies are accountable for their actions."

Consumers Association of Bangladesh: "As elsewhere in the world, many of the issues Bangladesh faces in tobacco control are international ones. These include transmission of tobacco ads through satellite television stations originating abroad, and the huge business of smuggling cigarettes. Bangladesh alone cannot act effectively on either of these issues. For these reasons, our organization strongly supports a comprehensive convention on tobacco control that will address transnational issues, while also giving governments guidelines and concrete goals for action on domestic issues. The Framework Convention on Tobacco Control (FCTC) could help our nation to address transnational issues, while strengthening local efforts."

Between the INB sessions, intersessional consultations were convened in most regions and subregions (23). For example, the WHO Regional Office for Europe organized a ministerial conference in February 2002 in Warsaw, Poland, during which governments expressed strong political support for the framework convention (24). During the INB sessions, regional and subregional technical briefings and meetings were held, which became opportunities for capacity-building and for strengthening networks.

Regional groups: reaching consensus and influencing policies

Dr Srinath Reddy (India): "The WHO regional meetings, preceding and during the INB sessions, were very helpful in developing and consolidating consensus and agreed positions, on major issues and even specific wording, among countries of each WHO region. Such regional consensus greatly facilitated the speeding up of the development and adoption of the FCTC, especially through INB4 to INB6."

Dr Douglas Bettcher (TFI Director, former WHO FCTC coordinator): "The tradition of informing different sectors and creating a space for different sectors to meet for the first time to focus on tobacco control was advanced throughout the negotiations by convening sequential intersessional meetings to prepare countries to move on to the next round of negotiations, and to arrive at common negotiating positions. These meetings were successful to a certain extent but a lesson learned is that if the negotiating positions of different groups become entrenched this approach may slow down negotiation; in this case building negotiating bridges across regions with similar positions is effective."

As it was essential to engage and ensure the strong participation of other ministries, including those for foreign affairs and finance, and because of the complex and sometimes contentious nature of the negotiations, it was imperative that the chairs be experienced in international multilateral negotiations. Therefore, from the first INB session up to the second session of the Conference of Parties, all the chairs have been ambassadors. In international treaty negotiations, it is also important to bridge opposing goals and negotiating positions effectively. Some of the major tobacco-producing countries were initially strongly opposed to the convention; however, Brazil was both a major tobacco producer and also a world leader in tobacco control. Brazil's chairmanship of the negotiations thus helped to create a political bridge between countries that were tobacco producers and those that were not, and illustrated that tobacco growing and production and controlling tobacco use were compatible in the context of negotiation of the treaty. This was an important lesson, which might be used to facilitate other complex public health negotiations in the future.

At the first INB session (Geneva, 16–21 October 2000) (25), Celso Amorim, Brazil's Permanent Representative to the United Nations, an experienced international diplomat, was elected Chair. A bureau comprised of vice-chairs from Australia, India, the Islamic Republic of Iran, South Africa, Turkey and the United States was likewise established. During this initial session, the INB accepted the provisional texts of the proposed draft elements for the framework convention prepared by the technical working group as a basis for initiating negotiations. In addition, Ambassador C. Amorim prepared a Chair's text; his first draft was released in January 2001 as a basis for further negotiations at the second session.

Insights from the Chair: Achieving balance on a contentious topic

Ambassador Celso Amorim (Brazil; Chair of the INB, 2000-2002)

"When I was chairing the first three sessions of the Intergovernmental Negotiating Body, the main challenge was to conduct an appropriate and balanced response to a rather thorny question. We needed a text that could bring countries together and, most importantly, be ratified by them afterwards. Otherwise the credibility of the World Health Organization itself could be in jeopardy.

"The starting-point was the common will to impose limits to the consumption of tobacco. The goal was reducing the number of deaths and diseases related to it by means of a common international effort. When negotiations started, tobacco consumption was responsible for around 4 million deaths per year worldwide. The promotion of health policies, however, affected concrete interests of the tobacco industry.

"It was then necessary to come up with a realistic proposal, capable of reconciling distinct perspectives and interests. With hindsight, I believe we moved forward beyond expectations. We were able to strike a deal that many people found extremely difficult to achieve.

"And if we see today the extraordinary number of ratifications of the treaty, in all regions of the world, it is self-evident that the whole exercise was highly successful. An international treaty with almost 160 States Parties, just five years after its adoption, must reasonably be a balanced one."

Courtesy of Ambassador C. Amorim

Ambassador C. Amorim also presided over the second and third INB sessions. At the second session (Geneva, 30 April–5 May 2001) (26), three working groups divided the responsibility for further delineating proposed draft elements of the framework convention. Despite the tedious, contentious and often confusing method of work, with multiple levels of bracketed text, the groups produced three co-chairs' working papers, merging the Chair's text with the textual proposals made at the session. These working papers became the rolling draft text of the framework convention. At the third INB session (Geneva, 22–28 November 2001) (27), the working groups prepared revised texts for use in the negotiations at the fourth session. To keep the process moving, Ambassador C. Amorim wisely repeatedly reassured Member States, many represented by public health professionals inexperienced in international negotiations, that "Nothing is agreed until everything is agreed" (D. Yach, personal communication, 2008).

Between the third and fourth sessions, Luiz Felipe de Seixas Corrêa, another experienced diplomat and negotiator, replaced Mr Amorim as Permanent Representative of Brazil to the United Nations, and the INB elected Mr de Seixas Corrêa as its Chair during its fourth session (Geneva, 18–23 March 2002) (28). He began work on a new Chair's text, which was released in July 2002 and served as the basis for negotiations during the fifth INB session (14–25 October 2002) (29). In the interim, the United States hosted an international technical conference on illicit trade in tobacco products at the United Nations headquarters in New York on 30 July–1 August 2002.

INB sessions

INB sessions

Because of the active participation of Member States during the first four INB sessions, a variety of textual alternatives were available at the onset of the fifth INB. Frequently working into the early morning hours, participants at the fifth session narrowed the options to focus the negotiations. At the first reading of the new Chair's text in plenary, six priorities were identified, which were discussed by open-ended, informal drafting groups: advertising, promotion and sponsorship; financial resources; illicit trade in tobacco products; liability and compensation; packaging and labelling; and trade and health. Other informal drafting groups dealt with legal, institutional and procedural issues and the use of terms. Through strategic diplomacy and careful deliberation, the negotiations progressed and consensus was reached in several areas. On the basis of the outputs of the informal sessions and intersessional consultations with various delegations and groups of delegations, Ambassador de Seixas Corrêa issued a revised Chair's text of a framework convention on tobacco control on 15 January 2003 (30).

Insights from the Chair: Consensus through a common commitment to health

Ambassador Luiz Felipe de Seixas Corrêa (Brazil; Chair of the INB, 2002-2003)

"The negotiation of the FCTC was carried out on the basis of consensus: a major global undertaking designed to set new standards for public health in an area involving major private and public interests not necessarily convergent—and in many cases strongly divergent—with the overall objectives of the negotiation. It has been a long, arduous and sometimes very conflicting process. Success was achieved at the end because the key players—despite their differences—remained committed throughout the whole process to the core objectives of the negotiation. This is indeed remarkable! The FCTC process succeeded while many other global negotiations in key areas (trade, environment, etc.) are failing. This shows that public health is a domain where one can eventually keep all the players committed because, in the last analysis it deals with lofty common ideals and objectives. In other global questions, unilateral economic, political, financial and security interests tend to prevail and often prevent consensus building."

