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GLOBAL PROGRESS REPORT
ON IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

FCTC

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2010 global progress report on the implementation of the WHO Framework Convention on Tobacco Control

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INTRODUCTION

This global progress report for 2010 has been prepared in accordance with the decision establishing reporting arrangements under the WHO Framework Convention on Tobacco Control (WHO FCTC) adopted by the Conference of the Parties at its first session (Geneva, 6–17 February 2006).[1] In that decision, the Conference of the Parties requested the Convention Secretariat to elaborate annual reports on global progress in the implementation of the Convention, based on regular implementation reports submitted by the Parties.

This report provides an overview of the status of implementation of the Convention globally, on the basis of the latest data provided by the Parties in their first (two-year) and second (five-year) implementation reports. For Parties that submitted both first and second reports, this report also tracks the progress made in the period between submissions of the two reports.

The Secretariat has produced three global progress reports to date. The first, prepared by the Interim Secretariat and submitted to the second session of the Conference of the Parties (Bangkok, Thailand, 30 June – 6 July 2007) analysed 28 reports that had been received by 27 February 2007.[2] The second, submitted to the Conference of the Parties at its third session (Durban, South Africa, 17–22 November 2008), analysed 81 reports that had been received by 15 July 2008.[3] The third, made available to Parties to the Convention in December 2009, referred to 117 two-year reports that had been received by 15 July 2009.[4]

Between 16 July 2009 and 30 June 2010 a further 18 **two-year reports** were received, bringing the total number of Parties reporting at least once to 135, i.e. 88% of the 153 expected by end of June 2010.

Sixty-one Parties for which the Convention entered into force before 30 June 2005 were also expected to submit their second (five-year) implementation reports by 30 June 2010. Almost half (30) of these Parties had submitted their reports by that date.

This report follows as closely as possible the structure of the Convention and phase 2 (Group 2 questions) of the reporting instrument.

Both the quality and accuracy of the data reported have improved since the original format of phase 1 (Group 1 questions) of the reporting instrument was amended, as the revised format provided Parties with more options on which to report. Phase 2 (Group 2 questions) of the reporting instrument further improved the amount and quality of information collected by providing more space for explanatory notes, especially for details concerning the progress made in a specific area.

[1] Decision FCTC/COP1(14).

[2] A/FCTC/COP/2/6.

[3] Document FCTC/COP/3/14.

[4] Available at http://www.who.int/fctc/FCTC-2009-1-en.pdf.

Owing to the fact that the reporting instrument evolved gradually over the period 2006–2008, not all questions and their associated answers are available across all three questionnaires.[1] Therefore, to ensure better comparability of data and provide a sound basis for analysis, three possible subsets of Parties are referred to when average figures are given in this report. **First,** the latest available data on the implementation of a particular measure were taken into account when calculating global implementation rates deriving from the information provided by all 135 reporting Parties. For Parties that submitted both their first and second implementation reports, the latest available data from the second reports were used for the global analysis. Unless specified otherwise, the implementation rates provided in this document refer to the above-mentioned 135 reporting Parties. **Second,** for several questions comparable answers were available only from the revised phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument; the number of reports received based on these two formats was 104. **Third,** as a number of new questions or answer options were introduced only in phase 2 (Group 2 questions) of the reporting instrument, comparative analysis of these answers from the 30 second reports submitted by Parties was also made.

This report also presents conclusions on overall progress, challenges and opportunities. A short version of this report, summarizing its key findings, was presented for review at the fourth session of the Conference of the Parties (Punta del Este, Uruguay, 15–20 November 2010).[2]

1. OBJECTIVE, GUIDING PRINCIPLES AND GENERAL OBLIGATIONS (PART II OF THE CONVENTION)

General obligations (Article 5 of the Convention)

Comprehensive tobacco-control strategies, plans and programmes. Parties were asked whether they had developed and implemented comprehensive and multisectoral national tobacco-control strategies, plans and programmes in accordance with the Convention. Fifty-one Parties (49%) replied "yes", 44 (42%) replied "no", and nine (9%) left the question unanswered. Almost all that answered "no" to the above question responded affirmatively when asked whether tobacco control was embedded in their national health, public health or health promotion strategies, plans and programmes. Only six Parties replied "no" to this question.

In their five-year reports, 22 Parties provided details of progress made in implementing Article 5 of the Convention. The majority of Parties referred to the enaction of new tobacco-control legislation, either through the drafting of new laws or the amendment of already existing national legislation. A few Parties also referred to the development and implementation of new tobacco-control strategies, plans or programmes.

Infrastructure for tobacco control. Eighty-one Parties (78%) indicated that they had established a national tobacco-control coordinating mechanism; 17 Parties (16%) indicated that they had not done

[1] The initial version of phase 1 (Group 1 questions) of the reporting instrument was adopted at the first session of the Conference of the Parties, and used by Parties for the preparation of their first (two-year) reports in 2007 and 2008. The initial questionnaire was then revised and revised Group 1 questions were adopted at the second session of the Conference of the Parties. Phase 2 (Group 2 questions) of the reporting instrument was also adopted by the second session of the Conference of the Parties to be used by Parties as the format of their second (five-year) reports.

[2] Document FCTC/COP/4/14. http://apps.who.int/gb/fctc/E/E_cop4.htm.

so and six left the question unanswered.[1] The same number of Parties reported having a national tobacco-control focal point. Thirteen Parties (12%) reported not having such a focal point and 10 left the question unanswered.

In their five-year reports, Parties were given the opportunity to add more details of their national tobacco-control strategies, plans or programmes, and of their tobacco-control infrastructure. Twenty-eight out of 30 Parties gave details of their national tobacco-control focal points and mechanisms of coordination. The focal point or the national coordinating mechanism is usually reported to be based in health ministries or at satellite institutions of health ministries (two Parties reported that the focal point was hosted by a public health agency). Two Parties (Ghana and the Netherlands) reported that their tobacco-control focal points or tobacco-control units were hosted by agencies responsible for food and drug safety.

Parties' reports showed that, in many cases, implementation of measures falling under Article 5 of the Convention remains high on the tobacco-control agenda, reflecting the view that the development of new legislation and the creation of sustainable tobacco-control infrastructure can serve as a basis and prerequisite for making progress in specific areas of the Convention.

Protection of public health policies from commercial and other vested interests of the tobacco industry. Overall, 65 Parties (48%) reported that they had taken steps to prevent the tobacco industry from interfering with their tobacco-control policies. Forty-eight Parties (36%) responded "no" and 22 (16%) left this question unanswered.

Twenty-four out of the 30 Parties that submitted their five-year reports also provided details of how they tackle this matter. Eleven Parties (Canada, Cook Islands, Finland, Hungary, Latvia, Mauritius, Mexico, Norway, Panama, Slovenia and Thailand) provided examples of good practice in implementing measures contained in the guidelines for implementation of Article 5.3.[2] Some Parties noted that they were considering incorporating the recommendations of the guidelines into their national policies and practice. On the other hand, Parties indicated that they regard the power of the tobacco industry as one of the key barriers to the complete implementation of the Convention in their jurisdictions.

2. REDUCTION OF DEMAND FOR TOBACCO (PART III OF THE CONVENTION)

Price and tax measures to reduce the demand for tobacco (Article 6 of the Convention)

While the data[3] contained in Parties' reports are indicative of the overall status of the implementation of price and tax measures, account should be taken of the fact that the information in the reports

[1] Combined responses from 104 reports that used the revised phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument.

[2] See *WHO Framework Convention on Tobacco Control: guidelines for implementation. Article 5.3; Article 8; Article 11; Article 13*. Geneva, World Health Organization, 2009.

[3] Both the quality and accuracy of data reported in this area have improved across the two reporting cycles. Phase 2 (Group 2 questions) of the reporting instrument further improved the amount and quality of information collected, in comparison with to the revised Group 1 questions, by providing more space for explanatory notes.

covers a rather long period of time (from 2006 to 2010) during which tobacco prices, average inflation and tax rates could have changed considerably.

Most Parties provided data on cigarettes. For other tobacco products data were insufficient for the calculation of price indices or average tax rates, and therefore only cigarette prices were taken into account during the comparative analysis of data.

Taxation of tobacco products

The information contained in Parties' reports has made possible a detailed analysis of excise duties, import duties and value-added tax (VAT) and other such taxes levied on tobacco products, and has also made possible an estimate of the total tax burden for cigarettes.[1] **Table 1** summarizes the levying of different taxes on tobacco products, also providing a regional breakdown of this information.

Table 1. Number of reporting Parties levying excise tax, VAT/goods and services tax (GST)/sales tax and import duty on tobacco products, by WHO region

WHO region	Excise tax					VAT/GST/sales tax		Import duty	
	Levied				Not levied (or tax structure not known)	Levied	Not levied (or not known)	Levied	Not levied (or not known)
	Ad valorem only	Specific only	Both ad valorem and specific	Total					
African	5 (19%)	6 (22%)	2 (7%)	13 (48%)	14 (52%)	13 (48%)	14 (52%)	11 (41%)	16 (59%)
Americas	8 (42%)	8 (42%)	0	16 (84%)	3 (16%)	15 (79%)	4 (21%)	3 (16%)	16 (84%)
South-East Asia	2 (20%)	4 (40%)	0	6 (60%)	4 (40%)	3 (30%)	7 (70%)	4 (40%)	6 (60%)
European	3 (7%)	9 (22%)	20 (51%)	33 (80%)	8 (20%)	25 (61%)	16 (39%)	5 (12%)	36 (88%)
Eastern Mediterranean	2 (13%)	1 (6%)	3 (19%)	6 (38%)	10 (63%)	4 (25%)	12 (75%)	11 (69%)	5 (31%)
Western Pacific	4 (18%)	10 (45%)	3 (14%)	17 (77%)	5 (23%)	11 (50%)	11 (50%)	5 (23%)	17 (77%)
Total	24 (18%)	38 (28%)	28 (21%)	90 (67%)	45 (33%)	71(53%)	64 (47%)	39 (29%)	96 (71%)

[1] Thirty Parties (22%) did not mention any form of taxation in their reports.

Excise taxes. Ninety Parties (67%) reported levying some form of excise tax on tobacco products. With respect to the application of various forms of excise taxes in the WHO regions, most Parties in the European Region (80%), reported that they levy a combination of ad valorem and specific excise taxes[1] as required by the community law applicable in all 27 Member States of the European Union. Almost two thirds of the reporting Parties in the Eastern Mediterranean Region, around 50% in the African Region and 40% of the reporting Parties in the South-East Asia Region indicated that they do not impose excise taxes.

Import duties. Thirty-nine Parties (29%) reported levying some form of import duty. Several Parties in the South-East Asia and Eastern Mediterranean Regions indicated their preference for the levying of import duties.

Value-added tax. Seventy-one Parties (53%) reported that they apply VAT or any of its alternatives, such as sales tax or goods and services tax.[2]

Total tax burden on cigarettes.[3] Eighty Parties (59%) provided enough data (both price and taxation information) to enable a calculation of the **total tax burden** in their cigarette prices. Forty out of these 80 Parties (50%) levy specific tax, 32 (40%) levy ad valorem tax and 42 (53%) use VAT. If the contribution of each of these types of tax to the total tax burden is compared, the rates are very similar. The contribution of VAT or any of its alternatives to the total tax amount of cigarette prices is 30%, while ad valorem taxes contribute 32% to this amount. Specific taxes make the highest contribution to the total tax burden, with a share of 38%.

Overall, the global average of **total tax burden** on cigarettes is 50%, although the total tax rate in the prices of cigarettes shows significant differences among Parties. The lowest tax rate is just under 10% (Kazakhstan), while the highest rate is 95% (Yemen). In nearly half of the Parties reporting (45%), the total tax rate on cigarettes ranges from 50% to 75%. **Table 2** provides details on the total tax burden by WHO region.

[1] The difference between the two forms of excise tax – ad valorem and specific – lies in how they are applied and, in the event of a change in the rate at which they are applied, how they influence the final retail price of the tobacco product. An ad valorem tax is most commonly defined as a percentage of the retail price, although it can also be defined as the percentage of the ex-factory (manufacturer's) price. This form of taxation increases the price of all tobacco products by an identical rate. The specific tax is generally defined as a given amount for 1000 cigarettes or for one kilogram of a particular tobacco product, and involves adding a proportionate sum to the price of each similar product type. If it is a substantial amount, it helps reduce the price differences between cheaper and more expensive tobacco products by increasing the price of the cheaper product by a higher rate than that of the more expensive product. The World Bank recommends using both types of excise in order to benefit from their combined effects.

[2] VAT and its alternatives are usually levied in addition to other items of the price, but some Parties exclude other taxes from the VAT tax base. The revised version of the reporting instrument seeks more precise information on rates and the tax base. Among the Parties providing information on taxation, some calculate VAT as a percentage of the net price and others as a percentage of the retail (gross) price.

[3] The tobacco tax burden was calculated from average price using the information on taxation contained in the reports. Three types of tax were taken into account (if levied): specific tax, ad valorem tax and VAT. First, VAT was deducted from the average price, then specific and ad valorem taxes were calculated using the tax rates of the country. The different tax amounts were added up and divided by the average tobacco price. In this report the different kinds of import duties were disregarded, because in the majority of cases the base of the import duty is the cost, insurance and freight (CIF) price and this price was not known.

Table 2. Average total tax rates levied by Parties on cigarettes and average cigarette prices in US$ per pack of 20 pieces, by WHO region

WHO region	Average total tax rates levied by Parties on cigarettes (%)			Average cigarette prices in US$ per pack of 20 pieces		
	Minimum	Maximum	Mean	Minimum	Maximum	Mean
African	12.3%	85.1%	44.8%	0.01	3.73	1.31
Americas	10.7%	75.4%	38.1%	0.41	8.41	2.87
South-East Asia	31.0%	85.0%	57.7%	0.47	2.14	1.13
European	9.9%	79.0%	56.2%	0.11	11.98	3.70
Eastern Mediterranean	25.0%	95.4%	55.0%	0.37	1.96	1.21
Western Pacific	18.2%	71.4%	48.9%	0.53	7.26	2.60
All regions	**9.9%**	**95.4%**	**50.2%**	**0.01**	**11.98**	**2.53**

Changes in taxation across the two reporting cycles

Changes in excise tax rates. In almost all of the 30 Parties that provided two sets of taxation information, changes were observed in both specific and *ad valorem* taxes.

As specific taxes are defined as a given amount for 1000 cigarettes or for one kilogram of a particular tobacco product, regular adjustments are needed in order to preserve or increase the real value of the specific tax. In three of the 30 Parties that submitted both their two-year and five-year implementation reports, specific taxes had decreased in real terms between the two reports. In Germany, the specific tax amount had not changed in the previous three years. In Mauritius and the Netherlands, specific taxes had increased but inflation rates were higher than the increase in each case, so that in these countries the specific tax increased in nominal terms but decreased in real terms.

