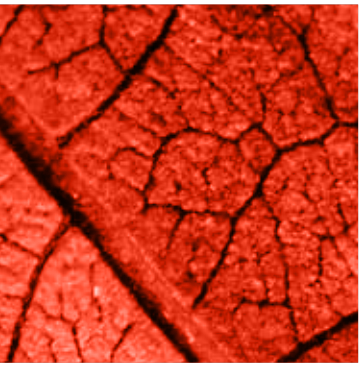

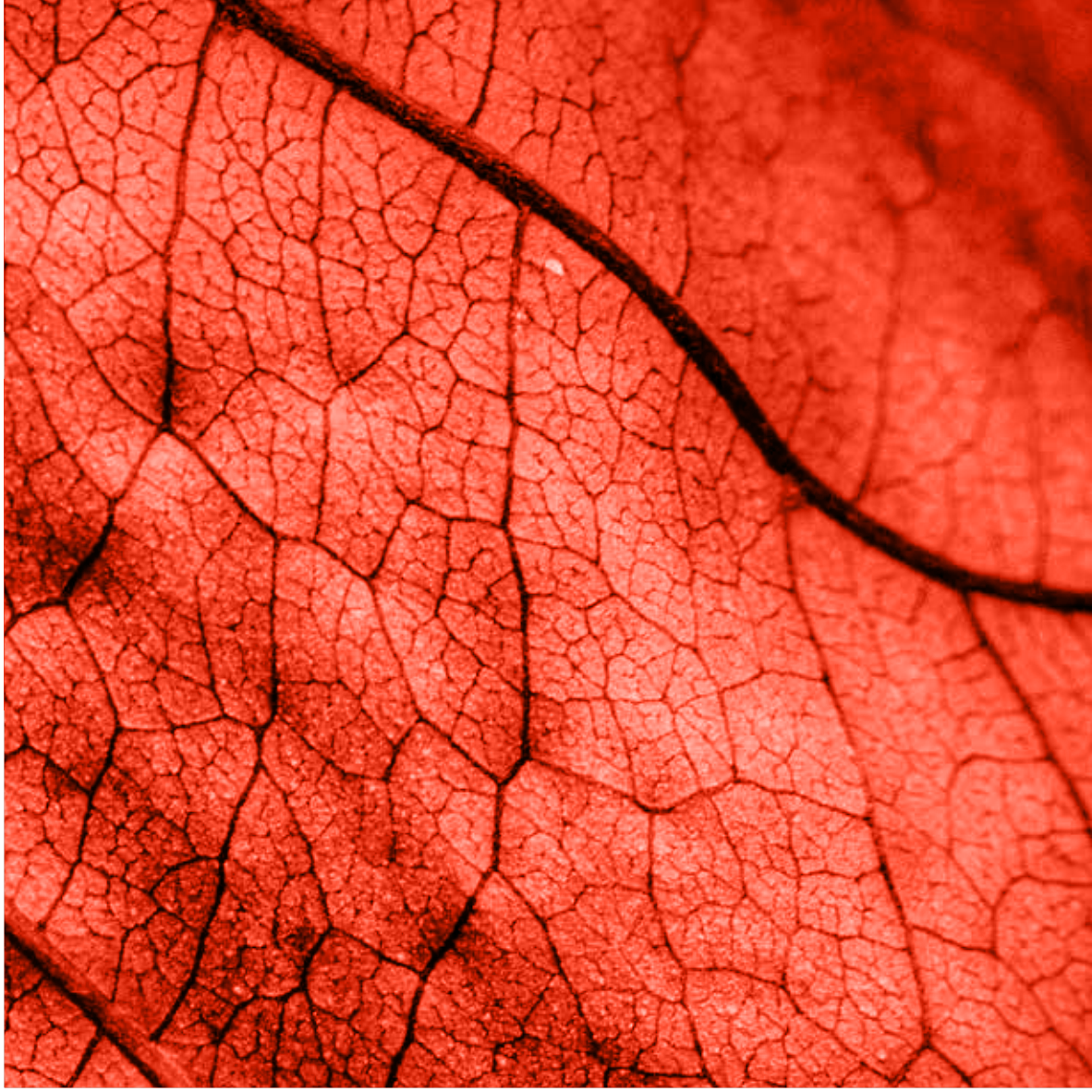

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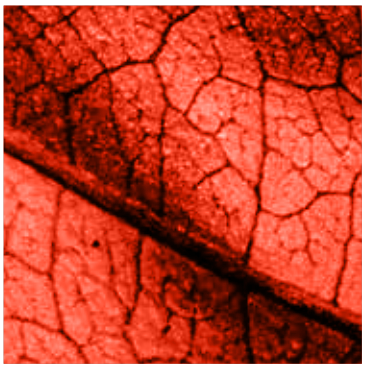
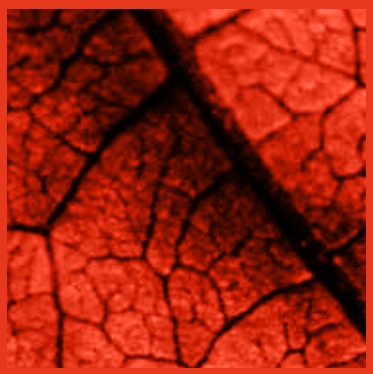


2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL



2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control

FCTC

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

2023 Global progress report on implementation of the WHO Framework Convention on Tobacco Control

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Acknowledgement

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Foreword

This *2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* is the tenth in the series of reports prepared since the entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) on 27 February 2005. The report reflects a period when the world began to breathe again after the suffocating experience of COVID-19, the most serious pandemic in more than a century.

Even though this Global Progress Report describes some limited progress on almost all indicators for which globally aggregated figures were calculated, and presents positive developments as reported by the Parties to the Convention, the level of acceleration in the implementation of the WHO FCTC still falls short of what was anticipated through the adoption by the Conference of the Parties to the WHO FCTC of the *Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025*. The impact of the COVID-19 pandemic is still affecting many Parties: some of them specifically mention it as an implementation barrier, but in many a lack of financial resources is quoted as the leading gap between the needs assessed and available resources for the comprehensive implementation of the Convention. Other Parties reported that the COVID-19 pandemic impacted human resources that otherwise would have been available for tobacco control by diverting them into covering urgent needs related to the pandemic.

This Global Progress Report will be the last such report based on the current reporting instrument and indicators, as the Parties to the Convention, at the Tenth session of the Conference of the Parties (COP10) to the WHO FCTC in November 2023, are expected to approve a new reporting system proposed by the Convention Secretariat. The proposed system would utilize a broader range of information sources to provide more tailored information for the Conference of the Parties (COP) to make its decisions while reducing the reporting burden on the Parties and ensuring better quality data.

The approaches first introduced in the previous report, *2021 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control*, were employed in the 2023 reporting cycle to ensure an easy comparison with the information presented in the 2021 report. This includes an analysis of the progress on indicators of the Global Strategy, contributions made by the WHO FCTC Knowledge Hubs to the analysis of information deriving from Parties' reports and an analysis of time-bound measures of the WHO FCTC through a clustered analysis of indicators. The latter continues to provide a more realistic picture of the comprehensive nature of approaches Parties are using in addressing various complex requirements under these time-bound articles. For the first time, the analysis in this report also was performed by World Health Organization regions.

As the global tobacco control landscape evolves, this Global Progress Report also highlights the Parties that have indicated that they wish to pursue measures beyond the WHO FCTC, in line with Article 2.1 of the Convention, to reduce the use of tobacco products to a minimum. The Global Progress Report provides examples of various approaches that could be used for this purpose. Another area of focus of the 2023 report is the expansion of the use of novel and emerging tobacco products and nicotine products, and the related challenges: their increased use; regulation lagging behind the expansion of the market; and the increasing interference of the "nicotine industry" with decision-makers.

Implementation gaps remain, as do constraints and barriers that must be addressed to ensure full implementation of all the articles of the Convention. The Convention Secretariat is committed and stands ready to further help Parties accelerate progress towards full implementation of the WHO FCTC.

The Convention Secretariat

Executive summary

The 2023 reporting cycle for the WHO Framework Convention on Tobacco Control (WHO FCTC) was conducted in accordance with decision FCTC/COP4(16) of the Conference of the Parties (COP) to the WHO FCTC, using an online reporting platform established in 2016. Of the 182 Parties to the Convention required to report in the 2023 cycle, 134 (74%) formally submitted their implementation reports. Most of the remaining Parties updated their data by the cut-off date for inclusion in this analysis, but they have not formally submitted their reports.

In this cycle, Andorra, which acceded the Convention on 11 May 2020, reported for the first time. The newest WHO FCTC Party, Malawi, which acceded the Convention on 18 August 2023, will only need to report for the first time in the next reporting cycle. This analysis also includes a review of the 10 reports received in response to the additional (voluntary) questions on the use of implementation guidelines adopted by the COP for certain articles of the WHO FCTC.

This *2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* summarizes key observations on the implementation of the Convention, provides examples of implementation of various articles by the Parties, and contains a description of progress made in the indicators included in the *Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025*.

The overall status of the implementation of the Convention was assessed based on key indicators under each substantive article. Implementation rates per article vary and are presented in the various sections of this Global Progress Report. Comprehensive implementation of key measures under the time-bound articles, as well as Article 5 of the Convention, was analysed globally and according to World Health Organization (WHO) regions. Comprehensive implementation of Articles 5, 8 and 11 varies greatly among WHO regions, and comprehensive implementation of Article 13 is lower in all WHO regions.

This Global Progress Report highlights, as usual, advanced practices in the implementation of the Convention under each of the articles. For example:

- In relation to **Article 2.1 (Measures beyond those required by the Convention and its protocols)**, several Parties reported on plans to reduce tobacco use prevalence to under 5% or achieve a smoke- or tobacco-free generation by a certain date through various mechanisms.
- In relation to **Article 5.1 (General obligations)**, an increasing number of Parties reported having developed a comprehensive multisectoral national strategy. In addition, a few Parties reported that they are in the process of developing noncommunicable disease prevention or public health plans, with tobacco control integrated into them. More Parties reported having established new national coordinating mechanisms or are in the process of doing so. There is still no breakthrough in adopting measures to protect public health policies from commercial and other vested interests of the tobacco industry, but more Parties seem to ensure that the public has access to information on the activities of the tobacco industry.
- In respect of **Article 6 (Price and tax measures to reduce the demand for tobacco)**, over three quarters of Parties provided tax information, and it was observed that a mixed excise tax system (a combination of specific and ad valorem taxes) continues to be the most common excise tax structure implemented globally. Parties in four WHO regions reported an increase in the average tobacco tax burden; however, only the European Region has an average tobacco tax burden that meets the 75% tax benchmark.

- Under **Article 8 (Protection from exposure to tobacco smoke)**, most Parties (95%) report banning smoking in all public places mandated in this article. However, a closer analysis of the comprehensiveness of implementation shows that still less than half of all Parties truly provide the universal protection in line with the *Guidelines for Implementation of Article 8 of the WHO FCTC*. The number of Parties reporting that they ban smoking through national law, subnational regulation or through administrative and executive orders has increased in all categories, at the expense of voluntary prohibitions. Since the last reporting cycle, most often Parties have reported progress in introducing new legislation or regulations concerning smoke-free environments, and a similar number of Parties reported strengthening enforcement of their smoke-free measures.
- In relation to **Article 9 (Regulation of the contents of tobacco products)** and **Article 10 (Regulation of tobacco product disclosures)** of the Convention, some progress was detected in the percentage of Parties requiring testing and measuring of the contents of tobacco products, and public disclosure of contents has also become more common. A positive trend has been observed in banning flavours or additives in tobacco products.
- Under **Article 11 (Packaging and labelling of tobacco products)**, several Parties reported increasing the size of the health warnings on tobacco products and some others reported to have adopted plain packaging. A WHO Collaborating Centre for Tobacco Plain Packaging was established in Saudi Arabia in November 2022.
- In relation to **Article 12 (Education, communication, training and public awareness)**, many Parties reported the implementation of new communication campaigns. A positive trend was observed in that more Parties have been implementing programmes targeted to ethnic groups, and progress was also observed in implementing programmes covering adverse environmental consequences of tobacco production. Targeted training or awareness-raising programmes were most often addressed to health workers and educators.
- Under **Article 13 (Tobacco advertising, promotion and sponsorship)**, more Parties have now adopted additional bans on the display and visibility of tobacco products at points of sale and on cross-border tobacco advertising, promotion and sponsorship (TAPS) originating from their territory. However, the number of Parties that reported having banned all types of TAPS, in line with the *Guidelines for Implementation of Article 13 of the WHO FCTC*, has increased only minimally.
- On **Article 14 (Demand reduction measures concerning tobacco dependence and cessation)**, approximately two thirds (65%) of Parties have developed and disseminated comprehensive and integrated guidelines based on scientific evidence and best practices. However, support services remained less available, including quit lines and the integration of diagnosis and treatment of tobacco dependence in primary health care.
- Under **Article 15 (Illicit trade in tobacco products)**, progress continued in the development of tracking and tracing regimes to further secure the distribution system and assist in the investigation of illicit trade. However, the implementation of most of the other measures under this article showed no further improvement. Additional Parties have ratified or acceded to the Protocol to Eliminate Illicit Trade in Tobacco Products since the last reporting cycle, as follows: Egypt, Hungary, Kenya, the Netherlands and the Seychelles in 2020; Ghana and Greece in 2021; the Republic of Moldova and Paraguay in 2022; and Rwanda in 2023.
- Parties continued to strengthen the implementation of most provisions under **Article 16 (Sales to and by minors)**. For example, more Parties reported banning the sale of tobacco products in any manner by which they are directly accessible, such as open store shelves. A few other Parties reported initiatives or concrete actions to raise the age limit under which the sale of tobacco products is prohibited to 18 or older.
- **Article 17 (Provision of support for economically viable alternatives)** and **Article 18 (Protection of the environment and the health of persons)** continue to be weakly implemented among the Parties that reported tobacco growing in their jurisdictions. Only less than one third of these Parties promote viable alternatives for tobacco growers, suggesting minor progress in this area (compared to 29% in 2020), and even fewer for tobacco workers and individual sellers.
- Some progress was observed in relation to implementation of **Article 19 (Liability)**. Both criminal liability measures in tobacco control legislation and criminal liability provisions outside of the tobacco control legislation that could apply to tobacco control became more common. Legal challenges raised by the tobacco industry have persisted in several Parties. However, the

legislation or regulations mandating the implementation of the WHO FCTC have been upheld by their respective courts.

- For **Article 20 (Research, surveillance and exchange of information)**, more Parties reported having a national surveillance system for the consequences of tobacco consumption, and several Parties continued to report progress with carrying out new surveys or research. Importantly, more Parties reported the regional and global exchange of publicly available national information on the practices of the tobacco industry.
- In relation to **Article 22 (Cooperation in the scientific, technical and legal fields and the provision of related expertise)**, in contrast to previous years, fewer Parties reported having engaged in providing and receiving most types of assistance. Only receiving assistance on training and sensitisation of personnel in accordance with Article 12 became slightly more common among the Parties.
- Regarding the appearance of novel and emerging tobacco products and nicotine products on the markets of the Parties, the trend is increasing on all fronts. It has been observed that there has been an increase in the availability in national markets of smokeless tobacco and water pipes, with a notable increase in the percentage of Parties reporting the availability of heated tobacco products (HTPs). An increasing number of Parties reported also availability of electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS) in their national markets. The adoption of policies for new products appearing in these markets has been slower.

Concerning **priorities, gaps, and constraints and barriers** for implementation of the WHO FCTC, there is ample information from many Parties. The obligations under Article 5 (General obligations) were mentioned by most Parties as priorities, particularly in relation to the development of legislation and the enforcement of existing regulations. They are followed as priorities by the implementation of tobacco cessation interventions (Article 14), price and tax measures (Article 6) and measures to ensure protection from exposure to tobacco smoke (Article 8).

In the case of identified gaps between available resources and needs for implementation of the WHO FCTC, the three most frequently mentioned gaps were: a lack of financial resources; a lack of human resources and expertise for tobacco control; and the need for more training and capacity-building in tobacco control. The most reported implementation barrier continues to be interference by the tobacco industry and those working to further its interests, followed by a lack of intersectoral cooperation and coordination.

Progress in implementation was also detected for some indicators of the **Global Strategy to Accelerate Tobacco Control**. However, the level of acceleration in the implementation of the WHO FCTC that was anticipated through the uptake of the Global Strategy has not been achieved. It is therefore essential that the Parties, with the assistance of the Convention Secretariat, WHO and other partners, focus on the comprehensive implementation of the Convention. Better implementation also is critical to prevent the new epidemic of novel and emerging tobacco products and nicotine products, which have spread over the unregulated markets of an increasing number of Parties.

1 Introduction

The *2023 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* is the tenth such report since the entry into force of the WHO Framework Convention on Tobacco Control (WHO FCTC) on 27 February 2005. The Global Progress Report has been prepared in accordance with decision FCTC/COP1(14) taken by the Conference of the Parties (COP) to the WHO FCTC at its first session, which established reporting arrangements under the Convention, and decision FCTC/COP4(16) taken at its fourth session, harmonizing the reporting cycle under the Convention with the regular sessions of the COP. Furthermore, in the latter decision, the COP requested the Convention Secretariat to submit a Global Progress Report on implementation of the WHO FCTC for the consideration of the COP at each of its regular sessions, based on the reports submitted by the Parties in the respective reporting cycle.

Introduction

The scope of this Global Progress Report is threefold. First, it provides an overview of the status of implementation of the Convention based on the information submitted by the Parties in the 2023 reporting cycle and presents some advanced practices that Parties reported in addressing the measures required under the Convention. Second, the report highlights needs and challenges related to the implementation of the Convention, and formulates key observations and conclusions for consideration by the COP in its decision-making to determine possible ways forward. Finally, this report provides updated data for the indicators established by the Parties to measure progress in implementing the *Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025*.

In the 2023 reporting cycle, as was the case for the previous cycle, two questionnaires were made available online for the Parties: 1) the core questionnaire, adopted by the COP in 2010 and subsequently amended for the 2014, 2016, 2020 and 2023 reporting cycles; and 2) a set of "additional questions on the use of implementation guidelines adopted by the Conference of the Parties", available for use by the Parties since 2014 and updated for the 2016 reporting cycle. Both questionnaires are public and can be viewed on the WHO FCTC website.[1] In 2016, reporting on the core questionnaire was conducted for the first time with an online questionnaire. Since 2018, the online questionnaire has been populated for each Party with the data from their latest available implementation report.

The Convention Secretariat conducted the 2023 reporting cycle for the WHO FCTC in accordance with decision FCTC/COP4(16). Of the 182 Parties to the Convention required to report in the 2023 cycle, 134 (74%) formally submitted their implementation reports.[2] Most of the remaining Parties updated their data by the cut-off date for inclusion of Party reports in this analysis but have not formally submitted their reports. Since the publication of the 2021 Global Progress Report, Parties have been able to update some of their 2020 data prior to the opening of the 2023 reporting cycle. In this 2023 Global Progress Report, the updated 2020 dataset is used for the comparative analysis among all 181 Parties that were due to report in the respective reporting cycle.

The report follows as closely as possible the structure of the Convention and that of the reporting instrument. In the reporting instrument, Parties can provide more detailed information of progress in the implementation of the Convention through open-ended

1 https://fctc.who.int/who-fctc/reporting/reporting-instrument

2 For the analysis presented here, all reports submitted and updated in the reporting platform were extracted on 5 May 2023 The following Parties had formally submitted reports by that time: Albania, Algeria, Andorra, Angola, Antigua and Barbuda, Armenia, Australia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belgium, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Cabo Verde, Canada, Chad, Chile, China, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Democratic Republic of the Congo, Denmark, Ecuador, Egypt, El Salvador, Estonia, European Union, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Greece, Guatemala, Guinea-Bissau, Guyana, Hungary, Iceland, India, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Kazakhstan, Kiribati, Kuwait, Latvia, Lebanon, Libya, Lithuania, Luxembourg, Malaysia, Maldives, Malta, Marshall Islands, Mauritius, Mexico, Micronesia (Federated States of), Montenegro, Nepal, Netherlands, New Zealand, Nicaragua, Nigeria, Norway, Oman, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Moldova, Romania, Russian Federation, Saint Kitts and Nevis, Saint Lucia, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, South Africa, Spain, Sri Lanka, Sudan, Suriname, Sweden, Syrian Arab Republic, Thailand, Togo, Tonga, Trinidad and Tobago, Tunisia, Türkiye, Turkmenistan, Tuvalu, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Uzbekistan, Vanuatu, Viet Nam and Yemen. The status of submitted reports is available at https://fctc.who.int/who-fctc/reporting/parties-reporting-timeline.

questions. This qualitative information was utilized for identifying examples of novel approaches or themes where several Parties tended to progress. In addition, examples of progress by individual Parties were searched from the updates regularly published in the WHO FCTC Implementation Database.[3] Further, 10 Parties[4] submitted information on their use of the implementation guidelines adopted by the COP by completing the additional questionnaire. This information is also utilized in the report.

Methodological notes

In this 2023 Global Progress Report, implementation of the Convention is analysed as a percentage of the Parties implementing individual key measures under substantive measures. The list of key indicators is available in Annex 1 of this report. In recent years, as shown in previous global progress reports, overall progress as measured by average implementation rates of the substantive articles of the Convention has developed relatively slowly. For this reason, this report focuses on the successes and challenges that Parties are encountering in the implementation of key individual measures. Further, emphasis is being given to the comprehensiveness of the implementation of selected articles reflected in the Global Strategy and/or being time-bound measures, namely articles 5, 8, 11 and 13. These analyses reviewed the implementation of a cluster of indicators derived from the reporting instrument (used in assessing the current status of implementation), with a detailed list of the combined indicators provided in the footnotes of the respective analyses in the corresponding article chapters. This analysis was a new addition to the previous report; it has been further developed in the present report to assess the implementation also by World Health Organization (WHO) regions. For Article 6, also included in the Global Strategy, additional analysis from the previous report in relation to total taxes was also updated for the present report.

Minor changes occurred in the way the analyses of the key measures under the substantive articles were performed in order to enable a better assessment of their global implementation status. This concerns indicators under Article 12 and Article 14, where most of the indicators are now calculated among all Parties. Under Article 14, analyses related to the reimbursement of costs were refined to be calculated among those providing the respective treatment, and those reporting having the respective medicine in the national market. These changes have also been calculated for the data from the 2020 reporting cycle utilized in this report. Detailed information of the changes is available in the footnotes of Annex 1.

It should also be noted that implementation of Article 17 (Provision of support for economically viable alternative activities) and Article 18 (Protection of the environment and the health of persons) is considered only among tobacco-growing Parties, but still the questionnaire allows for only little data collection on tobacco product manufacturing and on switching to alternative livelihoods among tobacco workers (in factories) and individual sellers (of tobacco products).

This report also provides *examples of how the Parties have progressed in their implementation* of the Convention. These include examples of recent activities, legislative processes and other actions. The examples are based on Parties' answers to the open-ended questions in the core questionnaire, responses to the additional questions and on news and updates identified or received from them in the period between the last two reporting cycles published in the WHO FCTC Implementation Database or on WHO FCTC social media. In addition to individual chapters on the implementation of the substantive

3 See them under https://extranet.who.int/fctcapps/fctcapps/fctc/implementation-database/implementation-news. Please note that this section is regularly updated as new information emerges from the Parties.
4 Cabo Verde, European Union, Lithuania, Malaysia, Mauritius, Netherlands, Nigeria, Saudi Arabia, Spain and Thailand.

articles, Parties experiences related to specific articles can be referenced under the sections on priorities, needs and gaps, and novel and emerging tobacco products and nicotine products.