The sixth and final INB session ran from 17 to 28 February 2003 (31). The negotiations were intense, emotional and occasionally contentious. Informal drafting groups tackled the issues of advertising, promotion and sponsorship and financial resources. The 'reservations clause' was the last part of the framework convention to be negotiated. Delegations from developing countries, which were in the majority in the body, remained undeterred by arguments from some countries to allow a reservations clause in the treaty. Such a clause would have allowed countries to ratify the convention but to select to be bound only by specific provisions. The decision not to allow reservations to the treaty distinguishes the WHO FCTC from most other global treaties.

After much hard work, ending at 04:00 on the final day of the session, the concluding plenary meeting agreed to transmit the text (32) to the Fifty-sixth World Health Assembly, and requested the Chair to draft a resolution recommending adoption by the Health Assembly. The INB also agreed to postpone the discussion on protocols until the Health Assembly.

A hard day's night: Standing firm for what we believe in

Ms Kathy Mulvey (former Executive Director, INFACT, now Corporate Accountability International))

"The event that stands out most for me is the 6th and final round of negotiations on the treaty. For most of those two weeks, it did not appear that consensus could be reached on a strong FCTC. But most countries stood firm for measures like a comprehensive ban on tobacco advertising, promotion and sponsorship, and held out for no reservations.

"I will always remember the final plenary, early on the morning of March 1, 2003, when the final FCTC text was sent to the World Health Assembly for adoption. Delegates were bleary-eyed with fatigue from two relentless weeks of negotiations. It would have been easy for them to sit quietly as the Chair gaveled the session to a close. Instead, many raised their boards and gave some of the most inspired and inspiring speeches I have ever heard. I felt proud to have contributed to a treaty that will save millions of lives and ultimately free the world from dependence on this deadly business."

Thus, just 4 years after resolution WHA52.18 called for work on the framework convention to begin, the INB completed its mission and delivered a final draft to the Health Assembly.

INB6 final plenary

INB6 final plenary

INB6 final plenary

In May 2003, Dr Jean Larivière was once again a delegate to the Health Assembly. As Chairman of Committee A, he had the distinct pleasure and privilege of lowering the gavel on a consensus decision by the Committee to support the framework convention as submitted by the INB. The next day, 21 May 2003, the Fifty-sixth World Health Assembly unanimously adopted the WHO Framework Convention on Tobacco Control (33). Eight years after pioneering efforts to persuade WHO to initiate work on an international regulatory approach to tobacco control, WHO had embarked on its first global public health treaty.

Adoption by the 56th World Health Assembly

Commitment and courage: The power of the process

The years of preparation and negotiation of the WHO FCTC were seminal years for WHO and its government and private sector partners. The engagement and negotiations were transforming, nurturing a sense of ownership of tobacco control that in many cases translated into early actions at national and local levels.

This commitment was most evident in the surprising number of national legislative and policy initiatives consistent with the Framework Convention that were adopted even before it entered into force. The negotiations appeared to have stimulated countries to take definitive action against tobacco use. Governments began issuing laws and policies that reflected the effective tobacco control interventions espoused by the Framework Convention, even before their formal commitment to the treaty.

Examples of national and subnational tobacco control policies developed in parallel with negotiations

Brazil: In December 2000, Brazil enacted a national law prohibiting print and broadcast advertising on tobacco products, restricting point-of-sale advertising and prohibiting sponsorship. In 2002, Brazil began providing free support for smoking cessation, including both pharmaceutical products and cognitive behavioural therapy (34).

Canada: In 2000, Canada pioneered legislation that requires multiple, strong, large, pictorial, rotated warnings on the top 50% of the front and back of cigarette packages. In 2002, legislation in the Province of Saskatchewan came into force, prohibiting the visible display of tobacco product packages in any store to which minors have access. The Province of Manitoba adopted similar legislation in 2004 (34).

Egypt: In 2002, the 1981 anti-smoking law was amended to include: (i) a stipulation that cigarette pack health warnings must occupy one third of the front face of the cigarette pack; (ii) a prohibition on advertising or promoting cigarettes and other tobacco products in newspapers, magazines, fixed or motion pictures (i.e. for commercial rather than artistic purposes), radio, television or any other means; (iii) a prohibition on the distribution of cigarettes or any other tobacco products in competitions as prizes or free gifts; and (iv) a prohibition on the sale of tobacco products to persons under the age of 18.

Norway: On 8 April 2003, the Norwegian Parliament enacted a complete ban on smoking in restaurants, cafes, bars, pubs, discotheques and other hospitality businesses that serve food or drinks for consumption on the premises. For the first time in the world, a country legislated a national ban on smoking in bars (34).

Republic of Korea: The Republic of Korea increased its tobacco taxes in 2002 and earmarked 3% of the tax revenues (amounting to about US$ 17 million per year) to the Health Promotion Development Centre within the Korean Institute for Health and Social Affairs. Funds are used for health promotion activities and health insurance (35).

South Africa: In 1999, the South African Parliament strengthened the 1993 legislation, effective in 2001, prohibiting all tobacco advertising, promotion and sponsorship, and banned free distribution of tobacco products and awards or prizes to induce the purchase of tobacco (34).

Thailand: The Thai Health Foundation Act of 2001 created the Thai Health Foundation, funded from earmarked revenues from tobacco excise taxes, to support the country's health promotion and tobacco control activities and networks (36).

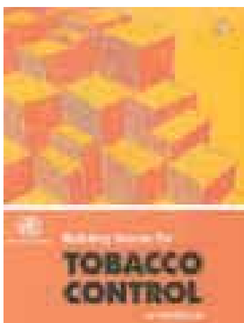
Negotiating the WHO FCTC raised the political profile of tobacco as a global public health problem, improved awareness of the issues and effective interventions among policy-makers, and resulted in an agreed global agenda for action. Lunchtime briefing seminars and technical meetings, interactions and discussions occurring in the corridors with experts and advocates and statements delivered in plenary transformed the negotiations into a 'tobacco control open university'. The negotiations presented a continuous opportunity for capacity-building for the tobacco control and public health community.

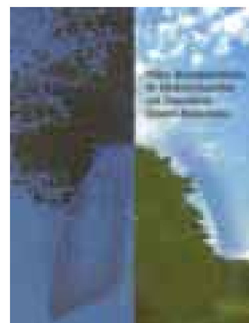
A powerful process: Catalysing legislative action within countries

Dr Fatimah El Awa (TFI Regional Adviser, Eastern Mediterranean Regional Office): "The FCTC process was very powerful; it paved the way for legislative changes that were mere reflection of the intensively diverse discussions which took place in the negotiations' meeting rooms. Some major successes were achieved, namely, the total ban of advertising, promotion and sponsorship in both Egypt and Qatar in the year 2002."