Ad valorem tax amounts increase as prices increase. Most Parties that reported twice had raised the rate of ad valorem tax. Six Parties reported that they had increased their ad valorem tax rate by between 1% and 10%, three Parties did not report any change in the rate of this tax, and only one Party (Slovenia) reported a decrease in the tax rate.

Changes in total tax burden on cigarettes. In the case of the 30 Parties that provided both their first and second implementation reports, the average total tax rate of cigarettes increased from 55.9% by 8.8% to 64.7%. Only Slovenia experienced a decrease for this indicator. In eight Parties, total tax rates remained steady (changes of between -5% and 5%) and in another six, total tax rates increased by over 10%. Changes in total tax burden are shown in **Table 3**.

High-income countries reported a lower increase in total tax burden than the average. Six high-income Parties reported an almost unchanged level of taxation; only Canada[1] and Latvia increased their total taxation by around 15%. Middle-income countries increased their total tax rate the most: the total tax

[1] In Canada several different taxes are levied on tobacco products by different provinces.

rates for cigarettes increased by 13.8% in middle-income countries between the two reports. Despite this significant increase, total tax rates of middle-income economies were still lower than those of high-income countries.

Analysis of the two sets of data on taxation reveals differences in the changes in total tax burden. In some Parties, specific rates increased more than the overall increase in tobacco prices, resulting in a higher total tax rate. Some Parties completely changed their tobacco tax systems between the submission of the two reports, which in some cases resulted in a higher tax rate, and in others a lower tax rate. The only tax change that resulted in all cases in an increase of total tax rate was a significant increase of the *ad valorem* tax rate. This was the case in Latvia and Lithuania, where ad valorem tax rates increased by 10%, resulting in a significant increase in the tobacco tax burden and, consequently, the prices of tobacco products.

Price of tobacco products

Although significant amounts of information on tobacco-product prices were provided in 122 of the 135 reports (90%), most of it referred to the price of cigarettes,[1] with only a few Parties reporting on other products, such as cigarettes with or without filter, bidis, cigars, stemmed tobacco or types of smokeless tobacco. Cigarette prices per pack range from less than US$ 1 to almost US$ 12. The average price for cigarettes is US$ 2.53 per pack of 20 pieces. **Table 2** provides average cigarette prices by WHO region. There are notable differences among the regions. Mean cigarette prices were found to be lowest in the South-East Asia and Eastern Mediterranean Regions, where regional averages are less than half of the global average. Mean cigarette price in the African Region is also below the world average. Parties in the European Region reported the highest cigarette prices, with an average of US$ 3.70. Reported cigarette price is highest in Norway and lowest in Sudan.

Price changes across the two reporting cycles

Of the 30 Parties that provided their second reports by 30 June 2010, almost all had reported for the first time in 2007 or 2008. For those Parties that provided two sets of price and/or taxation data, an assessment of progress is possible.

Twenty-three Parties provided price information in both of their reports. Comparison of the two price sets from these Parties indicates that, on average, nominal tobacco prices increased by 34% between the two reports. When average nominal prices are adjusted with inflation rates, **real-prices changes** can be calculated.[2] Five Parties reported that the real price of the cheapest cigarette decreased in the last three years (by 5–20%). Six Parties reported a slight increase (by 1–10 %) in real terms, and for nine Parties the real price increased by 10–50%. Three Parties reported that the cheapest tobacco price doubled in real terms. The **average real-price increase** of the cheapest tobacco products was 20.4% in three years, close to a 6.5% average annual increase in real prices.

[1] Prices given by the Parties are nominal prices. For Parties that provided price data for more than one cigarette brand, an average price was calculated. Thus, when reference is made in the text to nominal prices, this indicates an average of the prices reported by the Party.

[2] For example, in Panama the average nominal price of cigarettes increased by 124% between the two reports and in the Seychelles by 117%. In nominal terms, therefore, the price indices are very similar. However, in Panama, average inflation was 16%, whereas in the Seychelles inflation grew by 90%. This means that in Panama tobacco prices increased by 93% over average inflation, while in the Seychelles tobacco prices increased by only 14% over the average inflation rate.

During the period between the two reports, average real-price indices[1] of all cigarettes were lower than in the case of the minimum prices. Three Parties reported a real-price decrease, meaning that cigarette prices increased at a lower rate than average inflation. Ten Parties reported a moderate increase of average cigarette prices, and the remaining 10 Parties experienced significant increases. The **average real-price index** of tobacco was 15.3% over three years (close to a 5% annual average).

There are notable differences if comparison is made by income levels of various countries. **Table 3** presents changes in the real price and total tax rates by income levels of countries.

Table 3. Changes in prices and total tax rates between the submission of first and second reports by income level.[2]

Income levels of countries	Annual average real-price change of the cheapest cigarettes	Annual average real-price change of all cigarettes	Total tax rate	Change in total tax rates
High-income	3.3%	2.7%	65.3%	+4.4%
Middle-income	8.4%	7.5%	62.4%	+13.8%
Low-income*	12.0%	2.5%	72.5%	Data not available
Total	6.4%	5.0%	64.7%	+8.8%

*There are only two reports from low-income countries available. The two Parties presented very different price histories, therefore the average for this group may not be representative.

Other measures concerning price and taxation of tobacco products and the economics of tobacco

Tax- and duty-free tobacco products. Parties were asked whether they prohibited or restricted sales to – or imports by – international travellers of tax- and duty-free tobacco products.[3] Sixty-one (45%) replied "yes", 70 (52%) replied "no", and four left the question unanswered. There are differences between WHO regions with regard to this measure. Almost three quarters of Parties from the European Region reported that they had introduced limitations on duty-free imports, but only around one quarter of Parties from the African Region and the Region of the Americas reported that they had done so. In the South-East Asia and Western Pacific Regions, around half of the reports mentioned some rules regarding duty-free imports.

[1] Price indices were always calculated in real terms: price changes of cigarette products were adjusted with consumer price index (CPI). All results were calculated using the information received from the Parties. No missing data were filled in. For example, if VAT rates were not provided, that Party was considered not to apply any VAT. No regional breakdown is provided in this section since the number of reporting Parties was too low for some of the regions. CPI was obtained from the database of the International Monetary Fund (IMF).

[2] The income levels used are the IMF categories of high-, middle- and low-income. For more information, see: http://www.imf.org/external/pubs/ft/weo/2009/02/pdf/statapp.pdf.

[3] The initial and revised versions of Group 1 questions refer to both sales to and importation by international travellers of tobacco products. The Group 2 questions allow for the provision of these items of information separately.

Phase 2 (Group 2 questions) of the reporting instrument allows for the collection of more detailed information concerning tax- and duty-free tobacco products. Eighteen out of the 30 Parties that provided their five-year reports indicated that they prohibit or restrict sales of tobacco products to international travellers, and 21 reported they prohibit imports of tobacco products by international travellers. Twelve and nine Parties, respectively, reported that they have not introduced such measures. Eight of the Parties reporting the prohibition of sales of tobacco products to or the importation of such products by international travellers are in the WHO European Region.

Tax policies contributing to health objectives of the country. In phase 2 (Group 2 questions) of the reporting instrument Parties were asked, in accordance with Article 6.2(a) of the Convention, whether they implement tax policies and, where appropriate, price policies, so as to contribute to the health objectives aimed at reducing tobacco consumption. Twenty-two out of the 30 Parties that submitted their second reports responded that they do and eight responded "no".

Earmarking tobacco taxes for health. Some countries add a given percentage to the excise tax in order to collect revenues for special purposes, including health, while others earmark a given share of collected tobacco taxes. Thirteen of the 135 reporting Parties indicated that they implement this form of taxation: Barbados, Belize, Bulgaria, Jordan, Madagascar, Marshall Islands, Panama, Republic of Korea, Romania, Serbia, Sri Lanka, Thailand and Uruguay.

Economic burden of tobacco use. In phase 2 (Group 2 questions) of the reporting instrument, Parties were required to report whether they have any information on the economic burden of tobacco use in their population. Half of the Parties providing their second reports responded affirmatively. Some Parties only referred to health-related costs (direct costs) of tobacco use, while others also reported on indirect costs. Altogether US$ 84 billion was mentioned by the 15 Parties as social costs related to smoking. Many Parties also provided links to their economic impact studies, which could be of use to other Parties wishing to prepare similar calculations. Of those Parties that reported any figures concerning tobacco-related social costs the overall costs reported range from US$ 2.6 billion in Slovakia to US$ 29 billion in Germany.

Fifteen out of the 30 Parties providing their five-year reports (Bangladesh, Canada, Germany, Hungary, India, Japan, Latvia, Marshall Islands, Mexico, Netherlands, New Zealand, Norway, Panama, Slovakia and Thailand) reported that they collect information on tobacco-related mortality in their populations. Some Parties reported that they regularly investigate tobacco-related mortality using specific analytical tools; some also reported on death cases attributable to diseases which can be related to tobacco consumption. Many Parties also provided links to their reports on tobacco-related mortality.

Protection from exposure to tobacco smoke (Article 8 of the Convention)

Detailed analysis for this section was possible for 104 Parties that had used the revised phase 1 and phase 2 questionnaires. The data provided in Party reports show that levels of protection from exposure to tobacco smoke vary widely according to the setting.

Indoor workplaces. Parties were asked whether they had implemented any policy[1] to protect citizens from exposure to tobacco smoke in indoor workplaces. Eighty-seven Parties (84%) replied "yes", nine (9%) replied "no", and eight left the question unanswered. With respect to different settings, 92 Parties (68%) reported that they provide complete protection from exposure to tobacco smoke in health-care facilities. Thirty-seven Parties (27%) reported that they provide partial protection in such facilities, three provide no protection, and three left the question unanswered.

After health-care facilities, educational facilities are the workplaces most frequently covered by legislation. Seventy-nine Parties (59%) reported that they provide complete protection in educational facilities, 48 (36%) partial protection and five no protection. Three Parties did not answer this question. In government buildings, 70 Parties (52%) reported that they provide complete protection, 54 (40%) that they provide partial protection and eight that they provide no protection. Three Parties did not answer this question. Employees of private companies are usually less protected from exposure to tobacco smoke in the workplace; only 36 Parties (27%) reported that they also provide for complete protection from environmental tobacco smoke in private workplaces; 70 (52%) reported that they provide only partial protection, and 27 Parties (20%) reported that their bans do not cover private workplaces at all. Two Parties did not reply to this question.

Phase 2 (Group 2 questions) of the reporting instrument also requires Parties to report on motor vehicles used as places of work (e.g. ambulances and delivery vehicles). Seventeen out of the 30 Parties that submitted their five-year reports indicated that they provide complete protection (57%), nine (30%) reported that they have in place only partial measures and two that they do not have any measures in place. Two Parties left this question unanswered.

In summary, health-care facilities seem to provide the best protection from exposure to tobacco smoke by applying the strongest smoke-free policies. Indoor workplaces in government buildings and educational facilities and motor vehicles used as places of work also provide relatively good protection. People working for private companies are usually less protected from exposure to tobacco smoke in the workplace.

Public transport. Asked whether they had implemented any smoke-free policy on public transport, 86 Parties (83%) replied "yes", 10 (10%) replied "no", and eight left the question unanswered.

The revised version of the phase 1 questionnaire and the phase 2 questionnaire solicit separate responses for aircraft, trains, "ground public transport" (such as buses, trolleybuses and trams), and in the phase 2 questionnaire, for taxis as well. The reports show that aircraft are completely smoke-free in 66 Parties (63%), while five Parties only provide partial protection; two Parties answered "no" to this question and 31 (30%) left the question unanswered. Fifty-five Parties (53%) provide for complete protection in ground public transport, while 13 Parties (12%) only require partial measures; six Parties answered "no" to this question and 30 (30%) left the question unanswered. Finally, trains are covered by legislation in fewer Parties; only 31 Parties (30%) require a complete ban on smoking in trains and 16 Parties (15%) require only a partial ban. The remaining 12 Parties (12%) do not provide for protection from exposure to tobacco smoke at all on trains and 45 Parties (43%) did not answer the question.

[1] This question of the reporting instrument is to be answered by "yes" or "no"; therefore, the "yes" answers include any kind of policy concerning protection from exposure to tobacco smoke irrespective of whether it aims at complete or partial protection.

Twenty-four out of the 30 Parties that submitted their five-year reports indicated that they require complete protection from exposure to tobacco smoke in taxis. Four Parties reported that they require partial protection[1] and two Parties left the question unanswered.

Indoor public places. Asked whether they had implemented any policy to prevent exposure to tobacco smoke in indoor public places, 81 Parties (78%) replied "yes", 16 (15%) replied "no", and seven left the question unanswered. In cultural facilities, 63 Parties (47%) provide complete protection, 49 (36%) provide partial protection, and 18 (13%) provide no protection at all; five Parties did not answer the question. In restaurants, 40 Parties (30%) reported requiring a complete ban on smoking, 57 Parties (42%) require a partial ban and 33 Parties (24%) reported that they have no measures in place. Five Parties left this question unanswered. The phase 2 questionnaire requires that separate answers be given for bars and nightclubs. Half of the Parties that provided five-year reports have a complete ban on smoking in bars, and 14 in nightclubs. Eight Parties have partial measures in place in bars and nine in nightclubs. Four do not regulate smoking in these venues at all.

Time frame for implementation

The guidelines for implementing Article 8 of the Convention[2] include a timeline for Parties to achieve universal protection from environmental tobacco smoke by ensuring that all indoor public places and workplaces, all public transport, and possibly other (outdoor or quasi-outdoor) public places are free from exposure to second-hand smoke. Of the 135 reporting Parties, only 19 (14%) have reported that they apply universal protection in their jurisdiction, including seven out of the 30 Parties that submitted their second reports in accordance with the five-year deadline.

There have only been minimal changes in the area of protection from environmental tobacco smoke since the publication of the last summary report; most indoor workplaces and public transport facilities are well-covered by national legislation in a large number of countries. But there is still room to strengthen legislation and to ensure complete protection in settings where the measures in place remain mostly partial or are missing completely, such as trains, cultural establishments, restaurants, bars and nightclubs.

Regulation of the contents of tobacco products (Article 9 of the Convention)

Parties were asked if they **require testing and measuring** of the contents and emissions of tobacco products in their jurisdictions. With regard to contents, 59 Parties (44%) responded that they require such measures, while 69 Parties (51%) answered "no" to this question; seven Parties did not provide an answer. Meanwhile, 59 Parties (44%) reported having measured the emissions of tobacco products, and 68 Parties (50%) responded "no" to this question (non-response rate: 6%).