Some *limitations* concerning data analysis should also be noted. The Parties' implementation reports are not subject to systematic validation. For example, the confirmation of responses against laws, regulations and programmatic documents (such as national strategies or action plans) does not always include enforcement and compliance aspects, unless Parties provide this information in the open-ended questions (except in the Article 8 section of the core questionnaire, in which Parties are required to provide information on their enforcement activities). This may lead to some discrepancies between the information reflected in the implementation reports and experiences on the ground. In addition, the analysis of responses under Article 13 (Tobacco advertising, promotion and sponsorship) is also difficult and should be interpreted with caution, as Parties tend to interpret their regulation of tobacco marketing as comprehensive, while indicating that their bans do not include various advertising and marketing means listed in the Annex to the *Guidelines for Implementation of Article 13 of the WHO FCTC*, which guides the understanding used during the analysis for defining the comprehensive ban on tobacco advertising, promotion and sponsorship.

All *figures and tables* in this document have been prepared by the Convention Secretariat, based on information received in the reporting cycle, unless otherwise mentioned. Acknowledgements are included for each photograph published in this report.

In relation to the figures, the percentages up to 100% reflect the proportion of affirmative responses calculated among all Parties (n=182 in 2023; n=181 in 2020), unless otherwise stated, including the Parties that did not submit a report, the questions that were left without a response (including those that are "Not applicable" to the respective Party) and the "No" responses in the respective questions in the reports.

In recent years, as shown in previous global progress reports, the overall progress as measured by average implementation rates of the substantive articles of the Convention was relatively slow.

Overall progress in implementation of the Convention

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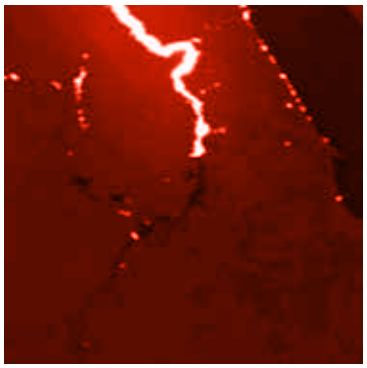


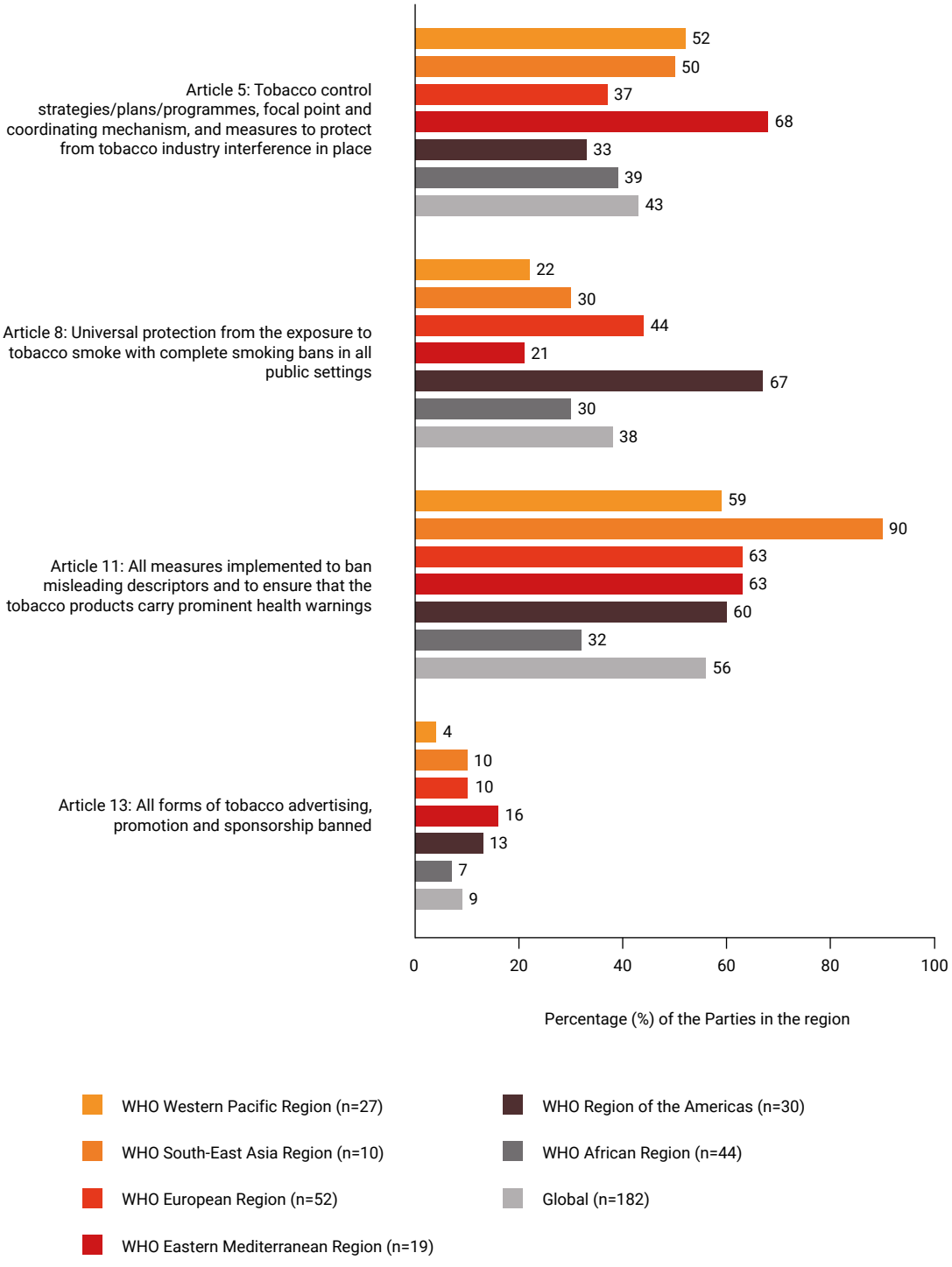
The overall status of the implementation of the Convention was assessed based on key indicators under each substantive article, presented as a whole in **Annex 1**. The status described in this report reflects the status as of 5 May 2023. Implementation rates of the key indicators and overall implementation rates per article continue to vary. They are presented in the following chapters.

As in the previous report, an analysis of the articles prioritized in the Global Strategy, namely 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 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship), was also conducted to shed light on the comprehensiveness of measures taken by the Parties. The comprehensiveness analysis was done both globally and by WHO region (Fig. 1). As seen in the figure, comprehensive implementation of Articles 5, 8 and 11 varies between WHO regions, and comprehensive implementation of Article 13 is significantly lower in all WHO regions. This analysis is further examined in the respective article chapters. Overall, Article 11 tends to be implemented in the most comprehensive manner, globally and in the WHO regions, followed by Articles 5, 8 and 13 of the Convention.

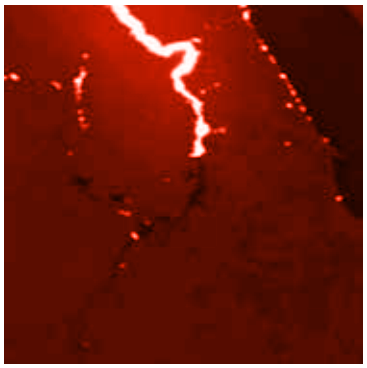
Additionally, to provide Parties an opportunity to observe and reflect on their status in the implementation of the Convention, the count of key requirements reported as implemented under the substantive articles was calculated for all Parties. The results are available by Party in **Annex 2** of this report.

Comprehensive implementation of Articles 5, 8 and 11 varies between WHO regions, and comprehensive implementation of Article 13 is significantly lower in all WHO regions.

Fig. 1. Percentage of Parties that have reported implementing all the key measures under articles 5, 8, 11 and 13 in 2023, globally and by WHO region. The list of the included indicators is provided in the respective article chapters.



3 Implementation of the Convention by provisions



Relationship between this Convention and other agreements and legal instruments (Article 2)

In relation to Article 2.1 (Measures beyond those required by the Convention and its protocols), several Parties reported in different parts of their reports on plans to reduce tobacco use prevalence under 5% or achieve a smoke- or tobacco-free generation by a certain date through different mechanisms. These Parties include, but are not limited to, the European Union, Finland, Ireland, the Netherlands, New Zealand, Norway, Sweden, Turkmenistan, and Scotland and Wales in the United Kingdom of Great Britain and Northern Ireland. Canada reported that it is exploring new opportunities to reduce tobacco consumption and achieve a prevalence of under 5% by 2035 during the review of its tobacco control strategy.

Turkmenistan reported that a new national plan for tobacco control for 2022-2025 has been drawn up and approved, aimed at achieving the country's tobacco-free status by 2025. In 2022 in Finland, the Ministry of Social Affairs and Health appointed a working group to make proposals for legislative amendments and other measures that could support and promote the end of the use of tobacco and nicotine products by 2030. The report of the working group was published in January 2023. The proposed areas for further action include taxation, prevention of starting the use of tobacco and nicotine products by young people, smoke-free environments, sales and marketing, support for quitting, passenger imports and regulation of new nicotine products, enhanced enforcement, and adequate resourcing, monitoring and evaluation.

Further, two Parties (India, Mexico) have legislated to ban or phase out novel and emerging tobacco products and nicotine products from the market. The Russian Federation is considering similar measures. A limitation on the number of outlets allowed to sell tobacco products was mentioned by two Parties (the Netherlands and New Zealand) as a strategy to reduce access to these products. New Zealand has also expanded the regulatory powers of the government over the composition of smoked tobacco products, including the levels of nicotine (see text box below).

Photo courtesy of Ministry of Social Affairs and Health, Finland

New Zealand

New law amendment aiming for a smoke-free generation

Case study

Photo courtesy of Hāpai Te Hauora

The Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Act 2022 (the Amendment Act)[5] came into force on 1 January 2023, introducing several innovative tobacco control measures that go beyond the requirements under the Convention, in line with Article 2.1 of the WHO FCTC. These include restricting the sale of smoked tobacco products to a limited number of approved retail outlets and prohibiting anyone from selling or supplying smoked tobacco products to people born on or after 1 January 2009 (from 1 January 2027).

Creating a smoke-free generation in New Zealand means anyone born on or after 1 January 2009 will never be able to be lawfully sold smoked tobacco products. The intent is to make sure that the current young generation and successive generations never take up smoking. This is a preventative measure: it is better to never take up smoking than to struggle with quitting at a later stage. This initiative will gradually de-normalize smoking in New Zealand while protecting future generations from the harmful effects of smoked tobacco products. The legislation will not criminalize smoking. Given that this policy will help to prevent people from starting to smoke, this will ensure the smoke-free goal, once achieved, is maintained long term.

Moreover, to make tobacco products less addictive and appealing, the amendment extends the Act's regulatory powers over the composition of smoked tobacco products, including nicotine levels, so that only the products that meet the requirements set out in the regulations can be manufactured, imported or sold in the country.

The Act is also intended to significantly reduce retail availability of tobacco products. The number of retailers around the country that can sell tobacco will be reduced to 600 or less by the end of 2024, representing a 90% reduction compared to the estimated 6000 current retailers.[6]

The various measures under the Act will be introduced gradually, according to a timeline published on the website of the Ministry of Health.[5]

In addition to these requirements, the new Act supports the implementation of the Smokefree Aotearoa 2025 Action Plan[7], which envisages three key outcomes: eliminating inequities in smoking rates and smoking-related illnesses; creating a smoke-free generation by increasing the number of children and young people who remain smoke free; and increasing the number of people who successfully quit smoking. To achieve these outcomes, the Action Plan contains six focus areas: 1) making sure there is M ori leadership and decision-making across all levels of the Action Plan; 2) promoting funding for health promotion and community activities; 3) giving people the "wrap-around" support they need to quit by investing in more tailored help, such as a stop smoking service for Pacific communities; 4) making it easier to quit and harder to become addicted by only having low-level nicotine smoked tobacco products for sale and restricting product design features that increase their appeal and addictiveness; 5) making smoked tobacco products harder to buy by reducing the number of shops selling them and kick-starting a smoke-free generation; and 6) making sure the tobacco industry and retailers obey the law.

5 https://www.health.govt.nz/our-work/regulation-health-and-disability-system/smoked-tobacco-products/smokefree-environments-and-regulated-products-smoked-tobacco-amendment-act
6 https://www.beehive.govt.nz/release/thousands-lives-and-billions-dollars-be-saved-smokefree-bill-passing
7 https://www.health.govt.nz/our-work/preventative-health-wellness/smokefree-2025/smokefree-aotearoa-2025-action-plan/about-smokefree-aotearoa-2025-action-plan

General obligations (Article 5)

Key observations

- Many Parties report having developed and adopted new tobacco control strategies, policies, plans or programmes since the previous reporting cycle. Some others included tobacco control in broader noncommunicable disease (NCD), health and development programmes.
- Several Parties also succeeded in adopting new or strengthening existing tobacco control legislations or parts of them.
- Parties appear to be more focused on implementing Article 5.3, which shields public health policies from the tobacco industry's interference by increasing the openness of its operations.
- The recommendations of Article 5.3 have been used by more than two thirds of the Parties to create and carry out policies that limit the influence of the tobacco industry.

Comprehensive, multisectoral tobacco control strategies, plans and programmes (Article 5.1) In relation to Article 5.1, a comprehensive, multisectoral national strategy has been reported to be in place in 74% of Parties, showing an increase since 2020 (71%) (Annex 1: Section A).

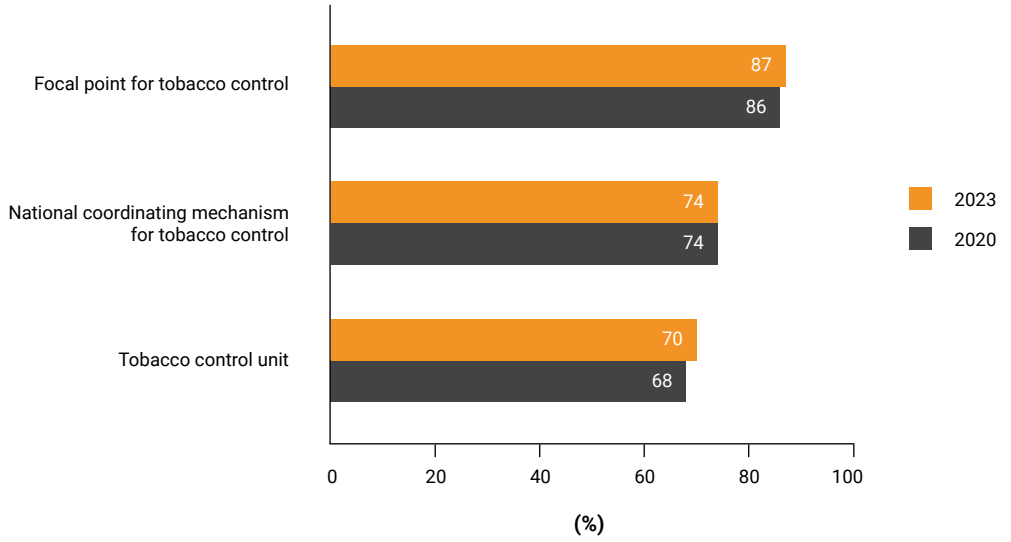
In their progress notes, a number of Parties (Australia, Belgium, Canada, Costa Rica, Denmark, Georgia, Greece, Jordan, Maldives, Mexico, New Zealand, Norway, Philippines, Republic of Moldova, Russian Federation, Saint-Lucia, Thailand, Togo, Turkmenistan, United Kingdom of Great Britain and Northern Ireland (Scotland and England)) reported having developed and adopted new strategies, policies, plans or programmes since the previous reporting cycle. Meanwhile, six Parties (Barbados, Brunei Darussalam, the Czech Republic, Ireland, Papua New Guinea and Spain) reported that their strategies are being developed. In both cases, most often these are stand-alone tobacco control strategies, policies, plans or programmes. In other cases, tobacco control actions are being included in broader NCD prevention programmes (for example, in Barbados and Maldives).

In Australia, a number of subnational governments have their own tobacco control strategies and plans in place to complement the National Tobacco Strategy.[8] China reported that it had integrated tobacco control into a series of national strategies, plans and programmes over the past three years, in areas such as national economic and social development, family education and development plans for women and children. In the framework of the *2nd Action Plan to fight the illicit tobacco trade 2018–2022*,[9] the European Union led and carried out a range of activities in relation to various tobacco issues, including the implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products, strengthened cooperation with third countries, developing further anti-fraud capacities and an awareness-raising campaign, among other measures.

Infrastructure for tobacco control (Article 5.2(a)). A solid infrastructure for tobacco control, with adequate mechanisms of protection from tobacco industry interference, is the basis of good governance which, in turn, ensures that WHO FCTC implementation is efficient and sustainable. The majority (157 Parties) reported having a focal point for tobacco control and more than two thirds (125 Parties) reported having a tobacco control unit (Fig. 2; Annex 1: Section A). Furthermore, nearly three quarters (133 Parties) reported having in place and operating national coordinating mechanisms for tobacco control.

8 https://www.tobaccoinaustralia.org.au/appendix-1/a1-4-australian-tobacco-control-strategies-and-doc
9 See document COM(2018)846 of 7 December 2018: https://anti-fraud.ec.europa.eu/system/files/2021-09/communication_2nd_action_plan_fight_illicit_tobacco_trade_en.pdf

Fig. 2. Percentage (%) of Parties with tobacco control infrastructure in 2020 (n=181) and 2023 (n=182)



Several Parties (Albania, Algeria, Bahrain, Bosnia and Herzegovina (Federation of), Eswatini, Ethiopia, Gabon, Ghana, Malta, Mozambique, New Zealand and Sudan) reported having established new national coordinating mechanisms or reconstituted the previous ones. Tonga reported that the national coordinating mechanism for tobacco control is now placed in the national NCD governance body, which is a committee approved at Cabinet level. Dominica reported that the coordinating mechanism is in the process of being established as a subcommittee of the national NCD commission. Two Parties, Colombia and Costa Rica, indicated that the creation of their national coordination mechanisms is the result of (or developed through) the FCTC 2030 project from which they benefited.

Australia and Canada, two Parties with policies coordinated both at federal and subnational levels, reported various mechanisms that have been put in place. For example, in Australia, the Department of Health regularly collaborates with other Government agencies, state and territory government departments and non-governmental organizations (NGOs), such as national, state and territory cancer councils. Similarly, Health Canada maintains national coordinating mechanisms with provinces and territories, including through the federal/provincial/territorial Tobacco Control Liaison Committee. Health Canada also maintains coordinating mechanisms with NGOs, including through quarterly NGO fora. In India, each state and district has been directed to constitute state and district level coordination committees to review the overall implementation of the National Tobacco Control Programme at the subnational level.

Panama reported the existence of coordination mechanisms between the Ministry of Health for the WHO FCTC and the National Customs Authority for the Protocol to Eliminate Illicit Trade in Tobacco Products, as Panama is a Party to both treaties. Other relevant institutions are also involved in the coordination of implementation of the two treaties, including, but not limited to, the development of a tracking and tracing system for tobacco products.

Yemen reported initiating the revitalization of its national programme and tobacco control infrastructure after the end of the civil war. In February 2021, the coordination mechanism for tobacco control that also encompasses public health offices in the governorates began restoring their operations.

Austria

New Office for Tobacco Coordination established

Case study

On 1 January 2021, the Office for Tobacco Coordination (*Büro für Tabakkoordination*) was established in Austria through an amendment of the Health and Food Safety Act (GESG). Pursuant to Section 6e (1) of this Act, the Office for Tobacco Coordination is established as a joint institution of the Federal Ministry of Social Affairs, Health, Care and Consumer Protection, and the Austrian Agency for Heath and Food Safety (Österreichische Agentur für Gesundheit und Ernährungssicherheit, AGES).

According to Section 6e (2) of the GESG, the new Office is entrusted with tasks related to the enforcement of the Tobacco and Non-smoker Protection Act (Tabak- und Nichtraucherinnen- bzw. Nichtraucherschutzgesetz, hereinafter called as TNRSG), including:

- Planning the statutory monitoring and control of tobacco and related products in accordance with the requirements of the Ministry of Health (either based on an annual plan or on an ad-hoc basis upon request by the Ministry of Health), including documentation of results; tobacco and related products are controlled on a comprehensive manner (not only testing and measuring contents and emissions of the products, but also how the products are presented on the market, what is their appearance, their compliance with packaging and labelling requirements and advertising bans, whether reporting obligations of the producers have been complied with, etc.);
- Sampling of tobacco and related products available on the market (regarding, for example, testing and measuring contents and emissions, packaging and labelling requirements, reporting obligations etc.), within the scope of the respective annual inspection plan or, in case of need, by specially trained agents of the AGES;
- Analysis, appraisal and risk assessment of tobacco and related products, including monitoring whether the reports by manufacturers or importers are compliant with the requirements of the law, as well as the control and evaluation of reported data;
- Preparation of correspondence with authorities, commercial and business enterprises, especially in the case of findings of non-compliance in tobacco and related products, including preparation of documentation for administrative and penal proceedings;
- Contribution to the supervision of the rapid alert, communication and information systems, in particular, the interfaces to, for example, the European Union Early Warning System (EWS/EMCDDA);
- Technical and legal handling of submissions and inquiries by authorities, business representatives, interest groups, international organizations and persons of the general public, to support the Ministry of Health as the competent authority;
- Technical and organizational matters in relation to the annual fees related to the supervision of tobacco products and for the approval of novel tobacco products, pursuant to the TNRSG, and annual evaluation of the fees collected;
- Technical evaluation of products as part of the process of approval of novel tobacco products by the Ministry of Health;
- Technical tasks related to the testing of tobacco product ingredients in accordance with the Tobacco Product Ingredient Survey Ordinance (including monitoring and evaluation of the ingredients and quantities thereof, used in the manufacture of the tobacco products and related products, as well as of the emission levels, which have to be obligatorily reported via the European Union Common Entry Gate (EU-CEG) system);

- Publication of technical information materials on tobacco and related products for the public (for example, available tobacco and related products; product warnings for consumers regarding health risks of tobacco and related products);
- Preparation of technical reports, expert opinions, evaluations and statements on tobacco and related products; and
- Participation in national and international projects and working groups in the field.

Section 6e (5) of the GESG ensures that sufficient professionally and legally competent staff are employed within the Office for Tobacco Coordination and suitable technical equipment is available to carry out its tasks. The head of the Office for Tobacco Coordination is bound by the instructions of the Federal Minister for Social Affairs, Health, Care and Consumer Protection in technical matters (see Section 6e (3) of the GESG).

The financing of the market monitoring measures is done through appropriate annual fees collected from the industry. According to Section 6e (4) of the GESG, those annual fees shall be used solely to cover the needs and expenses of the Office for Tobacco Coordination. The annual fees are set by an ordinance from the federal Minister of Health in agreement with the federal Minister of Finances, in line with the market, based on the sales figures of related products and tobacco products of the previous financial year, financial expenditures for control activities from the previous year and estimates of financial expenditures needed for control activities for the actual year. The budget of the Office for Tobacco Coordination should cover the duties assigned to the Office through the federal law and the ordinances adopted based on the federal law, in particular notification and control activities, data analysis and evaluation, laboratory inspections, risk evaluation and evaluation of studies. This budget does not cover the costs for the authorization of placing novel tobacco products on the market.

The Tobacco Coordination Competence Centre (*Kompetenzstelle Tabak*) – established in 2021 within the Ministry of Health – serves as a liaison between the Ministry and the Office for Tobacco Coordination of the AGES. One of the main tasks of the Tobacco Competence Centre is the coordination, control and assurance of the implementation of the regulations issued by the Office for Tobacco Coordination, in particular with regard to market surveillance and quality assurance of tobacco and related products, as well as of other nicotine products.