Dr Armando Peruga (former TFI Regional Adviser, Pan American Health Organization): "An event that stuck in my mind was when then WHO Director-General Dr Lee congratulated Ireland after they passed their smoke-free law. Dr Lee said that if Ireland could ban smoking in pubs and bars, any country could do it. That was a humorous moment, but a significant one because it pointed out the practical impact that the FCTC was already having."

WHO used the opportunity to organize and support capacity-building initiatives at regional and country level, in parallel with workshops to raise awareness about the treaty. This two-pronged approach laid the foundation for effective implementation of the Framework Convention's provisions at national level, while mobilizing support for ratification of the treaty. WHO also provided several capacity-building guides, such as the publication *Building blocks for tobacco control: a handbook* (37), and policy recommendations for issues such as cessation (38) and smoke-free public places (39). Thus, even in its initial stages, the Framework Convention reverberated beyond the global stage, to bolster tobacco control capacity within countries.





Negotiation of the framework convention and capacity-building

Mr Akinbode Oluwafemi (INFACT): "Before the FCTC, tobacco companies were having a field day in Africa. There were no organized resistance to advertisement sponsorships and promotion activities of the tobacco companies. The consequence was rising tobacco consumption and its health, social and economic costs. The FCTC created the forum for interaction between developing countries' NGOs and their counterparts from developed countries. It was a capacity building process not only for government delegates from the developing countries but also the NGOs. With the exposure to international tobacco control measures, developing countries' NGOs began to make definite public health demands on their governments. In Nigeria for instance, we began to ask for comprehensive advertisement ban and we got some results even before the entry into force of the treaty. Pockets of success were recorded in several African countries in the form of advertisement restrictions, tobacco free public places."

Mr Ross Hammond (Framework Convention Alliance): "The process of negotiations itself was significant in that many delegations got a crash-course in best-practice in tobacco control. They also got to interact with civil society in a much more relaxed and informal setting than if they had been meeting nongovernmental organizations at home. Those relationships extended beyond the negotiations process."

For many developing countries, the negotiations for the Framework Convention was a symbolic vehicle for redressing social injustice in public health. Increasingly, the burden of disease due to tobacco use is shifting to the developing world; these countries therefore seized the opportunity to negotiate a convention that contained the elements that would protect them from further ill health. The negotiations gave these countries the power to 'speak with a strong voice' in the global arena. African countries, islands in the Western Pacific, the WHO Eastern Mediterranean and South-East Asia regions formed alliances that could negotiate and vote as units, an approach which proved extremely effective. WHO and the South African Ministry of Health hosted a regional intersessional meeting in March 2001, at which the Member States in the African Region agreed to negotiate the rest of the treaty en bloc. The European Regional Office, in cooperation with host countries, facilitated coordination into subregional groups and held a Region-wide coordination meeting before the last round of negotiations in early 2003.

One region, many countries, one voice

Ms Patricia Lambert (South Africa)

"As the chief negotiator for the South African Government, I suggested to the African group at one of its early-morning regional meetings in Geneva that an intersessional meeting after INB1 and before INB2, during which we could focus exclusively on how a possible international treaty for tobacco control might affect Africa, should take place. There was general agreement in the room so I approached the South African Minister of Health, Dr Manto Tshabalala-Msimang, to host such an event. She agreed and the Tobacco Free Initiative of the WHO provided the funding. During our first intersessional meeting in Johannesburg in March 2001, the African negotiators were able to find so much common ground that we took a decision, moving forward, to negotiate with a single voice. To the best of my knowledge, this is the first time that a bloc of countries, especially an African bloc of countries, has negotiated an international treaty with the interests of a continent in mind rather the narrower interests of individual countries. I believe that in reaching this decision, the African group turned the tide in the negotiations in an important new direction. Together, we spoke up for the highest standard of tobacco control and we maintained that stance until negotiations were concluded."

Many poorer, less developed and smaller countries, often overlooked and overpowered in other international venues, saw equity accorded to them by the 'one country, one vote' policy of the treaty negotiations. At least one WHO regional office, that for the Western Pacific, built its regional mobilization strategy around the 'one country, one vote' policy to ensure early ratification by its Member States; It remains the first and only Region to attain 100% ratification of the Framework Convention by its Member States (S. Tamplin, personal communication, 2008).

Empowerment by the negotiations

Dr Caleb Otto (Palau)

"I remember thinking of how geographically, economically and politically insignificant we were, as Pacific islands, in these negotiations, while I was sitting between the ambassadors of two other large countries, both advocating for 'trade over health'. But one statement kept running through my mind: 'Who are these men … ambassadors, powerful politicians, corporate presidents, government officials, etc. Who are these men, that they should have so much power over the lives of our people?' So when these ambassadors argued for 'trade over health', I and other like-minded participants spoke for 'people over profit'. In the end, our position won out. The rest is history. This scene will stay with me always to encourage me to be fearless and to speak up even when powerful people try to make things tough."

Dr Mary Assunta (Framework Convention Alliance): "Size did not matter in the negotiations and the active participation of small countries did make a difference in getting a better Convention."

Strength in partnerships and multisectoral engagement were positive themes that emerged from the meetings of the INB. Engagement within countries, across sectors, across country delegations and between official government delegations and civil society participants gave rise to diverse opportunities for exchanging ideas, viewpoints and insights. Subregional and regional alliances proved effective in achieving the goals of the negotiations, despite occasionally delaying them.

Multisectoral engagement

Mr David Hohman (United States)

"In the INB we saw a number of countries take regional or subregional positions in a manner new to WHO negotiations. That new mode of operating has carried over to other WHO negotiations since the FCTC. On the negotiation process, I believe the most important lesson we learned was that we couldn't make progress until the full range of interested government agencies—foreign affairs, finance, commerce, trade and justice, for example—were represented on delegations. In a treaty process as broad as the FCTC, health ministries alone were not adequate."

Active involvement of several nongovernmental organizations working for tobacco control was an important factor in the process.

Partnerships with civil society

Mr Laurent Huber (Framework Convention Alliance)

"The FCTC served as a platform to unite civil society globally and in some cases regionally. It also linked government representatives with tobacco control experts from around the world, leading to a stronger FCTC and eventually positive policy changes at the national level."

The negotiations for the Framework Convention gave rise to the Framework Convention Alliance, a global network of nongovernmental organizations working on various aspects of tobacco control. The Alliance was one of the principal non-State participants to the process, promoting the important role of civil society in policy-making. Using a variety of strategies, the Alliance worked for a more equitable treaty. The Alliance set up the 'death clock' so that it could be seen by all participants during plenary sessions. It ticked on mercilessly, reminding the official delegates of the price being paid in human lives from tobacco use. The Alliance also published a daily newsletter, gave out 'Orchid' and 'Dirty Ashtray' awards during the negotiations and used media advocacy to support the process (40).

The work of nongovernmental organizations illustrated the complementary roles of civil society and the public sector in treaty negotiation. This role was recognized officially when Member States incorporated Article 4, Guiding principles, No. 7, into the text of the WHO FCTC, which reads, "The participation of civil society is essential in achieving the objective of the Convention and its protocols." (41). In some cases, relationships established at the INB sessions continued back home, with local nongovernmental organizations and their government counterparts complementing each other's work at national level.