[1] The four Parties indicating that they provide partial protection from exposure to tobacco smoke in taxis are Finland, Ghana, Japan and Jordan. The answers provided were checked against the available supporting documents or additional information provided in the reports. Based on this review, regulation in Jordan can be considered to provide complete protection from exposure to tobacco smoke in taxis. In the cases of Finland and Japan, the manager of the taxi company has the right to decide if the facility (in this case, the taxi) is smoke-free or not. In the relevant law in Finland, the clause that "no tobacco smoke can enter those indoor premises where smoking is prohibited" excludes the possibility of the driver being able to smoke when a passenger is on board, unless there is complete insulation between the driver's and passengers' area. Finally, Ghana did not provide any information in the support of its answer to this question.

[2] See *WHO Framework Convention on Tobacco Control: guidelines for implementation. Article 5.3; Article 8; Article 11; Article 13.* Geneva, World Health Organization, 2009.

As concerns **regulation** of the contents and emissions of tobacco products, the number of Parties doing so is slightly higher than the number of Parties that require testing and measuring of contents and emissions. Sixty-six Parties (49%) reported that they regulate contents and 62 Parties (46%) that they regulate emissions; 59 Parties (44%) and 64 Parties (47%), respectively, responded "no" to these questions. The non-response rate was 7%. Of the 30 Parties that provided five-year reports, 19 offered further details concerning regulations and/or their progress in this area.

Regulation of tobacco product disclosures (Article 10 of the Convention)[1]

When combining the information from all reports, 84 Parties (62%) responded that they had implemented policies requiring tobacco manufacturers and/or importers to disclose information to governmental authorities on the **contents** of tobacco products, 48 Parties (36%) replied "no", and three Parties left the question unanswered.

As seen in previous reports, in general fewer Parties require the disclosure of **emissions** of tobacco products to government authorities. Seventy-one Parties (53%) responded "yes" to the question of whether they require such disclosure, 58 Parties (43%) responded "no", and six Parties left the question unanswered.

In phase 2 (Group 2 questions) of the reporting instrument, Parties were also asked to report on whether they require public disclosure of the same information. Seventeen out of 30 Parties that submitted their five-year reports indicated that they require information on contents to be revealed to the public, while 13 Parties do not. A slightly higher number of Parties (19) also request information on tobacco product emissions to be made available to the public. Eleven Parties do not have such a requirement in place. The responses to the Group 2 questions show that more Parties continue to require disclosures of information than the testing, measurement or regulation of contents and emissions.

[1] Since questions on regulation of tobacco product disclosures expanded gradually from the initial to the revised phase 1 (Group 1 questions), and later, to phase 2 (Group 2 questions) of the reporting instrument, it is difficult to assess the progress in this area. The one question on Article 10 in the initial version of the reporting instrument was consequently divided into four in Group 2 questions, to provide Parties with more exact answer options. Due to this discrepancy in questions of the reporting instrument, the figures in this section should be assessed with caution.

Packaging and labelling of tobacco products (Article 11 of the Convention)

Article 11 of the Convention stipulates that each Party shall adopt and implement effective measures concerning packaging and labelling within a period of three years of the entry into force of the Convention for that Party.

Measures with deadlines under Article 11 of the Convention

The measures to which the three-year deadline applies and the status of global implementation of these measures are summarized below. Figure 1 also summarizes the implementation of some of these measures under Article 11 by WHO region.

Misleading or deceptive packaging and labelling. Eighty-eight Parties (65%) reported having banned descriptors on packaging and labelling that were misleading, deceptive or likely to create an erroneous impression of the product, while 37 (27%) reported that they have not introduced such a ban, and 10 left the question unanswered. Almost all Parties in the WHO European Region reported that they have implemented this measure.

Health warnings on tobacco product packaging. Parties were asked whether they had adopted policies that require tobacco product packaging to carry health warnings describing the harmful effects of tobacco smoke. A total of 111 (82%) replied "yes", 15 (11%) replied "no", and nine left the question unanswered. Every reporting Party in the European and Eastern Mediterranean Regions reported having such policies in place.

Approval of the warnings. One hundred Parties (74%) reported that they require the approval of health warnings by a competent national authority. Twenty-five Parties (18%) replied "no", and 10 left the question unanswered.

Rotation. Eighty-one Parties (60%) reported that they require the rotation of health warnings, while 45 (33%) reported that they do not and nine left the question unanswered. The highest share of Parties requiring rotation of warnings is in the European Region and the lowest in the African Region.

Position and layout. A total of 100 Parties (74%) have introduced measures to ensure that health warnings are large, clear, visible and legible, and 26 (19%) have no such requirements in place (non-response rate: 7%). All reporting Parties of the European Region have implemented this requirement of the treaty, along with about four fifths of the reporting Parties from the Region of the Americas and the South-East Asia and Eastern Mediterranean Regions.

Size. Asked whether they require health warnings to occupy no less than 30% of the principal display area, 87 Parties (64%) replied that they did, 38 (28%) replied that they did not, and 10 left the question unanswered. Overall, just over one quarter of the reporting Parties (38 or 28%) require larger health warnings that cover 50% or more of the principal display area. The highest percentage of Parties reporting that they require health warnings to cover 50% or more of the principal display area is found in the Region of the Americas.

Use of pictorials. Forty-four Parties (33%) reported that they require health warnings to take the form of – or include – pictures or pictograms, 82 (61%) reported that they have not introduced that requirement, and nine did not answer the question.

Information provided by the Parties themselves to the question on pictures/pictograms may not be the same as that obtained from other sources. This may be for a variety of reasons. In Kyrgyzstan, for example, regulations on pictorial warnings were completed and legislation was intended to be implemented by 1 April 2009. However, the order was overturned by the Minister of Justice in January 2009, after it had been reported by Kyrgyzstan. Some Parties also indicated that, in spite of the fact that they answered "yes" to the question, they were still to complete the legislative process concerning the introduction of health warnings. Therefore, information from the reports concerning pictorial warnings should be cross-checked with information from other sources, which may be updated more frequently than the submission of implementation reports by Parties.[1]

A web site designed to facilitate the sharing of pictorial health warnings and messages among the Parties was developed following a decision by the Conference of the Parties at its third session,[2] which is now operational.[3] So far, 14 Parties have made their pictorial warnings available through this web site.

Phase 2 (Group 2 questions) of the reporting instrument has introduced new questions concerning health warnings in the form of pictures/pictograms. Parties are asked if their governments own the copyright to these pictures/pictograms. Of those Parties that have reported through phase 2 (Group 2 questions), 12 responded that their governments own the copyright to these pictures and six answered that they do not.[4] Of the Parties in which the governments own the copyright, 11 (Brunei Darussalam, Canada, India, Jordan, Mauritius, Netherlands, Panama, Seychelles, Thailand, Turkey and Uruguay) indicated that they would grant non-exclusive and royalty-free licences for the use of their warnings by other Parties.

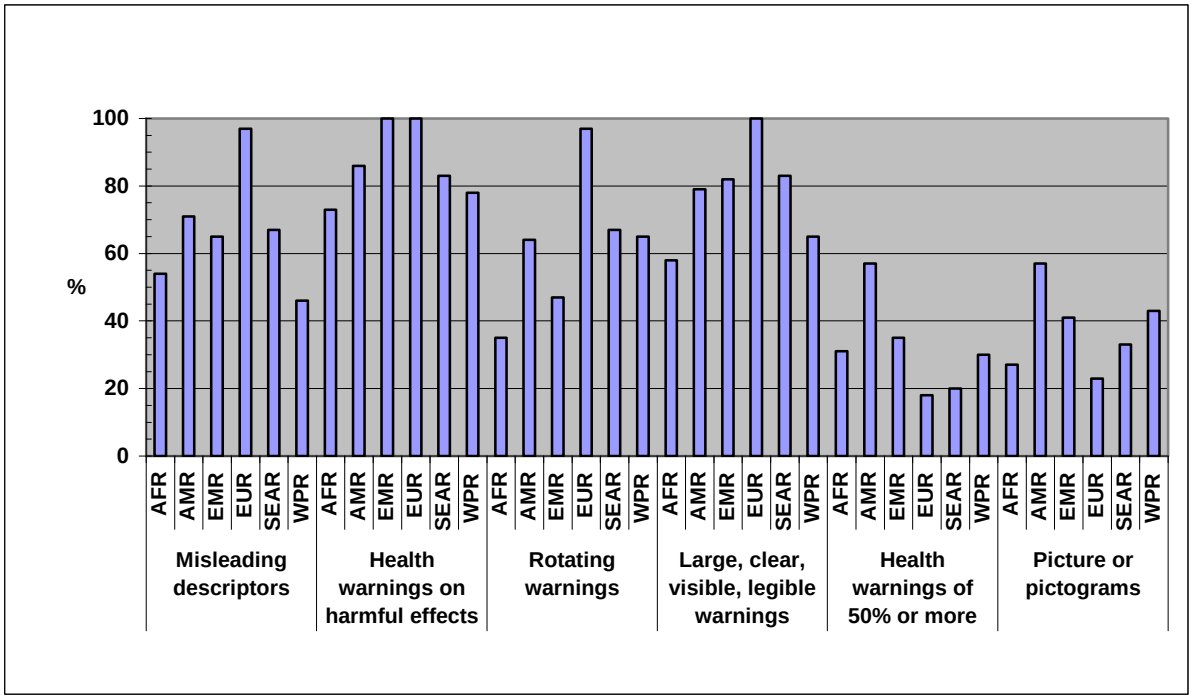
[1] One such source is the newsletter of the Convention Secretariat (see http://www.who.int/fctc/convnews). Other sources with up-to-date information can also be found at www.tobaccolabels.org and www.smoke-free.ca/warnings

[2] Decision FCTC/COP3(10).

[3] See http://www.who.int/tobacco/healthwarningsdatabase

[4] In addition, the Convention Secretariat was informed, in relation to decision FCTC/COP3(10) of the Conference of the Parties, that copyright of pictorial warnings is also owned by the governments of eight other Parties (Australia, Brazil, Egypt, Iran (Islamic Republic of), Mongolia, Pakistan, Singapore and Venezuela (Bolivarian Republic of)), as well as the European Union.

Figure 1. Percentage of Parties implementing selected measures under Article 11 of the Convention, by WHO region



Other measures under Article 11 of the Convention

There are other measures under this Article for which deadlines are not set in the Convention. The status of implementation of these measures is presented below.

Constituents and emissions.[1] Seventy-nine Parties (59%) reported that they require packaging and labelling to contain information on the relevant constituents and emissions of tobacco products, while 46 (34%) reported that they have no such requirement in place, and 10 left the question unanswered.

Warnings presented in the country's principal language or languages. Two thirds of Parties reported that they have introduced such a requirement. Thirty-five Parties (26%) reported that they have not and 10 left this question unanswered.

[1] Article 11.2 of the Convention requires Parties to publish on packages of tobacco products "*information on relevant constituents and emissions of tobacco products as defined by national authorities*". The guidelines for implementation of Article 11 recommend that Parties "*should not require quantitative or qualitative statements on tobacco product packaging and labelling about tobacco constituents and emissions that might imply that one brand is less harmful than another, such as the tar, nicotine and carbon monoxide figures.* In New Zealand, for example, the Smoke-free Environments Regulations of 2007 removed the requirement for cigarette packaging to display carbon monoxide, nicotine and tar figures determined in accordance with International Organization for Standardization standards, since they were deemed to be potentially misleading.

Packaging not to carry advertising or promotion. In relation to packaging and labelling of tobacco products, the guidelines for implementation of Article 13 (Tobacco advertising, promotion and sponsorship) recommends that "*packaging, individual cigarettes or other tobacco products should carry no advertising or promotion, including design features that make products attractive*". In the light of this recommendation, Parties are asked in phase 2 (Group 2 questions) of the reporting instrument whether they require that tobacco product packaging does not carry advertising or promotion. Twenty-three of the 30 Parties that submitted their five-year reports responded affirmatively, while seven Parties reported that they do not have such a requirement.

Time frame for implementation

The situation with regard to implementation of time-bound measures[1] under Article 11 is mixed. The majority of Parties include health warnings on the packaging of their tobacco products, these warnings are approved by a competent national authority, warnings do not include misleading descriptors, their layout ensures readability and their size is no less than 30% of the principal display areas as required by the Convention. On the other hand, implementation rates for the other two measures (requiring warnings that occupy more than 50% of principal display areas and the inclusion of pictures or pictograms in the warnings), which are recommended in the guidelines for implementation of Article 11, are significantly lower. These figures on the implementation of time-bound measures under Article 11 of the Convention can also be found in **Table 4**.

[1] To be implemented within a period of three years after the entry into force of the Convention for the Party.

Table 4. Implementation of time-bound measures under Article 11 of the Convention

Article and indicator	Status after two years of implementation (according to first reports of 135 Parties)[1]		Status after five years of implementation (according to second reports of 30 Parties)[1]	
	"yes"	"no"	"yes"	"no"
11.1(a) – misleading descriptors	**88**	**37**	**26**	**4**
11.1(b) – health warnings	**111**	**15**	**27**	**3**
11.1(b)(i) – approved by the competent authority	**100**	**25**	**26**	**4**
11.1(b)(ii) – rotating warnings	**81**	**45**	**24**	**6**
11.1(b)(iii) – large, clear, visible and legible warnings	**100**	**26**	**27**	**3**
11.1(b)(iv) – should be 50% or more of the principal display areas[2]	**86**	**39**	**26**	**4**
11.1(b)(iv) – shall be no less than 30% of the principal display areas	**37**	**86**	**13**	**17**
11.1(b)(v) – pictures/ pictograms	**44**	**82**	**15**	**15**

It should not be forgotten, however, that the majority of the 135 reports refer to measures introduced by the end of the second year after the entry into force of the Convention for that Party. The full picture concerning implementation of measures bound to a three-year deadline can only be assessed on the basis of responses provided by the Parties that have submitted their five-year reports (**Table 5**). Nine Parties responded affirmatively to all eight questions on time-bound measures (Cook Islands, Mauritius, Mexico, New Zealand, Panama, Seychelles, Thailand, Turkey and Uruguay).[3]. The last column of **Table 5** presents the number of affirmative answers provided by the 30 Parties from a maximum of eight time-bound measures.

[1] The sum of "yes" and "no" answers accounts for the total number of Parties that provided an answer within this category.

[2] The Convention requires Parties to have warnings of no less than 30% of principal display areas, but also stipulates that the warnings should be of 50% or more. They "may be" in the form of or include pictures and pictograms. The guidelines for implementation of Article 11 reinforce these measures by recommending that Parties use large warnings and pictorials.

[3] Canada reported that it does not require health warnings to be rotated. In the explanatory notes provided in the report, it was explained that Canada has implemented a process of random versus rotational display for the display of health warnings.