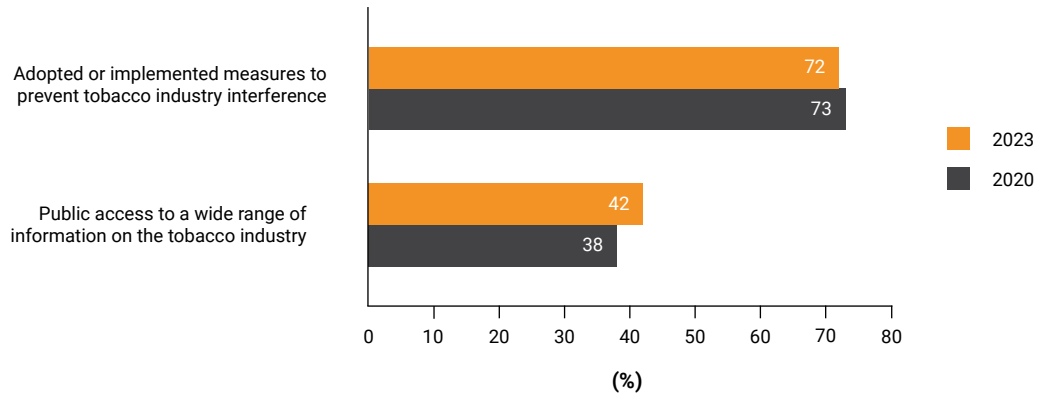
Documents accompanying products sent for testing (Photo courtesy of Ministry of Health, Austria)

Adopting and implementing effective legislative, executive, administrative and/or other measures (Article 5.2(b)). Several Parties reported the adoption of new or updating existing tobacco control legislation. These include Albania (2019), Bosnia and Herzegovina (Federation of) (2022), New Zealand (2022), Panama (2022), Sweden (2022), Trinidad and Tobago (2022), Ukraine (2022), Uzbekistan (2022) and Mexico (2023). Three other Parties (Andorra, Ireland and Serbia) reported being in the process of drafting new legislation.

China reported that reference to tobacco is made in two recent law amendments. On 1 June 2021, the Law of the People's Republic of China on the Protection of Minors came into force. The Law states that no one shall smoke or drink alcohol in schools, kindergartens and other public places where minors are concentrated. Furthermore, on 1 June 2020, the implementation of the Law of the People's Republic of China on Basic Medical Hygiene and Health Promotion helped by taking measures to ensure protection from environmental tobacco smoke. The control of smoking in public places was also strengthened through enhanced supervision and enforcement.

Protection of public health policies from commercial and other vested interests of the tobacco industry (Article 5.3) and related challenges. Overall, 72% (131) of the Parties had adopted or implemented at least one measure recommended in the *Guidelines for Implementation of Article 5.3* to protect public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry (Fig. 3; Annex 1: Section A). Additionally, information on the activities of the tobacco industry was increasingly made available to the public (up from 38% in 2020 to 42% in 2023). For example, Bosnia and Herzegovina had a new comprehensive tobacco control law, signed by the President in 2022. One principle of the new law was a commitment of the Government to regulate relations with the tobacco industry in an entirely transparent manner in order to safeguard public health policies and prevent privileged treatment of the tobacco industry. Additionally, the law requires that all ingredients in tobacco products and their toxicological data submitted by the tobacco industry to the health ministry be posted on the Ministry's website.

Fig. 3. Percentage (%) of Parties implementing provisions under Article 5.3 in 2020 (n=181) and in 2023 (n=182)



Guidelines for Implementation of Article 5.3. Nearly three quarters of the Parties (70%) have reported that they utilized these Guidelines when developing or implementing policies to prevent tobacco industry interference, a proportion similar to the previous reporting period (Annex 1: Section Q). Several Parties reported on their actions taken to implement Article 5.3 of the Convention.

For example, the Ministry of Health and Family Welfare of India established a code of conduct for its autonomous organizations in 2020 under Article 5.3 to protect public health initiatives from the vested interests of the tobacco industry. States at the subnational level have also adopted guidelines to ensure compliance in their respective jurisdictions.

In 2021 in Ireland, the Minister of State with responsibility for Public Health, Wellbeing and the National Drugs Strategy issued letters to all Government ministers and heads of departments to remind them of their obligations under Article 5.3 and requested that the *Guidelines for Implementation of Article 5.3* of the Convention be distributed to all department and agency officials. Additionally, similar letters were sent to all legislators in Dáil Eireann and Seanad Eireann informing them of their obligations in relation to Article 5.3 and enclosing a copy of the Guidelines. In October 2021, Kyrgyzstan implemented a new tobacco control law with a provision aimed at preventing tobacco industry interference, including a prohibition of government agencies from establishing any partnership with or providing preferential treatment for tobacco entities.

Costa Rica also reported producing a code of conduct for public officials in accordance with Article 5.3, as part of the National Tobacco Control Plan for 2020-2030. In Spain, an action protocol was established for meeting requests by the tobacco industry. If the tobacco industry wants to meet with the Tobacco Unit of the Ministry of Health, it must complete a form outlining the purpose of the meeting, participants and topics to be covered, which the Ministry may accept or reject upon review. If approved, a record of the meeting must be prepared and made public to ensure transparency. Mexico has also made significant progress in complying with Article 5.3 (see case study).

Austria reported developments related to the annual fees that must be paid by the industry to cover the supervision of tobacco and related products and the approval of novel tobacco products (Federal Law Gazette No. 43/2017). In 2022, an adjustment was made with regard to the rates of the annual fees (Tobacco Fees Ordinance 2022). It is noteworthy that the Constitutional Court confirmed the constitutionality of the annual fee to be paid by tobacco industry (E 248/2019-17, E 269/2019-18). The Austrian judiciary (Constitutional Court, Higher Administrative Court, Supreme Court) demonstrated in various judgments its restrictive interpretation of the bans on tobacco advertising, promotion and sponsorship.

Some Parties reported on policies under development. Health Canada is developing guidance on Article 5.3, which will be shared across government departments to increase compliance. Georgia had reviewed and updated the “Rules of observance of state policy related to tobacco control at public institutions and in conducting relations with entities involved in the tobacco industry” after it was rejected by the Government in 2018. In 2022, however, the Resolution of the Government of Georgia regarding the implementation of Article 5.3 was re-initiated by the Ministry of Health and is currently awaiting approval. Montenegro reported that on 22 June 2022 a multisectoral expert consultation was held on the protection of public health policies from commercial and other interests of the tobacco industry. Consideration was given to including provisions on Article 5.3 in the national legislation on tobacco control and the development of a draft national code of conduct for government officials at various levels to protect tobacco control policies and programmes from tobacco industry interference. Additionally, in Thailand, the National Strategic Plan was approved by the Cabinet on 15 February 2022. One of the strategies foresees monitoring of tobacco businesses.

Mexico

Development of a protocol of action for public servants, in light of Article 5.3

Case study

From October 2021 to February 2022, Mexico made important changes to its legal framework on tobacco control. The Tariff of the General Import and Export Tax Law was modified, prohibiting the export of the various categories of novel and emerging tobacco products and nicotine products. In addition, the General Law for Tobacco Control was amended, including several provisions to improve compliance with the WHO FCTC by emphasizing the reduction of exposure to tobacco smoke and the regulation of tobacco products, their manufacture and importation, as well as a ban on all forms of advertising, promotion and sponsorship.

Between 2022 and 2023, the Executive Branch issued several decrees related to the General Law for Tobacco Control to strengthen the ban on the import and export of electronic nicotine delivery systems, electronic non-nicotine delivery systems and heated tobacco products, as well as liquids, blends, cartridges and detachable units for these products.

Following the entry into force of the amendments and litigation by the tobacco industry, the Ministry of Health, through the National Commission on Mental Health and Addictions (CONASAMA), developed an action protocol for public servants and promoted its publication and implementation, in accordance with Article 5.3 of the Convention and its Guidelines for Implementation – specifically recommendations 1.2, 2.1,2.2, 3.2, 4.1, and 4.2 – as one of its priority actions. To highlight key measures, in line with recommendation 1.2 of the *Guidelines for Implementation of Article 5.3*, the Health Commission of the Senate raised the awareness of parliamentarians about the interference of the tobacco industry and the need to address it. The Commission is a legislative committee overseeing and legislating matters related to health policies. It also promoted public debates and parliamentary fora for stakeholders free of conflicts of interest, thus avoiding the participation of any representative belonging to, associated with or related to the tobacco and nicotine industry. The aim is for this protocol be implemented progressively: in the short term, it will focus on the Ministry of Health; in the medium term, at the federal executive level; and in the long term, at the federal level, including the three powers of the state, namely executive, legislative and judiciary.

As a first outcome of the process, the signing of a written declaration of interests at CONASAMA related to the tobacco industry or those working to further its interests has been established in all external meetings, to be provided by all participants who are not Ministry of Health staff. The Ministry of Health also uses a generic text in its external official communications, which emphasizes its obligations to the Article 5.3 of the WHO FCTC, as follows:

“The relationship with the tobacco industry and related associations, is restricted by the WHO Framework Convention on Tobacco Control (WHO FCTC) signed by the Government of Mexico on 12 August 2003, ratified by the Senate of the Republic on 14 April 2004 and published in the Official Gazette of the Federation on 12 May 2004, which mentions in its Article 5.3 ‘General obligations’ and in its Guidelines for Implementation that, when establishing and applying public health policies related to tobacco control, these must be

Photo courtesy of Oficina Nacional para el Control del Alcohol y Tabaco, Mexico

protected from commercial interests and other vested interests, and that governments should limit interactions with the tobacco industry and its partners to the maximum extent possible."[10]

Mexico, as a Party to the WHO FCTC, recognizing the adverse challenges posed by the tobacco and nicotine industry or those working to further its interests, has made great strides to strengthen implementation of Article 5.3 of the Convention by establishing various measures in accordance with the recommendations prescribed in the implementation guidelines. With the commitment of the executive branch – and based on the right to health and a healthy environment, and the protection of the best interests of children over any other vested or commercial interests – Mexico is actively working to safeguard its public health policies from the interference of the tobacco industry.

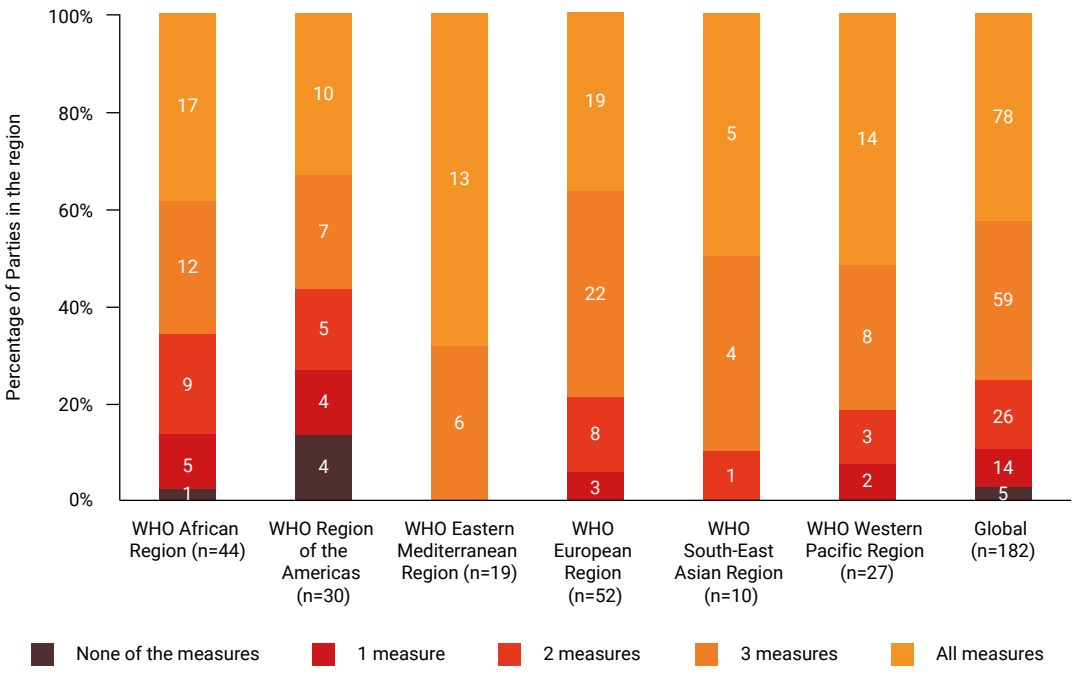
10 Not official translation. Original text in Spanish as follows: "El relacionamiento con la industria del tabaco y asociaciones afines, se encuentra restringido por el Convenio Marco de la OMS para el Control del Tabaco (CMCT OMS) firmado por el Gobierno de México el 12 de agosto de 2003, ratificado por el Senado de la República el 14 de abril de 2004 y publicado en el Diario Oficial de la Federación el 12 de mayo de 2004, el cual menciona en su artículo 5.3 "Obligaciones generales" y en sus directrices de aplicación que, a la hora de establecer y aplicar políticas de salud pública relativas al control del tabaco, éstas se deben proteger de los intereses comerciales y otros intereses creados, asimismo establece que los gobiernos deberán limitar al máximo las interacciones con la industria del tabaco y sus asociados".

Comprehensiveness of the implementation of Article 5. In addition to the analysis of the individual measures required under the Article 5, the comprehensiveness of the implementation was analysed by reviewing a cluster of measures related to the national strategies, tobacco control infrastructure and protection from tobacco industry interference. The indicators used included: national multisectoral tobacco control strategies, plans and programmes; focal points for tobacco control; national coordinating mechanisms for tobacco control; and measures to prevent tobacco industry interference.

Globally, 78 Parties (43% of the 182 total Parties) had reported implementing all measures included in this analysis. Comprehensive implementation of requirements under Article 5 was most prevalent in the WHO Eastern Mediterranean Region, reported by 68% (13 out of 19) of the Parties in the Region, followed by the WHO Western Pacific Region with 14 Parties (52% of the 27 Parties in the Region).

Globally, only five Parties (3% of the 182 total Parties) had reported implementing none of the measures included in this analysis (see Fig. 4).

Fig. 4. Number of requirements implemented under Article 5, global and by WHO regions, in 2023 (n=182)[11]



11 This analysis includes the following indicators from the reporting instrument: 1) national multisectoral tobacco control strategies, plans and programmes; 2) focal points for tobacco control; 3) national coordinating mechanisms for tobacco control; and 4) measures to prevent tobacco industry interference. The figures presented within the bars are number of Parties in the respective category in the respective region. The percentage (%) distribution is within the respective region.

Comprehensive implementation of requirements under Article 5 was most prevalent in the WHO Eastern Mediterranean Region, reported by 68% (13 out of 19) of the Parties in the Region.

Measures relating to the reduction of demand for tobacco

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

Key observations

- About 20% more Parties have cigarette price data available for analysis in 2023 than did in 2020; however, reporting on the price of other tobacco products remains a challenge.
- Parties with data available on taxation on tobacco products increased as well by 5% (from 127 Parties in 2020 to 133 in 2023). However, similar to price data figures, Parties that report tax rates commonly provide information on tax rates for cigarettes only, not for other tobacco products.
- Parties in four WHO regions reported an increase in the average tobacco tax burden. However, as in the previous reporting cycle, only the European Region has an average tobacco tax burden that meets the 75% tax benchmark.
- A mixed excise tax system (a combination of specific and *ad valorem* taxes) continues to be the most common excise tax structure implemented globally.
- Relatively few Parties report that they consider price and income elasticities of demand and inflation when they are adjusting tax rates.

Taxation of tobacco products: total tobacco-tax burden. After the 2023 reporting cycle, 133 Parties had sufficient information for the analysis of the total tobacco-tax burden.[12] Based on these data, the median global total tax burden is 60%, which is unchanged since 2020. Table 1 shows that the WHO European Region continues to have the highest total tax burden, as was the case in the 2020 reporting cycle. The Region continues to be the only one that meets the recommended minimum tax burden threshold of 75%. At the same time, the WHO African Region continues to have the lowest median total tax burden, at 30%, down by four percentage points since 2020. Similarly, a negative change in the median total tax burden was detected in the Western Pacific Region, where the median tax burden has decreased by 12 percentage points from 60% in 2020 to 48% in 2023. The remaining four regions have experienced an increase in the median total tax burden since the previous reporting cycle, with the biggest improvement coming from the Region of the Americas. Similar to the 2020 dataset, overall only 38 Parties (21%) reached the 75% average tax incidence benchmark.

12 It should be noted however that there was no consistency in the responses to this question. Some Parties that reported in 2020 did not report in 2023, and vice versa. Also, some Parties reported increases in tax burdens, while others reported decreases. The overall analysis was made using the latest available data provided by the Parties to the Convention Secretariat.

Table 1. Median total tax burden by WHO region, and global tax burden weighted average and median,[13] 2020 vs 2023

Median total tax burden		
WHO region	**2020** (% and No. of reporting Parties)	**2023** (% and No. of reporting Parties)
African	34% (27)	30% (27)
Americas	49% (26)	56% (25)
Eastern Mediterranean	68% (11)	71% (14)
European	76% (39)	77% (42)
South-East Asia	54% (5)	59% (7)
Western Pacific	60% (19)	48% (18)
Global tax burden weighted average and median		
Weighted average global tax burden	55%	56%
Median global tax burden	60%	60%
Number of Parties included in the calculation	**127**	**133**

Tobacco tax structures. In the 2023 reporting cycle, 160 Parties provided data on their tobacco tax structures, compared to 119 Parties in 2020. Table 2 shows that the most common tobacco excise tax structure globally is the mixed excise tax system which incorporates both specific and *ad valorem* taxes. This applies to all WHO regions, except for the Western Pacific, where the preference is for pure specific tax structures. These trends have remained unchanged since the last reporting cycle.

Similar to 2020, only Sao Tome and Principe in the African Region, China in the Western Pacific Region, and Afghanistan, Iraq and Jordan in the Eastern Mediterranean Region continued to have import duties only. On the other hand, in the Eastern Mediterranean Region, Tunisia has shifted from having import duty only to a mixed excise tax, and Lebanon shifted to *ad valorem* tax only.

Table 2. Tobacco tax regime based on the 2023 reporting cycle, by WHO region

WHO region	Type of excise tax							Import duty only	%	Total no. reporting (i.e. with tax answer)	Without tax answer
	Specific only	%	Ad valorem only	%	Both specific and ad valorem	%	Total excise				
African	8	22%	9	24%	19	51%	36	1	3%	37	6
Americas	2	8%	4	16%	19	76%	25	0	0%	25	1
Eastern Mediterranean	5	28%	3	20%	7	47%	15	3	17%	18	0
European	9	19%	1	2%	38	79%	48	0	0%	48	0
South-East Asia	2	33%	1	17%	3	50%	6	0	0%	6	1
Western Pacific	13	50%	2	8%	10	38%	25	1	4%	26	1
Overall	**39**		**20**		**96**		**155**	**5**		**160**	**9**

13 The "weighted average" takes into consideration the total number of Parties in each region, in order to account for the differences between each region, and non-responses on the reporting of the total tax burden. The "median" is useful for a skewed distribution and denotes the value which lies at the midpoint of that distribution.

Prices of cigarettes. In the 2023 reporting cycle, 147 Parties reported information on the prices of the most widely sold brands of domestic and/or imported cigarettes, up from 123 Parties in the 2020 cycle. This improvement is mainly due to several Parties in the African, Americas, Eastern Mediterranean, European, and Western Pacific Regions that provided additional information.

Table 3 presents, by WHO region, the lowest and highest reported prices for a pack of 20 cigarettes of the most widely sold brands based on the 2020 and 2023 reporting cycles. These prices were converted from Parties' national currencies to US dollars using purchasing power parity conversion factors. The ratio of the highest and lowest prices within each region is also presented. Other than the Western Pacific and South-East Asia regions, WHO regions experienced an increase in the highest prices compared to 2020. The European Region reported a substantial increase in the highest prices, making it the Region with the highest prices of the most widely sold brands of cigarettes. Overall, in five of the six WHO regions, the ratio of the highest to the lowest price is higher than in 2020, indicating an increase in the spread of the highest prices.

Table 3. Lowest and highest reported prices of the most sold pack of 20 cigarettes in US dollars at purchasing power parity by WHO region in 2020 and 2023[14]

WHO region	2020[15]				2023			
	Lowest US$	Highest US$	Ratio	Total reporting Parties with data in 2020	Lowest US$	Highest US$	Ratio	Total reporting Parties with data in 2023
African	0.14	18.89	134.9	31	0.11	19.46	176.9	38
Americas	3.15	15.61	4.96	23	3.00	22.28	7.42	24
Eastern Mediterranean	0.99	12.29	12.41	13	0.66	14.49	21.95	16
European	0.65	18.79	28.91	34	0.65	23.95	36.84	41
South-East Asia	1.50	21.05	14.03	6	4.33	14.18	3.27	6
Western Pacific	3.54	21.31	6.02	16	0.28	20.96	74.86	22
Total				**123**				**147**

Tax- and duty-free tobacco products. Globally, nearly two thirds (63%) of the Parties reported that they prohibit tobacco imports by international travellers, and nearly half of the Parties (48%) indicated that they restrict the sale of cigarettes to international travellers. These figures are unchanged compared to the previous reporting cycle.

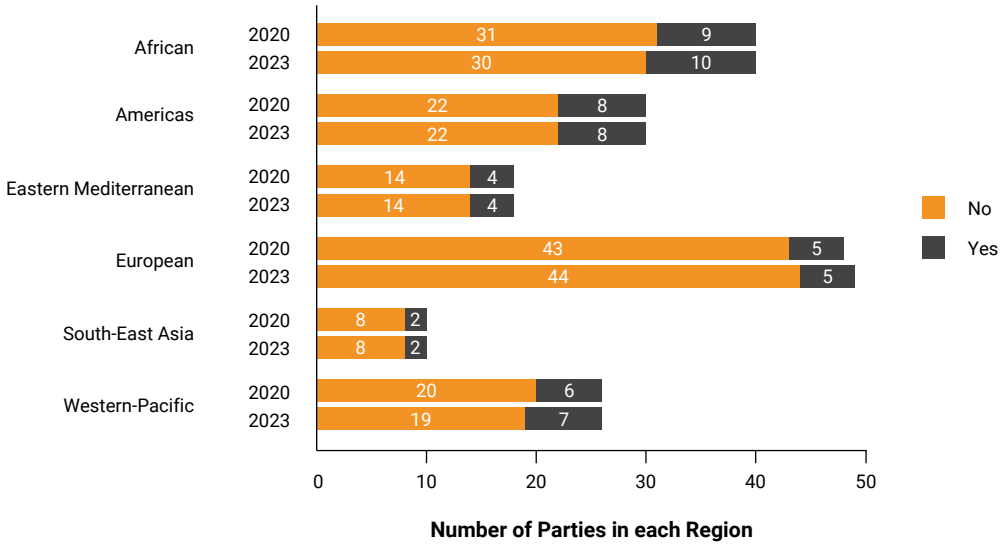
Earmarking tobacco taxes. Between 2020 and 2023, the number of Parties that reported earmarking a portion of tobacco tax revenue to support tobacco control policies and other activities aimed at national development increased from 34 to 36. Madagascar in the African Region and Kiribati in the Western Pacific Region were added to the list. The European Region has the lowest proportion of Parties that earmark tobacco taxes for

14 Notes to Table 3: In the 2023 reporting cycle, 153 countries reported price data on the most widely sold brands of domestic and/or imported cigarettes. However, data for only 147 Parties were taken into account due to data quality issues. The cigarette prices refer to the mostly widely-sold domestic and/or imported packs of 20 cigarettes converted to international US dollars ($) using 2020 and 2022 purchasing power parity conversion factors collected from the International Monetary Fund (IMF) database.

15 It should be noted that the 2020 prices presented here differ slightly from the ones presented in the 2021 Global Progress report. This is because although five Parties (Ethiopia, Guinea-Bissau, Palau, Tajikistan and Zimbabwe), reported their prices in US dollars, their prices seemed to have been further converted to US dollars, as for many other countries that reported their prices in their national currencies.

national tobacco control policy programmes (Fig. 5).