Death Clock

Press conferences and media briefings were held throughout the negotiations, resulting in frequent, widespread coverage of the tobacco epidemic and the treaty. The world could no longer turn a blind eye to the tobacco epidemic.

For many participants, reviewing the evidence and deciding on and expressing their negotiation positions also resulted in a personal transformation. This was especially true for participants from outside the health sector, who, before their involvement in the negotiations, had had little to do with tobacco control. Internalization of the values and knowledge absorbed from engaging in discussions on tobacco control had profound repercussions on these individuals' personal and professional lives. Reaffirmation of the importance of situating health over profit or trade, the inevitability of stewardship for protecting future generations from the harm of tobacco, and the importance of personally giving up tobacco use were some of the issues that affected several participants individually. These persons returned to their countries at the end of the negotiations with greater personal commitment to tobacco control, and some have since emerged as tobacco control champions in their own spheres.

The reaction of the tobacco industry to the negotiations for the Framework Convention was predictably negative. Sometime between 1999 and 2001, British American Tobacco, Philip Morris and Japan Tobacco International set up Project Cerberus, a voluntary regulatory scheme for the tobacco industry, as an alternative to the Framework Convention (42). The aim of the Project was to institute a voluntary regulatory code of practice to be overseen by an independent audit body, focusing primarily on preventing smoking among young people. While this move failed to derail the negotiations for the Framework Convention, the industry continues to promote its 'international tobacco products marketing standard' and its 'youth prevention programmes', despite evidence of their ineffectiveness in curbing tobacco use. The investigation commissioned by Dr Brundtland in 1999 to assess tobacco industry interference in United Nations tobacco control efforts resulted in a detailed report (18), which documents the industry's many attempts to prevent, delay and weaken WHO tobacco control activities. As a result, WHO has reinforced its policies, to ensure that its staff and consultants have no ties with the tobacco industry. The need to maintain a strict firewall between the tobacco industry and the negotiations provides an important lesson for the implementation phase of the treaty (D. Bettcher, personal communication, 2008). In this context, the agreement at the third session of the Conference of the Parties on guidelines for implementation of Article 5.3, which calls on Parties to the Convention to protect tobacco control policies from commercial and other vested interests of the tobacco industry (43), was critical.

Conferring legitimacy on the framework convention: signature and entry into force

The Framework Convention was opened for signature from 16 to 22 June 2003, at WHO headquarters in Geneva, and thereafter at United Nations headquarters in New York City, from 30 June 2003 to 29 June 2004. Signing the treaty was a political act that indicated the agreement of a Member State to ratify it and its commitment not to oppose implementation of the provisions of the treaty by other States. On the first day, 28 Member States and the European Union signed the treaty, and Norway handed over its instrument of ratification to the United Nations depositary secretariat on the same day as part of the ceremony. Children accompanied each of the official representatives from Member States that signed the treaty, signifying the stewardship role of these countries in ensuring a healthy, tobacco-free world for future generations. When the treaty was closed for signature on 29 June 2004, it had 168 signatories, which makes it one of the most widely embraced treaties in United Nations history.

WHO Headquarters, Geneva, 2003

Depending on country procedures, the Framework Convention required ratification, acceptance, approval, formal confirmation or accession by at least 40 Member States in order to enter into force. Regional workshops convened by the interim secretariat of the convention provided technical assistance for ratification to Member States that requested it. On 29 November 2004, the fortieth instrument of ratification, acceptance, approval, formal confirmation or accession was deposited at United Nations headquarters. Ninety days later, on 27 February 2005, the WHO FCTC entered into force.

Ceremony marking the entry into force of the Convention, Geneva, 2005

Fewer than 6 years had passed between World Health Assembly Resolution WHA52.18 (1), which called for a start to work on a framework convention, and its entry into force. Indeed, the WHO FCTC is among the fastest treaties to be negotiated, adopted and entered into force in the history of treaty-making. The conclusion of negotiations, the unanimous adoption of the convention by the World Health Assembly, its acceptance by signature and its rapid entry into force make the WHO FCTC a landmark for the future of global public health.

The first 40 countries to become Parties to the WHO FCTC

1 Norway
2 Malta
3 Fiji
4 Sri Lanka
5 Seychelles
6 Mongolia
7 New Zealand
8 India
9 Palau
10 Hungary
11 Myanmar
12 Slovakia
13 Cook Islands
14 Singapore
15 Mauritius
16 Maldives
17 Mexico
18 Brunei Darussalam
19 Japan
20 Bangladesh
21 Iceland
22 Kenya
23 Nauru
24 San Marino
25 Qatar
26 Solomon Islands
27 Panama
28 Jordan
29 Trinidad and Tobago
30 Bhutan
31 Uruguay
32 Madagascar
33 France
34 Australia
35 Pakistan
36 Thailand
37 Syrian Arab Republic
38 Canada
39 Ghana
40 Armenia

The WHO FCTC

The WHO FCTC is the first treaty negotiated under the auspices of WHO. It is an evidence-based treaty that reaffirms the right of all people to the highest standard of health and is the first regulatory strategy to address addictive substances. Unlike previous drug control treaties, the Convention emphasizes the importance of balancing demand reduction strategies with supply strategies.

The core provisions for demand reduction are contained in Articles 6–14, which address both price and tax measures and non-price measures to reduce the demand for tobacco. The latter are:

- protection from exposure to tobacco smoke;
- regulation of the contents of tobacco products;
- regulation of tobacco product disclosures;
- packaging and labelling of tobacco products;
- education, communication, training and public awareness;
- tobacco advertising, promotion and sponsorship; and,
- measures to reduce tobacco dependence and to assist cessation.

The core provisions for reducing supply are contained in Articles 15–17 and cover:

- illicit trade in tobacco products;
- sales to and by minors; and
- support for economically viable alternative activities.

The Framework Convention also covers other important areas, such as liability; protection of public health policies with respect to tobacco control from interests of the tobacco industry; protection of the environment; national coordinating mechanism; international cooperation, reporting and exchange of information and institutional arrangements (Articles 5 and 18–26).

Continuing the momentum: Conference of the Parties and national implementation

Tobacco control is a marathon effort in public health, and the entry into force of the WHO FCTC is just one milestone in a long, ongoing struggle to address the tobacco epidemic effectively. As the WHO FCTC enters into its next phase, the challenge is ensuring that obligations and commitments under the treaty are successfully translated into effective national and community action. Just as the INB played a pivotal role during the negotiations, in the next phase it is the Conference of the Parties that is the main actor.

To prepare the first session of the Conference of the Parties, two sessions were held by the Intergovernmental Working Group (44), which was created by WHA56.1 (33), the same resolution in which the WHO FCTC was adopted during the Fifty-sixth World Health Assembly. This resolution also maintained the interim secretariat within WHO. Ambassador L.F de Seixas Corrêa was requested by Member States to continue his role as chair. The Working Group outlined the procedures necessary for implementation of the treaty and delivered its report at the first session of the Conference of the Parties (45).

