REGIONAL COMMITTEE
16

Provisional Agenda item

Fifty-third Session

SEA/RC53/14

24 July 2000

THE FRAMEWORK CONVENTION ON TOBACCO CONTROL IN THE SOUTH-EAST ASIA REGION

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1. INTRODUCTION

One of the most serious consequences of the efforts of the developed world to reduce tobacco consumption has been the gradual yet steady shift in the operations of the tobacco multinationals to developing countries – countries where restrictions to curb the operational excesses are mostly non-existent. The massive marketing efforts of the tobacco companies have convinced about 1.5 billion people in the world to become regular tobacco smokers. Increasingly, more women and children are taking to tobacco use. Currently, low and middle income countries account for 82 per cent of all smokers. By 2030, 70 per cent of the 10 million tobacco-related deaths would occur in these countries. The countries of the South East Asia Region are not spared the scourge of the tobacco epidemic. Any success in tobacco control in the Region would require a strong and all-embracing global, legally-binding instrument, which would curb both national and international tobacco marketing and consumption. This is what the WHO Framework Convention on Tobacco Control seeks to provide.

2. THE REGIONAL SITUATION

The South-East Asian Region has the second highest (2.8 per cent) annual per capita growth rate among adults for cigarette consumption among the six WHO regions, over a decade. This situation is likely to deteriorate further as the major tobacco companies strive to increase their share holdings, open up new, and expand existing tobacco processing plants in the Region.

The current consumption rates range from 50 to 80 per cent for men and from about 1 to 71 per cent for women. According to the WHO global status report on tobacco consumption (1997), Indonesia is reported to have the fourth largest number of smokers in the world. In India and Thailand, there are an estimated 240 million and 11 million tobacco users respectively. Bangladesh has reported 20 million smokers. Tobacco, in its smoking and smokeless forms, is extensively used by women, thus posing a major threat to the measures to improve the health status of women in the Region. Chewing tobacco has been found to be more predominant among women, particularly in the rural communities of the Region. Anecdotal studies carried out in the Member Countries from time to time indicate an increasing use of tobacco products among children, some as young as 8 years.

A unique and major disturbing aspect of the tobacco situation is the comparatively high nicotine (up to 3.2mg) and tar (up to 50mg) levels of tobacco products in the Region. The exceptionally high nicotine and tar content in bidis and kreteks, combined with the increasing levels of daily consumption, put tobacco users at a higher risk for tobacco-related diseases as compared to their counterparts elsewhere. Further, adult non-smokers and children are at increased risk for environment tobacco smoke (ETS)-related diseases after a long exposure.

The many negative consequences of tobacco production and use are already evident in the Region. A high proportion of the major causes of morbidity and mortality, such as cancers, cardiovascular and respiratory diseases in some countries, are largely attributable to tobacco use. Cancers of the lung are expected to rise considerably with increased use of bidis and kreteks. Reports of studies in some countries in the Region, such as India and

Thailand, suggest increased risk of cervical and breast cancers, unsuccessful pregnancies and low birth-weight babies among women tobacco users. In addition, thousands of children of tobacco users suffer from respiratory diseases and ear infections every year due to polluted household environment resulting from ETS. In Nepal, the high incidence of respiratory tract infections among under fives is linked to smoke from cigarettes and cooking in enclosed areas. WHO estimates that about 700 million children – almost half of all children worldwide – live in homes where one parent is a smoker.

On the economic front, the cost of tobacco production and its use substantially outstrip revenue that the Member Countries earn from tobacco. A classic example is that of India. The results of a recent study estimated that the cost of treating three major tobacco-related diseases – cancer, heart and respiratory diseases – to be US$ 6.5 billion. This far exceeds the sales value and tax revenue obtained from tobacco. The direct and indirect economic effects on the poor in the Region are enormous with one-third of the family income being used for the purchase of tobacco products. This is mostly in lieu of expenditure on other essential items, such as food, clothes, health, education and shelter. This negates the positive outcomes of social development and poverty alleviation programmes in the Region.