Fig. 5. Number of Parties earmarking tobacco taxes for various purposes, by WHO region



Consideration of demand elasticities and inflation in tobacco taxation design. An analysis was done for this indicator based on responses by the Parties that completed (at least once) the additional (voluntary) questions on the use of implementation guidelines. Of the 113 Parties that ever provided a response by 2023 to this question, 34 (30%) responded that they consider (or considered if they have not reported on this matter in the 2023 reporting cycle) the price and income elasticities of demand and the inflation rate when establishing tax rates. Of these, 15 Parties (44%) are based in the European Region. Some Parties in the African Region and the Region of the Americas have also reported considering demand elasticities or the rate of inflation in designing their tobacco tax rates (see Table 4).

Table 4. Number of Parties that reported that they consider(ed) demand elasticities and rates of inflation when designing tobacco taxation rates, by WHO region in 2023[16]

WHO region	Price elasticity and/or income elasticity of demand only	Elasticity (price and income – either or both) and inflation	Total
African	4	2	6
Americas	5	5	10
Eastern Mediterranean	0	0	0
European	8	7	15
South-East Asia	2	1	3
Western Pacific	2	1	3
Total	**21**	**16**	**37**

Guidelines for Implementation of Article 6. By 2023, 112 Parties (62%) reported having utilized these Guidelines, compared with 110 (61%) in 2020 (Annex 1: Section Q).

16 This information is based on the dataset extracted from the responses for the additional (voluntary) questions on the use of implementation guidelines. Similar information was not extracted from the 2020 dataset; therefore a comparison was not possible.

Montenegro

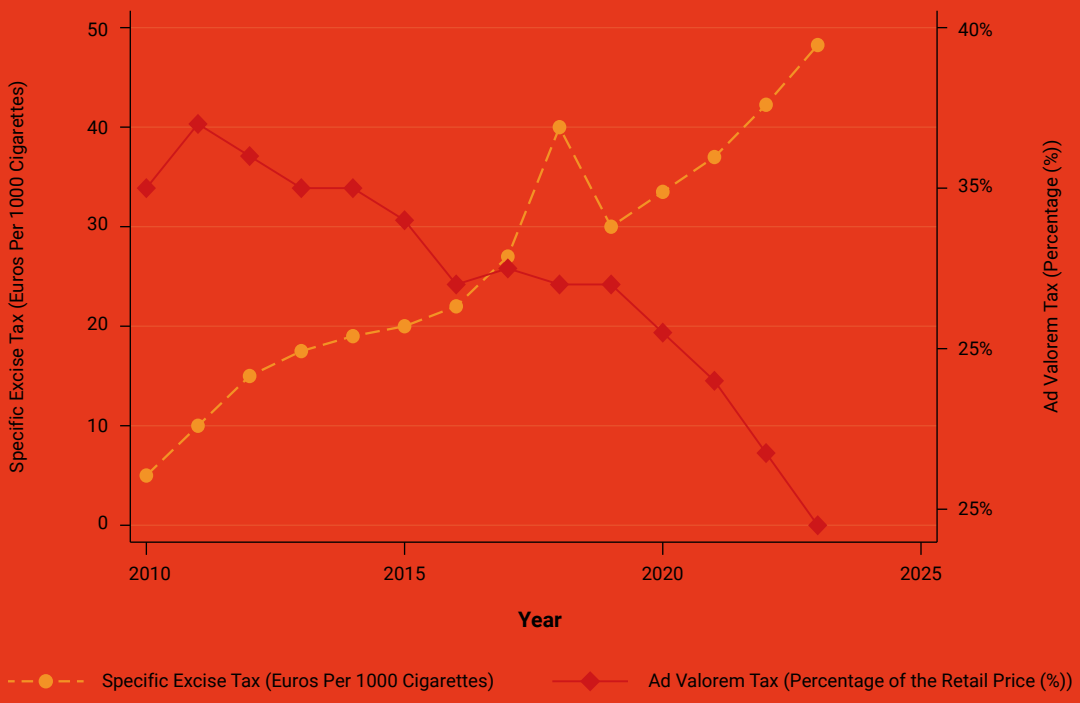
Utilizing the Guidelines for Implementation of Article 6 of the WHO FCTC

Case study

Montenegro is an upper-middle-income Party to the WHO FCTC in the WHO European Region and is a candidate country to become a member of the European Union. Montenegro ratified the WHO FCTC in October 2006[17] and has reported on its implementation since 2009[18]. From the 2016 reporting cycle to date, Montenegro reported that it used the *Guidelines for Implementation of Article 6 of the WHO FCTC* to strengthen its tobacco taxation policy and promote public health.

The total tobacco tax burden of the country is of 76%, which is slightly above the 75% tax incidence benchmark suggested by WHO. Montenegro's tobacco excise tax system is mixed, consisting of both a specific and an *ad valorem* component with a minimum specific floor (€49 per 1000 cigarettes).

Trends in specific and *ad valorem* tax rates in Montenegro, 2010-2023



17 https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IX-4&chapter=9&clang=_en.
18 https://extranet.who.int/fctcapps/fctcapps/fctc/implementation-database/parties/montenegro

In 2019, Montenegro implemented a new law on "limiting the use of tobacco products", which fully aligns with the European Union Council Directive 2011/64/EU.[19] From 2010 to 2023, the minimum specific excise tax has been trending upwards, increasing nearly tenfold, from €5 (in 2010) to €49 (in 2023). In 2022 and 2023, the specific tax increased twice yearly. In 2022, it increased from €40.5 to €44, while in 2023, it increased from €47.5 to €49. On the other hand, the *ad valorem* tax has decreased since 2010 from 35% of the cigarette retail price to 24.5% in 2023 (see "Trends in specific and *ad valorem* tax rates in Montenegro, 2010-2023" figure above). The tax trends shown in the figure above reflect how Montenegro relies more on specific than *ad valorem* taxes. This is one of the best practice tax structures recommended by section 3.1.5 of the *Guidelines for Implementation of Article 6 of the WHO FCTC*.

As described in this Global Progress Report, many countries do not report tax rates and prices of tobacco products other than cigarettes. Montenegro is an exception. Although cigarettes dominate its national tobacco market, in the 2023 reporting cycle the country reported the tax rates and prices of different tobacco products: cigars, cigarillos, fine tobacco products, processed tobacco intended for heating, electronic cigarettes and other new tobacco products. Table 5 details the tax structures and rates for different tobacco products reported by Montenegro in the 2020 and 2023 reporting cycles.

Table 5. Montenegro's excise tax structure and rates by tobacco product, as reported in 2020 and 2023

	2020			2023		
Tobacco Product	**Type of excise tax**	**Rate/ Amount**	**Base**	**Type of tax**	**Rate/ Amount**	**Base**
Cigarettes	Specific	€30	1000 Cigarettes	Specific	€47.50	1000 Cigarettes
Cigarettes	Ad valorem	32%	Retail price	Ad valorem	24.5%	Retail price
Cigars and Cigarillos	Specific	€25	Kilogram (kg)	Specific	€25	Kilogram (kg)
Fine-cut tobacco	Specific	€35	Kilogram (kg)	Specific	€55	Kilogram (kg)
Other tobacco products	Specific	€25	Kilogram (kg)	Specific	€25	Kilogram (kg)
Liquids for refilling e-cigarettes				Specific	€.07	Millilitres (ml)
Processed tobacco intended for heating				Specific	€140	Kilogram (kg)
New tobacco products				Specific	€35	Kilogram (kg)

19 https://tobaccocontrol.bmj.com/content/tobaccocontrol/31/Suppl_2/s124.full.pdf.

Case study

The specific excise taxes are increased annually in the country, in line with the 2017 “Law on Amendments of the Law on Excise Taxes”. Accordingly, from 2010 to 2023, Montenegro has consistently increased specific taxes, and there has been a concomitant increase in tobacco prices per annum. Despite these positive tobacco tax measures, smoking prevalence has increased from 35.4% (2020) to 36.2% (2023). This slight increase could be due to significant illicit trade in tobacco products, which is a threat to tobacco taxation efforts aimed at reducing smoking prevalence.

Montenegro has already implemented measures to combat illicit trade. In 2017, the country ratified the Protocol to Eliminate Illicit Trade in Tobacco Products. Since July 2021, it has prohibited the storage of tobacco products in the free-trade zone in the country’s main seaport and source of cigarette smuggling, Port of Bar. It has also increased surveillance and enforcement measures in the free-trade area in the former state-owned tobacco factory in the capital, Podgorica. Following implementation of these measures, BMJ Tobacco Industries announced that they were closing the factory. Despite the fact that some offshoring fictitious companies are still present in Port of Bar, evidence[20] shows that the size of the illicit trade declined significantly from 51% (in 2019) to between 21% and 26% (in 2022).

Finally, because of Montenegro's commitment to implementing the WHO FCTC since 2006, it was one of the nine additional countries selected to be part of the FCTC 2030 project in 2021. This project aims to provide Montenegro with technical and financial assistance so that it can accelerate and further develop solid tobacco control policies to improve public health and, ultimately, achieve the United Nations Sustainable Development Goals (SDGs).

Photo courtesy of Ministry of Finance, Montenegro

20 https://tobacconomics.org/files/research/846/montenegro-illicit-trade-report-v3.0.pdf.






From 2010 to 2023, Montenegro has consistently increased specific taxes, and there has been a concomitant increase in tobacco prices per annum. Despite these positive tobacco tax measures, smoking prevalence has increased from 35.4% (2020) to 36.2% (2023).

Protection from exposure to tobacco smoke (Article 8)

Key observations

- Article 8, a time-bound article that is among the priorities identified in the Global Strategy, remains the most implemented article of the Convention.
- The areas of progress most often mentioned are the development of new policies to ensure smoke-free environments and strengthening the enforcement of existing measures.
- Comprehensive implementation of Article 8 is still a challenge for many Parties, as is achieving complete smoking bans in the hospitality sector and private workplaces.

Measures to protect from environmental tobacco smoke. In relation to Article 8 (Protection from exposure to tobacco smoke), as reiterated in the Guidelines for Implementation, Parties should strive to provide universal protection within five years of the WHO FCTC's entry into force for that Party. This means ensuring that all indoor public places, all indoor workplaces, all public transport and possibly other (outdoor or quasi-outdoor) public places are free from exposure to second-hand tobacco smoke.

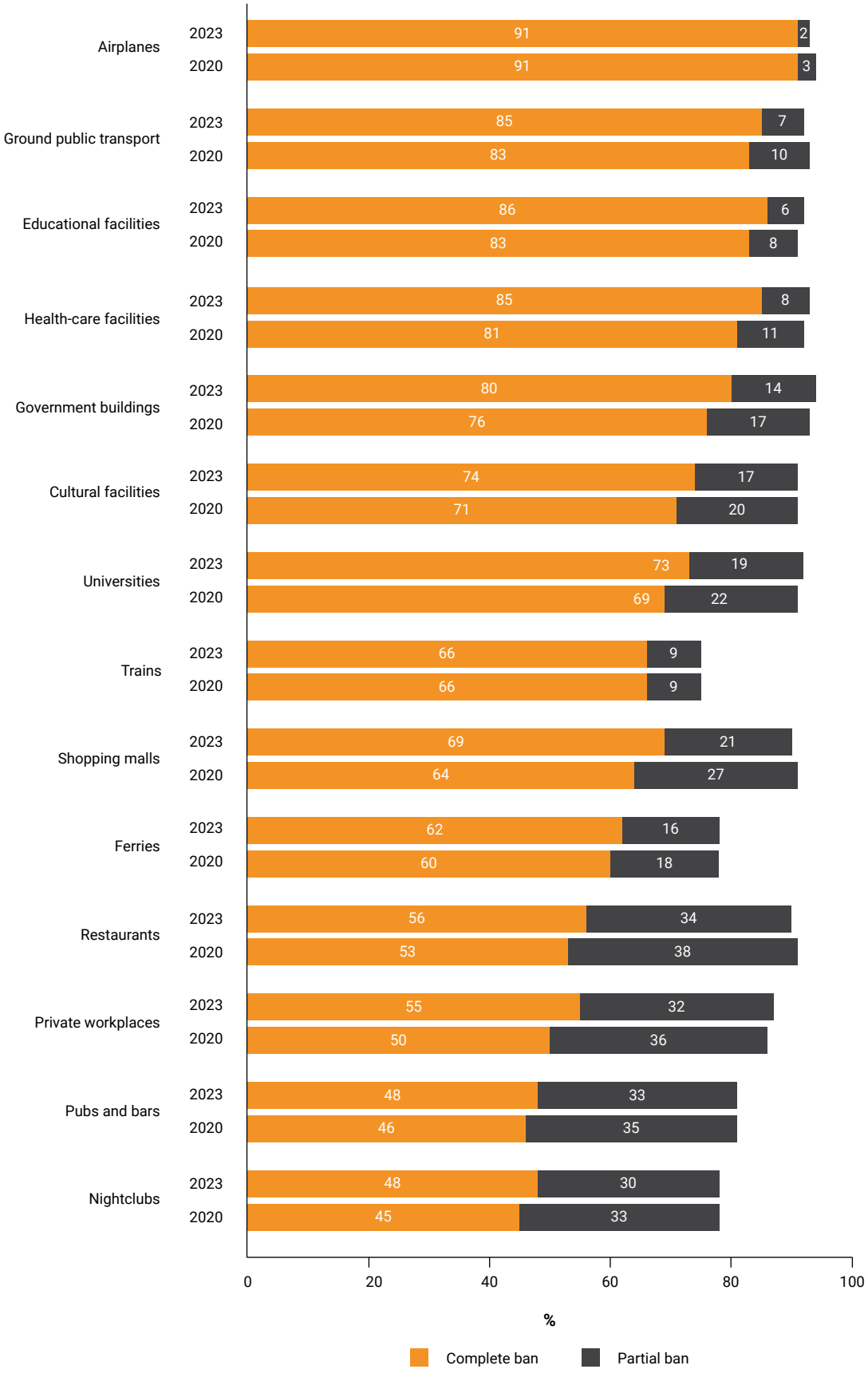
In 2023, 172 Parties (95%) reported that they had implemented measures to protect their citizens from exposure to tobacco smoke by applying a ban – either complete or partial – on tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places (Annex 1: Section C). There was a minor increase as compared to 170 Parties (94%) in 2020.

In 2023, 162 Parties (89%) reported that their national laws require measures to regulate or ban smoking in public places, up from 160 Parties (88%) in 2020 (Annex 1: Section C). In addition, 49 Parties (27%) reported that they have subnational legislation on smoke-free environments. On the other hand, 37 Parties (20%) still reported having smoking bans based on voluntary agreements, although this figure is down from 39 Parties in 2020. The number of Parties providing smoking bans in the form of administrative and executive orders increased from 84 Parties (46%) in 2020 to 90 (49%) in 2023.

As Fig. 6 shows, complete smoking bans are most common in aeroplanes, ground public transport, educational and health-care facilities, where they are applied by more than 80% of Parties. Partial bans are still typical in hospitality establishments – restaurants, pubs, bars and nightclubs – and in private workplaces; around one third of Parties only have partial bans in these settings, although the situation is slightly improved as compared to 2020. A considerably higher number of Parties report having established complete bans in settings such as government buildings (three percentage points increase), health-care facilities (four percentage points), educational facilities (two percentage points) and universities (four percentage points), and private workplaces (five percentage points). A parallel reduction in the number of Parties reporting partial bans has been observed. Another positive trend is observed in relation to public transport facilities and indoor public places. For example, a 7% increase in complete bans for shopping malls was reported.

Photos courtesy of Ministry of Social Affairs and Health, Finland; Convention Secretariat; and National Center for Disease Control and Public Health, Georgia, respectively

Fig. 6. Percentage (%) of Parties that have reported having complete or partial smoking bans in different settings in 2020 (n=181) and in 2023 (n=182)



In the past two years – or since their last report – most often Parties reported progress in introducing new legislation or regulations concerning smoke-free environments and strengthening enforcement of their smoke-free measures. WHO also has dedicated its latest report, *WHO Report on the Global Tobacco Epidemic, 2023* to protecting people from tobacco smoke.[21] Several Parties described new legislative measures, or amendments of their existing legislation, to strengthen the protection of their citizens from second-hand smoke. Those Parties that have reported that they adopted or enacted, since 2020, new legislation with measures concerning Article 8 of the Convention include: Bosnia and Herzegovina, Denmark, Finland, Georgia, Kyrgyzstan, Lithuania, Mauritius, Mexico, Paraguay, Saint Lucia, Ukraine and Uzbekistan. Most Parties that responded to the additional questions (21) confirmed that to ensure smooth implementation of their laws covering protection from exposure to tobacco smoke they implemented awareness-raising programmes among the public and opinion leaders on the risks of second-hand smoke in the course of developing the legislation, consulted with the affected businesses and other organizations and institutions, and led an educational campaign in the period leading up to the implementation of the law.

In Mexico, the amendments to the General Law for Tobacco Control, passed in 2021 and enacted in December 2022, establish, in accordance with the recommendations of the *Guidelines for Implementation of Article 8* of the Convention, a complete ban on smoking and on the consumption of novel tobacco and nicotine products in all enclosed spaces with public access, regardless of whether they are public or private, or whether their structure is temporary or permanent. The ban also applies to open spaces such as stadiums, parks and beaches. Mexico reported that it considers the General Law for Tobacco Control and its Regulations, enforced since 2022, as "the most significant advance in the field of tobacco control, since the creation of the Law itself in 2008. This is a clear example of the political will of the Government to privilege the protection of public health above any other vested interest." It is estimated that the measures contained in the new regulations would generate savings to the Treasury of the order of 155 billion Mexican pesos (approximately US$ 9 billion per year, and the country will avoid 290 000 new diseases and more than 50 000 premature deaths over a 10-year time horizon.
In Uzbekistan, the law – Restricting the distribution and consumption of alcohol and tobacco products – was signed by the President on 25 May 2023 and entered into force three months later. It regulates the use of tobacco products and provides for a ban on the use of tobacco as well as of novel tobacco and nicotine products in all workplaces, public places, public transport, entertainment facilities, and in parks and beaches.

The new legislation and regulations adopted by the Parties, in general, tend to extend smoking bans to the use of novel and emerging tobacco products and nicotine products (that is, vaping) or to outdoor areas or other settings that were not included previously in smoking bans, for example, prisons, casinos, beaches, parks, gardens, and smoke-free buffer zones around outdoor eating and drinking places. For example, Georgia and New Zealand reported new rules for smoking in private cars when children are present. Lithuania and the Russian Federation reported on new rules on smoking in common areas of apartment buildings. Australia (Australian Capital Territory) and Finland reported targeting smoking in prisons. The Law of the People's Republic of China on the Protection of Minors, which took effect on 1 June 2021, stipulates that no one shall smoke or drink alcohol in schools, kindergartens and other public places where minors are concentrated.

Some Parties reported that they are in the process of reviewing their policies in relation to smoke-free environments. For example, the European Commission announced its plans to propose, in 2023, a revision of the Council Recommendation on Smoke-free Environments. Norway reported that in its new tobacco control strategy, the Government committed to

21 https://www.who.int/publications/i/item/9789240077164

consider extending the smoking ban further to outdoor areas. In Tunisia, a presidential decree is currently being developed to ban smoking in enclosed public places. Andorra, Bahamas, Botswana, Dominica and Luxembourg reported that they are preparing to update their tobacco control legislations in which they include new measures concerning Article 8 of the Convention.

Mechanisms/infrastructure for enforcement. Of all Parties, 149 (82%) reported having put in place a mechanism/infrastructure for the enforcement of smoke-free measures (Annex 1: Section C).

Based on their progress notes, strengthening the enforcement of their current laws and regulations was another important focus of Parties' work. Several Parties referred to various enforcement actions they have taken. For example, Azerbaijan reported on the number of administrative penalties imposed by city and district police authorities on people for smoking tobacco in places where it is prohibited by law, but also for environmental pollution with tobacco product waste and for selling tobacco products to minors. In Canada, Ontario has reported having a robust inspection system that included the elements of the *Guidelines for Implementation of Article 8* of the Convention, including signage, regular inspections, penalties and public access to a complaint process. Ontario also regularly monitors progress through a provincial database that records all inspections. In addition, a government agency, Public Health Ontario, is responsible for producing a monitoring report that offers a wider analysis.

The Law of the People's Republic of China on Basic Medical Hygiene and Health Promotion, enforced since 1 June 2020, calls for strengthened supervision and enforcement of measures regulating smoking in public places. Panama provided a detailed description of the operation of their enforcement infrastructure (see the case study). The Republic of Korea notes that administrative fines imposed for smoking within non-smoking areas could be reduced if the smoker agrees to receive cessation advice or attends smoking cessation support services. In Seychelles, in December 2022, randomly selected hospitality premises were inspected concerning the implementation of smoke-free regulations, as well as the ban on tobacco advertising promotion and sponsorship, to assess compliance with the country's tobacco control legislation. Türkiye reported an increase in inspections of the entities serving water pipes. In Trinidad and Tobago, the Tobacco Control Unit of the Ministry of Health developed a public report form with the purpose of capturing reports from the public on violations of the ban on smoking in public places. The form can be found on the Ministry of Health's website.

Panama

A Party engaged with WHO in a tobacco compliance pilot project

Case study

Article 5 of Law 13 of 2008[22] stipulates that "Managers or persons in charge of public or private establishments will be responsible for making the general public and their employees comply with the provisions of this Law and if necessary, may request help from the National Police." This means that the onus of enforcing the smoke-free regulations is placed on the owners and/or managers in the place in which smoking is prohibited. Smokers are not penalized.

Article 12 of Executive Decree 230 of 2008,[23] that provides details on how Law 13 of 2008 should be implemented, establishes the actions that each owner, manager or administrator of an establishment must carry out. It includes a requirement for placing no-smoking signs at the respective venue and taking action against any individual who smokes in an area where it is prohibited by law. Accordingly, the Decree requires that owners and managers "ask anyone smoking in prohibited places to stop said activity due to violating Law 13 of 2008. If this request is refused, require the offender to leave the facilities, and, if necessary, seek help from the National Police to fulfil the eviction requirement."

Implementation of these regulations is monitored by the Ministry of Health (MINSA) and its local, regional and national governing bodies. The inspections are carried out by environmental sanitation and food protection inspectors. This surveillance is conducted in accordance with the provisions of the Sanitary Code, modified by Law 40 of 2006 and Law 54 of 2017. The Sanitary Code mandates MINSA to enter any establishment in order to carry out sanitary inspections.

The inspections carried out by MINSA to verify compliance with the law could occur in three ways: scheduled inspections; special operations; and inspections done as a response to complaints that are made to the national hotline (311), via email, directly at health facilities or through the website www.panamalibredetabaco.com.

The established system for public health surveillance is utilized. As part of the surveillance and monitoring process, measurements of the air quality, that is, the particulate matter in the surveyed environment, could also be carried out, for which "Side Pack" equipment is used. This equipment is made available to health inspectors at the regional and national levels. To ensure their proper use, regular training for the sanitary inspectors is carried out to teach them the use of the equipment and the analysis of results. Work is conducted based on an inspection schedule that, depending on the case, is accompanied by environmental measurements. The environmental sanitation and food protection inspectors are trained based on the training programmes related to tobacco control, in order to keep them updated on the aspects that must be monitored and controlled.

In case of non-compliance, the Law 40 of 2022 establishes five categories of sanctions: written reprimand; pecuniary sanctions ranging from US$ 10 to US$ 100 000; confiscations of tobacco products or any kind of advertising that favours tobacco selling; temporary closures; and permanent closures. The sanctions depend, among other factors, on the seriousness of the offence, recidivism and/or the level of damage to public health.

22 https://panamalibredetabaco.com/documents/20182/99249/Ley+13+De+24+de+Enero+de+2008/3ab2b2ef-62b7-4dcc-918f-904dd9f41db4

23 https://www.minsa.gob.pa/sites/default/files/publicacion-general/10415.pdf

These categories of fines are the same that apply to other violations in the framework of the application of public health measures. The Ministry of Health also plays a role in the enforcement process, as it has created an executing judge position, which is not part of the judicial structure, who must ensure that those who are sanctioned actually pay their fines.