Table 5. Responses of the 30 Parties that submitted their five-year reports to questions on time-bound measures under Article 11

Party	11.1(a)	11.1(b)	11.1(b)(i)	11.1(b)(ii)	11.1(b)(iii)	11.1(b)(iv)	11.1(b)(iv)	11.1(b)(v)	**Number of "yes" answers out of a maximum of eight**
1. Armenia	yes	yes	yes	yes	yes	yes	no	no	**6**
2. Bangladesh	yes	yes	yes	yes	yes	yes	no	no	**6**
3. Brunei Darussalam	no	yes	yes	yes	yes	no	yes	yes	**6**
4. Canada	yes	yes	yes	no	yes	yes	yes	yes	**7**
5. Cook Islands	yes	yes	yes	yes	yes	yes	yes	yes	**8**
6. Finland	yes	yes	yes	yes	yes	yes	no	no	**6**
7. Germany	yes	yes	no	yes	yes	yes	no	no	**5**
8. Ghana	yes	yes	yes	yes	yes	yes	yes	no	**7**
9. Hungary	yes	yes	yes	yes	yes	yes	no	no	**6**
10. India	yes	yes	yes	yes	yes	yes	yes	yes	**8**
11. Japan	yes	yes	yes	yes	yes	yes	no	no	**6**
12. Jordan	yes	yes	yes	no	yes	yes	no	yes	**6**
13. Latvia	yes	yes	yes	yes	yes	yes	no	yes	**7**
14. Lesotho	no	no	no	no	no	no	no	no	**0**
15. Lithuania	yes	yes	yes	yes	yes	yes	no	no	**6**
16. Marshall Islands	no	no	no	no	no	no	no	no	**0**
17. Mauritius	yes	yes	yes	yes	yes	yes	yes	yes	**8**
18. Mexico	yes	yes	yes	yes	yes	yes	yes	yes	**8**
19. Netherlands	yes	yes	yes	yes	yes	yes	no	no	**6**
20. New Zealand	yes	yes	yes	yes	yes	yes	yes	yes	**8**
21. Norway	yes	yes	yes	yes	yes	yes	no	yes	**7**

Party	11.1(a)	11.1(b)	11.1(b)(i)	11.1(b)(ii)	11.1(b)(iii)	11.1(b)(iv)	11.1(b)(iv)	11.1(b)(v)	**Number of "yes" answers out of a maximum of eight**
22. Palau	no	no	no	no	no	no	no	no	**0**
23. Panama	yes	yes	yes	yes	yes	yes	yes	yes	**8**
24. Seychelles	yes	yes	yes	yes	yes	yes	yes	yes	**8**
25. Slovakia	yes	yes	yes	yes	yes	yes	no	no	**6**
26. Slovenia	yes	yes	yes	yes	yes	yes	no	no	**6**
27. Syrian Arab Republic	yes	yes	yes	no	yes	yes	no	no	**5**
28. Thailand	yes	yes	yes	yes	yes	yes	yes	yes	**8**
29. Turkey	yes	yes	yes	yes	yes	yes	yes	yes	**8**
30. Uruguay	yes	yes	yes	yes	yes	yes	yes	yes	**8**
Number and percentage of "yes" answers	**26 (87%)**	**27 (90%)**	**26 (87%)**	**24 (80%)**	**27 (90%)**	**26 (87%)**	**13 (43%)**	**15 (50%)**	

In conclusion, Parties have made good progress in implementing time-bound measures under Article 11 of the Convention, but less than one third of Parties have completed the process. The majority of Parties need to strengthen the implementation of measures concerning the size of the warnings and the use of pictures/pictograms.

Education, communication, training and public awareness (Article 12 of the Convention)

Parties were asked whether they implemented any "educational and public awareness programmes"[1] total of 114 Parties (84%) replied "yes", 14 (10%) replied "no", and seven left the question unanswered, which indicates generally good global progress in the implementation of this Article of the Convention. There is no notable difference in answer rates concerning programmes targeted at adults or youth; around four out of five Parties indicated that they have implemented such targeted programmes.

[1] In phase 1 (Group 1 questions) of the reporting instrument (both in the initial and revised questionnaires) the question referred to "*broad access to comprehensive educational and public awareness programmes*".

Public awareness of health risks. The revised version of Group 1 questions and Group 2 questions provide for a breakdown of public awareness programmes covering the health risks of tobacco consumption and of exposure to tobacco smoke, and the benefits of stopping tobacco use in favour of a tobacco-free lifestyle. There is no notable difference between the share of Parties implementing such focused programmes; around 80% of the 104 Parties that completed revised Group 1 and Group 2 questions responded affirmatively to the question of whether these considerations are taken into account when their awareness programmes are designed.

Public access to information on the tobacco industry. Sixty-five Parties (48%) reported that they have such programmes in place, in accordance with Article 12(c) of the Convention. Forty-eight Parties (36%) responded "no" and 22 (16%) did not answer the question.

Awareness programmes targeted at various groups. Phase 2 (Group 2 questions) of the reporting instrument collects data on educational and public awareness programmes based on a number of criteria. Parties were also asked whether they take into account some key characteristics of target groups (age, gender, educational and cultural background and socioeconomic status) when implementing educational and public awareness programmes. Twenty-five Parties reported that they implement age-specific programmes, while two thirds of Parties reported that they take gender-specific matters into account. Less than half of the Parties that reported take into account the educational or cultural backgrounds of their target groups, while a little more than half of those Parties also take into account the socioeconomic status of their target group when implementing awareness programmes.

With regard to the targeting of adults or children with awareness-raising programmes, all but one Party of those that provided their second (five-year) implementation reports responded affirmatively when asked about the implementation of such programmes. In relation to gender-specific programmes, 19 Parties indicated that their programmes specifically target men, and 20 Parties reported that they design special programmes for women. Nineteen Parties specifically target pregnant women, but only one third of the Parties reported that they target ethnic groups.

In phase 2 (Group 2 questions) of the reporting instrument, Parties were also asked whether their educational and public awareness programmes cover the adverse economic and environmental consequences of tobacco production and consumption. Parties give more attention to both the economic and environmental consequences of tobacco consumption than to the economic and environmental aspects of tobacco production; 24 of the 30 Parties reported that they refer to the economic consequences of tobacco consumption in their programmes. Nineteen of these Parties also include the environmental consequences of tobacco consumption in their communication programmes. In contrast, only around one third of the Parties refer to the economic and environmental aspects of tobacco production in their awareness-raising efforts.

Participation of public and private agencies and nongovernmental organizations. Previous reports indicated that a high percentage of reporting Parties ensure that public agencies and nongovernmental organizations not affiliated with the tobacco industry participate in the development and implementation of intersectoral programmes and strategies for tobacco control. Phase 2 (Group 2 questions) of the reporting instrument provides for a breakdown of answers by different type of organization; this resulted in a confirmation by all but one Party of those that submitted their five-year reports that public agencies and nongovernmental organizations are aware of and participate in such programmes. Only two thirds of Parties indicated the same in the case of private organizations.

Targeted training or sensitization programmes. The revised version of Group 1 questions as well as the Group 2 questions solicit data from Parties on which groups, if any, undertake targeted tobacco-

control training/sensitization and public awareness programmes. Based on the reports of the 104 Parties using these instruments, the most frequently targeted groups are health workers and educators, with specific programmes implemented by 69% and 66% of Parties respectively, followed by community workers (55%), decision-makers (55%), media professionals (55%), administrators (51%), and social workers (50%).

Some Parties also reported that they have implemented training and awareness-raising programmes for other, less frequently targeted, groups such as representatives of faith-based organizations and nongovernmental organizations, business owners, police and other law enforcement officers, students and so on. One Party (Latvia) also mentioned peer education as a vehicle for reaching young people with tobacco-related messages.

Tobacco advertising, promotion and sponsorship (Article 13 of the Convention)

Comprehensive ban on advertising, promotion and sponsorship

When asked whether they had introduced a comprehensive ban on tobacco advertising, promotion and sponsorship, 74 Parties (55%) replied "yes", and 39 Parties, around half of those replying "yes", also stated that they include cross-border advertising in the ban. Fifty-nine Parties (44%) replied "no", and two Parties did not respond to the question.

Among the WHO regions, implementation of this measure varies widely, from 77% of Parties in the Eastern Mediterranean Region, through nearly 64% in the European Region and 63% in the South-East Asia Region, 58% in the Western Pacific Region and 50% in the African Region, to 13% in the Region of the Americas.

Restrictions on all tobacco advertising, promotion and sponsorship

Under this Article of the Convention, Parties prevented by their constitutions or constitutional principles from imposing a comprehensive ban are expected to apply restrictions on all forms of tobacco advertising, promotion and sponsorship. The situation is similar to that observed in the global progress report of December 2009, with less than one quarter (24%) of the reporting Parties applying restrictions on tobacco advertising, promotion and sponsorship. Sixty-three (47%) of the reporting Parties have not applied such restrictions, and 39 (29%) left this question unanswered.

In the reporting instrument, only Parties in which there is no comprehensive ban pursuant to the requirements of Article 13 of the Convention are expected to report on the restrictions that are applied. Therefore, this indicator did not apply to Parties that have implemented a comprehensive ban (74 Parties or 55%). It is encouraging to note that more than half (56%) of the Parties in which there is no comprehensive ban on tobacco advertising, promotion and sponsorship do apply restrictions.

Parties that apply restrictions were required to respond to a series of six additional questions. Indicators referred to in these questions, which describe different forms of advertisement, and the relevant figures concerning implementation, are described below. These figures should be interpreted with caution, because even Parties that have implemented a comprehensive ban provided answers to some questions referring to the application of restrictions. Therefore, the calculations below take into account all reporting Parties and not just those that replied that they do not apply a comprehensive ban on tobacco advertising, promotion and sponsorship.

Prohibition of misleading or deceptive advertising. When asked whether they prohibited the promotion of tobacco products by any means that were false, misleading, deceptive or likely to create an erroneous impression, 66 Parties (49%) replied "yes", 42 (31%) replied "no", and 27 (20%) left the question unanswered.

Health warnings to accompany all remaining advertising. The Convention requires Parties prevented by their constitution or constitutional principles from imposing a comprehensive ban, to ensure that all tobacco advertising and, as appropriate, promotion and sponsorship are accompanied by health warnings or other suitable warnings or messages. Despite this being a minimum requirement, only 50 Parties (37%) replied "yes", 45 (33%) replied "no", and 40 (30%) left the question unanswered.

Use of direct and indirect incentives. When asked whether they had restricted the use of direct and indirect incentives to encourage the public to purchase tobacco products, 61 Parties (45%) replied "yes", 45 (33%) replied "no", and 29 (22 %) left the question unanswered. At the regional level, restrictions have been applied by 72% of Parties in the European Region, 63% of Parties in the Western Pacific Region, close to 55% of Parties in the Eastern Mediterranean Region and the Region of the Americas, 50% in the South-East Asia Region, and eight of the 20 Parties that responded in the African Region.

Disclosure of expenditures. Only 16 Parties (12%) – one in the Eastern Mediterranean Region, two in the Region of the Americas, three in the African Region, and five in the European and Western Pacific Regions – require the tobacco industry to disclose its expenditures on tobacco advertising, promotion and sponsorship to relevant government authorities. Eighty-two Parties (61%) reported that they have not introduced such a requirement, and 37 Parties (27%) did not answer the question.

Advertising, promotion and sponsorship in the media.[1] In phase 2 (Group 2 questions) of the reporting instrument, this section was broken down into six specific questions, and therefore only the 30 Parties that have reported for a second time have provided information in this regard. Analyses of the six indicators, taken separately, are provided below.

- **Restricting tobacco advertising, promotion and sponsorship on radio.** Of the 30 Parties that submitted their second implementation reports, 12 indicated that they have restricted tobacco advertising on the radio, six that they have not, and 12 left the question unanswered.

- **Restricting tobacco advertising, promotion and sponsorship on television and in print media.** Parties reported equivalent figures for both television and print media: 13 Parties replied "yes", six replied "no", and 11 left the question unanswered.

- **Restricting tobacco advertising, promotion and sponsorship on the domestic Internet.** Eleven Parties indicated that they apply such restrictions, seven that they do not, and 12 left the question unanswered.

- **Restricting tobacco advertising, promotion and sponsorship on the global Internet and in other media.** With regard to the global Internet, less than half of the reporting Parties have

[1] Details on advertising, promotion and sponsorship published in various media are referred to in Group 2 questions only. Due to the low number of reporting Parties in phase 2 of the reporting cycle, regional comparisons have not been included in this section.

applied this restriction in their jurisdiction: seven Parties replied "yes", 11 replied "no", and 12 left the question unanswered. When asked whether they apply restrictions to tobacco advertising in any other media, only seven Parties responded to the question, with five replying "yes" and two replying "no". The Parties that have applied restrictions in other media, indicated that by "other media" they meant posters, billboards, buildings and structures and advertising sent by SMS and/or other electronic media.

Tobacco sponsorship. Trends in the prohibition or restriction of tobacco sponsorship of international events and activities – and/or their participants – were analysed as two separate indicators as they were presented as two distinct answer options in phase 2 (Group 2 questions) of the reporting instrument.

- **Restricting tobacco sponsorship of international events and activities.** Sixty-four Parties (47%) replied "yes", 43 (32%) replied "no", and 28 (21%) left the question unanswered. Implementation rates of this indicator varied across WHO regions, with the highest rates found in the Eastern Mediterranean Region (86%), followed by the European Region (82%), the Western Pacific Region (56%), the South-East Asia Region (50%), and the African Region and the Region of the Americas (36% each).

- **Restricting tobacco sponsorship participants therein.** Concerning the restrictions applied to the sponsorship of participants of such events, 65 Parties (48%) replied "yes", 41 (30%) replied "no", and 29 (22%) left the question unanswered. Similarly to the previous indicator, implementation rates vary across WHO regions: they were again highest in the Eastern Mediterranean Region (86%), followed by the European Region (83%), the South-East Asia Region (60%), the Western Pacific Region (56%), and the African Region and the Region of the Americas (37% and 36%, respectively).

Time frame for implementation

Article 13 of the Convention requires each Party to undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship, in accordance with their constitutions or constitutional principles within five years of the entry into force of the Convention for that Party. Of all 135 reporting Parties, 74 reported that they have introduced comprehensive bans on tobacco advertising, promotion and sponsorship, and 59 reported that they have not. Around half of the Parties having comprehensive bans also include cross-border advertising in their ban. Among the 30 Parties that have reported for the second time, after reaching the five-year deadline, only 21 Parties have established a comprehensive ban on tobacco advertising, promotion and sponsorship. **Table 6** summarizes the answers to questions covering time-bound measures of this Article given by the 30 Parties that submitted their second implementation reports.