Tobacco farming is also a major cause of environmental degradation in the Region. This has a direct bearing on sustainable development. For forest deficit countries, such as Bangladesh, India and Indonesia, tobacco cultivation and curing, which involves intensive deforestation and the use of large amounts of chemicals and fertilizer, pose a major threat to sustainable development in the Region. In Bangladesh, the use of wood for tobacco production alone is estimated to be responsible for over 30 per cent of the annual deforestation.

3. CURBING THE TOBACCO EPIDEMIC – WHO TOBACCO FREE INITIATIVE

The WHO global Tobacco Free Initiative (TFI) was launched as a Cabinet Project in 1998. Its specific aim is to reduce tobacco consumption among vulnerable groups, such as women, children and the poor. The long-term mission of global tobacco control, which will take several decades to achieve, is to reduce smoking prevalence and tobacco consumption in all countries and thereby reduce the burden of disease caused by tobacco. The focus of TFI include the following areas:

- Building and strengthening of national and regional capacity for sustainable and effective tobacco control.
- Establishing a solid evidence base for tobacco control through global surveillance and research as well as an information management and information exchange system.
- Developing a global legal instrument (WHO Framework Convention on Tobacco Control – FCTC) to strengthen national efforts towards tobacco control. The development of FCTC has been the cornerstone of the WHO Tobacco Free Initiative.
- Providing external liaison and advocacy which maximizes on media advocacy, coordination of tobacco control within the United Nations system, mobilization of nongovernmental organizations, and interaction with private sector groupings, particularly the pharmaceutical industry, the entertainment business, media and leisure groups.

WHO employs the principles of partnerships, decentralization of functions to partners and the provision of policy leadership in responding to the above priority areas. Partnerships, both within and beyond the Organization, has been built not only to maximize on resources for the formidable task of tobacco control but also to create a better understanding of the sectoral process.

4. WHAT IS WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL?

The Fifty-second World Health Assembly unanimously adopted a resolution WHA52.18, calling for intensified action by WHO towards the development of a WHO Framework Convention on Tobacco Control (FCTC). The resolution maps out the process and the time-frame for the development of FCTC and related protocols. FCTC will be an international legal instrument that will attempt to control the global spread of tobacco use and tobacco products. This is the first time that WHO has made use of Article 19 of its constitution, which allows the Organization to develop and adopt such a convention.

The guiding principles of the Convention will include both national and transnational measures making it clear that tobacco is an important contributor to inequity in health in all societies; *that tobacco* must be considered a harmful *commodity which requires regulation,* that the public has a right to be fully informed about the health consequences of using tobacco products; and that the health sector must play a leading role in combating the tobacco epidemic. However, success cannot be achieved without the involvement of all sectors of the society.

The process of developing and adopting FCTC and related protocols will also help to mobilize national and global technical and financial support for tobacco control; raise awareness among several ministries likely to be involved in global tobacco control, as well as various sectors of the society directly concerned with the public health aspects of tobacco; strengthen national legislation and action; and mobilize NGOs and other members of the civil society in support of tobacco control.

- WHO has reiterated that FCTC development, its negotiation and adoption should be seen as a process and a product in the service of public health. The Convention as such is being developed by the 191 Member States of WHO to ensure that their concerns are adequately reflected throughout the process. It is envisaged that the Framework Convention would be adopted by Member Countries not later than the year 2003.
- Under the Convention, States would take appropriate measures to achieve the general objectives they had jointly agreed upon. Thus, FCTC could include the following general objectives:
  - Protecting children and adolescents from exposure to and use of tobacco products;
  - Preventing and treating tobacco dependence among children;
  - Promoting smoke-free environments;
  - Promoting healthy tobacco-free economies;
  - Preventing smuggling;
  - Strengthening women's leadership role in tobacco control;

- Enhancing the capacity of all Member States in tobacco control;
- Improving knowledge and exchange of information at national and international levels, and
- Protecting vulnerable communities, including indigenous peoples.