The Conference of the Parties comprises all Parties to the WHO FCTC. In accordance with Article 23 of the Convention, the Conference of the Parties "shall keep under regular review the implementation of the Convention and take the decisions necessary to promote its effective implementation and may adopt protocols, annexes and amendments to the Convention". The Conference of the Parties also establishes the criteria for the participation of observers in its proceedings. Members of the Bureau of the Conference of the Parties are elected at each regular session. The Bureau has six members, with one representative from each WHO region. The Conference elects its President from among the members of the Bureau.

The first session of the Conference of the Parties was held in Geneva on 6–17 February 2006, under the chairmanship of Ambassador J. Martabit (Chile). During this session (46), the Rules of Procedure and Financial Rules for the Conference of the Parties were adopted. In addition, the Conference adopted the budget and workplan for the period 2006–2007, financed from voluntary assessed contributions from Parties.

Ambassador Juan Martabit (Chile, first President of the Conference of the Parties, 2006–2007)

"The joint effort of diplomats, experts in public health, international organizations such as in particular the World Health Organization and of the Secretariat of the Convention, as well as the broad sectors of civil society, shows that they are able—if they really want—to achieve great shared objectives. This method to confront problems could also be applied as a way to resolve other serious problems of the world. This Framework Convention is a very good example of an intelligent and realistic effort."

A number of other substantive decisions were made by the Conference of the Parties at its first session, such as that to initiate possible protocols on cross-border advertising, promotion and sponsorship (Article 13.8) and on illicit trade in tobacco products (Article 15). It also decided to initiate the elaboration of guidelines on Article 8 (Protection from exposure to tobacco smoke) and Article 9 (Regulation of the contents of tobacco products) of the Convention. A reporting instrument was adopted for provisional use by Parties to assist them in meeting their obligations under Article 21 of the Convention.

The Conference of the Parties also decided that a permanent secretariat, the Convention Secretariat, should be established within WHO in Geneva. Pursuant to that decision, the Convention Secretariat was created in May 2006, in accordance with resolution WHA59.17 (47), establishing the "permanent secretariat of the Convention within the World Health Organization and located in Geneva. The head of the Convention Secretariat was recruited according to the procedure outlined in decision FCTC/COP1(10) (48). On 1 June 2007, the Director-General announced the appointment of Dr Haik Nikogosian to the position. The head of the Convention Secretariat is "responsible and accountable to the Conference of the Parties for the delivery of treaty and technical activities" and to the Director-General of WHO "on administrative and staff management matters and also on technical activities where appropriate".

By the end of the session, the Convention had entered into force for 113 Parties. The Conference also elected its first Bureau, comprising Ambassador J. Martabit (Chile), the President of the Conference of the Parties, and Ms D. Mafubelu (South Africa), Mr R. Bayat Mokhtari (Islamic Republic of Iran), Dr C. Lassmann (Austria), Dr Hatai Chitanondh (Thailand) and Ambassador Sha Zukang (China) as Vice-Presidents.

One of the fastest treaties to come into force

Dr Katharina Kummer Peiry (former external senior legal advisor to WHO)

"One unique aspect of the WHO FCTC was the short time span within which the negotiations went from a fairly chaotic process of statement and restatement of positions and proposals to forging a comprehensive and structured text, followed by the rapid entry into force of the Convention, and the speed of its development since then."

First session of the Conference of the Parties

Establishment of the permanent secretariat

Dr Haik Nikogosian (Head of the Convention Secretariat)

"When I voted for the start of treaty negotiations, as Health Minister of Armenia at the 1999 World Health Assembly, I never expected I would be the first head of the Secretariat years after. What I did not also expect was that the absolute majority of governments who voted on the same day would be Parties to the Convention in less than 10 years from that time.

"Obviously, there are special expectations from the first secretariat to the first treaty in WHO's history. Much needs to be analysed, developed, established and demonstrated. It was with this sense of responsibility—for the treaty and for a new legal dimension in international health—that the Convention Secretariat commenced its work in the summer of 2007."

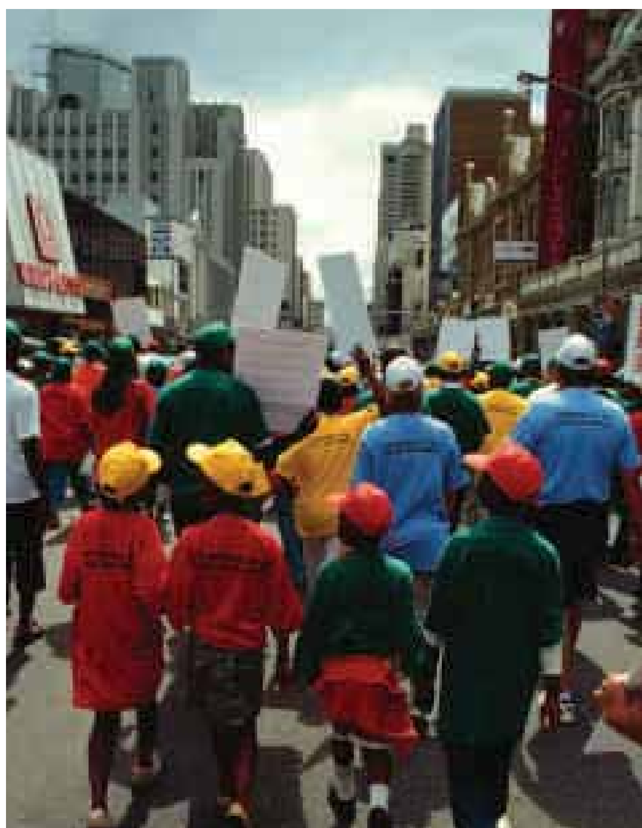
The second session of the Conference of the Parties was convened between 30 June and 6 July 2007 under the extended mandate of Ambassador J. Martabit (Chile) in Bangkok, Thailand (49). The meeting made important strides forward in deciding how best to make the vision contained in the WHO FCTC a reality for countries. One notable decision established an INB to prepare the first protocol to the Convention, on illicit trade in tobacco products. The Conference also adopted guidelines for implementation of Article 8 of the WHO FCTC (Protection from exposure to tobacco smoke). It reviewed Articles 5.3, 9 and 10, 11, 12 and 13 and created procedures for preparing guidelines for their implementation. Other decisions included extending the mandate of the study group on economically sustainable alternatives to tobacco growing (Articles 17 and 18) and requesting a first report on tobacco dependence and cessation (Article 14). The Conference also adopted the budget and workplan for the period 2008–2009, adopted the instrument for the second phase of reporting arrangements under the Convention and agreed on a decision on financial resources and mechanisms of assistance to promote implementation of the Convention.

Second session of the Conference of the Parties: Ambassador J. Martabit (right), the first President of the Conference of the Parties and Dr H. Nikogosian, the first Head of the Convention Secretariat (left)

By the end of the session, there were 146 Parties to the Convention. The Conference elected the following officers to the Bureau for the third session: Dr Hatai Chitanondh (Thailand), President of the Conference of the Parties, and Dr A. Bloomfield (New Zealand), Ambassador C. Lassmann (Austria), Dr H.A. Qotba (Qatar), Ambassador A. Artucio (Uruguay) and Ms N. Dladla (South Africa) as Vice-Presidents.