Financing of the inspection process comes from different sources: regular budget funds; funds that are earmarked from tobacco excise taxes for this purpose; and the revenues obtained from fines. With the funds that MINSA accesses from the collection of the selective tax on tobacco consumption, vehicles and other resources are provided to enhance the operational capacity of the regular inspection system.

As part of the compliance strategies, comprehensive anti-smoking campaigns have been carried out on the radio, television and written media, although the emphasis has been concentrated on social networks. Three fixed campaigns are carried out each year that take place in carnivals (which could not be carried out during the COVID-19 pandemic), World No-Smoking Day, National No-Smoking Day and specific campaigns throughout the year, which are based more on social networks and on radio and television interviews. Videos are also made that are placed in health facilities or shared in the actions that are carried out with schools and other educational entities.

In respect of the mobilization and participation of the community, it is worth mentioning that the provisions for smoke-free environments continue to be very well accepted by the population, which became very vigilant and observant of compliance with the rules and denounces violations of the same.

Law 315 of 2022[24] "prohibiting the use, importation, and commercialization of electronic nicotine delivery systems, electronic cigarettes, vaporizers, tobacco heaters, and other similar devices, with or without nicotine" applies the same requirements concerning enforcement and surveillance as described above.

Additional details available at: https://panamalibredetabaco.com/normativa-legal1.

Photos courtesy of Ministry of Health, Panama

24 https://assets.tobaccocontrollaws.org/uploads/legislation/Panama/Panama-Law-No.-315_2022.pdf

Building enforcement capacity was also highlighted by several Parties. For example, Brazil trained sanitary surveillance officers in five states on legislative and enforcement issues. Guatemala, India, Montenegro, and Trinidad and Tobago also reported that training enforcement personnel is an important component of their focus to improve enforcement.

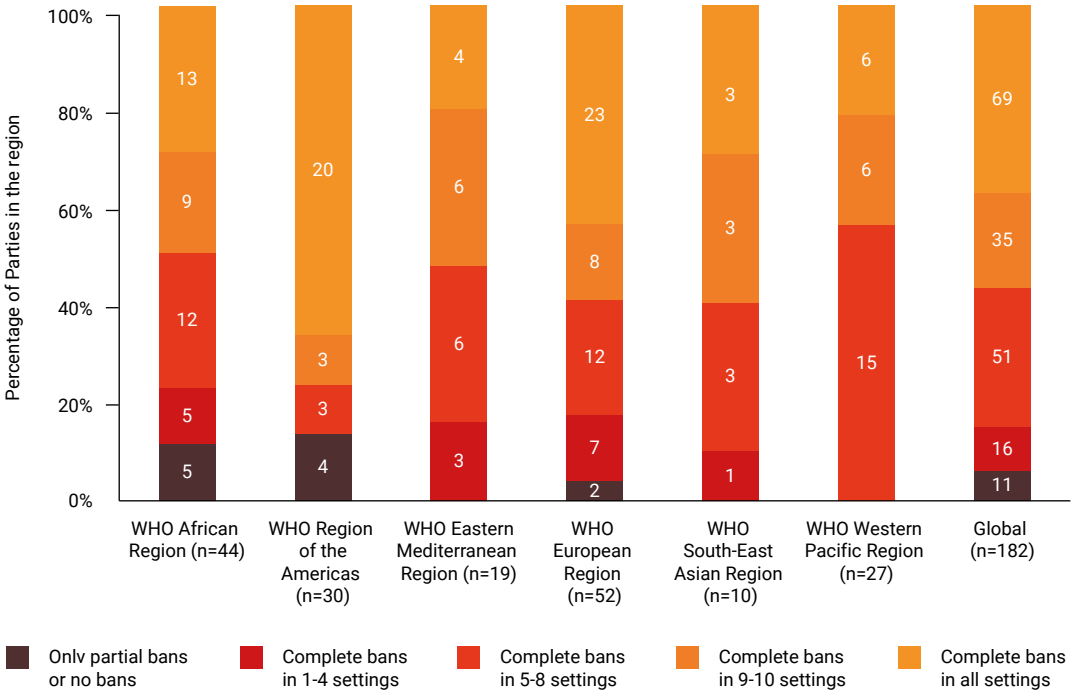
Some Parties reported progress in subnational jurisdictions, with some of those achievements of subnational jurisdictions of the Parties having been mentioned in the paragraphs above. China reported that a few provinces and cities further regulated smoke-free environments and strengthened enforcement (Hangzhou, Henan, Shanghai and Wuhan). The Philippines reported that at the subnational level, there is an increasing number of local government units with local ordinances on 100% smoke-free environments. This is consistent with the conscious efforts to ensure that local ordinances are consistent with WHO FCTC provisions. Australia (Australian Capital Territory, New South Wales, Queensland, Victoria and Western Australia), Canada (British Columbia and Saskatchewan) and the United Kingdom of Great Britain and Northern Ireland (Scotland and Wales) reported making progress in regulating further smoke-free environments in specific settings.

On the challenges side, there are still Parties that reported operating smoking zones in various settings (for example, Luxembourg on train platforms; in Oman the law allows allocating places for smokers within closed areas; Portugal in enclosed places and leisure areas of more than 100 square meters). In Bhutan, smoking in all public places was banned since 2004. However, as the tobacco sales ban was lifted in 2022, now shops openly sell tobacco products and people openly smoke, thus exposing non-smokers to second-hand smoke. Papua New Guinea reported that enforcement is a challenge due to a lack of resources; it is planned that once the registration and licensing fees in relation to tobacco products are raised, resources could be found for this purpose.

Universal protection from the exposure to tobacco smoke – Comprehensiveness of measures under Article 8 of the Convention. Globally, 69 Parties (38% out of 182 Parties) had reported implementing complete bans in all settings included in this analysis (airplanes, ground public transport, educational facilities, health-care facilities, government buildings, cultural facilities, universities, trains, shopping malls, ferries, restaurants, private workplaces, pubs and bars, and nightclubs) (Fig. 7). Two regions stand out in having a higher proportion of Parties with complete bans in all analysed settings: the Region of the Americas has 20 Parties (67% out of the 30 Parties in the Region) that, based on their reports, had reported that they have bans in place for all settings, followed by 23 Parties (44% out of the 52 parties) in the European Region.

Globally, only 11 Parties (6% out of 182 Parties) had reported that they have only partial bans or no smoking bans in any of the settings included in this analysis.

Fig. 7. Number of settings covered by complete smoking bans in indoor workplaces, indoor public places and public transport, global and by WHO regions, in 2023 (n=182)[25]



Guidelines for Implementation of Article 8 of the Convention. By 2023, 136 Parties (75%) reported having utilized these Guidelines compared to 133 (73%) in 2020, continuing the marginally increasing trend (Annex 1: Section Q).

25 The list of included settings from the reporting instrument include: 1) airplanes; 2) ground public transport (buses, trolley buses and trams); 3) government buildings; 4) health-care facilities; 5) educational facilities; 6) universities; 7) private workplaces; 8) cultural facilities; 9) shopping malls; 10) pubs and bars; and 11) restaurants.

Regulation of the contents of tobacco products (Article 9) and regulation of tobacco product disclosures (Article 10)

Key observations

- Approximately half of the Parties reported regulating, testing or measuring the contents and emissions of tobacco products.
- Testing and measuring the contents of tobacco products became more common among Parties compared to 2020.
- No increase in the number of Parties reporting testing and measuring the emissions of tobacco products and regulating the emissions of tobacco products.

Regulating contents and emissions of tobacco products. A total of 87 Parties (48%) reported regulating the emissions of tobacco products, with no change since the 2020 reporting cycle. (Annex 1: Section D).

The reforms of tobacco control in Australia, announced in November 2022, focused on product regulation. Parties that are Member States of the EU, in an effort to put in place measures that are in line with EU's Tobacco Products Directive (2014/40/EU), advanced the development and implementation of their national legislation from 2020. Malaysia amended Regulation 8A on the retail selling price under the Control of Tobacco Product Regulation from 2004, requiring industries to submit reports on product specifications, content and emissions since 2021. In Mauritius, the Restrictions on Tobacco Products, amended in 2022, regulates the contents and emissions of tobacco products. These measures, as well as the testing of products will be implemented by 2024. As of 25 February 2020, the import of electronic devices, components, spare parts and solutions used for the consumption of all kinds of tobacco products is prohibited in Türkiye. Georgia has established the threshold amounts of emissions of filtered and unfiltered cigarettes, and tobacco importers are obliged to provide information on the extent to which their product complies with the specified threshold amounts. In Uruguay, as of January 2023, an electronic form for the declaration of nicotine and tar is required for all tobacco products. In Armenia, the raw tobacco and tobacco products available in the domestic market should be stamped with a compliance sign or accompanied by a compliance certificate. In Jordan, the Tobacco Unit at the Food and Drug Administration monitors and licences tobacco products.

A positive trend has been observed in banning characterizing flavours or additives in tobacco products. Many Parties have reported amending their national laws to regulate new products, including the prohibition on the use of additives and flavourings. Bulgaria, the Lao People's Democratic Republic and Uzbekistan have revised the definition of tobacco products in their national laws.

As part of ongoing efforts to update of Law 1335 of 2009, Colombia carried out, in 2020–2021, a regulatory impact analysis of the regulation of contents and components of tobacco products. This is a document necessary to advance the regulatory processes. The document addresses the effects of flavourings on health and discusses the potential impact of a ban on flavourings.

The Georgian legislation requires disclosure of information about all toxic components, ingredients and flavours used in tobacco products. Mexico reported a legislative proposal that is being worked on with the support of CONADIC (Comision Nacional contra las Adicciones) to promote an amendment to the General Law for Tobacco Control prohibiting all types of additives and flavourings in tobacco products.

Testing and measuring of the contents and emissions of tobacco products. Progress continued in testing and measuring the contents of tobacco products, with 95 Parties (52%) reporting having implemented these measures, as compared to 88 Parties (49%) in 2020 (Annex 1: Section D). The same number of Parties, (88 or 48%) test or measure the emissions of tobacco products as of 2020. Access to governmental or independent laboratories for testing contents and/or emissions of tobacco products is still identified as a challenge by several Parties, but many are managing the testing of tobacco products in either national laboratories or other reference laboratories.

Regulation of tobacco product disclosures. Altogether, 127 Parties (70%) require the disclosure of information on the contents of tobacco products to government authorities, but fewer Parties, 112 (62%), require the same for the emissions of products. Public disclosure of information about the contents of tobacco products has become more common, reported by 106 Parties (58%), while it remains less common for emissions of tobacco products, reported by 86 Parties (47%).

Partial guidelines for implementation of Articles 9 and 10. A greater number of Parties reported that they are now using these Partial guidelines. By 2023, for Article 9, 102 Parties (56%) reported having utilized the Partial guidelines, up from 96 Parties (53%) in 2020. For Article 10, by 2023, 103 Parties (57%) reported having utilized the Partial guidelines, up from 93 Parties (51%) in 2020.

Progress continued in testing and measuring the contents of tobacco products, with 95 Parties (52%) reporting having implemented these measures, as compared to 88 Parties (49%) in 2020.

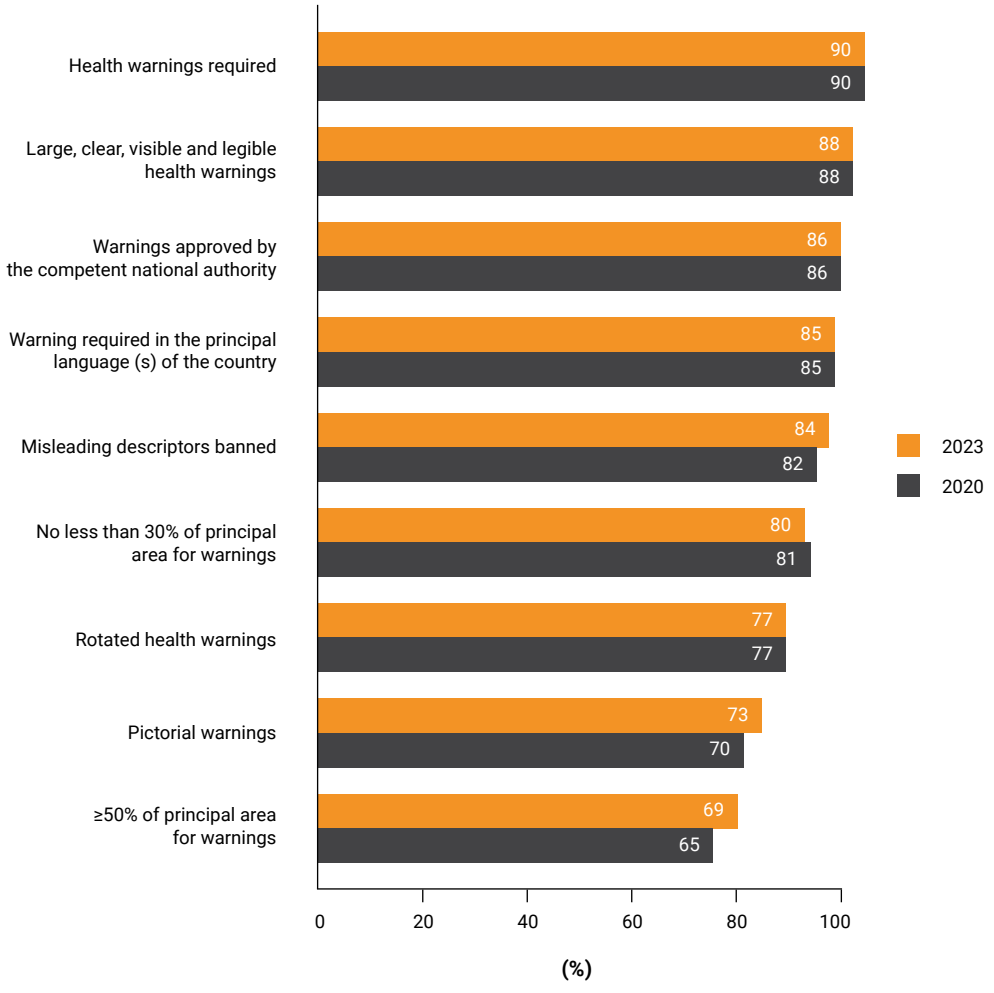
Packaging and labelling of tobacco products (Article 11)

Key observations

- Over half of the Parties have reported having adopted and implemented effective packaging and labelling measures through prominent health warnings, while 19 Parties have not implemented any of the measures on packaging and labelling under the Convention.
- Increasing slightly from 2020, two thirds of Parties require that health warnings cover at least 50% of the main display area of tobacco packages; four out of five Parties reported ensuring that warnings occupy no less than 30% of the principal display areas.
- Almost three quarters of Parties now require that health warnings include pictures or pictograms, and plain packaging also continues to be adopted by more Parties across the globe.

Health warnings. Most Parties (90%) now require health warnings on the packaging of tobacco products, while 19 Parties still do not require any warnings (Fig. 8; Annex 1: Section E). Of all Parties, 126 (69%) reported health warnings covering 50% or more of the principal display areas of the package, with slight improvement from 118 Parties (65%) in 2020, while approximately one third of Parties still need to comply with this requirement. 20 Parties (11%) report that they have not yet reached the requirement of 50% or more of the principal display areas, but are requiring no less than 30% (another 16 Parties have shown improvement regarding these two requirements).

Fig. 8. Percentage (%) of Parties implementing the time-bound provisions under Article 11 in 2020 (n=181) and in 2023 (n=182).



New regulations have been adopted by some Parties requiring an increase in the size of the health warnings. In July 2020, Kazakhstan adopted a new act that increased the size of pictorial health warnings from 40% to 65% of each side of a tobacco product pack or tobacco product packaging, including on packages of products such as heated tobacco or tobacco for a hookah. An order of the Ministry of Health of Tunisia, from January 2022, requests the health warnings cover at least 70% of the packaging of all tobacco products, which previously covered only 30% of the surface, as well as to include images, whereas previously only-text warnings were required. Ukraine also adopted a law in December 2021 requiring that the pictorial health warnings cover 65% of both sides of an individual pack or outer packaging of tobacco products, up from previous requirement of 50%. Uzbekistan adopted a new law in October 2022 requiring an increase in the size of the health warnings from 40% to 65% on the packaging of devices for the use of tobacco and nicotine.

Many Parties (Colombia, Costa Rica, Ecuador, Mexico, Panama, the Philippines, the Republic of Korea, Saint Lucia, Trinidad and Tobago, and Ukraine) reported having adopted and/or implemented a new set of health warnings since the last report.

New tobacco labelling regulation amendments came into force in Canada on 1 August 2023, which include a new requirement forcing manufacturers to display a health warning directly on individual cigarettes, little cigars with tipping paper, and tubes (see text box).

Sixty-five Parties (36%) required the inclusion of information about emissions on packs, seven Parties less than in 2020. The number of Parties that reported that they would grant a non-exclusive and royalty-free licence for the use of health warnings developed in their jurisdiction with other Parties increased from 63 Parties (50%) to 71 Parties (54%). As an example, Malaysia confirmed having given permission to other countries to use their pictorial health warnings.

Use of pictorial warnings. A total of 132 Parties (73%) reported requiring that their health warnings include pictures or pictograms, representing a slight improvement compared to 2020 (Fig. 9). A few Parties reported the introduction of pictorial health warnings. A new rule in Georgia requires the placement of text health warnings on heated tobacco products. And, from 1 January 2025, such health warnings must include a pictorial warning. Tunisia, as mentioned earlier, adopted the incorporation of images in their health warnings, in addition to the increase in their size.

Enforcement of the legislation. In relation to enforcement, Trinidad and Tobago reported how the Ministry of Health, through its Tobacco Control Unit, initiated the assessment of the compliance with the requirements on packaging and labelling among the tobacco products sold locally. It reported that, until December 2022, up to 63% of brands were found to be compliant with the regulations.

Plain packaging. The pioneers on the introduction of plain packaging in their jurisdictions include Australia, in 2012, followed by France and the United Kingdom of Great Britain and Northern Ireland in 2017. Many other Parties have followed their example, with the latest since the 2020 report being, in order of their date of adoption of such legislation: Denmark, Finland, Georgia, Mauritius, Myanmar and Oman.

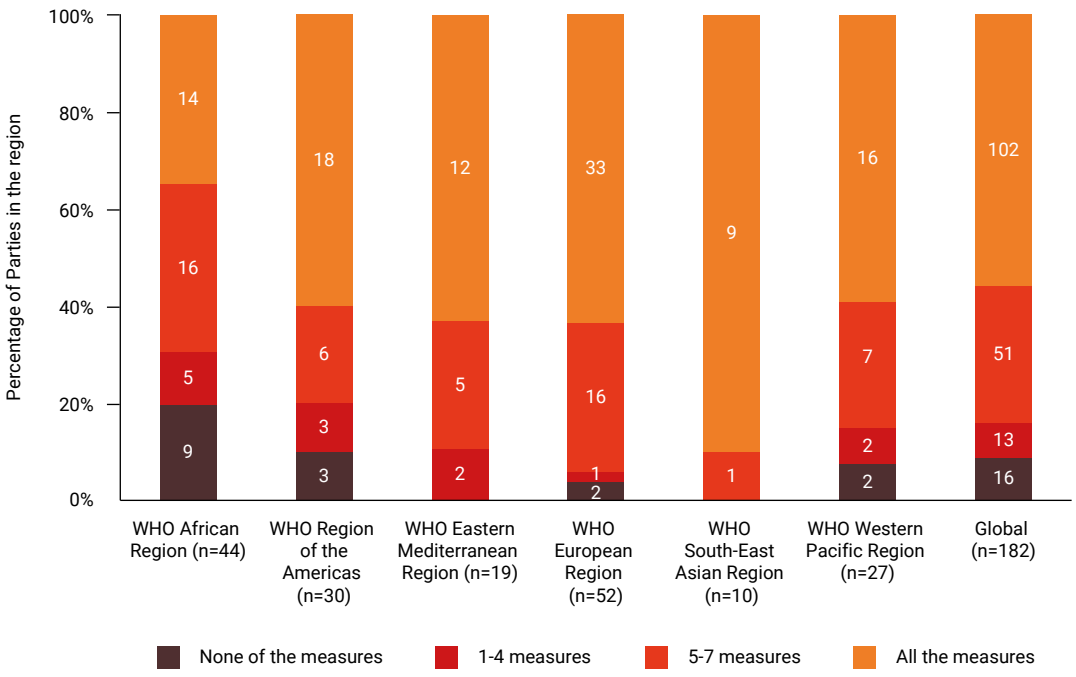
Comprehensiveness and prominence of health warnings under Article 11 of the Convention. By 2023, at the global level, 102 Parties (56% out of 182 Parties) have reported meeting the obligation of adopting and implementing effective packaging and labelling measures through prominent health warnings, and having implemented all the measures covered by this analysis, in line with the *Guidelines for Implementation of Article 11*, as follows:

prohibition of misleading descriptors; health warnings required; health warnings approved by the competent national authority; rotated health warnings; large, clear, visible and legible health warnings; health warnings occupying no less than 30% of the principal display areas; health warnings occupying 50% or more of the principal display areas; and health warnings in the form of pictures or pictograms (Fig. 9). The compliance continues to be low, considering that Parties to the WHO FCTC were to implement these measures in three years following their ratification of the Convention.

The South-East Asia Region leads on the implementation of the aforementioned measures, with nine Parties (90% out of the 10 Parties in the Region) reporting having prominent health warnings. It is followed by the European Region, with 33 Parties (66% out of the 52 Parties in the Region) and the Eastern Mediterranean Region, with such measures in place in 12 Parties (63% out of the 19 Parties in the Region).

Globally, 16 Parties (9% out of 182 Parties) have indicated not implementing any of the measures on packaging and labelling, as required by the WHO FCTC.

Fig. 9. Number of effective packaging and labelling measures, global and by WHO regions, in 2023[26]



Guidelines for Implementation of Article 11. A total of 130 Parties (71%) reported having utilized these Guidelines, a minor increase from 125 Parties (69%) in 2020 (Annex 1: Section Q).

26 List of included measures from the reporting instrument include: 1) prohibition of misleading descriptors; 2) health warnings required; 3) health warnings approved by the competent national authority; 4) rotated health warnings; 5) large, clear, visible and legible health warnings 6) health warnings occupying no less than 30% of the principal display areas; 7) health warnings occupying 50% or more of the principal display areas; and 8) health warnings in the form of pictures or pictograms.

Canada

Health warning labels to be displayed on individual cigarettes

Case study

Canada's latest tobacco labelling regulation amendments came into force on 1 August 2023. These amendments include a new requirement forcing manufacturers to display a health warning directly on individual cigarettes, little cigars with tipping paper, and tubes – making Canada the first country in the world to do so.

Two series of six health warnings, in rotation, will have to be displayed in both English and French on the tipping paper (paper around the filter) of these products. These health warnings include messages such as "POISON IN EVERY PUFF" and "CIGARETTES CAUSE CANCER". This approach is in line with the *Guidelines for Implementation of Article 11 of the WHO FCTC*, which call for Parties to consider the introduction of innovative measures such as, but not limited to, requiring health warnings to be printed directly on cigarettes, increasing the effectiveness of tobacco packaging and labelling measures.
In addition, the amendments strengthen and renew the health-related messages that appear on tobacco product packages, extend health-related information requirements to all tobacco product packages and implement periodic rotation of messages. The changes will be implemented through a phased approach that will see most measures implemented by mid-2024.

The amendments support Canada's tobacco strategy and its target of reaching less than 5% tobacco use by 2035; they are part of continuing efforts to help adults who smoke to quit, to protect youth and non-tobacco users from nicotine addiction, and to further reduce the appeal of tobacco products. Pictorial tobacco package labelling requirements were first adopted in 2000 to increase awareness of the health hazards and health effects associated with tobacco use. The recently adopted amendments share the same purpose.