The protocols could include specific obligations to address the following: prices, smuggling, tax-free tobacco products, advertising/sponsorships, internet advertising/trade, testing methods, package design/labelling, information sharing and agricultural diversification.

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5. WHY FRAMEWORK CONVENTION ON TOBACCO CONTROL

The urgent need for a global legal instrument for tobacco control has been demonstrated by the inadequacy of the various resolutions of the World Health Assembly on tobacco. Over the past 25 years, the World Health Assembly has adopted 16 resolutions on several aspects of tobacco control with varying degrees of success. While some Member States have sharpened these resolutions domestically, giving them more focus, little has been done by most countries. This piece-meal approach has lead to disparity in the effectiveness of tobacco control globally and the gradual shift of tobacco use to developing countries. A more binding and collective commitment by all Member Countries is needed.

Tobacco is a global commodity. Its effective control requires laws and regulations which take into consideration its global trade value and pervasive marketing strategies. The Framework Convention brings into focus these tangible aspects of effective tobacco control policies and interventions.

6. PROGRESS OF FCTC

By its resolution WHA52.18 the Fifty-second World Health Assembly established two bodies – the FCTC Working Group and an Intergovernmental Negotiating Body. The mission of the FCTC Working Group, which was open to participation by all Member States of WHO and regional economic integration organizations, was to prepare proposed draft elements of FCTC and to submit a report to the Fifty-Third World Health Assembly. The Working Group held two meetings, one in October 1999 and the other in March 2000 for drafting the elements of the Framework Convention and three related protocols. The report of the Working Group as well as the comments of representatives of Member countries and NGOs and Groups which are in official relationships with WHO were presented to the Fifty-third World Health Assembly in May 2000.

The Fifty-third World Health Assembly adopted a resolution (WHA53.16), which highlights the process and time-frame for the negotiation of the Framework Convention. The Assembly urged the participation of Member States to give high priority to accelerate work on the development of the WHO Framework Convention on Tobacco Control and related

protocols, including the provision of resources and cooperation necessary to accelerate the work. At the same time, the Assembly requested WHO to promote support for the development of FCTC and related protocols, to complete the technical work required for facilitating negotiations on FCTC and related protocols.

Formal negotiations will commence with the convening of the first meeting of the Intergovernmental Negotiating Body, by the Director-General from 16-21 October 2000. The Intergovernmental Negotiating Body, which will be open to participation by all WHO Member States and regional economic integration organizations, will be charged with the responsibility of negotiating the text of the Convention and related protocols. Before the first meeting of the Negotiating Body, however, the Director-General of WHO has agreed to the organization of a public hearing session on FCTC. This schedule is to be held on 12-13 October 2000 and is meant to provide a forum for all sectors and groups, including the tobacco industry to put forth their views on the WHO Framework Convention on Tobacco.

The hearing is the first of its kind in the history of WHO and is widely seen as an opportunity for the tobacco industry to make its views known to the international public health community. Beginning 18 May 2000, WHO has been receiving comments and submissions from all interested parties in six official United Nations languages. The submissions are not to exceed five pages, including attachments. Each organization and institution will be allowed one comment. Submissions should reach TFI-WHO before 31 August 2000. The two-day hearing, from 8 a.m. to 8 p.m., will be held at Geneva's International Conference Centre (GICC). Submissions in reply to presentations may be filed after the hearing, but should reach WHO before 27 October 2000. Each comment must clearly identify the organization or institution, the scope or mandate of its activities or its interest in the FCTC process and the source of funding of the commenting/submitting organization.