The INB on a protocol on illicit trade in tobacco products met for the first time on 11–16 February 2008 and continued negotiations on the issue at its second meeting (20–25 October 2008).

The third session of the Conference of the Parties was convened in Durban, South Africa, 17–22 November 2008 (50), under the Presidency of Dr Hatai Chitanondh of Thailand. It was attended by more than 600 delegates from 130 Parties to the Convention as well as representatives of States non-Parties and other observers. During the session, the Parties to the Convention adopted guidelines for implementation of Article 5.3 (Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry), Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship). The Conference requested the working groups on Articles 9 and 10 (Regulation of the contents of tobacco products and of tobacco product disclosures) and Article 12 (Education, communication, training and public awareness) to submit draft guidelines for consideration by the Conference at its fourth session. Additional working groups were created for Article 14 (Demand reduction measures concerning tobacco dependence and cessation) and economically sustainable alternatives to tobacco growing (in relation to Articles 17 and 18 of the Convention).



Marking the opening of the third session of the Conference of the Parties: health walk, Durban, South Africa, 2008

The third session of the Conference of the Parties decided that its fourth session would be held in Uruguay in the last quarter of 2010 and elected Mr Thamsanqa Mseleku (South Africa) as President and Dr A.M. Al-Bedah (Saudi Arabia), Dr C. Otto (Palau), Professor S. Modasser Ali (Bangladesh), Mr C. Chocano (Peru) and Mr J.G.H. Draijer (Netherlands) as Vice-Presidents. The Bureau of the Conference of the Parties adopted 15–20 November 2010 as the dates of the fourth session of the Conference of the Parties (Punta del Este, Uruguay).

The third session of the Conference of the Parties also reviewed the progress in negotiations for the first protocol to the Convention, and mandated the INB to present a draft protocol for consideration by the next session of the Conference of the Parties. The third session of the INB was convened in Geneva, 28 June - 5 July 2009, and the fourth session is scheduled to take place in March 2010.

INB on a protocol on illicit trade in tobacco products

The future of the WHO FCTC: Health over trade

Dr Hatai Chitanondh (Thailand, President, Conference of the Parties, 2007–2008)

"My fight for the health-over-trade issue dated back to 1989. I was a delegate of Thailand to the Forty-second World Health Assembly and our group drew up a resolution advocating that trade sanctions should not be used to force a country to accept imported tobacco products. When our delegates went around explaining the issue, asking for support from delegates of other countries, our friends would not agree and said "We are here to discuss health, not trade". However I intervened in Committee A to address the issue. This was the first time WHO officially recognized the potential menace from trade on tobacco control. It remains a critical area that will require much attention from the Conference of the Parties."

Dr H. Chitanondh

Five years in force

The WHO FCTC marked substantial progress after its entry into force in February 2005:

- The principal treaty bodies, the Conference of the Parties and the Permanent Secretariat, were established and are fully functional.
- Several key tools for implementation, such as the first protocol and several guidelines covering more than 10 Articles of the Convention, have been adopted or are in an advanced stage of development.
- The treaty reporting system is established, and more than 80% of the reports expected from Parties have been received and analysed.
- Support to Parties in meeting their obligations is gradually being put in place by the dissemination of guidelines, convening of needs assessments, support in developing legislation, the transfer of expertise and facilitation of access to internationally available resources.

The absolute majority of States have now ratified the WHO FCTC, making it one of the most widely embraced treaties in the history of the United Nations. This has increased its appeal for partners, and several more international organizations have been accredited as observers to the Conference of the Parties, resulting in greater technical cooperation.

WHO FCTC and the future of public health

The Framework Convention represents a new approach to international health cooperation, with a legal framework to shape the future of health for all people. It provides a model for a powerful, effective global response to the negative effects of globalization on health with potentially other similar applications in public health.

Role of the treaty in promoting international action

Dr Margaret Chan (WHO Director-General)

"… the WHO FCTC is the first modern treaty to tackle an individual public health threat directly. The sheer power of being first, and of being so successful, has changed the way that we think about global public health, the tools that we have to combat multifaceted health problems, and the capacity that we have when the global community works together on health. Beyond the political impact of the WHO FCTC, I also believe that the treaty demonstrates very practically the need for concerted horizontal, multilateral action to solve difficult multisectoral health problems. This horizontalism needs to happen at local, national and international levels, with practitioners speaking to each other, Ministries working together, and countries sharing their expertise and experiences. The WHO FCTC provides a roadmap for that kind of work and serves at the same time as a living example of the success of this kind of joint action."

The WHO FCTC has given rise to noteworthy changes in public health, both in countries and within WHO. By necessity, the Convention brought together diverse ministries (some of which had never engaged closely with each other) and civil society to work on a single public health issue, under the auspices of WHO and later the Conference of the Parties. Thus, it led to the creation of mechanisms for multisectoral coordination, which were eventually carried over into tobacco control work in many countries. Within WHO, international treaty work, which had never previously been undertaken by the Organization, became an integral component of the work of the office of the Legal Counsel. For Member States, negotiation of the WHO FCTC showed that effective engagement and agreement are possible despite widely divergent views.

A model for other areas of public health

Dr Jawad Al-Lawati (Oman): "Public health is about saving people's lives and that is what the treaty does... In addition, it sets a precedent—that any risk factor can be regulated and public health can be actively protected."

Mr Steve Tamplin (former TFI Regional focal point, WHO Regional office for the Western Pacific): "The FCTC process has been the single most successful health promotion capacity building initiative ever undertaken by WHO. Among other things, it has required the health sector to substantially engage and work with other public sectors, the private sector and civil society. The success of the FCTC process can and should inform the development and use of effective mechanisms for resolving other complex, multi-sector public health problems."

Improving the way we work

Dr Abdullah M Al-Bedah (Saudi Arabia): "The FCTC process is a unique example of continuous education and capacity building in all aspects of tobacco control. No public health process has been as successful in bringing people from different sectors and interests under the leadership of the public health sector, and in accelerating global interest and action to control tobacco use."

Dr Bill Kean (WHO headquarters, former INB Secretary): "One major impact [of the WHO FCTC] not related to tobacco is that WHO Member States have more confidence in each other and are more able to listen to each other's perspectives. Subsequent intergovernmental processes [under WHO's auspices] demonstrated a heightened degree of respect and trust."

Mr Gian Luca Burci (Legal Counsel, WHO): "The negotiation and then the implementation of the FCTC made WHO fully appreciate, probably for the first time, the importance of international law and of treaties in particular, as a tool for the pursuit of crucial public health goals."

Dr Derek Yach (South Africa, former WHO Executive Director): "[The WHO FCTC] set the scene for WHO to take a more multisectoral and regulated approach to global health…. Tobacco became legitimized as a major global issue at a time when pressures were shrinking the scope of global health towards AIDS, malaria and TB. It opens the door to addressing chronic diseases."

Moving further with the WHO FCTC

For the next phase of the WHO FCTC, the focus is different, and many of the players are new. The legacy of the early days remains valuable, even as the urgency of the tobacco epidemic reminds us of the need for speedy, effective action at national and local levels. The Death Clock is truly inexorable. But today, the rules of the game have shifted. And, because we now have the WHO FCTC, the odds are no longer insurmountable.