Photos courtesy of Health Canada

Education, communication, training and public awareness (Article 12)

Key observations

- Most Parties implement educational and public awareness programmes. Importantly, a number of Parties succeeded in sustaining and further developing campaigns or activities established in the previous reporting period, or prior to it.
- A number of Parties reported implementation of new communication campaigns.
- Most of the Parties had addressed their training or sensitization programmes to at least one specific target group. Such programmes were most often addressed to health workers and educators.

Implementation of educational and public awareness programmes. Based on the latest information available from Parties, most Parties (92%) reported that they had implemented educational and public awareness programmes (Annex 1: Section F). A number of Parties succeeded in continuing or further developing their previously established campaigns or activities. These include Albania, Australia, Austria, Azerbaijan, Bangladesh, Belgium, Bosnia and Herzegovina, Bulgaria, China, Colombia, Costa Rica, Ecuador, the European Union, France, Georgia, Germany, Hungary, India, Iraq, the Islamic Republic of Iran, the Marshall Islands, Mexico, Montenegro, New Zealand, Nicaragua, the Netherlands, Norway, Panama, Peru, the Republic of Korea, Saint Lucia, Samoa, Singapore, South Africa, Spain, Trinidad and Tobago, Turkmenistan, the United Arab Emirates, and the United Kingdom of Great Britain and Northern Ireland.

Among them, Turkmenistan reported that every year, the month of May is dedicated to tobacco control. This activity is held throughout the country, and it includes a competition to select a winning “non-smoking enterprise”.

New communication campaigns covering the health risks of tobacco consumption were reported by Gabon, Guatemala, India, the Marshall Islands, New Zealand, Nicaragua, the Russian Federation, Singapore and Thailand. Other new campaigns covering different topics were reported by some Parties, including by Australia (campaign to raise awareness on tobacco industry interference), Austria (campaign to prevent the initiation of tobacco use), China (campaign involving the closest network of family and friends in the cessation of tobacco use), Ecuador (the social costs of tobacco production), the European Union (youth smoking prevention campaign), France (campaign for socioeconomically disadvantaged smokers), the Islamic Republic of Iran (campaign related to tobacco and the environment), Lithuania (healthy lifestyle promotion mass media campaign), Norway (lifestyle/well-being campaign), the Republic of Korea (smoking prevention campaign for teenagers and the smoking cessation encouragement campaign for smokers), Saint Lucia (smoke-free spaces campaign), Spain (campaign on smoking prevention, and on tobacco and the environment), Thailand (second- hand smoke and health risks of e-cigarettes), Trinidad and Tobago (legislation compliance campaign), the United Arab Emirates (second-hand smoke campaign), Uzbekistan (campaigns about benefits of quitting tobacco use, negative environmental and economic consequences of tobacco consumption, prevention of interference of the tobacco industry in the decision-making process) and Vanuatu (campaigns on smoking and COVID-19).

As compared to the previous reports, World No Tobacco Day continued to be the single most-often highlighted event by the Parties. This event was noted by Azerbaijan, Botswana, Brunei Darussalam, China, Colombia, Czech Republic, Equatorial Guinea, Georgia, Guinea, India, the Islamic Republic of Iran, Jamaica, Libya, Panama, Papua New Guinea, Peru, the Philippines, Serbia, Seychelles, Thailand, the United Arab Emirates, and the United Kingdom of Great Britain and Northern Ireland. For example, India reported that on 2021 World No Tobacco Day several activities were performed in collaboration with the Ministry of Health. Through the MyGov platform, online competitions were organized on essay writing, video-making and poster/slogan creation, including for young children and young people.

Target groups and messages of educational and public awareness programmes.
The majority of Parties reported that they had implemented educational and public awareness programmes targeting children or young people (89%), and adults or the general public (86%) (Annex 1: Section F). Many Parties also reported having targeted women (74%), men (73%), and around two thirds of them reported targeting pregnant women (68%). These figures remain stable if we compare them to the previous report. For example, Canada developed the Helping Women Live Smoke-Free Initiative, which supports Family Resource Centres (Healthy Baby Clubs) to address tobacco use among pregnant and post-partum women. This initiative focused on screening for tobacco use and initiating a conversation with women about smoking (see photo below). Targeting ethnic groups remained least common, with less than one third of the Parties (30%) reporting it. However, a small increase was registered when compared to 2020.

Communication material of the Canadian programme Helping Women Live Smoke-Free Initiative

Peru

Preventing drug use in the student population

Case study

The Ministry of Education, in agreement with the National Commission for Development and Life without Drugs, carries out the Programme of Prevention of Drug Use in the Student Population throughout the school year, which targets adolescents aged between 12 and 17 years of age in public education institutions. This programme addresses the prevention of use of all types of legal and illegal drugs, including tobacco.

The objectives of the programme is:

- to strengthen efforts for the prevention of the consumption of tobacco and other drugs among secondary school students;
- to support families in their capacity to help their children face the dangers of all drugs; and
- to support the capacity of teachers to address the prevention of the consumption of legal and illegal drugs.

Moreover, within the framework of the National Curriculum for Basic Education, pedagogical activities are required to address health matters, including, among others, the prevention of the use of substances harmful to health, such as tobacco. According to the Curriculum, these initiatives, carried out in the successive years of education, should include interactive sessions supporting students: 1) to identify tobacco as a drug and learn about its negative health consequences; 2) to de-normalize the use of tobacco, understand the value of smoke-free environments and how to tackle peer pressure to initiate tobacco use; 3) to identify how tobacco advertising has an influence in tobacco initiation; and 4) to communicate assertively to protect themselves and avoid tobacco use.

Another school activity related to health prevention is based on the *Tutoring and Educational Orientation Guidelines* for Basic Education. The related programme focuses on prevention as a line of action to anticipate or reduce the appearance of risk situations or behaviours that endanger the development and well-being of students. For this, two hours per week should be dedicated to sessions that cover various topics, including the prevention of drug use.

Several Parties reported progress in programmes and activities, especially in the school context. For instance, in Austria, a tobacco prevention initiative was launched with the aim of preventing children from taking up smoking as early as possible. The target audience was 10- to 14-year-old children. This initiative focused on the language and media of young people to encourage participation. A service centre for health promotion in Austria's schools (with cooperation between the Federal Ministry for Education, Science and Research, the Federal Ministry for Social Affairs, Health, Care and Consumer Protection, and the Austrian Red Cross) provided information on tobacco and tobacco products for teachers.

In Panama, civil society, including the Panamanian Coalition Against Tobacco, has designed, among other campaigns, the video story *El Pato Fumador*. This video has been used as educational material in schools in the country (see photo below). In order to adapt health communication to the needs of young people, campaigns were developed for them on Instagram and on social networks, particularly related to the communication of health damage caused by electronic nicotine delivery systems (ENDS) and traditional tobacco products. In Singapore, youth programmes were established with the aim to raise awareness about the benefits of leading a tobacco-free lifestyle, dispel common misconceptions about smoking, and equip youth with life skills to refuse cigarette offers. Student health advisers provided tailored smoking cessation counselling to youth smokers in schools.

Screenshot from a video of the Panama campaign "El Pato Fumador"

The majority of the Parties reported having implemented programmes covering the health risks of tobacco consumption (90%) and the risks of exposure to tobacco smoke (89%) in their messages (Annex 1: Section F). The majority of Parties also covered the benefits of cessation (87%). The proportions remained similar to the previous report. The economic and environmental consequences of tobacco production continue to be the least-covered areas in the programmes (45% and 49%, respectively). As an example of communicating about adverse economic consequences of tobacco production, Ecuador carried out educational activities with the participation of various national and international actors (Healthy Latin America Coalition, Corporate Accountability, Global Alliance for Tobacco Control, Fundación Ecuatoriana de Salud Respiratoria and Fundación Anáas de Colombia). Among the main activities, there was a cycle of webinars on illicit trade in tobacco products. In general, no major changes were observed in comparison with the 2018–2020 period.

Addressing training or sensitization programmes on tobacco control to special groups. Most Parties reported addressing their training or sensitization and awareness programmes to at least one specific group (Annex 1: Section F). The programmes were most often addressed to health workers (87%) and educators (73%), followed by decision-makers and community workers (both 64%). No major changes were observed in comparison to the previous reporting cycles; a minor decrease was observed in the proportion of Parties targeting educators, and a minor increase in programmes targeting community and social workers.

Finalists of the campaign "Nicotine takes more than it gives you!", launched by the National Institute of Public Health in 2022, Czech Republic

In training programmes, most Parties targeted health workers on smoking cessation counselling, mostly focusing on brief advice and behavioural counselling. New training programmes were reported by Albania, Colombia, Ecuador, India, the Marshall Islands, Lithuania, the Republic of Moldova, Saint Lucia, Samoa, Singapore and Thailand. For instance, in Albania, a new national training programme was implemented at the level of primary health care for all residents; it includes systematic and structured advice about the cessation of tobacco use. In India, dedicated funds have been made available to state and district tobacco control programmes to conduct training programmes targeted at various stakeholders. In Thailand, short-term training courses for health professionals were implemented to enhance skills to help quit smoking. The aim was to be knowledgeable in providing tobacco cessation services and promoting healthy lifestyles. The courses were built as a Training Programme on Treatment of Nicotine Use Disorder and an Advanced Training Programme on Treatment of Nicotine Use Disorder for Health Professionals.

Several Parties reported advancing their targeted training or programmes to decision-makers and other key stakeholders. In Colombia, the Leadership for Health and Tobacco Control programme was carried out to build capacities among a wide range of actors from territorial entities, government agencies and civil society organizations. In Ecuador a virtual course was created promoting tools for the comprehensive prevention of addictive behaviours. This course was addressed to educators, decision-makers and administrators. In the Philippines, the Department of Health's Health Promotion Bureau, in partnership with civil society organizations, has developed a legal training manual, which is used to inform national government agencies, local government units and any other relevant stakeholders that may be subject to legal challenges by the tobacco industry.

Parties also continued to mention several other groups that they had targeted in their programmes. These included parents and foster parents (China and Ecuador), religious groups (Jordan and Samoa), social and community leaders (Lithuania and Madagascar), police and local authorities (Panama, and Trinidad and Tobago), teachers (Finland and Lithuania), students (Austria and Czech Republic), youth workers (Finland), and employees in private organizations and non-health public sector (Hungary and the Philippines). In Mexico, as a stop-smoking motivation strategy targeting pet owners, a campaign was designed with the slogan "A sniff at health" (*Una olfateada a la salud* in Spanish) that indicates the damage that cigarette smoke causes to pets.

Awareness and participation of agencies and organizations, and use of research to guide the development of programmes. Most Parties (91%) involved public agencies – and the majority of them (84%) involved NGOs – in the development and implementation of intersectoral programmes and strategies for tobacco control (Annex 1: Section F). Over half of the Parties (58%) reported that they involved private organizations. In Austria, the Austrian Red Cross provides information on tobacco and tobacco products for teachers following a programme implemented by the Federal Ministry of Education. In Bosnia and Herzegovina, the Federal Institute for Public Health and the cantonal institutes for public health have undertaken activities with the aim of creating programmes that educate the public about the dangers of smoking. In Cameroon, media and local press are important actors of public awareness for young people and communities. In Costa Rica, a national tobacco control strategy is currently being prepared, and the civil society was invited to participate in the process. In Jamaica, the National Council on Drug Abuse has been providing ongoing public education through universal and selective school and community-based prevention programmes, as well as traditional and social media campaigns. In Trinidad and Tobago, authorized officers, NGOs and the smoking cessation clinics of the Regional Health Authorities were involved in the Commit to Quit campaign.

Parties also continued to report the involvement of other stakeholders in the development and implementation of strategies and programmes. These included academic and higher education institutions, community and scientific groups, professional colleges, police and the military, the media and international organizations including WHO. For example, Malaysia, Panama and Spain reported that researchers and academic societies have been involved in the development and implementation of their programmes.

Altogether, 75% of Parties reported using research to guide the development, management and implementation of their communications, education, training and public awareness programmes, as well as requiring pretesting, monitoring and evaluation, as suggested in the *Guidelines for Implementation of Article 12* (Annex 1: Section F). A small increase in the percentage was observed as compared to 2020 (73%). However, very few Parties gave examples of the results obtained from evaluations in their report. In Australia, the most recent youth campaign – Don't get hooked! – was evaluated in 2020–2021. In the Netherlands, the campaign NIX18 has been evaluated each year since 2014, and the programme *Puur Rookvrij* was being evaluated at the time the Party submitted its report. In Singapore, the programme called I Quit is now into its 10th year and evaluation data has shown that 10% of the participants stayed smoke-free for 28 days.

Guidelines for Implementation of Article 12. By 2023, 122 Parties (67%) reported having utilized these Guidelines, remaining at similar level than in 2020 (Annex 1: Section F).

Celebration of World No Tobacco Day 2023. Photo courtesy of Ministry of Health, Oman

Tobacco advertising, promotion and sponsorship (Article 13)

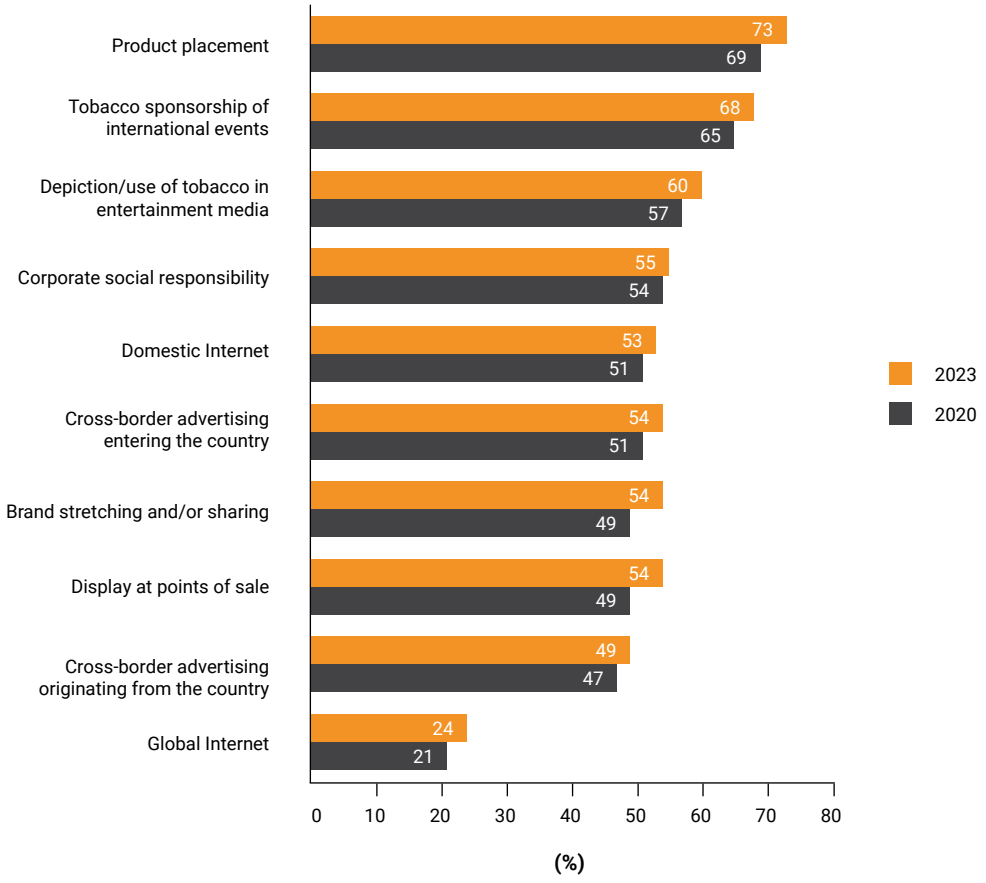
Key observations

- Globally, only 17 Parties have reported having banned all forms of tobacco advertising, promotion and sponsorship (TAPS) as recommended in the *Guidelines for Implementation of Article 13*, despite this being one of the time-bound measures under the Convention.
- In case of banning the various forms of TAPS, a slight improvement is detectable since the 2020 reporting cycle, with the highest increase in the number of Parties banning the display of tobacco products at the point of sale, as well as in brand stretching and/or brand sharing.

Comprehensive ban on tobacco advertising, promotion and sponsorship. Parties have reported on having a comprehensive ban on all TAPS, having increased from 76% in 2020 to 80% in 2023 (Annex 1: Section G). This information should be understood carefully, given the variations in the definitions in the scope of a comprehensive ban on TAPS, which might not cover all the specific measures required by the *Guidelines for Implementation of Article 13*.

It was most common to ban TAPS related to product placement as a means of advertising or promotion (73%), tobacco sponsorship of international events or activities and/or participants therein (68%), and the depiction of tobacco or tobacco use in entertainment media products (60%) . Bans on TAPS on the global internet continue to be implemented by only 24% of Parties. Additionally, more Parties reported having implemented a ban on the display and visibility of tobacco products at points of sale, as well as brand stretching and/or brand sharing. (Fig. 10)

Fig. 10. Percentage (%) of Parties reporting having banned different types of tobacco advertising, promotion and sponsorship in 2020 (n=181) and in 2023 (n=182)

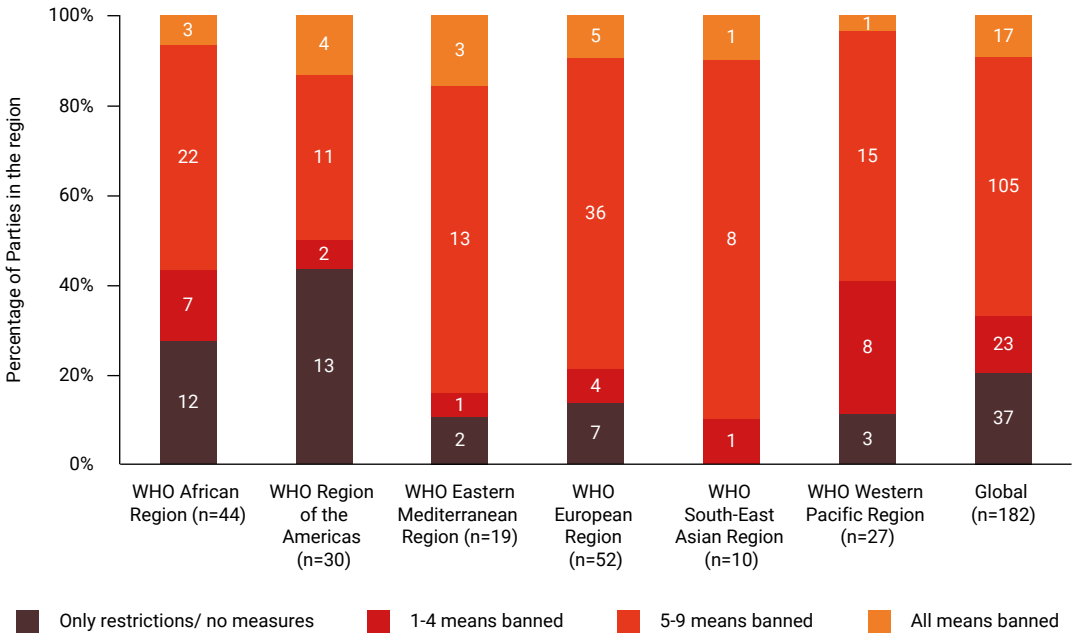


Comprehensiveness of bans on TAPS. Only 17 Parties (9% out of 182 Parties have reported having banned all the listed types of TAPS (three more than in 2020) and, therefore, having implemented a comprehensive TAPS ban in line with the recommendations of the *Guidelines for Implementation of Article 13* (Fig. 11). These data indicate how the understanding of a comprehensive ban could differ taking into account that, responding to a question in the reporting instrument, 145 Parties responded having instituted a comprehensive ban on all TAPS.

According to an analysis by the Convention Secretariat, 105 Parties banned most means of TAPS (103 Parties in 2020), while 23 Parties have banned one to four types of TAPS, no change from the previous reporting cycle. An additional 37 Parties apply only restrictions or no measures at all in relation to TAPS (20% out of 182 Parties), with eight Parties having moved out of this group since 2020.

Fig. 11 also indicates that implementation of TAPS bans continues to vary across the six WHO regions. The Eastern Mediterranean Region is ahead on the implementation of a comprehensive TAPS ban, as reported by three Parties (16% out of the 19 Parties in the Region). The Region of the Americas follows with four Parties (13% out of the 30 Parties in the Region).

Fig. 11. Number of means of tobacco advertising, promotion and sponsorship banned by Parties, global and by WHO regions, in 2023 (n=182).[27]



As far as new advertising laws are concerned, Mexico reported having adopted one in December 2021, becoming the ninth country in the Region of the Americas to establish this sort of comprehensive package. A few other Parties (Bahamas, Madagascar and Peru) reported having developed or working on draft bills including measures on Article 13. New legislation or amendments covering some of the bans on TAPS have also been adopted across the globe. In Georgia, the term "brand stretching" was defined in the law, clarifying that it is also to be considered as a promotion of tobacco products and is prohibited.

27 List of included means of TAPS from the reporting instrument include: 1) display of tobacco products at points of sales; 2) domestic Internet; 3) global Internet; 4) brand stretching and/or sharing; 5) product placement; 6) the depiction/use of tobacco in entertainment media; 7) tobacco sponsorship of international events/activities; 8) corporate social responsibility; 9) cross-border advertising originating from the country; and 10) cross-border advertising entering the country.

Amendments to the Tobacco Products Act in Germany, adopted in July 2023, have expanded the advertising restrictions. For example, new bans have added to outdoor advertising for tobacco products, electronic cigarettes and refill containers (except the outside areas of specialist shops), cinema advertising for these products in films accessible to young people, the commercial payout for these products (particularly in sweepstakes), and the supply of commercial-free samples of cigarettes, roll-your-own tobacco and water-pipe tobacco outside of the business premises of specialist retailers. In addition, the amendment also includes nicotine-free electronic cigarettes in the scope of the tobacco law. Tunisia reported having banned advertising at points of sale. Two new laws have been adopted in Uzbekistan: in June 2022, Law No. ZRU-776 On Advertising banned advertising of tobacco products and devices for the use of tobacco and nicotine, the distribution of free samples and the sponsorship of events; and in October 2022, the Law On Restricting the Distribution and Consumption of Alcohol and Tobacco Products introduced the ban on the sale on internet, and the display and open demonstration of products at points of sale.

Regarding the ban of the display of products at points of sale, in addition to Uzbekistan already mentioned above, Denmark reported that visible placement and presentation of tobacco products, tobacco substitutes and herb-based smoking products at points of sale, including on the internet, is prohibited – with an exception for the online sales of water pipes and the sale of water pipes, water-pipe tobacco and cigars at specialist shops. According to amendments to the Tobacco Control Law in Lithuania, the ban on the display of tobacco products, electronic cigarettes and devices to use them was adopted and will come into force on 1 January 2025. The Republic of Moldova reported having adopted in August 2020 such ban for all types of tobacco products, electronic cigarettes, and devices for heated tobacco products and electronic cigarettes. In 2020, the Russian Federation extended the ban on TAPS to nicotine-containing products and devices for its consumption, including electronic nicotine delivery systems, tobacco heating devices and hookahs.

Cross-border advertising, promotion and sponsorship. The ban on cross-border advertising –originating from one country and viewed in another – is implemented by less than half of Parties (49%), slightly more than in 2020 (47%) (Annex 1: Section G). The cooperation with other Parties in the elimination of cross-border advertising has almost remained the same, at 30% of the Parties, while the imposition of penalties on this type of advertising has seen a decrease, from 41% of the Parties in 2020 to 38% in 2023. According to amendments to the Tobacco Control Law in Lithuania, the Drug, Tobacco and Alcohol Control Department of the Ministry of Health is allowed to block websites containing information not complying with the TAPS regulation, including websites from outside the country with information intended for Lithuanian consumers (see text box).