Table 6. Implementation of time-bound measures under Article 13 of the Convention *(section 3.2.7 of phase 2 of the reporting instrument)*

Party	Have you adopted and implemented measures or programmes instituting a comprehensive ban on all tobacco advertising, promotion and sponsorship?	Does the ban cover cross-border advertising originating from the Party's territory?
1. Armenia	no	no answer
2. Bangladesh	yes	no
3. Brunei Darussalam	no	no answer
4. Canada	no	no answer
5. Cook Islands	yes	no
6. Finland	yes	no answer
7. Germany	yes	yes
8. Ghana	yes	no
9. Hungary	no	no answer
10. India	yes	no answer
11. Japan	no	no answer
12. Jordan	yes	yes
13. Latvia	no	no answer
14. Lesotho	yes	no answer
15. Lithuania	yes	no answer
16. Marshall Islands	yes	no
17. Mauritius	yes	no
18. Mexico	no	no answer
19. Netherlands	yes	no answer
20. New Zealand	yes	no answer

Party	Have you adopted and implemented measures or programmes instituting a comprehensive ban on all tobacco advertising, promotion and sponsorship?	Does the ban cover cross-border advertising originating from the Party's territory?
21. Norway	yes	no
22. Palau	no	no
23. Panama	yes	yes
24. Seychelles	yes	yes
25. Slovakia	yes	yes
26. Slovenia	yes	yes
27. Syrian Arab Republic	yes	yes
28. Thailand	yes	yes
29. Turkey	yes	yes
30. Uruguay	no	no answer
Number and percentage of "yes" answers	**21 (70%)**	**9 (30%)**

The guidelines for the implementation of Article 13 propose a new definition for a comprehensive ban on tobacco advertising, promotion and sponsorship and list the forms of tobacco advertising, promotion and sponsorship for which the definition of a comprehensive ban should apply. Group 2 questions allow for the assessment of the implementation of a comprehensive ban on the basis of this new definition and this assessment shows that only 13 of the 21 Parties would meet the conditions for having a comprehensive ban in place. Therefore, more than half of the Parties (17) that have reported at five years have not implemented a comprehensive ban, based on the definition proposed by the guidelines.

Measures concerning tobacco dependence and cessation (Article 14 of the Convention)

The number of questions concerning Article 14 have increased from six (with five additional answer options) in the revised phase 1 (Group 1 questions) of the reporting instrument to 14 (with 48 different answer choices) in the phase 2 (Group 2 questions) of the instrument. Where data are comparable across the instruments, answers from the different questionnaires have been analysed together.

Guidelines. When asked whether they had developed and disseminated comprehensive, integrated guidelines based on scientific evidence and best practices, 59 Parties (57%) replied "yes", 38 Parties (37%) replied "no", and seven left the question unanswered.[1] Three Parties (the Netherlands, Norway and Uruguay) actually provided the text of their national guidelines (and/or a weblink to the document).

Programmes to promote cessation. Phase 2 (Group 2 questions) of the reporting instrument requires Parties to report on programmes such as: media campaigns emphasizing the importance of quitting; programmes specially designed for women and/or pregnant women; and local events, such as World No Tobacco Day. Twenty-four out of the 30 Parties that submitted their five-year reports indicated that they have implemented media campaigns with a focus on cessation, five responded "no", and one left the question unanswered. Seventeen out of the 30 Parties reported that they had implemented special programmes targeted at women and/or pregnant women; 12 reported that they have not implemented such programmes. All Parties except for one indicated that they use the opportunity of various local events to promote cessation of tobacco use.

Design and implementation of cessation programmes.[1] The revised Group 1 questions and Group 2 questions collect data on cessation programmes implemented in various settings, such as educational institutions, health-care facilities, workplaces and sporting environments. The responses received were as follows:

- fifty Parties (48%) reported that they have designed and implemented cessation programmes for educational institutions; 38 Parties (37%) replied "no", and 16 (15%) left the question unanswered;

- fifty-seven Parties (55%) reported that they have designed and implemented cessation programmes in health-care facilities; 33 Parties (32%) replied "no", and 14 (13%) left the question unanswered;

- forty-seven Parties (45%) reported that they have designed and implemented cessation programmes in workplaces; 42 Parties (40%) replied "no", and 15 (15%) left the question unanswered;

- thirty-nine Parties (38%) reported that they have designed and implemented cessation programmes in sporting environments; 49 Parties (47%) replied "no", and 16 (15%) left the question unanswered.

Findings on the use of health-care institutions for programmes promoting the cessation of tobacco use and treatment of tobacco dependence indicate that the opportunities inherent in those settings and the presence of health-care professionals are not being sufficiently exploited.

Inclusion of diagnosis and treatment of tobacco dependence in national programmes, plans and strategies and the health-care system. Twenty-five out of the 30 Parties that provided their five-year reports indicated that their national programmes, plans and strategies also cover diagnosis and treatment of tobacco dependence. Two thirds of Parties reported that they include these items in more

[1] Combined responses from 104 reports that used phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument.

general national programmes, plans and strategies on health. Twelve Parties also reported that they include them in their educational programmes, plans and strategies.

Parties were also required to report on whether they include programmes on the diagnosis and treatment of tobacco dependence in their health-care systems. Out of the Parties that submitted their second reports, 23 Parties reported doing so, five replied "no", and two left the question unanswered. The structure within health-care systems that is most frequently reported to incorporate cessation programmes is primary health care. Around half of the Parties reported they also include dependence treatment among the activities of secondary and tertiary health-care structures, specialist health-care systems (such as addictologists, narcologists, psychologists and occupational health centres), and structures specially established to provide cessation counselling and treatment of tobacco dependence. Less than one third of Parties implement such programmes in rehabilitation centres.

Three Parties also reported that they have cessation programmes in place that are run by structures other than those mentioned in the questionnaire. India indicated that such programmes are being provided by both public and private health-care institutions; Jordan also referred to the private sector, where such programmes may be implemented; and Lesotho indicated that a cessation programme is being run by a religious organization. To the question of whether services provided in these settings are covered by public funding or reimbursement schemes, in most cases the answer was that they are not or are only partially covered by such schemes. Eleven Parties indicated that services provided by primary health-care units in their jurisdictions are covered by public funding or reimbursement schemes; and seven Parties reported the same for services provided by specialized cessation units.

In their five-year reports Parties are also required to report on which health and other professionals are involved in programmes offering treatment for tobacco dependence and counselling services. References to the different service providers (from the highest to the lowest number) are as follows: nurses (23 references in 30 Party reports); physicians (21); family doctors (17); midwives, pharmacists and social workers (12 references each); community workers and dentists (10 references each); and practitioners of traditional medicine (6 references). Some of the 30 Parties that provided their five-year reports indicated that dental therapists, health education officers, medical technicians, psychologists, narcologists, and public health workers also provide such services in their jurisdictions.

Training on tobacco dependence treatment. Parties were asked whether they require the incorporation of training on tobacco dependence treatment within the curricula of health professionals at pre- and post-qualification levels. Half of the Parties reported that they do so for medical schools and 12 Parties reported the same for nursing schools. Eight and seven Parties, respectively, also include matters related to tobacco dependence treatment in the curricula of dental and pharmacy schools.

Accessibility and affordability. Twenty-one of the 30 Parties that submitted their five-year reports stated that they facilitate the accessibility and affordability of treatment for tobacco dependence, including pharmaceutical products for the treatment of tobacco dependence. Parties that responded affirmatively were also asked to report on whether nicotine replacement therapy (NRT), bupropion, varenicline or other products are available in their jurisdictions. Twenty-one Parties reported that NRT is available in their jurisdictions; 17 Parties reported that both bupropion and varenicline are available. Five Parties reported that they also have other pharmaceutical products available for tobacco dependence treatment. These products are clonidine (reported by Mexico), cytosine (Latvia) and nortriptyline (India, Mexico, New Zealand and Thailand).

Parties reporting on available pharmaceutical products were also required to report on whether the costs of treatment with these products are covered by public funding or reimbursement. Five Parties

(Brunei Darussalam, Jordan, New Zealand, Panama and Uruguay) reported that treatment with NRT is fully covered by public funding or reimbursement schemes; five Parties (India, Netherlands, New Zealand, Panama and Uruguay) also reported the same for bupropion, and three Parties (Jordan, Netherlands and Panama) reported the same for varenicline.

3. REDUCTION OF THE SUPPLY OF TOBACCO (PART IV OF THE CONVENTION)

Illicit trade in tobacco products (Article 15 of the Convention)

Parties were asked whether they had enacted or strengthened legislation against illicit trade in tobacco products. Ninety-three (69%) replied "yes", 40 (30%) replied "no", and two left the question unanswered.

Seizures. Of the 135 Parties providing their first implementation reports, 43 (32%) provided volumes of seized tobacco products. Twenty-three of the 30 Parties providing their second reports provided quantitative information on seizures of illicit tobacco products, indicating an improvement in reporting on this matter. Of the 30 Parties that submitted their second reports, only five provided the percentage of smuggled tobacco products on the national tobacco market and only three provided information on the trend over the past three years (or since submission of their previous report).

Marking of packaging. Eighty-three Parties (61%) reported that they require the marking of tobacco packaging to assist in determination of the origin of the product. Eighty-nine Parties (66%) also reported that they require marking determining whether the product was legally sold on the domestic market. Fifty-one Parties (38%) and 44 Parties (33%), respectively, reported they have not introduced such requirements. Ninety-one Parties (67%) reported that the marking is legible and/or presented in the principal language or languages of the country.

In phase 2 (Group 2 questions) of the reporting instrument Parties also report on whether they require unit packets and packages of tobacco products for retail and wholesale use to carry the statement "Sales only allowed in …" or to carry any other effective marking indicating the final destination of the product. Fourteen Parties responded "yes" and 16 Parties responded "no" to this question.

Tracking and tracing. Phase 2 (Group 2 questions) of the reporting instrument requires Parties to report on whether they have developed a practical tracking and tracing regime that would further secure the distribution system and assist in the investigation of illicit trade. Thirteen Parties of the 30 that submitted their second reports indicated that they have done so, while 17 Parties reported they do not have such a system in place. Twenty of the Parties that reported for the second time indicated that they require monitoring and collection of data on cross-border trade in tobacco products, including illicit trade. One third of those Parties have therefore not yet established this requirement in their jurisdictions. All those Parties that have such a requirement in place indicated that they facilitate the exchange of this information among customs, tax and other authorities, as appropriate.

Confiscation. Seventy-six Parties (56%) reported enabling the confiscation of proceeds derived from the illicit trade in tobacco products, 54 (40%) reported not doing so, and five did not answer the question.

In phase 2 (Group 2 questions) of the reporting instrument Parties are asked whether they require the destruction of confiscated equipment, counterfeit and contraband cigarettes and other tobacco products

derived from illicit trade, using environmental friendly methods where possible, or their disposal in accordance with national law. Twenty-five of the 30 Parties that reported for a second time responded "yes" to this question, three responded "no", and two did not answer this question. In the five-year reports, Parties also report on whether they have adopted and implemented measures to monitor, document and control the storage and distribution of tobacco products held or moving under the suspension of taxes or duties. Twenty-three Parties responded that they did, five responded "no", and two left the question unanswered.

Licensing. When asked if they require licensing or other actions to control or regulate production and distribution of tobacco products in order to prevent illicit trade, 85 Parties (63%) responded affirmatively, 48 (36%) responded "no", and two left the question unanswered.

Promoting cooperation on illicit trade in tobacco products. In phase 2 (Group 2 questions) of the reporting instrument Parties are asked whether they promote cooperation between national agencies and relevant regional and international intergovernmental organizations in investigations, prosecutions and proceedings, with a view to eliminating illicit trade in tobacco products. Of the 30 Parties providing their second reports, 24 responded that they do, four Parties responded "no", and two left the question unanswered.

Of the 30 Parties providing their second reports, 18 provided more details on their progress in combating illicit trade in tobacco products, including examples of measures they have implemented and/or how these measures are reflected in domestic legislation. For example, Canada provided details of the new stamping system it introduced in 2010 that will make counterfeit tobacco products easier to identify. Finland reported on its new system of licensing units involved in the retail sale of tobacco products. Thailand reported that in 2009 the Office of the Prime Minister established a committee to work on the prevention and control of illicit trade in tobacco products.

Sales to and by minors (Article 16 of the Convention)

Sales to and by minors. A total of 106 Parties (79%) reported having prohibited sales of tobacco products **to minors**. The legal age of majority was specified as ranging from 15 to 21 years, with 18 years being the legal age in 81 countries, and 16 years in another 10. Twenty-six Parties (19%) have not reported implementing such a measure and three left the question unanswered. Seventy-five Parties (56%) have adopted policies to prevent the sale of cigarettes individually or in small ("kiddie") packs.

Seventy-one Parties (53%) reported having policies prohibiting the sale of tobacco products **by minors**. Sixty-three Parties (47%) reported that they did not, and one Party did not answer the question.

Penalties against sellers. Ninety-four Parties (70%) reported providing for penalties against sellers and distributors in order to ensure compliance; 40 Parties (30%) responded that they do not provide for such measures, and one Party did not respond to this question.

Distribution of free tobacco products. Ninety-six Parties (71%) reported having implemented measures to prohibit distribution of free tobacco products to the public, especially minors. Thirty-five Parties (26%) reported that they have not, and four did not answer the question.

Circumstances of tobacco sale. Phase 2 (Group 2 questions) of the reporting instrument requires Parties to report on some specific circumstances of the sale of tobacco products. Parties are asked

whether they require all sellers of tobacco products to place a clear and prominent indicator inside their point of sale about the prohibition of tobacco sales to minors. Twenty-three of the 30 Parties that provided their second reports answered "yes", and seven replied "no".

When asked whether they require, in case of doubt, each seller of tobacco products to request that the purchaser provide appropriate evidence of having reached full legal age, 26 Parties answered "yes" and four answered "no".

Parties are also asked whether they ban the sale of tobacco products in any manner by which these are directly accessible, such as open store shelves. Seventeen Parties responded affirmatively, and 13 Parties replied "no". Seventeen Parties also reported that they prohibit the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products which appeal to minors.

Group 2 questions also refer to the sale of tobacco products from vending machines. Twenty-one out of 30 Parties reported that they prohibit the sale of tobacco products from vending machines, and nine Parties reported that they do not. However, all but two Parties (Ghana and Lesotho) which have not yet banned the sale of tobacco products from vending machines indicated that they require these machines to be placed in such a manner that they are inaccessible to minors, and/or these vending machines do not promote the sale of tobacco products to minors.

Provision of support for economically viable alternative activities (Article 17 of the Convention)

Economics of tobacco growing.[1] In phase 2 (Group 2 questions) of the reporting instrument Parties are required to report on tobacco growing in their jurisdictions. Fifteen Parties out of the 30 that submitted their second reports indicated that there is tobacco growing in their jurisdictions. Nine Parties also provided statistical data on the number of workers employed in tobacco growing. The number of people involved in tobacco growing varies from a few hundred or thousand (e.g. Germany and Mauritius) to 36 million in India. Some Parties provided a breakdown of those employed in tobacco growing and indicated whether these employees work full-time in tobacco growing or are seasonal workers. Very little information is available on the number of tobacco workers by gender. Where such information was available in Parties' reports, the number of female workers was higher than that of males.