Already, tangible benefits have accrued from the WHO FCTC. Numerous countries have passed or are renewing and strengthening national legislation and policies to conform to the evidence-based interventions set forth in the Framework Convention. Tobacco control is now acknowledged almost universally as a significant public health priority, and donor support is growing. The global tobacco control community has expanded, and tobacco control capacity continues to improve at various levels.

The global public health community cannot, however, relax its vigilance. The tobacco industry continues to thrive and continues to fuel the conflict between profit and health. Nicotine's addictiveness persists to enslave over one third of the world's adult population, and globalization continues to facilitate the spread of the tobacco epidemic through trade, travel and communication.

While the WHO FCTC represents a pivotal step in controlling the tobacco epidemic, it remains a tool. Its success, or failure, depends on how it is used by countries and how well it is explained and implemented at national and community level. The political theorist John Schaar said:

"The future is not a result of choices among alternative paths offered by the present, but a place that is created—created first in the mind and will, created next in activity. The future is not some place we are going to, but one we are creating. The paths are not to be found, but made, and the activity of making them, changes both the maker and the destination." (51)

The WHO FCTC represents a future that is being created by committed men and women who believe that all people deserve a healthy, tobacco-free world. These men and women have the vision and the courage to tackle a global health challenge with a powerful, innovative and radical experiment in global public health, one that has literally 'changed the rules' of tobacco control.

If there is one lesson to be learnt from the history of the WHO FCTC's early days, it is that the determinants of its success in tobacco control were the leadership, commitment, political will, integrity, vision and courage of the people, organizations and governments entrusted by their countries to turn the framework convention into reality. Now that the rules have changed, the commitment of all the players will make the difference.

Insights and lessons from the Framework Convention

Ambassador Luiz Felipe de Seixas Corrêa (Brazil): “The FCTC has provided a firm basis for individual States to set up and develop their own national policies for tobacco control. It has also put in place an efficient and increasingly effective platform for international cooperation. The public health sector of countries who are Parties to the Convention have been getting a formidable boost for their national activities. They are becoming stronger and more capable of controlling the forces that until recently prevented progress in tobacco control activities worldwide. As we proceed, these public health sectors will become more and more capable of setting up high standards and practices and, thus, able to influence overall political decisions in their respective countries.”

Dr Mary Assunta (Framework Convention Alliance): “We learnt it was important for civil society to galvanize efforts and present a united front as one voice. We also learnt that despite a highly bureaucratic process, and the many obstacles that came our way, it was possible for civil society to make an impact with some creativity, perseverance and persistence.”

Mr Akinbode Oluwafemi (INFACT): “Change is possible where there is will power, commitment and unrelenting pressure.”

Mr Burke Fishburn (formerly TFI adviser at the WHO Regional Office for the Western Pacific): “The FCTC process increased WHO’s credibility with Member States, mobilized major donors, and has become a model for other chronic disease issue initiatives.”

Dr Khalil Rahman (Regional Adviser, Tobacco Free Initiative, WHO South-East Asia Region): “In a cross-cutting and highly contentious issue like tobacco control, evidence-based information is not enough. Bold and decisive leadership at the highest levels is critical.”

Dr Judith Mackay (WHO-TFI Senior Policy Adviser): “The FCTC ‘kicked tobacco upstairs’ in all governments. No longer is tobacco an issue only for the Minister of Health, but it became a “whole of government” position, debated and considered at a much higher level.”

Mr Matti Rajala (European Union): “The importance of tobacco control as part of development and health policies in developing countries could be strengthened. Here as well FCTC can play an important role.”

Dr Eduardo Bianco (Uruguay): “The main lesson learned was that a group of intelligent people, committed, convinced of a cause, with leadership and supported by the scientific evidence really can influence health policies and perhaps ‘change the world’.”

Dr Patricia Lambert (South Africa): “…solidarity can be powerful force in international negotiations. Achieving solidarity takes patience, diplomacy, hard work and long hours, but it is worth it, especially for developing countries in the international arena.”

Ambassador Celso Amorim (Brazil): “The top priority today is to keep strengthening the instruments adopted multilaterally under the Framework Convention. Also, the Conference of the Parties needs to focus on how to make compliance mechanisms more effective.”

WHO FCTC timeline

Year	Month	Milestone
1993-1994		Initial conceptualization of an international legal approach to tobacco control
1994	October	A resolution is passed at the 9th World Conference on Tobacco or Health in Paris urging adoption of an international instrument for tobacco control.
1995	May	The World Health Assembly, in resolution WHA48.11 officially introduces the concept of an international strategy for tobacco control.
1996	May	The World Health Assembly, in resolution WHA49.17 requests the WHO Director-General to initiate preparation of a framework convention on tobacco control.
1998	May	Dr Gro Harlem Brundtland is elected WHO Director-General; she makes tobacco control one of her priorities.
	July	The WHO Tobacco Free Initiative (TFI) is created.
1999	May	The World Health Assembly, in resolution WHA52.18 calls for work on the framework convention to begin and establishes an intergovernmental negotiating body (INB) to draft and negotiate the convention and possible related protocols, and creates a technical working group open to all Member States to prepare for the INB.
	October	First meeting of the Technical Working Group convened.
2000	March	Second meeting of the Technical Working Group results in provisional texts of proposed draft elements for the framework convention.
	May	The World Health Assemby, in resolution WHA53.16 recognizes that the draft elements for a framework convention establish a sound basis for initiating negotiations and calls on the INB to commence negotiations.
	October	The public hearing on the framework convention is held.
		The first session of the INB is held, with Ambassador C. Amorim of Brazil as Chair. Work on the Chair’s text of the framework convention starts.
2001	January	The Chair’s text of the framework convention is released.
	March–May	Regional intersessional consultations are held in preparation for the second session of the INB.
	April–May	The second session of the INB produces the first partial draft of the framework convention.
	May	The World Health Assembly, in resolution WHA54.18 notes the findings of a committee of experts on tobacco industry documents and calls for transparency in tobacco control.
	September November	Regional intersessional consultations are held in preparation for the third session of the INB.
	November	The third session of the INB is held.
2002	February March	Regional intersessional consultations are held in preparation for the fourth session of the INB.
	March	The fourth session of the INB is held. Ambassador L.F. de Seixas Corrêa replaces Ambassador C. Amorim as the Chair, and a revised Chair’s text is produced.