Depiction of tobacco in entertainment media. The Czech Republic reported on the completion of the transposition of the EU's Audiovisual Media Services Directive (AVMSD), which includes the ban of all forms of commercial communications for tobacco products and electronic cigarettes in the framework of video-sharing platform services. Paraguay and Uruguay mentioned in their respective progress reports that, in June 2022, the Health Ministers of the Southern Common Market (Mercosur) signed an agreement that, among other purposes, included "developing updated regulatory frameworks and tools to regulate and control the promotion and advertising of tobacco products and alternatives in digital media". The indirect advertising of tobacco products in the mass media has now been banned in Tunisia.

Enforcement of the legislation. China reported having dealt with 65 cases of illegal advertisements of tobacco products and issued fines in a value of 2.2994 million yuan (more than US$ 300 000). The European Commission continues monitoring the implementation of the AVMSD (see above), for example, through regular application

reports. Georgia reported establishing a mechanism to monitor and enforce the ban on advertising of tobacco products in printed and electronic media; it also reported imposing administrative fines to points of sales that employed promotional girls to promote tobacco products.

The Ministry of Health and the National Tobacco Control Commission in Panama continue to monitor and control the bans on TAPS at points of sale, the media, the internet, social networks, mobile messaging platforms and in video games. It was reported that these actions are carried out at the local, regional and national levels of these organizations, but the application of corresponding sanctions are implemented at the central level of the Ministry of Health. In Peru, the Commission for the Control of Unfair Competition of the National Institute for the Defence of Competition and Intellectual Property (INDECOPI, as per the acronym in Spanish) oversees compliance with the Law for the Repression of Unfair Competition and the laws that, in general, prohibit and sanction practices against good commercial faith, including advertising regulations. Since 2020, Trinidad and Tobago has sought to intensify enforcement efforts, working closely with authorized officers such as the Multi-Agency Task Force in this regard, as a result of which no instances of TAPS were reported. The Advertising Board of Türkiye is responsible for examining and inspecting advertisements in all media. If the Board finds evidence of illegal selling or promoting a tobacco product, the advertisements and promotions are stopped and/or an administrative fine is imposed on the advertising company.

Research on compliance. The marketing and media communication from the tobacco industry regarding the ban on menthol in cigarettes in the Czech market was analysed in 2020, and the results were published in an academic journal in 2021. Additionally, the perception of promotion online of heated tobacco products among adolescents has also been studied, and the outcomes will soon be published as a research paper. It was reported by Panama that, during 2023, the second version of the study to evaluate compliance with the on TAPS on tobacco products at points of sale, the media, the internet, social networks, mobile platforms, video games and packaging would be carried out.

Implementation challenges. Some Parties have mentioned in their 2023 reports on certain difficulties encountered on their implementation work in relation to Article 13. Panama reported having identified that the advertising with actors and actresses on television and in cinema is the most difficult to control, since the total prohibition of direct advertising in these media is effectively complied with. A similar situation is identified regarding advertising on the internet, social networks, video-streaming platforms, and messaging or video messaging platforms. Although some amendments are proposed in the Philippines to the existing TAPS ban, no development has been achieved due to competing priorities on the legislative agenda. In order to address this issue, some local governments have issued their own policies banning TAPS at the local or provincial level. In the Republic of Korea, despite the fact that the three major terrestrial broadcasters (Korean Broadcasting System, Munhwa Broadcasting Corporation and Seoul Broadcasting System) had agreed to eliminate drama scenes containing tobacco consumption, tobacco products, but smoking scenes are still being exposed in self-produced content by online video-sharing platforms or cable broadcasting channels, and criticisms have arisen regarding the limits of regulations, especially as these products have been appearing more frequently in recent times.

Guidelines for Implementation of Article 13. By 2020, 123 Parties (68%) reported having utilized these Guidelines, with a minor increase from 119 Parties (66%) in 2020 (Annex 1: Section G).

Lithuania

Enforcement of tobacco advertising on the web

Case study

The Parliament of Lithuania adopted, on 24 November 2022, an amendment to the Law on the Control of Tobacco, Tobacco Products and Related Products,[28] including electronic cigarettes and refill containers for electronic cigarettes, as well as herbal product for smoking, which entered into force on 1 January 2023.

Article 191 (1) of the Law provides that the Drug, Tobacco and Alcohol Control Department (the Department) shall, in accordance with the procedure approved by the Minister of Health, have the power to issue mandatory instructions to an information-hosting service provider (meaning the company which provides website content and information hosting services) and/or a public electronic communications network service provider (meaning the company which provides telecommunications services) to remove urgently, or to withdraw access to information stored by the information-hosting service provider and/or the public electronic communications network service provider that is used for the advertising of tobacco products and/or tobacco-related products, as well as the remote selling of these products. The Law applies at national level, but if it is found that advertising of tobacco products and/or tobacco-related products or distance selling of these products is directed to the Lithuanian market, the Department takes appropriate measures.

The following steps describe a simplified algorithm that explains the process to identify the breach on the bans and how the implicated website(s) may get blocked:

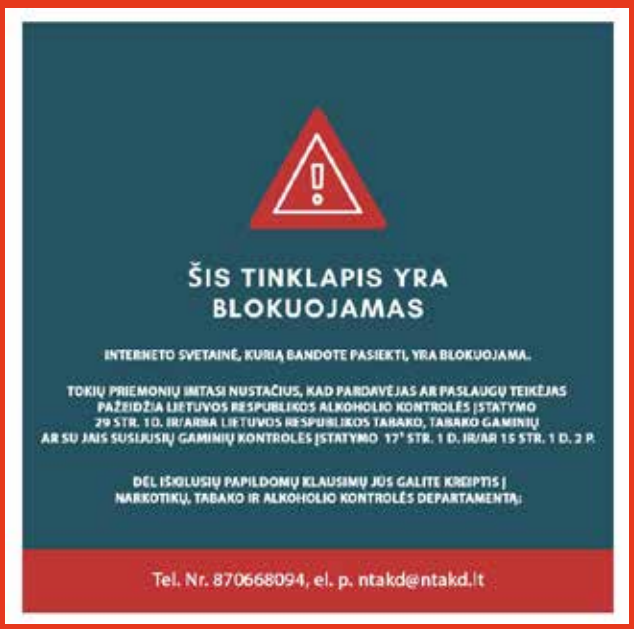
1. The Department finds an advertising of tobacco products and/or tobacco-related products or distance selling of these products by monitoring the information published on the internet as a preventive measure and by receiving information from other institutions and citizens.
2. The Department writes a letter to the company requesting to remove an advertising of tobacco products and/or tobacco-related products or distance selling of these products.
3. In case the company does not remove such advertising of tobacco products and/or tobacco-related products or distance selling of these products, the Department requests the Court for the permission to block the related website(s).
4. In case the Court grants the permission, the website(s) are then blocked.

The Department oversees the preventive controls of websites. When infringements are detected, and the Department contacts the respective company, most often the advertisement in question is removed and/or the remote selling of prohibited products is discontinued, without the need to block the website(s). Currently, 18 websites and social media accounts are blocked as a result of the Department's intervention. Information on the blocked websites and social media accounts is published on the Department's website.[29]

28 The text of the law in Lithuanian is available at: https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/7291c8c170bd11ed8a47de53ff967b64

29 This information is available at: https://ntakd.lrv.lt/lt/blokuojamos-svetaines

If the user trying to access a blocked website, they are redirected to the Department's page and see a warning from the Department that the site is being blocked, see below:



Whenever a user is trying to access a blocked website, this warning indicating that the site is blocked appears, and the search is redirected to the webpage of the Drug, Tobacco and Alcohol Control Department

Measures concerning tobacco dependence and cessation (Article 14)

Key observations

- Nine Parties reported establishing new quit lines.
- More Parties reported including the diagnosis and treatment of tobacco dependence and counselling services for tobacco control in their national programmes, plans and strategies for health and education.
- At each level of health care, a few additional Parties reported using public funding to cover the cost of diagnosis and treatment of tobacco dependence.

National guidelines on cessation. Overall, 118 Parties (65%) have reported having national cessation guidelines based on scientific evidence and best practices, with a marginal increase from 115 Parties (64%) in 2020 (Annex 1: Section H). New guidelines were reported by Canada, Costa Rica, the Philippines and Thailand. Costa Rica reported advances from the regulatory point of view at the institutional level, through guidelines, manuals, protocols and updating standardize care. The Philippines reported that the Department of Health had issued guidelines on the implementation of standardized and unified tobacco cessation services at different levels of care. Currently, capacity development activities are being conducted by the department for tobacco programme managers at the subnational level. Vanuatu noted that it organized a national workshop on tobacco cessation, technically supported by WHO, and that national guidelines are being developed.

Inclusion of diagnosis, treatment and counselling services for tobacco cessation in national programmes, plans and strategies. In the most recent dataset, 128 Parties (70%) included tobacco dependence diagnosis, treatment and counselling services in their national strategies, plans and programmes for health (Annex 1: Section H). In addition, 74 Parties (41%) reported that they include tobacco dependence in their national educational strategies, plans and programmes, up from 67 Parties (37%) in 2020.

In its progress notes, Latvia reported that its national Public Health Strategy for 2021–2027, adopted by the Cabinet of the Ministers in 2022, includes the development and implementation of a national state-funded smoking cessation programme. In 2023, proposals will be developed and discussed to implement it, including on where the different services – psychological support, behavioural therapy, prescription of nicotine replacement therapy and other medications – could be provided.

Photo courtesy of Ministry of Public Health and Social Welfare, Paraguay

Hungary

Operation of a national system for smoking cessation

Case study

In Hungary, institutional smoking cessation support has a long history. The usefulness and cost-effectiveness have been established and published in several studies, and the public need for it is supported by data; yet, it is continually striving for the creation of its long-term and stable financing, as well as its appropriate place in the health-care system.

The first smoking cessation counselling services network in Hungary was established in 1987 at outpatient pulmonary clinics (OPCs) through a state insurance tender. The professional supervision was provided by the Methodology Department of the National Korányi Institute of Tuberculosis and Pulmonology (NKIP), Budapest, Hungary. In the 1990s, the programme continued thanks to repeated subsidies from the pharmaceutical industry and since 2005 the smoking cessation support activity in OPCs has been funded by the National Health Insurance Fund. Of the medications that could help users quit, cytisine has been available on the market since 1974, nicotine replacement therapy (NRT) from the beginning of the 1980s and varenicline since 2007, all without reimbursement.

Having recognized the need for professional coordination, the National Methodology Centre for Smoking Cessation Support was established at the NKIP in 2012 with support from a European Union project grant (Social Renewal Operative Programme - TÁMOP 6.1.2-11/4-2012-0001; active period: 2012–2014; maintenance period: 2015–2018) and trusted with the following tasks:

- education of health-care workers in brief intervention and behavioural counselling;
- operation of the national proactive telephone counselling service;
- formulation and regular updates of the smoking cessation guidelines;
- coordination of cessation support programmes and cooperation in tobacco control activities;
- integration of the curricula on cessation support into the continuing education of primary care physicians; and
- continuous review and development of the operation of the Centre.

The Centre's staff comprises physicians, psychologists, health promotion and communication specialists. (https://www.leszokastamogatas.hu/national-methodology-center-for-smoking-cessation-support/)

Due to a related project grant for 2013–2014, with a three-year maintenance period, OPCs received funding for cessation counselling services again. The Centre supervised the work. During the active period of the project, 5138 smokers were recruited in group counselling at OPCs and 5067 in telephone counselling. The 12-month cessation rate for the OPCs was 18% and 15% for the telephone.

Since 2014 the Centre's operation has been financed annually by the state budget. In 2014–2019 the Centre took part in the Eastern Europe Nurses' Centre of Excellence for Tobacco Control (EE-COE) project coordinated by the Czech organization Society for Treatment of Tobacco-Dependence (STTD) in collaboration with the International Society of Nurses in Cancer Care (ISNCC), with expert support from the Schools of Nursing at the University of California at Los Angeles and at San Francisco. The project aimed to scale

Case study

up efforts to build nursing capacity for addressing tobacco dependence in Central and Eastern Europe. In the case of Hungary, the project significantly boosted the education of nurses and other health-care professionals, such as health visitors and health promotion specialists in the practice of brief intervention and advocacy in tobacco control. Apart from the EE-COE project, the decision in 2020 that every health promotion office (HPOs), a network of institutions promoting health awareness, must employ a trained cessation support counsellor reinforced the training of professionals. As a result, in 2012–2023, some 676 physicians, nurses, health visitors and health promotion specialists received training in behaviour counselling and 1841 health-care workers in brief intervention.

Due to organizational difficulties and low funding, since 2020 cessation support counselling activity has gradually shifted from OPCs to HPOs. However, a long-term funding system for cessation programmes and communication is inevitable but has yet to be established. Nevertheless, the population has broad access to cessation support services as the counselling is available in 92% of HPOs.

Apart from the mandatory pictorial and text health warnings that must be featured on the packaging of tobacco products based on the EU Tobacco Products Directive, according to Hungarian legislation, tobacco packaging and no smoking signs must also contain information on assistance in quitting, such as a phone number (one of the possible endpoints being the telephone counselling service) and a website (www.leteszemacigit.hu). Interest in the telephone counselling service is steady, on average 1000 incoming calls in a year, except for campaign periods, when the number of smokers seeking help rises. Approximately 40% of callers agree to participate in the programme, a rate that could be increased with targeted public awareness campaigns. In 2015–2020, the average abstinence rate of telephone counselling after proactive calls was 16%, at the six-month follow-up it was 13% and at the one-year follow-up it was 9%. The cessation results correspond to the telephone counselling data from the international literature. Still, at the same time, they fall short of the effects of providers specializing in intensive counselling and also providing pharmaceutical support. Although telephone counselling is a well-developed behaviour-change programme that can help motivated individuals to quit, it is insufficient in cases of high nicotine dependence. Consequently, the Centre aims not only to promote the telephone counselling service among the population but also among health-care professionals with whom the Centre can cooperate in building motivation for smoking patients to quit and aiding the process of quitting.

In 2019–2023 significant developments have been implemented by the Centre:

- The lecturers of the public health departments of all four Hungarian medical universities have completed the Centre's training on cognitive behaviour therapy and have included the practice of cessation support in the curricula of medical students and those participating in health science courses. Several nursing schools have also begun to include cessation support in their curricula.
- In 2019 the Centre developed the mobile app called "Facing a problem? Don't reach for the stick!" that was designed to help smokers maintain their motivation by giving an overview of how their health improves with their efforts to stop smoking and by showing how much money they have saved since their last cigarette. In 2022, the app

was upgraded with the "21-day Quit Challenge" programme, offering daily guidance and tasks to smokers motivated to quit but who preferred to try to quit on their own rather than with a counsellor's help. WHO announced the development on the website: https://www.who.int/hungary/news/item/19-11-2019-hungary-launches-new-app-to-help-smokers-quit

- In 2021 the Centre launched a four-month public media campaign to encourage quitting. The campaign had two pillars. The "Live with clean lungs!" campaign targeted young and middle-aged individuals who are otherwise health conscious but still smoke. In contrast, the other campaign was designed to emphasize the dangers of nicotine addiction and was primarily aimed at young adult smokers with shorter smoking backgrounds. The campaign delivered its message to the target groups through press releases, two campaign films: (https://www.youtube.com/watch?v=pPG59J__ZXQ; https://www.youtube.com/watch?v=RhIwCXEbj6o), "citylights" (96 spots in the capital city and 44 spots in county capitals), online ads (YouTube and Google) and social media posts (Facebook and Instagram). The press releases generated several expert media appearances and further communication on national radio and television. Within the framework of the campaign, the website https://nepegeszsegugyi-egyesulet.hu/elj-tiszta-tudovel was launched that provides helpful information to those wanting to or thinking of quitting and seeking help in the process. The website lists the available support options: the phone number of the telephone counselling service; the map of HPOs with a trained counsellor; and the app. The most notable result of the campaign was that the number of people downloading the app increased by 110%.

Case study

The Centre's activity during the past decade has resulted in several significant findings that define the future tasks:

- Despite the many health-care professionals trained in brief intervention and cessation counselling, patient motivation and referral to intensive counselling must be embedded in everyday routine work. This requires health awareness to be prioritized among the population and health-care professionals, that is, through professional communication and campaigns.
- Holding counselling at medical providers' offices during routine work hours (such as in OPCs) requires adequate funding, a disproportionate amount of organization and flexibility from the provider and the smoker, which may reduce willingness to join a counselling programme. Cessation support counselling services should operate as independent specialist care. They must function in connection to frequently visited outpatient and inpatient health-care services with adequate funding and trained professionals dedicated to cessation support.
- The guideline on smoking cessation support emphasizes the need for monitoring counselling activity. Thus, tobacco use, brief intervention and intensive cessation support data should be interconnected between health-care providers and cessation support services.
- Long-term, balanced and predictable financing should be available for tobacco control programmes and organizations responsible for tobacco control.

Photo courtesy of the National Korányi Institute of Pulmonology

Activities and programmes to promote tobacco cessation in the general population. A total of 150 Parties (82%) reported that they utilized the opportunities raised by local events, such as World No Tobacco Day, to promote tobacco cessation (Annex 1: Section H). In addition, second-most frequently, 138 Parties (76%) reported that they carried out media campaigns on the importance of quitting (see also the section on Article 12), and the number of countries providing telephone quit lines have increased from 71 (39%) to 80 (44%) since 2020. In 2023, there are 71 Parties (39%) that reported providing programmes designed specifically for pregnant women and 56 Parties (31%) for women in general.

In 2022, at the Institute of Public Health of Serbia, a free telephone quit line was established. Trinidad and Tobago reported that a proposal for the implementation of a quit line was drafted, and discussions were initiated with partners regarding its financing.

Hungary reported that their National Methodology Centre for Smoking Cessation Support coordinated a four-month long national campaign on cessation support in 2021 (see case study). The China Centers for Disease Control and Prevention is currently developing a personalized smoking cessation intervention application. Chile highlighted the fact that a tobacco dependence treatment programmes has been developed and piloted, and is now awaiting for its nationwide implementation. In addition, new cessation programmes have been reported by Canada's Prince Edward's Island and British Columbia.

The European Union launched in December 2021 the "Healthier together – EU non-communicable diseases initiative" to support EU countries in identifying and implementing effective policies and actions to reduce the burden of major NCDs and improve citizens' health and well-being. The initiative includes a strand on health determinants and projects on tobacco control or with a tobacco control component are co-financed by the EU.

Activities and programmes to promote tobacco cessation in different settings. Programmes to promote cessation are most commonly reported in health-care facilities (141 Parties, 77%) (Annex 1: Section H). In addition, 107 Parties (59%) reported such programmes in educational institutions and 101 Parties (55%) in workplaces. These proportions remained at similar levels as in 2020. Only 59 Parties (32%) reported programmes in sporting environments, a slight increase from 56 Parties (31%) in 2020.

In September 2022, a new smoking cessation clinic was opened in the Bahrain, covering residents in the Southern Governorate. The clinic has trained staff and offers nicotine replacement therapy (NRT) free of charge. Furthermore, a free quit line for extended working hours is planned. Turkmenistan reported that nine centres for smoking cessation counselling were opened in the country. In addition, neuropsychiatric dispensaries now include services for the treatment of tobacco addiction.

Inclusion of programmes on the diagnosis and treatment of tobacco dependence into health-care systems. Of all Parties, 127 (70%) reported that they integrated diagnosis and treatment into their health-care systems (Annex 1: Section H). The majority of Parties 104 (57%) reported having integrated it into primary health care, an increase of three Parties from 2020. This was followed by integration it into secondary and tertiary health care by 87 Parties (48%) compared to 81 Parties (45%) in 2020. It was included in specialized centres for cessation counselling and treatment of tobacco dependence by 75 Parties (41%), in specialist health-care systems by 60 Parties (33%), and rehabilitation centres by 40 Parties (22%) – an increase from 37 Parties (20%) in 2020.

The China Centers for Disease Control and Prevention highlighted the new China Smoking Cessation Platform mini-programme launched in 2021, developed jointly with WHO to improve the accessibility of smoking cessation resources and provide smokers with a more convenient and efficient platform for obtaining smoking cessation services.

Through the effective promotion of this programme, the number of outpatient visits of smoking cessation clinics in each province has increased significantly compared with the same period in previous years, resulting more smokers being able to obtain professional smoking cessation service resources.

Albania noted that a new national programme has been implemented at the level of primary health care for all residents aged 35 to 70 years. The programme includes systematic and structured counselling about quitting smoking. In Uzbekistan, with the support of the Finnish Lung Association (FILHA), a working group of the Ministry of Health and the WHO country office have developed a draft clinical protocol for tobacco cessation at the primary health-care level. The protocol is currently being reviewed with the Ministry of Health.

Paraguay reported observing that the public is beginning to become aware of dependence and the harmful effects of tobacco, and the demand by smokers seeking help to quit smoking in clinics has increased. The Republic of Korea highlighted the linkage of the integrated information system for those who require smoking cessation services based on their national health check-up results from the regional public health medical system for the discovery of the new targets and the expansion of services. Thailand reported having developed an integrated tobacco cessation service for NCD patients, and Costa Rica and Saudi Arabia have highlighted the expansion of cessation clinics nationally.

Involvement of various health professionals. Observing the involvement of health-care professionals in programmes and counselling, 115 Parties (63%) involved physicians, 106 Parties (58%) involved nurses (up from 101 Parties in 2020) and 72 Parties (40%) involved social workers (Annex 1: Section H). The number of Parties that involve pharmacists increased from 60 (33%) in 2020 to 66 (36%) in 2023. In addition, 52 Parties (29%) reported having involved midwives and 51 Parties (28%) having involved community workers in providing tobacco cessation counselling. Thirty-one Parties (17%) included practitioners of traditional medicine, remaining as the least-involved group in counselling among all the Parties, despite an increasing trend from 26 (14%) in 2020. On 1 April 2022, Manitoba, Canada, launched the "Quit Smoking with your Manitoba Pharmacist" imitative with the participation of Pharmacists Manitoba. The programme's goal is to improve smoking cessation rates through pharmacist-led interventions, products and counselling support.

Curricula for health professionals. The inclusion of dependence treatment in the curricula of medical schools increased from 100 Parties (55%) to 103 Parties (57%), and the inclusion of nursing schools increased from 71 Parties (39%) to 74 Parties (41%) (Annex 1: Section H). Incorporating it to the curricula in the training of other health professionals was less common; for dental schools, 54 Parties (30%) and for pharmacy schools 48 Parties (26%) reported that they integrated dependence treatment in the curricula, without major change from 2020.

The China Centers for Disease Control and Prevention reported that three national smoking cessation intervention skills training courses were held during this reporting cycle, training about 320 people in the management and medical treatment in smoking cessation clinics across the country. Thailand reported the development of a Training in Tobacco Control Leadership programme for health professionals, such as the Tobacco Cessation Provider Training Course and the Tobacco Cessation Instructor Training Course. Spain highlighted the training courses for health professionals to address smoking in primary care of which several editions already carried out.

Pharmaceutical products for the treatment of tobacco dependence. A total of 110 Parties (60%) reported facilitating accessibility and/or affordability of pharmaceutical products for the treatment of tobacco dependence. Ninety-nine Parties (54%) had reported that they have nicotine replacement therapy (NRT) legally available in their jurisdiction for the

treatment of tobacco dependence. Seventy-two Parties reported the same for bupropion and 63 (35%) for varenicline (Annex 1: Section H). Five Parties indicated that varenicline was withdrawn from their market by the manufacturer, and Norway reported that bupropion is no longer on the market. Trinidad and Tobago reported ongoing discussions regarding increasing the availability of bupropion in the primary health-care setting. Availability of cytisine is reported by 12 Parties, five more than in 2020. For example, Portugal reported having introduced cytisine in its market as a new product for cessation treatment in 2022. Nortriptyline was referenced by six Parties, and clonidine by three Parties.