7. WHAT HAS BEEN THE REGIONAL RESPONSE TO TFI AND FCTC?

Significant actions have been taken at both regional and country levels in response to the goals and objectives of TFI as well as the specific tenets of WHA52.18. The salient actions include:

(1) A Regional Policy Framework on Tobacco Control and a Plan of Action 2000-2004 were adopted at the 52nd session of the Regional Committee, to guide country actions on tobacco control in the SEA Region. The Regional Committee also adopted a resolution (SEA/RC52/R7) that urged Member States:

(a) To constitute a multisectoral national council to facilitate nationwide tobacco control activities;

(b) To adopt and strengthen policies that will reduce tobacco consumption, particularly among women, children and the poor;

(c) To dedicate a portion of the taxes earned on tobacco products for tobacco control activities;

(d) To regulate nicotine not used for therapeutic purposes as a controlled drug;

(e) To actively participate in the development and negotiation of the WHO Framework Convention on Tobacco Control and related protocols, and

(f) To promote regional advocacy for a policy change through intercountry activities, such as the SEAAT Flame.

(2) All Member Countries have actively participated in the two meetings of the FCTC Working Group.

(3) For the current biennia, countries have developed national PAs with budgetary allocations.

(4) All Member Countries are participating in the South-East Asia Anti-Tobacco (SEAAT) Flame campaign, a regional advocacy campaign towards the mobilization of youth and women for tobacco control actions.

The following are some of the country-specific interventions towards FCTC:

Bangladesh	– A bill to ban smoking in public places has been developed. – The SEAAT Flame was taken around the country in February and March 2000.
Bhutan	– A multisectoral meeting on tobacco control has been organized. – Five more districts have become tobacco-free making a total of 12 smoke-free districts. – A National Task Force on tobacco control is being established. – The SEAAT Flame was taken around the country in June 2000.
India	– Co-hosted the International Conference on Global Tobacco Control Law. The first multisectoral meeting was conducted to facilitate legislation on advertisement and promotion. – Legislation on “Ban on Smoking in Public Places” in Kerala and on “Prohibition of Smoking and Spitting” in Goa enacted. – Government of New Delhi has established a cell for tobacco control. – Participation in media and advocacy project “Tobacco Kills – Don’t be Duped". – The SEAAT Flame was launched in New Delhi on 7 January 2000 jointly by DG, RD and Ministers of Health and Family Welfare and Youth, Culture and Sports of India. The Flame travelled within the country for three weeks and was sent to Bangladesh through the Petropole border.
Indonesia	– National policy developed through National Tobacco Control Committee. – National regulation on cigarette packaging and nicotine and tar levels awaits approval. – The SEAAT Flame was in Indonesia in June and July.
Maldives	– Regulations banning the advertisement of tobacco and tobacco production enacted in Maldives.

Myanmar	– Advertising of tobacco products in the electronic media banned.
Nepal	– National smoking (Prohibition and Control Act 2057 (2000) formulated for promulgation.
	– The SEAAT Flame was taken around the country in April 2000.
Sri Lanka	– A national policy on tobacco and alcohol has been developed. A bill for the prohibition of advertisement and promotion of tobacco and alcohol is under consideration of the Parliament.
	– A Gazette notification on the Bill to establish a National Authority on Tobacco and Alcohol has been issued.
	– Government has banned acceptance of advertising and sponsorship funds from tobacco and alcohol industries by government agencies. Participated in WHO/UNICEF project "Building Alliances and taking action to create a generation of tobacco-free children and youth".
Thailand	– Two bills have been endorsed by the Government.
	– The first bill will set up a Health Promotion Fund. The second seeks 2 per cent of the revenue earned from alcohol and tobacco excise taxes to be channelled to support the Health Promotion Fund. This bill still awaits parliamentary approval.
	– Health warnings on cigarette packages made stronger and varied.
	– The SEAAT Flame was taken around in May 2000. DG visited Thailand and lighted the Torch to mark the Global launch on World No Tobacco Day on 31 May 2000.

8. WHAT HAS BEEN SEARO'S CONTRIBUTION TO TFI AND THE FCTC PROCESS IN THE REGION

(1) Provide Member Countries with relevant technical information on tobacco control issues, such as taxation, marketing, litigation, agricultural diversification, international trade and other transnational issues including: smuggling and cross-border advertising on tobacco control in relation to FCTC. This has been done through the production and distribution of information and advocacy kits and regional quarterly newsletter, dissemination of technical papers on tobacco control issues, such as tobacco and women and the youth, cessation and the economics of tobacco.