Only eight Parties submitted information on the **share of the value of tobacco leaf production** in their national gross domestic product (GDP). Shares provided seem to be small, ranging from 0.0002% (Canada) to 0.045% (Turkey).

Economically viable alternative activities. In the revised version of Group 1 questions and Group 2 questions Parties are required to answer separately whether they promote economically viable alternatives for tobacco workers, tobacco growers and/or sellers of tobacco products. Ten Parties indicated that they have established specific programmes for tobacco workers and individual sellers and 13 Parties reported having programmes for tobacco growers.[2] Around two thirds of Parties

[1] When assessing the implementation of policy measures under Articles 17 and 18 of the Convention, it must be recalled that not all reporting Parties grow tobacco or manufacture tobacco products.

[2] Combined responses from 104 Parties that filled in the revised phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument.

reported not providing any programmes on alternative livelihoods for tobacco workers, individual sellers, and tobacco growers.

More than half of the Parties that submitted their second implementation reports provided further details concerning their activities in this area. Some Parties (Bangladesh, Canada, India, Mauritius and Turkey) provided examples of how they approach the provision of alternative livelihoods to those involved in the tobacco chain. These examples include intensifying research on alternative livelihoods (India), setting up a multisectoral committee to analyse the matter and make recommendations thereon (Mauritius), and providing loans or compensation from public sources to those who stop growing tobacco (Bangladesh and Turkey).

4. PROTECTION OF THE ENVIRONMENT (PART V OF THE CONVENTION)

Protection of the environment and the health of persons (Article 18 of the Convention)

In phase 2 (Group 2 questions) of the reporting instrument, questions concerning Article 18 have been redrafted and made more practical. Parties were asked whether they implement measures in respect of tobacco cultivation that take into consideration protection of the environment and the health of persons in relation to the environment. Out of 30 Parties that submitted their second reports, six reported that they implement measures that take into consideration protection of the environment and eight reported that they implement measures that take into consideration the health of persons in relation to the environment. Half of the Parties responded that these questions are “not applicable” to them.

When asked the same question in relation to tobacco manufacturing, seven Parties indicated that they take due account of the protection of the environment and six to the health of persons in relation to the environment. The share of “no” answers and the number of Parties that found the questions “not applicable” remained the same.

While Articles 17 and 18 continue to be less-well implemented, seven Parties (Canada, Hungary, Japan, Latvia, Syrian Arab Republic, Thailand and Turkey) provided examples of how consideration should be given to the environment and the health of persons in relation to tobacco growing and tobacco manufacturing. Such examples include regulations concerning health and safety in the workplace and the regulation of pesticides used in tobacco cultivation.

5. QUESTIONS RELATED TO LIABILITY (PART VI OF THE CONVENTION)

Liability (Article 19 of the Convention)

Forty-six Parties (34%) reported having implemented measures that tackle criminal and civil liability, including compensation where appropriate, for the purposes of tobacco control. Eighty-one (60%) replied “no” to the question, and eight left it unanswered.

Two new questions were added to the section on Article 19 in phase 2 (Group 2 questions) of the reporting instrument; these refer to specific actions Parties may take to advance the use of liability actions for tobacco control in their jurisdictions. When asked whether any person in their jurisdiction had launched any criminal and/or civil liability action, including compensation where appropriate, against any tobacco company in relation to any adverse health effect caused by tobacco use, only nine

of the 30 Parties that submitted their second reports responded "yes", 20 responded "no", and one left the question unanswered.

Parties were also requested to report on whether they have taken any legislative, executive, administrative and/or other action against the tobacco industry for full or partial reimbursement of medical, social and other relevant costs related to tobacco use in their jurisdiction. Only three Parties responded affirmatively and 27 Parties replied "no". Canada and Japan indicated that they included liability in their national legislations and also provided the text of such legislation. Canada also provided an extensive list of provincial legislation (which varies between provinces) concerning compensation for health damage by the tobacco industry. Five Parties (Finland, Japan, Marshall Islands, Norway and Panama) reported on court cases in which compensation for health damage caused by tobacco use was sought.

6. SCIENTIFIC AND TECHNICAL COOPERATION (PART VII OF THE CONVENTION)

Research, surveillance and exchange of information (Article 20 of the Convention)

The revised phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument have provided Parties with more options in reporting on their policies concerning research, surveillance and exchange of information, compared with the initial version of Group 1 questions. The following information is derived from the reports of 104 Parties that responded to these questions, unless otherwise indicated.

National surveillance programmes. Forty-four Parties (42%) reported having in place a national system for epidemiological surveillance of patterns of tobacco consumption. Forty-five Parties (43%) reported that they do not have such a system in place, while 15 Parties left the question unanswered.[1] As far as data on tobacco-related social, economic and health indicators are concerned, 34 Parties (33%) reported that their national surveillance programmes also cover such information. Fifty-six Parties (54%) responded "no", and 14 Parties (13%) left the question unanswered.[2]

Phase 2 (Group 2 questions) of the reporting instrument enables Parties to provide further details of the range of data collected through their national surveillance programmes. For example, half of the 30 Parties that provided their five-year reports indicated that their surveillance system also covers the determinants of tobacco consumption; 12 out of the 30 Parties reported that it covers the consequences of tobacco consumption. A higher number of Parties (23) indicated that their systems also cover aspects of exposure to tobacco smoke.

Training and support for research. With respect to training and support for those engaged in tobacco-control activities, including research, implementation and evaluation, 41 Parties (40%)

[1] The progress made in this area is evident when only responses from the five-year report are taken into account. Among the 30 responses so far received to that report, 23 Parties (77%) responded affirmatively, six Parties (20%) replied "no", and one left the question unanswered.

[2] Again, progress is seen in this area when analysing five-year reports. Thirteen Parties responded affirmatively, 16 Parties replied "no", and one left the question unanswered.

confirmed having such programmes in place, 48 (46%) replied "no" to the question and 15 (14%) left it unanswered.

Exchange of information. Forty-nine Parties (47%) reported having promoted the exchange of scientific, technical, socioeconomic, commercial and legal information; only 30 (29%) the exchange of information on the practices of the tobacco industry; and 25 (24%) the exchange of information on the cultivation of tobacco, although it should be remembered that not all Parties grow or manufacture tobacco. Around 15% of Parties did not answer any of these questions.

Database of laws and regulations. Article 20.4(a) of the Convention suggests that Parties should endeavour to progressively establish and maintain a database of laws and regulations on tobacco control and, as appropriate, information about their enforcement, as well as on pertinent jurisprudence. Overall, 55 Parties (53%) reported that they maintained a database of national laws and regulations on tobacco control; 45 (43%) that it contained information on the enforcement of those laws and regulations; and 27 (26%) that it contained information on pertinent jurisprudence. The percentages of Parties that answered "no" to the above questions were 34%, 43% and 57%, respectively.

Research.[1] Phase 2 of the reporting instrument enables Parties to report on details of the scope and areas of research on various aspects of tobacco use and control. Findings indicate that research programmes most often address the determinants and consequences of tobacco consumption, followed by social and economic indicators and tobacco use among women. The analysis of the information from the second reports can be summarized as follows:

- 24 Parties reported that they have research programmes that address the **determinants of tobacco consumption**, while 21 Parties reported that they have implemented research that addresses the **consequences of tobacco consumption**; six and nine Parties, respectively, answered that they have not implemented such research programmes;

- 20 Parties had reported that they have research programmes that address **social and economic indicators** related to tobacco consumption, while one third of Parties reported that they do not have such programmes;

- 18 Parties reported that they have research programmes that focus on **tobacco use among women**, especially pregnant women; 12 Parties reported that they have not implemented such research activities;

- 15 Parties reported that they have research programmes aimed at identifying effective programmes for the **treatment of tobacco dependence**;

- only seven Parties have research programmes that address the **identification of alternative livelihoods**, an activity clearly linked to Article 17, while 22 do not have such programmes, and one Party did not answer the question;

- the question requiring Parties to report on whether they have research programmes on the determinants and consequences of **exposure to tobacco smoke** remained the same in the

[1] Taking into account the discrepancy between questions on Article 20 in the initial and revised versions of Group 1 questions, and also the level of detail required in the revised Group 1 and Group 2 questions, only the information from the five-year reports was analysed in detail. The progress made by the Parties in implementing Article 20 of the Convention is referred to in the section, below, on "Progress in the implementation of the Convention across the two reporting cycles".

revised Group 1 and Group 2 questions. Of the 104 Parties that reported using these instruments, 43 (41%) responded "yes", 53 (51%) responded "no", and eight left the question unanswered. If only the responses given in the five-year reports are taken into account, 18 Parties (60%) reported that they have research programmes on exposure to tobacco smoke, a significant increase in the implementation of such research.

Twenty-four of the 30 Parties that provided their second implementation reports provided further details on their research activities. Many Parties referred to the surveys and studies that they have commissioned in recent years. Two Parties reported on research that is being undertaken on other areas of tobacco control. Hungary reported that research activities are taking place that focus on pictorial warnings. Panama reported that research activities are taking place that focus on the monitoring of implementation of various tobacco-control policies. One Party (Canada) noted that there are no guidelines for the implementation of Article 20 of the Convention available to Parties.

International cooperation and assistance (Articles 22 and 26 of the Convention)

Article 21.1(c) of the Convention requires Parties to report on any technical and financial assistance provided or received for specific tobacco-control activities.

Areas of assistance. Parties were requested to provide information on technical and financial assistance in specific areas linked to the provisions of Article 22. The main findings of the analysis of their answers are provided below:

- 36 Parties (27%) reported that they have provided and 59 (44%) that they have received assistance for the development, transfer and acquisition of technology, knowledge, skills, capacity and expertise related to tobacco control (pursuant to Article 22.1(a)). Fourteen and four Parties, respectively, did not provide an answer;

- 38 Parties (28%) reported that they have provided and 61 (45%) that they have received assistance in the form of technical, scientific, legal and other expertise to establish and strengthen national tobacco-control strategies, plans and programmes (pursuant to Article 22.1(b)). Fourteen and seven Parties, respectively, did not provide an answer;

- 31 Parties (23%) reported having provided and 41 (30%) having received assistance with training or sensitization programmes for appropriate personnel, in accordance with Article 12 (pursuant to Article 22.1(c)). Sixteen and nine Parties, respectively did not provide an answer;

- 24 Parties (18%) reported that they have provided and 44 (33%) that they have received the necessary material, equipment and supplies, as well as logistic support, for tobacco-control strategies, plans and programmes (pursuant to Article 22.1(d)). Sixteen and eight Parties, respectively, did not provide an answer;

- 16 Parties (12%) reported that they have provided and 25 (19%) that they have received assistance in the identification of methods for tobacco control, including comprehensive treatment of nicotine addiction (pursuant to Article 22.1(e)). Seventeen and eight Parties, respectively, did not provide an answer;

- only nine Parties (7%) have provided and 13 (10%) have received assistance in the area of research to increase the affordability of comprehensive treatment of nicotine addiction

(pursuant to Article 22.1(f)). Twenty-one and 13 Parties, respectively, did not provide an answer.

In general, the responses to questions on Article 22 of the Convention indicate that Parties report more often on the assistance they have received than on the assistance they have provided.

Around two thirds of the Parties that submitted their second implementation reports provided more information to support their affirmative answers in various areas of international cooperation, including the names of countries or organizations from which they received assistance or names of countries to which they provided assistance. There has also been a slight increase in the figures as compared with the 2009 summary report, especially in the number of Parties that received assistance. This remains an area in which further efforts are needed to fully use the capacity of the Convention.

In the phase 2 questionnaire of the reporting instrument, Parties are required to report on whether they encourage relevant regional and international intergovernmental organizations and financial and development institutions in which they are represented to provide financial assistance to developing country Parties and Parties with economies in transition, in order to assist them in meeting their obligations under the Convention, in reference to Article 26.4 of the Convention. Only five Parties out of the 30 that submitted their second reports indicated that they did, 18 replied "no", and seven left the question unanswered. Of the five Parties (Canada, Cook Islands, Lesotho, Mauritius and Panama) that reported having done so, three provided details on their efforts. For example, Canada provided a list of activities funded within the framework of the International Health Grants Program of Health Canada. Mauritius reported on advocacy efforts targeted at WHO for an increase of financial and technical support to other countries in the area of tobacco control. Panama reported on the efforts of the Minister of Health Promotion in the Council of Ministers of Health of Central America and Dominican Republic (COMISCA) to promote implementation of the WHO FCTC in the region.

Relationship between the WHO FCTC and other agreements and legal instruments. With reference to Article 2.2 of the Convention, Parties are required to communicate to the Conference of the Parties through the Convention Secretariat any bilateral or multilateral agreements, including regional or subregional agreements, that they have entered into on issues relevant or additional to the Convention and its protocols. So far only two Parties (Canada and the European Union) have reported in this area.[1]

The needs assessment exercises undertaken in several Parties suggest that such agreements, in general, may also exist in other Parties, but that they are yet to be reported to the Conference of the Parties.

The scarcity of information on the implementation of Article 2.2 indicates that further efforts are needed to generate knowledge in this area.

[1] They reported on the Memorandum of Understanding between the Department of Health of Canada and the Health and Consumers Directorate General of the European Commission in the Area of Tobacco Control. In addition, Canada reported on another memorandum of understanding concluded with the Ministry of Health of Brazil on health sector collaboration, which also includes some components with relevance to tobacco control.

7. PROGRESS IN THE IMPLEMENTATION OF THE CONVENTION ACROSS THE TWO REPORTING CYCLES

By 30 June 2010, 30 Parties[1] submitted their second (five-year) reports on the implementation of the Convention. The individual progress of these Parties can be assessed when comparing their answers and supporting information from the two- and five-year reports. Taking into account the fact that 30 Parties[2] have now provided two data sets, an initial assessment of the trend in implementation of the Convention is also possible.

An attempt was made to assess the progress made by the Parties that submitted their first and second reports. Eleven articles[3] were selected for the purposes of this analysis (those for which a high level of comparability of data exists between the phase 2 questionnaire and the two phase 1 questionnaires of the reporting instrument). Within these articles, selected indicators that allow such comparison were used in assessing the progress of implementation. These indicators are given in the **Annex**.

Five articles had already attracted relatively high implementation rates (more than two thirds of reporting Parties indicated that they have implemented key measures under these articles) at the time of the first reports of the Parties, namely: Article 8 (Protection from exposure to tobacco smoke), Article 10 (Regulation of tobacco product disclosures), Article 11 (Packaging and labelling of tobacco products), Article 12 (Education, communication, training and public awareness) and Article 16 (Sales to and by minors). At five years, three other articles had reached similar implementation rates (more than two thirds of reporting Parties): Article 14 (Demand reduction measures concerning tobacco dependence and cessation); Article 15 (Illicit trade in tobacco products); and Article 20 (Research, surveillance and exchange of information). All five articles that had attracted high implementation rates at the baseline (two years) have seen further increases in their implementation rates, all reaching rates of higher than 80% of measures referred to in the reporting instrument.