Year	Month	Milestone
	July August	An international technical conference on illicit trade in tobacco products is organized by the United States Government in the United Nations headquarters in New York City.
	August September	Regional intersessional consultations are held in preparation for the fifth session of the INB.
	October	The fifth session of the INB is held.
2003	January	The revised Chair's text of the framework convention is released.
	February	The sixth session of the INB is held. The draft framework convention is transmitted to the Fifty-sixth World Health Assembly for adoption.
	21 May	**The Fifty-sixth World Health Assembly unanimously adopts the WHO Framework Convention on Tobacco Control.**
	16 June	The Framework Convention is opened for signature. On the first day, 28 Member States and the European Union sign the treaty.
2004	June	The Convention has 168 Signatories by the end of the signature period, on 29 june 2004. The first session of the Intergovernmental Working Group is held.
	29 November	The requirements for entry into forca of the Framework Convention are met with the deposit of the fortieth instrument of ratification, acceptance, approval, formal confirmation or accession.
2005	January February	The second session of the Intergovernmental Working Group is held.
	27 February	**The WHO Framework Convention on Tobacco Control enters into force**, 90 days after the deposit of the fortieth instrument of ratification, acceptance, approval, formal confirmation or accession.
2006	February	The first session of the Conference of the Parties is convened in Geneva.
	May	The Convention Secretariat is established by the Fifty-ninth World Health Assembly at the request of the Conference of the Parties.
2007	June	The first head of the Convention Secretariat is appointed.
	June July	The second session of the Conference of the Parties is convened in Bangkok, hosted by the Government of Thailand. The Conference, inter alia, opens negotiations for the first protocol to the Convention, on illicit trade in tobacco products.
2008	February	The INB holds its first session in Geneva, commencing negotiations for a protocol on illicit trade in tobacco products. The second session is held in October 2008.
	November	The third session of the Conference of the Parties is convened in Durban, hosted by the Government of South Africa.
2009	June July	The INB on a protocol on illicit trade in tobacco products conducts its third session in Geneva. Its fourth session is scheduled in March 2010.
2010	27 February	Fifth anniversary of the entry into force of the Convention.

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Personal stories from the treaty experience

Dr Kimmo Leppo (Finland)*:* "The night before the first IGWG there was a small informal working dinner at the home of the first secretary/attaché of the mission of Finland, with people from the secretariat and representatives of Member States. Brazil, as everybody knows, was one of the strongest advocates of the FCTC among the developing countries. The Brazilian delegate, Councillor Frederico S. Duque Estrada Meyer, used a beautiful phrase when we were talking about the significance of the whole FCTC. He said: 'Look, I think this has just become such a big thing politically. It is like abolition of slavery… now that the time is ripe, it must be done.' Diplomats and politicians are often so much better than us public health people in such allegories!"

Mr Neil Collishaw (former head of WHO's tobacco control programme)*:* "In 1996, after adoption of the FCTC resolution by the World Health Assembly, I found myself in the office of the Legal Counsel. I [was told] there would be no tobacco treaty because that was not how things were done at WHO. I folded my arms, smiled, looked heavenward and said words to this effect: 'But the World Health Assembly has spoken. And around here the World Health Assembly is supreme. We are duty-bound to carry out direction given to us by the World Health Assembly.' It was the beginning of a new era in the WHO Office of the Legal Counsel."

Ambassador Celso Amorim (Brazil)*:* "I think an interesting, personal fact about this is the impact of the WHO FCTC on my own quality of life. I used to be a pipe smoker. During the negotiations, I made the wise decision to quit this old bad habit. My wife was happy that my work as a diplomatic negotiator would bring such an amazing outcome and improve our well-being at home!"

Ambassador Luiz Felipe de Seixas Corrêa (Brazil)*:* "One colleague in particular, a heavy smoker from a country that seemed unsure about its commitment to the process, once tried to embarrass me in public by having me meet a delegation of officials from his country at the Delegates Lounge during a break in the negotiations. As I approached him, he was smoking. I politely asked him to extinguish his cigarette and I explained that I could not be seen in public talking to someone with a cigarette in his hands. He refused. I turned my back on him and went away. He extinguished his cigarette and invited me back to address the group. We then had a very productive discussion. Afterwards, every time we met he would say that nobody in the world—except me!—had ever forced him to do something against his will. We remained friends and I am convinced that this particular episode helped to develop in his perception the seriousness of my commitment to the ultimate goals of the FCTC."

Mr Seiji Morimoto (Japan)*:* "I was shocked by some posters presented by a nongovernmental organization at an entrance hall in the conference building when we were negotiating the FCTC. They showed brutal facts of negative effects on human body that may have been caused by smoking. Those facts tell us everything."

Ms Liu Guangyuan (China): "As Chair of the Regional Consultation during the Second Session of the Conference of the Parties, I knew it would be very challenging to reach consensus in a region as diversified as the Western Pacific. I approached the consultation process by assuring the Parties that they were free to express their own opinions, and that, as a body, we would discuss and see how much agreement we could reach. It worked. Listening and respecting the different views can actually build trust. In the end, the Western Pacific Parties regarded it as a breakthrough in the region's participation and cooperation at the COPs."

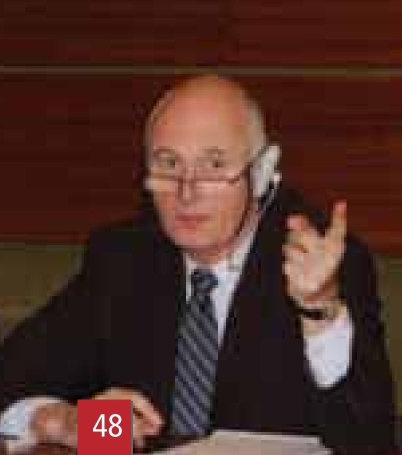
Ms Lizzie Tecson (WHO headquarters): "One historical event I remember clearly happened on the last day of the INB6. During the internal coordination meeting earlier that day, Dr Bettcher raised the possibility that the last session could continue past midnight because important issues remained unresolved in the negotiations. Everyone was really exhausted and tired, but, as anticipated, at the end of the evening session, the plenary body agreed to convene another session shortly before midnight. Our team was certain that few delegates would return to attend the midnight session, as they, too, were exhausted and most were catching their flights back home the next day. To our great surprise, as midnight approached, the Plenary Hall started filling up. By midnight, the plenary room was full. The delegates did not cease working until consensus was reached. I witnessed the commitment of each and everyone in that room... I saw the dedication of all these people to achieve a common goal for tobacco control. When the future generation reaps the benefits from the treaty, I can proudly say to my future grandchildren, that I was part of, and I contributed to the WHO FCTC process."

Dr Abdullah M Al-Bedah (Saudi Arabia): "Many things [about the WHO FCTC process] stand out but the most striking to me was when we stayed up late, working through the night of March 1st, to give the world the first public health treaty early morning of the next day, exactly like a pregnant mother delivering her first baby..."

Ambassador Juan Martabit (Chile): "It was very gratifying for me as a diplomat to have the opportunity to work in a specific way in order to find solutions for such sensitive issues that in the end have to do with the health of millions of people, as well as with the economies of very fragile countries or regions of the world, and also with companies and institutions that represent interests that differ from that pursued by the Convention".

Dr Haik Nikogosian (Head of the Convention Secretariat): "The history of the WHO Framework Convention on Tobacco Control deserved a solid publication, and that was in my plans since I was appointed. But it was Dr Hatai Chitanondh, the second President of the Conference of the Parties, who called me for a short meeting during coffee break in one of the working groups meetings and advised me to start such a process without any delay. I cannot forget that moment of inspiration which became decisive in developing this publication."

Moments of History



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Tobacco Control
Choose a healthy lifestyle

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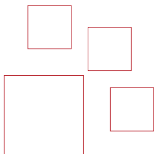

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