(2) Provide technical and financial support to countries to carry out relevant formative and operational research and establish appropriate databases to develop effective demand reduction policies.

(3) Support the development of national plans of action to enhance tobacco control and to enable participation in the FCTC process and its adoption by Member Countries.

(4) Promote demand reduction interventions, including interventions on smoking cessation, particularly among youth and women through partnerships with organized groups and NGOs and the media.

(5) Promote intensified inter-regional collaboration within WHO in the area of surveillance in order to sharpen priority setting and strengthen activities related to tobacco control and development of FCTC.

(6) Provide advocacy with regional organizations and institutions, such as SAARC and ASEAN, with a view to placing the tobacco issue high on the political agenda of Member Countries.

(7) Advocate inter-agency action for tobacco control by other UN agencies and other bilateral donors towards a strong and comprehensive FCTC.

(8) Document and disseminate success stories of tobacco control, help pilot appropriate indicators for monitoring the progress of implementation of tobacco control measures in the Member Countries, as well as establish mechanisms for surveillance of issues related to tobacco.

9. WHAT IS THE ROLE OF WRs IN REGARD TO TFI AND FCTC?

The role of the WHO Representatives in tobacco control at the country level cannot be underestimated. In collaboration with TFI, Geneva, the following actions have been identified for pursuit by these representatives:

(1) Promote the implementation of resolution SEA/RC52/R7 at the country level.

(2) Facilitate the multisectoral forum in reaching a consensus on tobacco control and FCTC, as indicated in the TFI/HQ memorandum of 31 January 2000 entitled “Sectoral Issues Required for Tobacco Control”.

(3) Facilitate the participation of Member Countries in the meetings of the Working Group of FCTC and subsequently in the public hearing on FCTC as well as the active participation in the negotiation process.

(4) Advocate the integration of tobacco control as a component of other health and social development programmes.

(5) Brief other UN agencies and other health development donor agencies on country tobacco control and urge their active promotion at the national level of the FCTC negotiation processes.

(6) Catalyze resource mobilization for tobacco control activities, where feasible, through inter-agency and inter-departmental collaboration.

Despite these interventions, it is crystal clear that to achieve any appreciable success in reducing tobacco consumption in the Region, Member Countries would need to actively participate in the negotiation process as well as adopt and implement FCTC as a regional process.

10. WHAT ACTIONS SHOULD SEAR COUNTRIES TAKE LEADING TO FCTC ADOPTION AND IMPLEMENTATION

(1) Continue to give priority to accelerating the negotiation process at the country level.

(2) Provide resources and cooperation necessary to accelerate the work.

(3) Promote inter-governmental consultations to address specific issues, for example, public health matters and other technical matters relating to negotiation of FCTC and related protocols.

(4) Establish, where appropriate, relevant structures, such as national commissions for FCTC or multisectoral councils and mechanisms, to examine the implications of an FCTC within the health and economic context, especially its beneficial effects for states whose economy depends on agriculture.

(5) Facilitate and support the participation of NGOs, recognizing the need for multi-sectoral representation.

(6) Consider further development and strengthening of national and regional tobacco policies, including the appropriate application of regulatory programmes to reduce tobacco use, as contributions to development and adoption of FCTC and related protocols.

(7) Provide technical information on taxation, marketing, litigation, agricultural diversification, international trade and other transnational issues, such as smuggling and cross-border advertising on tobacco control and in relation to FCTC.

(8) Carry out relevant research and establish appropriate databases to develop effective demand reduction policies.

(9) Participate in the FCTC negotiation process and its adoption by making conscious efforts at public debate at the national level.

(10) Use regional institutions, such as ADB, SAARC and ASEAN, to push forward global trade issues that positively influence reduction in tobacco consumption in the Region.

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