Nine out of the 30 Parties (Brunei Darussalam, Canada, Cook Islands, India, Japan, Netherlands, New Zealand, Thailand and Uruguay) that submitted two implementation reports reported implementing more than 80% of the analysed measures at the two-year baseline. Five other Parties (Mexico, Panama, Slovakia, Slovenia and Turkey) joined this group on the basis of their reported data at five years.

Twelve Parties reported making progress in five or more articles analysed in this exercise, with the Cook Islands and the Seychelles reporting progress in nine articles and Ghana in seven articles, followed by the Marshall Islands, Mexico, Panama and Turkey in six articles and Bangladesh,

[1] The Parties that submitted both first and second reports are the following: Armenia, Bangladesh, Brunei Darussalam, Canada, Cook Islands, Finland, Germany, Ghana, Hungary, India, Japan, Jordan, Latvia, Lesotho, Lithuania, Marshall Islands, Mauritius, Mexico, Netherlands, New Zealand, Norway, Palau, Panama, Seychelles, Slovakia, Slovenia, Syrian Arab Republic, Thailand, Turkey and Uruguay.

[2] Account should also be taken of the fact that only a limited number of Parties have submitted their second reports so far, and that in phase 1 (Group 1 questions) of the reporting instrument not all questions were mandatory; "optional" questions may have attracted lower response rates.

[3] Article 5 (General obligations); Article 6 (Price and tax measures to reduce the demand for tobacco); Article 8 (Protection from exposure to tobacco smoke); Article 10 (Regulation of tobacco product disclosures); Article 11 (Packaging and labelling of tobacco products); Article 12 (Education, communication, training and public awareness); Article 13 (Tobacco advertising, promotion and sponsorship); Article 14 (Demand reduction measures concerning tobacco dependence and cessation); Article 15 (Illicit trade in tobacco products); Article 16 (Sales to and by minors); Article 20 (Research, surveillance and exchange of information).

Lithuania, Mauritius, Norway and Thailand on five articles. A total of 17 other Parties have made progress in fewer than five articles analysed.

Three Parties (Canada, Finland and Thailand) that had reported the implementation of a high number of measures at two years have succeeded in further improving their implementation rates at five years.

Overall, global progress in implementing the Convention was observed, taking into account the data reported at five years by a limited subset of Parties. This initial trend may become clearer when more Parties provide their five-year reports.

8. PREVALENCE OF TOBACCO USE

The analysis of prevalence data reported by Parties is presented, below, by gender, for both smoking and smokeless tobacco, in adults and in youth. Data reported by Parties were verified against the supporting documents submitted or directly with the quoted data source. In a few cases, data could not be verified and were not used in the analysis. Indicators were disaggregated by adults and by youth and within each category by sex and by smoking and smokeless tobacco use. Instead of presenting simple averages, weighted averages[1] were created to reflect more accurately the figures for countries with larger smoking populations in the overall average by region.

Tobacco use by adults

Smoking tobacco. Of the 135 reports received, 111 (82%) contained data on adult tobacco smoking and 108 of these 111 reports (97%) also provided data broken down by gender. The reports also provided information on the adult population by specific age groups, over all ages combined or both. The contents of these reports, however, differed in quality and completeness.

The age range and age groups reported on varied considerably. For some Parties, the starting age of the first adult age group reported was as low as 10 years, whereas in other cases the lowest age was 15, 18 or even 25 years. Likewise, there was variation in the highest age reported on: for some Parties the highest age was 49 years, for others 64 years, and in some the highest age was not limited (e.g. the range was 15 years and above). Nearly two thirds of the 111 Parties that reported on adult smoking prevalence provided age-specific tobacco use prevalence data in 10-year age groupings as recommended in the reporting instrument, with variations among the WHO regions. The share of Parties using the 10-year groupings varied from 36% in the African Region to 79% in the European Region. Comparisons of prevalence figures by age groups have been difficult to make on account of the heterogeneity of age groups for which Parties have provided data. Nevertheless, the highest

[1] Weighted averages were created with population figures serving as weights for countries within each WHO region. Population data were obtained from the United Nations population database. The weighted averages represent a crude measure of the magnitude and patterns of tobacco use by sex in adults and in youth at the regional and global level. They do not account for differences in the survey instruments (such as sampling strategies employed), survey years, definitions used for tobacco types (e.g. cigarettes, all forms of smoked tobacco), definitions of the frequency of tobacco use (e.g. current smoking can be measured over the past one month or defined as those that have smoked at least 100 cigarettes and currently smoke at the time of the survey) and ages (e.g. some countries provide information from 15 years and above whereas others provide information from 25 to 64 years). Averages were calculated for tobacco users and did not draw a distinction between the types of tobacco products. This is because in many reports the type of smoking tobacco product was not reported. The prevalence figures used to calculate weighted averages were those that were officially submitted by Parties to the Convention Secretariat by 30 June 2010.

prevalence rates were more often reported among young and middle-aged adults while the lowest were reported among older adults for both men and women.

Globally, the weighted average calculated from the data submitted by Parties showed that 36% of males and 8% of females currently smoked. These averages were found to vary across the six WHO regions (see **Table 7**).

For daily smoking among males, average prevalence rates varied from 22% in the African Region and the Region of the Americas to 46% in the Western Pacific Region. Greater relative differences were observed for females, with rates varying from 2% in the South-East Asia Region to 17% in the European Region.

For current smoking among males, the rates varied from 26% in the Region of the Americas to as high as 47% in the Western Pacific Region. For females, the rates varied from 2% in the South-East Asia Region to 22% in the European Region. The greatest difference by gender was observed in the South-East Asia Region, with current smoking in males nearly 18 times higher than in females. The smallest difference was observed in the Region of the Americas, where the average current smoking rate among males was only 1.6 times higher than among females.

Of the 30 Parties that submitted their second reports, 27 (90%) reported data on tobacco use for the whole adult population[1] compared with 80% of Parties (84 of 105) in their first reports. This improvement may reflect an increasing awareness of the importance of and increasing engagement in tobacco surveillance activities among Parties, as well as the improved layout of phase 2 (Group 2 questions) of the reporting instrument and the solicitation of supporting documents from Parties.

Concerning the frequency of tobacco use, 89 of the 111 Parties (80%) that submitted information on tobacco use in adults in their two-year and five-year reports provided information on the total population prevalence rate for tobacco use. Almost all Parties provided frequency information: daily smoking (97%), occasional smoking (72%) and current smoking (25%).

Information on former smokers and people who have never smoked was only sought in phase 2 (Group 2 questions) of the reporting instrument. Twenty-three out of the 30 Parties that submitted their five-year reports provided information on former adult smokers, with the information broken down for men and women separately. Similarly, 22 out of 30 Parties provided information on never smokers for men and women separately.

For former users of tobacco, the weighted averages reveal a wide variation across WHO regions from as low as 4% in the African Region to as high as 29% in the Western Pacific Region in males; for females the weighted proportions varied from as low as 1% in the African Region and the South-East Asia region to as high as 19% in the European Region. For never smokers, weighted averages vary from 33% in the European Region to 58% in the African Region in males; for females the lowest figure (58%) was obtained in the European Region and the highest (97%) in the South-East Asia Region.

[1] In 19 of these cases, the Parties reported data from a more recent survey in their second (five-year) reports.

Parties were also required to report on the average number of cigarettes consumed per day.[1] Weighted averages for this indicator were also calculated separately for males and females. Again, variations were observed across the regions. The number of cigarettes consumed per day by region was as follows: seven in men and six in women in the African and South-East Asia Regions; 12 in men and 11 in women in the Region of the Americas; 15 in men and 8 in women in the Eastern Mediterranean Region; 16 in men and 14 in women in the Western Pacific Region; and 17 in men and 13 in women in the European Region.

Smokeless tobacco. Of the 135 Parties that submitted reports, 20 provided data on the use of smokeless tobacco products.[2] Among those Parties that did not provide information on smokeless tobacco consumption, some stated that sales of smokeless tobacco were prohibited by law in their jurisdictions. The remaining Parties have not indicated a reason for not providing information. This could reflect a lack of data or an assessment (correct or false) that smokeless tobacco is not used in their country.

The weighted averages calculated from the data submitted by Parties showed that globally 27% of males and 9% of females currently used smokeless tobacco. These weighted averages were also found to vary across gender and by WHO region (see **Table 7**).

[1] Most Parties provided information on the average number of cigarettes smoked per day. In cases where the tobacco product was not specified, it was assumed to be cigarettes.

[2] The data for water pipes were not included under smokeless tobacco.

Table 7. Estimated regional averages for prevalence of smoking and use of smokeless tobacco (%)

WHO region	Males						Females					
	Current users		Daily users		Former users	Never users	Current users		Daily users		Former users	Never users
	Smoking	Smokeless	Smoking	Smokeless	Smoking	Smoking	Smoking	Smokeless	Smoking	Smokeless	Smoking	Smoking
African Region	30	NA	22	NA	4	58	7	NA	5	NA	1	94
Region of the Americas	26	1	22	NA	24	49	16	NA	14	NA	13	77
South-East Asia Region	35	33	32	33	11	44	2	10	2	10	1	97
European Region	42	9	37	5	21	33	22	2	17	1	19	58
Eastern Mediterranean Region	31	12	31	10	18	38	5	4	4	3	2	88
Western Pacific Region	47	1	46	1	29	34	8	10	7	10	6	84

NA: Data not available.

For current smokeless tobacco consumers, the weighted averages varied from 1% in the Region of the Americas and the Western Pacific Region to 33% in the South-East Asia Region in males; in females the rates varied from as low as 2% in the European Region to as high as 10% in the South-East Asia and Western Pacific Regions.

As regards daily consumers of smokeless tobacco, in males the lowest weighted average of 1% was found in the Western Pacific Region and the highest of 33% in the South-East Asia Region; in females, the lowest weighted average of 1% was found in the European Region and the highest of 10% in the South-East Asia and Western Pacific Regions.

Information on never users and former users of smokeless tobacco was only sought in phase 2 (Group 2 questions) of the reporting instrument and only five of the 30 Parties that completed the questionnaire provided such information. As a result of this low reporting rate, comparable regional averages could not be generated for these two categories of smokeless tobacco users.

Tobacco use by youth

Smoking tobacco. Of the 135 Parties that submitted reports, 103 (76%) included data on tobacco smoking by youth. The most frequently reported age group was people aged 13–15 years (61 reports). In other cases, age groups for which data were provided varied widely among the Parties. Some provided separate data for different ages, for example in single year ages such as 11 or 13 years, and a few used the expression “school year” in lieu of a specific age or age range.

Weighted averages were calculated for tobacco use by youth for smoking. Globally, the proportion of boys who smoke (12%) was double that of girls (6%). Intraregional variations between boys and girls are highest in the South-East Asia Region (with boys smoking 3.5 times more than girls), followed by the African, Eastern Mediterranean and Western Pacific Regions, where the proportion of girl smokers is approximately half of what it is for boys (see **Table 8**). Of the 103 Parties that provided prevalence information on smoking in youth, 15 reported prevalence rates in girls that were equal to or higher than those for boys (in the Region of the Americas and the European Region).

Table 8. Estimated regional averages for prevalence of smoking and smokeless tobacco use in youth (%)[1]

WHO region	Boys		Girls	
	Smoking	Smokeless	Smoking	Smokeless
African	20	17	9	11
Americas	18	7	12	5
South-East Asia	7	15	2	7
European	13	8	10	4
Eastern Mediterranean	15	15	7	12
Western Pacific	19	42	9	32

Smokeless tobacco. Use of smokeless tobacco by youth has been reported by 25 (19%) of the 135 Parties. Globally the weighted average calculated for boys and girls from the data submitted by Parties showed that 15% of boys and 7% of girls consume smokeless tobacco. The proportion in boys using smokeless tobacco is highest (42%) in the Western Pacific Region and lowest (7%) in the Region of the Americas. Among girls, the highest proportion is found in the Western Pacific Region with 32% and the lowest in the European Region with 4%.

Other tobacco products. In phase 2 (Group 2 questions) of the reporting instrument, Parties were also given the option to report on "other tobacco products", such as water pipes. In this regard, 15 of the 30 Parties provided prevalence data.

Tobacco use in ethnic groups[2]

Nineteen (14%) of the 135 Parties have presented data on tobacco use by ethnic groups. Data in this section were not sufficient to draw conclusions on the basis of comparisons between prevalence rates in ethnic groups. Nevertheless, some observations regarding tobacco use in ethnic groups can be made. In Norway and New Zealand, there are significant differences among different ethnic groups, with tobacco use prevalence rates ranging from 9% to 39% and from 12% to 45%, respectively. In addition, the report by the United Kingdom of Great Britain and Northern Ireland provided data for 15 different ethnic groups that show that daily cigarette use in those groups ranges from 10% to 33%.[3]

[1] Data refer to current users of tobacco. No comparable data for daily use were available.

[2] Both phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument request Parties to provide information by ethnicity. However, no formal definition of ethnic groups is provided, leaving the interpretation of which groups to include open to interpretation by Parties. In some cases, Parties have defined reported prevalence of tobacco use among indigenous populations whereas in other cases different nationalities or birthplaces have been used as an indicator of ethnicity.

[2] Norway, New Zealand and the United Kingdom used different definitions of ethnic groups.

Changes in tobacco use across two reporting cycles [1]

Tobacco use in adults. Any analysis of changes in prevalence is constrained by the data presented for the same tobacco use indicators in both reporting instruments. A comparison was made only for the seven Parties that provided **smoking prevalence** rates for all adults across the two reports. In the Cook Islands, Slovenia and the Syrian Arab Republic, current and daily adult smoking prevalence rates were the same in both reports, as the same survey had been used. A slight decrease was observed in current and daily smoking in males and in females in Mauritius and Norway. As regards daily smoking, a decline in prevalence was observed in both males and females in Mexico; in India a decrease in daily smoking was observed in females only.

Comparison of adult **smokeless tobacco** consumption over all age groups could only be made for Bangladesh, India and Norway. In Norway, a slight decrease was observed in current smokeless consumption among males whereas consumption among females increased by more than 1.5 times. In Bangladesh, smokeless tobacco consumption among males increased by 11.6 percentage points whereas for females it increased by 3.5 percentage points. With regard to daily smokeless consumption, in Norway no trend was observed in males but female consumption doubled; in India, daily smokeless consumption in males increased by 8.4 percentage points whereas in females it declined by 3.6 percentage points.

Tobacco use in youth. Reports of nine of the 25 Parties could be used to compare changes in youth prevalence values across the two reporting cycles, as these Parties provided overall youth prevalence data in both reports. A decrease in **smoking prevalence** across the two reporting instruments was observed in boys and girls in Armenia, Jordan, Mauritius, New Zealand and Panama. An increase in smoking prevalence in boys and girls was observed in Latvia, the Syrian Arab Republic and Turkey. In the Seychelles, a decrease in smoking prevalence in boys and an increase in girls was reported over the period covered by the two reporting instruments.

Comparable estimates of tobacco use

The data provided by Parties reflect different methods of data collection reported for different years that do not employ standardized survey instruments. This makes direct comparison of prevalence across countries difficult. WHO has developed a regression method that attempts to adjust the estimates in order to enable comparisons of the results between countries to be made. Prevalence estimates for a standard set of indicators for tobacco can be obtained in this way.[2]

Age-standardized estimates for 2005 and 2006 are available in the WHO reports on the global tobacco epidemic for 2008 and 2009.[3] Currently WHO is in the process of producing updated age-standardized prevalence estimates for 2008 which will be available in the forthcoming *Global report on non-communicable diseases prevention and control, 2010.*

[1] It is not possible to state whether the trends observed for smoking and smokeless tobacco consumption for each country across the two reporting cycles are statistically significant. This is due to an insufficiency of data on the prevalence rates provided that would ideally be supplemented by confidence intervals.

[2] See: *WHO report on the global tobacco epidemic, 2009*, page 76 (available at http://www.who.int/tobacco/mpower/2009/gtcr_download/).

[3] The reports are available at: http://www.who.int/tobacco/mpower.

9. PRIORITIES AND CHALLENGES IN IMPLEMENTING THE CONVENTION

Priorities. The majority of Parties (124) reported on their priorities for implementation of the WHO FCTC. Some of them refer to creating a solid basis for sustainable tobacco-control efforts (such as development and implementation of a national tobacco-control action plan; strengthening infrastructure and capacities for tobacco control; and establishing national surveillance programmes). Many of them refer to activities linked to specific articles of the Convention. The most frequently reported priority areas are: protection from exposure to tobacco smoke (Article 8); packaging and labelling of tobacco products (Article 11); and treatment with regard to tobacco dependence and cessation (Article 14). Findings indicate that, globally, Parties consider the establishment of the basics of tobacco control (e.g. infrastructure, national action plan and tobacco-control legislation) as their main priority in parallel with the implementation of specific programmes concerning various articles of the treaty.

If only information from the five-year reports is taken into account, the most frequently mentioned priority areas are: development, implementation and enforcement of smoke-free policies (Article 8); strengthening treatment of tobacco dependence and cessation of tobacco use (Article 14); further progress in packaging and labelling of tobacco products, including plain packaging (Article 11); drafting of new national legislation and/or regulations for the implementation of such laws (Article 5); further strengthening of awareness-raising, education and training programmes (Article 12). Other key areas identified include strengthening price/tax measures (Article 6), banning advertising and promotion of tobacco products (Article 13), preventing illicit trade in tobacco products (Article 15), programmes to prevent young people from starting tobacco use (Article 16) and research and surveillance programmes (Article 20).

Needs and gaps. Parties were asked whether they had identified gaps between resources available and needs assessed. Of the 135 Parties that reported at least once, 50 (37%) replied “yes”, 57 (42%) replied “no” and 28 (21%) left the question unanswered. Of the 18 Parties that submitted their two-year reports between 16 July 2009 and 30 June 2010, eight replied “yes” to this question and seven (Djibouti, Gambia, Iraq, Swaziland, Tuvalu, Uganda and Yemen) indicated that technical and financial resources devoted to tobacco control do not match the existing needs. Among the most urgent needs, Parties mentioned the establishment of clinics for the treatment of tobacco dependence, the building of capacities in the area of tobacco control and the provision of training to all involved in tobacco control.

Of the 30 Parties that submitted their five-year reports, 15 provided details on specific gaps they have identified between resources available and needs assessed. The most frequently mentioned item is the inadequacy of technical and financial resources, especially the lack of personnel to work full-time in tobacco control. The need for a dedicated mechanism to fund tobacco-control efforts was emphasized by several Parties. Some Parties noted that there is a need to strengthen national capacity for tobacco control and to make tobacco control a priority for non-health sectors. Some also mentioned technical areas, such as cessation programmes, surveillance, and the development of regulations to assist implementation of already adopted legislation.

Constraints or barriers. A total of 114 Parties (84%) have provided information on more than 20 constraints or barriers that they have encountered in implementing the Convention. Such constraints and barriers include: lack of adequate technical and financial resources and capacities for tobacco control; weakness or lack of effective national legislation on tobacco control; lack of public and media awareness of the harmful effects of tobacco use; tactics of the tobacco industry in hindering effective implementation of already adopted legislation (e.g. by filing lawsuits aimed at annulling parts of the

legislation) or interference in the development of such legislation; and lack of or insufficient political will or intersectoral cooperation in tobacco control.

Party feedback on the use of the reporting instrument. The Conference of the Parties adopted, at its third session, both the revised phase 1 (Group 1 questions) and phase 2 (Group 2 questions) of the reporting instrument. In response to question 5.6 of the Group 2 questions, Parties reported on their first experience with the five-year questionnaire.

In general, Parties recognized that improvements have been made in the reporting instrument and found the questionnaire easy to administer and complete. Some Parties expressed concern about the level of detail required in the questionnaire, while others called for more space for entering information on their achievements. Parties also called for the harmonization of the reporting system of the WHO FCTC with other data collection initiatives, particularly the survey of the Global Tobacco Control Report of WHO's Tobacco Free Initiative.[1] Recommendations were also put forward concerning the format of the reporting instrument with a view to making it easier for certain sections to be completed by focal points within the relevant government departments.

There were improvements in both the completeness and quality of data reported by the Parties in their five-year reports. In phase 2 (Group 2 questions) of the reporting instrument all questions were made mandatory, and there were good response rates even for the questions requiring details or qualitative information concerning specific "yes" or "no" answers. The proportion of Parties attaching relevant documentation to their reports in support of their answers also increased to more than 70%. The attached files, available on the web site of Parties' reports,[2] contain additional information on matters such as legislation (e.g. texts of laws and regulations), national tobacco-control action plans, levels of taxation and the prevalence of tobacco use.

10. CONCLUSIONS

1. Reporting rates for the first (two-year) reports of the Parties have increased since 2007, when the first Parties started providing their two-year reports. There are lower initial reporting rates for the second (five-year) implementation reports.

2. The revision of phase 1 (Group 1 questions) and introduction of phase 2 (Group 2 questions) of the reporting instrument has helped to improve the quality, completeness and comparability of data reported by the Parties, both with regard to policy measures and tobacco use. In the five-year reports received so far, Parties have inserted a substantial amount of information in data entry fields reserved for the provision of details on the reported measures, and more than two thirds of Parties also submitted separate documents that provide background for the "yes" or "no" answers ticked in the questionnaire.

3. After five years of implementation a positive trend in global progress is visible. More than half of the substantive articles of the Convention attracted high implementation rates, with more than two thirds of Parties that reported twice indicating that they implemented key obligations under these

[1] This issue was addressed by the Conference of the Parties at its fourth session (15–20 November 2010). See the report of the Convention Secretariat on this matter in document FCTC/COP/4/15 (available at http://apps.who.int/gb/fctc/E/E_cop4.htm) and the decision of the Conference of the Parties (FCTC/COP4(16)).

[2] See http://www.who.int/fctc/reporting/party_reports.

articles. Half of the Parties that reported twice implemented more than 80% of measures contained in all substantive articles.

4. Implementation rates continue to vary substantially between different policy measures. Overall, Parties have reported high implementation rates for measures on protection from exposure to tobacco smoke (Article 8), packaging and labelling (Article 11), sales to and by minors (Article 16), and education, communication, training and public awareness (Article 12). Rates remained low in other areas such as regulation of the contents of tobacco products (Article 9), tobacco advertising, promotion and sponsorship (Article 13), provision of support for economically viable alternative activities (Article 17), protection of the environment and the health of persons (Article 18), and the use of litigation as a tool for tobacco control (Article 19).

5. Significant improvements in implementation rates across the two reporting cycles were found for selected measures under Article 6 (Price and taxation measures to reduce demand for tobacco), Article 8 (Protection from exposure to tobacco smoke), Article 14 (Demand reduction measures concerning tobacco dependence and cessation) and Article 15 (Illicit trade in tobacco products).

6. The analysis of implementation of time-bound requirements of the treaty reveals a mixed picture. The majority of Parties indicated that they have implemented most of the time-bound measures under Article 11 concerning packaging and labelling of tobacco products (three-year timeline); however only half of the Parties have succeeded in implementing measures such as introducing health warnings of more than 50% of main surface areas or pictorial warnings, as recommended by the guidelines for the implementation of this Article. Only around half of the Parties have introduced a comprehensive ban on tobacco advertising, promotion and sponsorship as required under Article 13 (five-year timeline) and only half of those that reported having a ban included cross-border advertising, promotion and sponsorship in the ban. While there are no time-bound requirements under Article 8, the relevant guidelines call on Parties to provide universal protection from exposure to second-hand smoke within a five-year timeline. According to the reports, less than one fifth of Parties had implemented this recommendation by 30 June 2010. Further assessment of the implementation of time-bound measures will be possible once more Parties submit their five-year reports.

7. Issues of international collaboration, information exchanges and mutual assistance – vital elements of the Convention that emphasize the global nature of the problem and the need for concerted action – also saw minor improvements in spite of the fact that only a limited number of Parties submitted their second implementation reports. The overall situation remains, however, comparable with that of the previous global progress report: assistance has mostly covered transfer of capacity and skills in general, rather than in specific areas. The potential of this component of the treaty remains underutilized.

8. An analysis of the recently received reports reveals a slight change in priorities. In the early years of implementation of the treaty, Parties emphasized the need to establish the basics of tobacco control (e.g. infrastructure, national action plan and tobacco-control legislation). When referring to their priorities in the recent reports, the focus has shifted to specific programmes aimed at meeting various policy requirements of the treaty.

9. Many reports also refer to gaps between needs and the resources available for meeting obligations under the Convention. While the development of human capacity and the provision of adequate financial resources for tobacco-control programmes remain high on the agenda of many Parties, the need for progress in treating tobacco dependence as well as strengthening surveillance and

developing regulations to enforce the already adopted legislation emerge as urgent matters that many Parties would like to tackle.

ANNEX

INDICATORS USED IN ASSESSING PROGRESS MADE IN THE IMPLEMENTATION OF THE CONVENTION ACROSS THE TWO REPORTING CYCLES

Article	Indicators
Article 5 *(4 indicators)*	• Development and implementation of comprehensive multisectoral national tobacco control strategies, plans and programmes; • Partially developed and implemented tobacco control strategies, plans and programmes; • Existence of a national coordinating mechanism or focal point for tobacco control; • Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry.
Article 6 *(2 indicators)*	• Prohibition or restriction of sales to international travellers of tobacco products; • Prohibition or restriction of imports by international travellers of tobacco products.
Article 8 *(10 indicators)*	• Protection from environmental tobacco smoke in: – indoor workplaces; – government buildings; – health-care facilities; – educational facilities; – private workplaces; – public transport; – indoor public places; – cultural facilities; – bars and nightclubs; – restaurants.
Article 10 *(1 indicator)*	• Requiring manufacturers to disclose to government authorities information about contents.
Article 11 *(10 indicators)*	• Requiring that packaging and labelling does not promote a product by any means that are false, misleading and deceptive; • Requiring packaging and labelling also carry health warning describing the harmful effects; • Health warnings are approved by the competent national authority; • Ensuring that health warnings are rotating; • Ensuring that health warnings are clear, large and visible; • Ensuring that health warnings occupy no less than 30% of principal display area; • Ensuring that health warnings occupy 50% or more of the display area; • Ensuring that health warnings are in the form of pictures or pictograms; • Requiring that packaging contains information on relevant constituents and emissions of tobacco products; • Requiring that the warnings appear on each unit package in principal language(s) of the country.

Article 12 *(13 indicators)*	• Implementation of any educational and public awareness programmes; • Programmes targeted at adults or the general public; • Programmes for children and young people; • Programmes on health risks of tobacco consumption; • Programmes on health risks of exposure to tobacco smoke; • Programmes on the benefits of cessation and tobacco-free lifestyles; • Programmes on the adverse economic consequences of tobacco production; • Programmes on the adverse economic consequences of tobacco consumption; • Programmes on the adverse environmental consequences of tobacco production; • Programmes on the adverse environmental consequences of tobacco consumption; • Public access to a wide range of information on the tobacco industry; • Special training or sensitization and awareness programmes on tobacco control addressed to various target groups; • Awareness and participation of public agencies in the development and implementation of tobacco control programmes and strategies.
Article 13 *(4 indicators)*	• Instituting a comprehensive ban of all tobacco advertising, promotion and sponsorship; • Inclusion of a ban of cross-border advertising originating from the Party's territory; • Applying restrictions, in the absence of a comprehensive ban, on all tobacco advertising, promotion and sponsorship; • Restricting cross-border advertising, promotion and sponsorship originating from the Party's territory.
Article 14 *(9 indicators)*	• Developed comprehensive and integrated guidelines to promote cessation; • Design and implementation of cessation programmes in educational institutions; • Design and implementation of cessation programmes in health-care facilities; • Design and implementation of cessation programmes in workplaces; • Design and implementation of cessation programmes in sporting environments; • Inclusion of diagnosis and treatment of dependence and counselling for cessation in national programmes, plans and strategies on tobacco control on health and/or education; • Establishment of programmes on treatment of tobacco dependence in health care facilities; • Establishment of programmes on treatment of tobacco dependence in rehabilitation centres; • Facilitating accessibility and/or affordability of pharmaceutical products for the treatment of tobacco dependence.
Article 15 *(6 indicators)*	• Requiring marking of packaging to assist in determining origin of the product; • Requiring marking of packaging to assist in determining whether product is legally sold on the domestic market; • Requiring that marking is legible or appears in the country's principal language or languages; • Enacting or strengthening legislation against illicit trade; • Enabling the confiscation of proceeds derived from illicit trade; • Licensing actions to control production and distribution.

Article 16 *(6 indicators)*	• Prohibiting the sales of tobacco to minors; • Prohibiting the distribution of free tobacco products to the public; • Prohibiting the distribution of free tobacco products to minors; • Prohibiting the sale of cigarettes individually or in small packets; • Providing for penalties against sellers and distributors; • Prohibiting the sales of tobacco products by minors.
Article 20 *(7 indicators)*	• Research addressing determinants and consequences of tobacco consumption; • Research addressing determinants and consequences of exposure to tobacco smoke; • Research on identification of alternative livelihoods; • Training and support for those engaged in tobacco control activities; • Existence of a national system for epidemiological surveillance of tobacco; • Regional and global exchange of publicly available national information on tobacco; • Existence of an updated database of laws and regulations on tobacco control.

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