Public funding or reimbursement schemes for treatment costs. Of the Parties that reported that they facilitate accessibility and/or affordability of pharmaceutical products for the treatment of tobacco dependence, included diagnosis and treatment in primary care, 96 Parties (93%) covered fully or partially the costs of services and treatment in this setting by public funding or reimbursement schemes (Annex 1: Section H). Out of the Parties that included the diagnosis and treatment in secondary and tertiary health care, 79 Parties (91%) covered the costs fully or partially. Out of the Parties that included the diagnosis and treatment in specialized centres for cessation counselling and treatment of tobacco dependence, 66 Parties (86%) covered the costs fully or partially.

Of the Parties that had NRT legally available, 28 Parties (28%) reported covering its costs fully and 23 Parties (23%) partially by public funding or reimbursement schemes. Among the Parties that had bupropion available, 20 Parties (28%) covered the costs fully and 22 Parties (31%) partially. The costs of varenicline were covered fully by 13 Parties (21%) and partially by 20 Parties (32%) among the Parties where it was legally available. Altogether, a minor increase can be observed in the number of Parties that cover the costs fully and a minor decrease in the number of Parties that cover the costs partially.

For example, in India, NRT was added in the National List of Essential Medicines in 2022. Nepal reports that NRT (chewing gum) has been enlisted in the National Essential Drug List, and distribution has begun at two hospitals as a pilot project. In Montenegro, an initiative has been launched for NRT to be included in the Mandatory List of Drugs, so that users can obtain it on prescription, and in Ireland the Government removed value-added tax from all NRT in 2022. In 2021, the Russian Federation approved a procedure for the provision of medical care to the adult population for cessation of tobacco consumption. In Colombia, pharmacological treatment for tobacco cessation has been financed by the health system since December 2021.

In France, accessibility to cessation medications has increased through changes in the health insurance policies on 1 January 2019; the changes now allow for the reimbursement of more products, such as NRT, in different forms (transdermal devices, chewing gum, tablets and lozenges). In Germany, with the amendment of the Act on the Further Development of Health Care of 11 July 2021, the coverage of the costs of medicines for tobacco cessation was introduced in certain cases. This regulation is now awaiting implementation by the responsible bodies.

Guidelines for Implementation of Article 14. By 2023, 111 Parties (61%) reported having utilized these Guidelines, a minor increase from 2020 when 107 (59%) reported utilization of the Guidelines (Annex 1: Section H).

Measures relating to the reduction of the supply of tobacco

Illicit trade in tobacco products (Article 15)

Key observations

- An increased number of Parties had information on the percentage of illicit tobacco products in the national market and had developed tracking and tracing regimes to assist in determining whether the products are legally sold in the domestic market.
- A decreased number of Parties facilitated information exchange among customs, tax and other authorities. There were fewer Parties developing new legislation against illicit trade compared to last reporting cycle.
- Parties to the WHO FCTC are invited to refer to the *2023 Global Progress Report on the Protocol to Eliminate Illicit Trade in Tobacco Products* for more examples of implementation of measures under Article 15 of the Convention, including on tracking and tracing of tobacco products.

Under Article 15, progress continued in the development of tracking and tracing regimes to further secure the distribution system and assist in the investigation of illicit trade. Some Parties (46%) reported progress in this area, compared to 43% in 2020 (Annex 1: Section I). However, the implementation of most of the other measures required under this article showed no further improvement. Slightly more Parties (24%) now report having information on the percentage of illicit tobacco products in the national market, but collecting such data remains a challenge. The following Parties have acceded to the Protocol to Eliminate Illicit Trade in Tobacco Products since the last reporting cycle: Egypt, Hungary, Kenya, Netherlands and Seychelles in 2020; Ghana and Greece in 2021; Moldova and Paraguay in 2022; and Rwanda in 2023.

Enacting or strengthening legislation against illicit trade. Overall, 132 Parties (73%) reported having adopted or strengthened legislation against illicit trade in tobacco products, decreasing from 137 (76 %) in 2020 (Annex 1: Section I). However, in some countries, such as Palau, new and comprehensive customs legislation has been drafted with assistance from Oceania Customs Organization (OCO) and is undergoing review by the administration.

Confiscation and destruction. Of all Parties, 132 (73%) reported allowing the confiscation of proceeds derived from illicit trade in tobacco products, and 125 Parties (69%) monitored, documented and controlled the storage and distribution of tobacco products held or moving under suspension of taxes and duties, showing no changes from 2020 (Annex 1: Section I). In addition, 134 (74%) required the destruction of confiscated equipment, counterfeit and contraband cigarettes, and other tobacco products derived from illicit trade, using environmentally friendly methods when possible, or their disposal in accordance with national law. For example, Azerbaijan, China, the Czech Republic, India, Kazakhstan, Kyrgyzstan, Malaysia, Mexico, Montenegro, Panama, Paraguay and Thailand have reported confiscating and destroying extensive amounts of illicit cigarettes since the last reporting cycle. For example, Montenegro reported that during 2021, a total of 50 921 cartons and during 2022, 92 024 cartons of cigarettes were confiscated through Basic State Prosecutor (1 carton = 10 packs of cigarettes), and the Special State Prosecutor conducted several criminal investigations during the reporting cycle.

Licensing. In 2023, 126 Parties (69%) require licensing or other actions to control or regulate production and distribution to prevent illicit trade, a minor decrease from 128 (71%) in 2020 (Annex 1: Section I). In Ireland, the Public Health (Tobacco Products and Nicotine Inhaling Products) Bill is currently being drafted and will require retailers to acquire a licence for the sale of tobacco products, this licence must be renewed annually. The bill is expected to be enacted in 2023.

Tracking and tracing. In the latest data, 98 Parties (54%) reported that they require monitoring and collection of data on cross-border trade in tobacco products, including illicit trade (Annex 1: Section I). Of all parties, 83 (46%) reported developing or implementing a practical tracking and tracing regime to secure the distribution system, and assist in the investigation of illicit trade, with a notable increase from 77 Parties (43%) in 2020. This increase could also be attributable to the fact that the introduction of a tracking and tracing regime is a time-bound measure under the Protocol.

Croatia reported experiencing the so-called “ant smuggling” of cigarettes. Recent trends demonstrate a tendency by smuggling organizations to smuggle cigarettes in Eastern and South Europe, including Croatia, in small quantities. This phenomenon of ant smuggling involves many travellers who individually smuggle small quantities of cigarettes, transporting them clandestinely across the border in vast numbers of small consignments in private cars, vans and small buses, by individuals traveling by train or by pedestrians. Some of the smuggled cigarettes remain in the country for personal use or for sale on local markets, but officials presume that most of them are stored in clandestine warehouses for introduction on a large scale in markets in Northern and Western Europe.

Promoting cooperation. Overall, 122 Parties (67%) reported promoting cooperation between national agencies and relevant regional and international intergovernmental organizations (IGOs) with a view to eliminating illicit trade in tobacco products (Annex 1: Section I).

Marking of packaging. Of all Parties, 121 (66%) reported that they require markings to assist in determining whether a tobacco product was legitimately and legally sold on the domestic market and/or to assist in determining the origin of the product (Annex 1: Section I). Similarly, 121 Parties (66%) reported requiring the marking to be legible and/or presented in the principal language or languages of the country. However, to a significantly lesser extent, only 71 Parties (40%), which is two Parties fewer than in 2020, require that unit packs of tobacco products for retail and wholesale use carry the statement “Sales only allowed in ” or have any other effective marking indicating the final market destination.

Share of illicit tobacco products in the national tobacco market. The information collected from the Parties suggests that measuring illicit trade in tobacco products is still an important challenge for them; however, improvement can be observed. In 2023, 44 Parties (24%) responded as having information on the percentage of illicit tobacco products in the national tobacco market, increasing from 39 (22%) in 2020 (Annex 1: Section I). Thirty-eight Parties provided data related to the national market share of illicit tobacco products. In most cases, the data were provided by customs authorities and other government ministries or agencies.

Parties still face challenges in quantifying their illicit tobacco markets. Several Parties including Afghanistan, El Salvador, Guinea, Mongolia and Serbia reported having no system in place to measure or no official data about illicit trade trends. Some Parties, including New Zealand reported about difficulties in measuring illicit markets, methodological issues and the incentives involved to under- or over-reporting the size of illicit market.

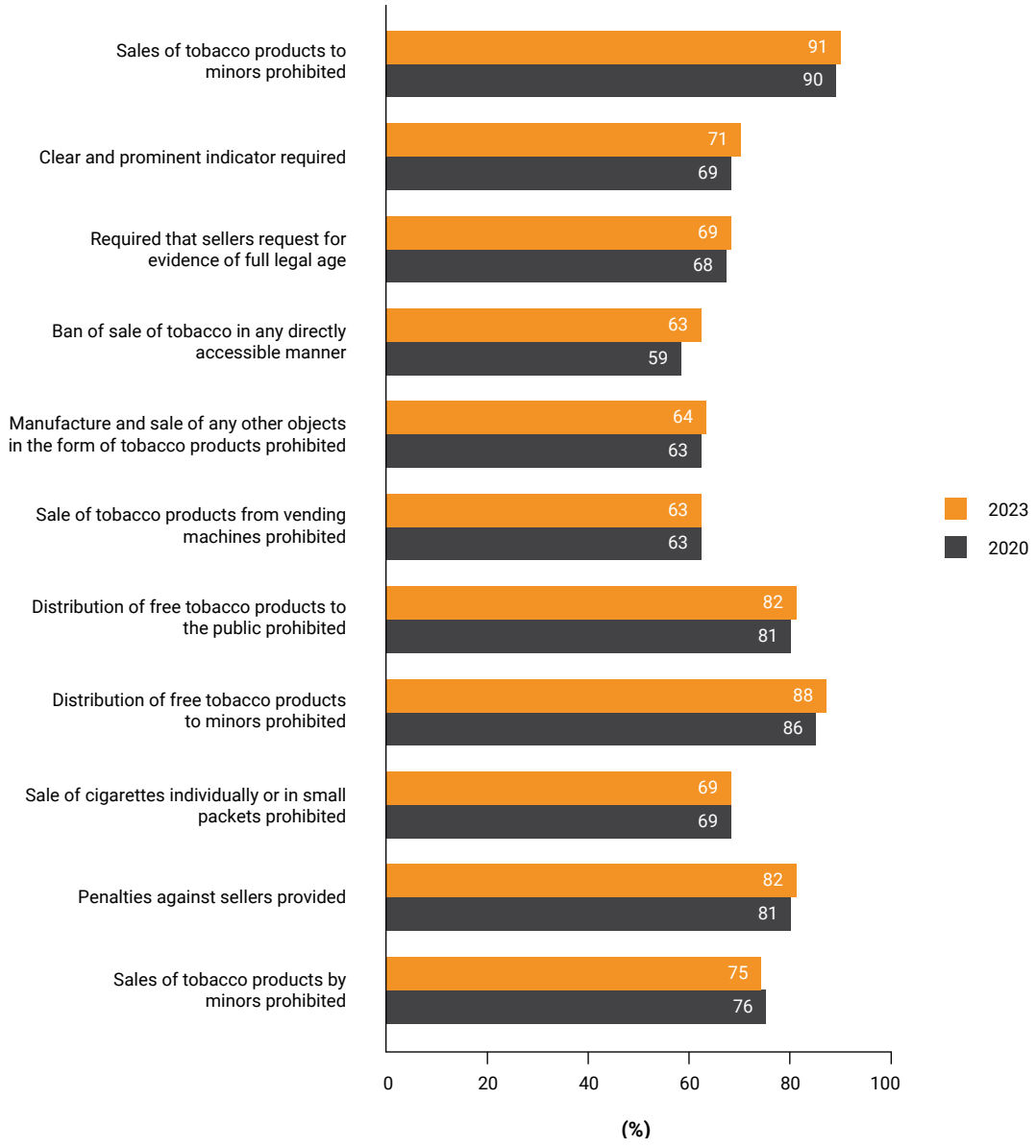
Sales to and by minors (Article 16)

Key observations

- A slight increase was detected in almost all measures on sales to minors; for example, more Parties reported banning the sale of tobacco products in any directly accessible manner.
- Still, 16 Parties have not reported prohibiting sales of tobacco products to minors.

Sales to minors. Overall, based on the responses by the Parties, the implementation of all measures under Article 16 slightly improved as compared to 2020 (Fig. 12; Annex 1: Section J). In 2023, a total of 166 Parties (91%) reported having prohibited sales of tobacco products to minors.

Fig. 12. Percentage (%) of Parties reporting on implementation of Article 16 provisions in 2020 (n=181) and in 2023 (n=182)



The legal age for tobacco purchases ranged from 15 to 24 years, with the average being 18 years, which was reported by 141 Parties. Similar to the last reporting cycle, Sri Lanka had the highest legal age (24) for purchasing tobacco products, followed by nine parties with legal age of 21. Comoros had reported the lowest age limit (15), followed by the Republic of North Macedonia and Mali (both 17 years). In the Philippines, a new regulation requires the printing of the legal age for smoking on the containers/packs of tobacco products. The state of Victoria in Australia legislated e-cigarettes as smoking products, making their sale to minors illegal. Additional Parties reported raising the age limit for purchasing tobacco products, for example, Singapore raised the minimum legal age from 20 to 21 as of 1 January 2021 following its stepwise approach begun in 2019. In Finland, the Ministry of Social Affairs and Health appointed a working group in 2022 to consider raising the age limit from 18, among other tasks. The working group proposed in its report in January 2023 amending the Tobacco Act so that tobacco products, nicotine liquids and tobacco substitutes containing nicotine may not be sold or otherwise supplied to a person under 20 years of age. The age limit for the bans on the import and possession of products would also rise to 20 years of age according to the proposal.

New Zealand became the first country in the world to do so when it prohibited anyone from selling or supplying smoked tobacco products to people born on or after 1 January 2009. With this, and other accompanying measures, the intention is to create a “smoke-free generation” (see the text box under Article 2.1).

The legal age for tobacco purchases ranged from 15 to 24 years, with the average being 18 years, which was reported by 141 Parties.

Uzbekistan

Case study

On 24 May 2023, Uzbekistan adopted Law No. 844 On Restricting the Distribution and Use of Alcohol and Tobacco Products (https://lex.uz/docs/6472104), which entered into force on 25 August 2023. Provisions related to the tobacco industry come into force on 25 May 2024 (Article 45), in particular they require:

- health warnings occupying at least 65% of the main area (increased from 40%) will be placed on the consumer packaging of tobacco products, tobacco- and nicotine-use devices and hookah flasks (Article 36);
- prohibiting the importation into Uzbekistan and sale in Uzbekistan of non-smoking tobacco products, including nicotine-containing non-smoking products other than nasvay (Article 37).
- The new law expanded the range of existing restrictions on retail trade, namely, the sale of tobacco products and devices for tobacco and nicotine use are prohibited (Article 21):
- by persons under 21 years of age;
- without the direct involvement of a salesperson (for example, vending machines);
- from self-service shelves;
- in the form of e-commerce;
- on-site and distance selling;
- in premises intended for the sale of children's goods;
- in a form imitating children's toys, candy or other children's goods;
- on the properties of health-care organizations, educational facilities, cultural institutions, physical fitness and sports facilities, sanatoriums, and medical and social institutions;
- trade items located at a distance of less than 100 metres in a straight line from educational, sports and religious organizations, except for cases when the trade item is located on the property of trade complexes (markets) with a total trading area of more than 1000 square metres and in fair pavilions;
- if the consumer package of tobacco products contains less than 20 cigarettes, in respect of cigarettes;
- without consumer packaging, in respect of tobacco products, as well as devices for tobacco and nicotine use;
- piece by piece or with the consumer package opened (a violation of its integrity), in respect of cigarettes and products with heated tobacco;
- on the property and premises (except for duty free shops) of railway stations, bus stations, airports, river ports and urban train stations, in respect of tobacco products, as well as tobacco and nicotine consumption devices.

A person who directly sells tobacco products and devices for the use of tobacco and nicotine is obliged to demand that a purchaser who looks under 21 years of age present a document certifying their identity and age, and in the absence of a document, to refuse to sell alcoholic and tobacco products and devices for the use of tobacco and nicotine (Article 21).

In addition, the display and open display of tobacco products and devices for tobacco and nicotine use is prohibited in retail trade (Article 37).The law also requires that places where tobacco products and tobacco- and nicotine-use devices are sold must display a warning sign or sign prohibiting their sale to persons under the age of 21, as well as a health warning (Article 22). It also states that the Advertising Act (Article 23) regulates relations relating to the advertising of tobacco products and devices for the use of tobacco and nicotine.

According to Law No. ZRU-776 of 7 June 2022 on Advertising, advertising of tobacco products and devices for the use of tobacco and nicotine is not permitted (Article 40). In addition, the sale of tobacco products and devices for tobacco and nicotine use may not be promoted by:

- distributing free of charge samples of tobacco products and devices for tobacco and nicotine use, as well as applying discounts on them;
- sponsoring events that use the name, trademark (service mark) or image of tobacco products and devices for tobacco and nicotine use;
- distribution, including sale of goods (T-shirts, hats, games and other such items) using the name, trademark (service mark) or image of tobacco products and devices for the use of tobacco and nicotine, as well as tobacco products and devices for the use of tobacco and nicotine that imitate children's toys, candy or other children's goods;
- the installation of images, names and other information about tobacco products and devices for tobacco and nicotine use on the facade, entrance, display cases, displayed items and other such places of commercial facilities;
- use of any terms, descriptions, signs, symbols, images or other designations associated with tobacco products and devices for tobacco and nicotine use in the manufacture of other types of goods that are not tobacco products, devices for tobacco and nicotine use, accessories or separate parts of these devices;
- conducting incentive promotions or other similar activities.

In conclusion, other provisions of the Law will also contribute to limiting the availability of tobacco products and tobacco and nicotine use devices. In particular, new products are equated to tobacco products (Article 4):

- products containing tobacco leaf and/or other parts of the tobacco plant as raw material (for example, products with heated tobacco);
- products containing nicotine or its derivatives, including nicotine salts, solutions, nicotine liquids or gels containing nicotine (nicotine liquids for electronic nicotine delivery systems, e-cigarettes with nicotine liquid and nicotine-containing mixtures for hookahs);
- products that do not contain tobacco and nicotine but are intended for use with tobacco and nicotine consumption devices (nicotine-free liquids for electronic nicotine delivery systems, electronic cigarettes with nicotine-free liquid, nicotine-free hookah mixtures).

Case study

Thus, the provisions on the restriction of the sale and availability of tobacco products also apply to new tobacco, nicotine and nicotine-free products. The prohibition on the importation into Uzbekistan and sale of non-smoking tobacco products, including nicotine-containing non-smoking products (Article 37), restricts young people's access to new products such as nicotine snus and tobacco snus. To limit the appeal of tobacco products, the law prohibits the use of substances in the manufacture of tobacco products (Article 34):

- that give the impression that tobacco products have benefits or result in the reduction of health risks;
- that are associated with energy and/or vitality (including caffeine, taurine and guarana);
- that have properties that colour tobacco smoke; and
- that have carcinogenic, mutagenic or reproductive toxic properties in a non-combustible form.

In addition, the size of the area on the consumer packaging of tobacco products for placing medical warnings has been increased from 40% to 65%. The same rules are established for consumer packaging of devices for tobacco and nicotine consumption, and hookah bulbs (Article 36). It is also prohibited to put on the consumer package of tobacco products and devices for the use of tobacco and nicotine:

- any terms, descriptions, signs, symbols or other designations that directly or indirectly give the impression that such products are less harmful than other tobacco products;
- any terms, descriptions, signs, symbols or other indications that directly or indirectly indicate taste, odour, flavouring or other substances that enhance the attractiveness of tobacco products, or the absence thereof;
- images of foodstuffs, medicines and medicinal plants, as well as words or word combinations that directly or indirectly create an association of tobacco products with foodstuffs, medicines or medicinal plants;
- information that directly or indirectly creates the impression that tobacco products are more biodegradable or have other favourable effects on the natural environment;
- information that directly or indirectly gives the impression that tobacco products have a stimulating, invigorating, therapeutic, rejuvenating or other beneficial effect;
- information that directly or indirectly misleads consumers about the harmfulness of tobacco products, including words such as "low tar", "light", "very light", "mild", "extra", "ultra", "thin", or words with the same cognates as such words, analogues of such words in foreign languages, and analogues of such words translated from foreign languages (Article 36).

Thus, measures to prevent the sale of tobacco products, tobacco-using devices and nicotine-using devices to persons under the age of 21 will be implemented in conjunction with other provisions of the Law that have the effect of limiting the availability and attractiveness of tobacco products, tobacco-using devices and nicotine-using devices, as well as increasing the effectiveness of medical warnings.

Sales by minors. A total of 136 Parties (75%) reported prohibiting the sales of tobacco products by minors (Annex 1: Section J). Ireland reported that a Public Health (Tobacco Products and Nicotine Inhaling Products) Bill is currently being drafted with the expectation that it will be enacted in 2023. The bill would prohibit the sale of tobacco products by persons under 18 years of age, along with some other measures related to the sales of tobacco products, such as the introduction of a licensing system for the retail sale of tobacco products and nicotine products, prohibiting the sale of tobacco products in vending machines, at events for children and from temporary or mobile units.

Requirements for tobacco retailers. The number of Parties requiring that all sellers of tobacco products place a clear and prominent indicator inside their points of sale about the prohibition of tobacco sales to minors increased from 125 (69%) to 130 Parties (71%) in 2023 (Fig. 12). A total of 125 Parties (69%) reported that they request sellers of tobacco products to ask the purchaser to provide evidence of having reached full legal age.

A total of 114 Parties (63%) prohibited tobacco sales from vending machines. Of those Parties which still have vending machines, 27 (40%) reported that they ensure that vending machines are not accessible to minors and/or do not promote the sale of tobacco products to minors. Of all Parties, 150 (82%) reported prohibiting the distribution of free samples of tobacco products to the public, up from 147 Parties (81%) in 2020. Altogether, 160 Parties (88%) reported the same in relation to the distribution of free samples to children, up from 156 Parties (86%) in 2020.

Some new requirements for tobacco retailers were also noted by the Parties. In Finland, a ministerial working group has proposed banning the granting of a retail licence under the Tobacco Act for temporary and mobile sales outlets, apart from a retail vehicle travelling on a regular route. This intends to prevent the so called “pop-up” stores, which are being used to circumvent advertising bans to promote new products and attract new young customers, for example in festivals. The example of Ireland has already been mentioned above.

Belgium reported that it will prohibit sales of tobacco products through vending machines starting in December 2023. As of May 2022 in China, the Administrative Measures for Electronic Cigarettes regulations came into effect, which states that e-cigarette product sales outlets shall not be set up around schools or kindergartens. In Norway’s new tobacco control strategy, the Government presented plans for banning online sales of tobacco products and e-cigarettes. The Philippines reported that schools must have posters that state the sale of cigarette products being prohibited within 100 metres.

Prohibition of tobacco products with specific appeal to minors. According to 2023 data, 126 Parties (69%) prohibited the sale of cigarettes individually or in small packets and 116 (64%) prohibited the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products (Annex 1: Section J). For example, in the Philippines local government units have issued regulations prohibiting the sales of small packets. As of May 2022 in Congo, the manufacture, import, possession, sale or offer free of charge of flavoured capsule cigarettes, as well as cigarettes containing characterizing flavours, and shisha has been prohibited.

Enforcement and sanctions. The number of Parties providing for penalties against sellers and distributors to ensure compliance with the regulations on sales to and by minors increased from 147 Parties (81%) in 2020 to 150 Parties (82%) in 2023 (Annex 1: Section J). In New South Wales (Australia), the Public Health (Tobacco) Regulation 2022 was enacted on 1 September 2022, replacing the Public Health (Tobacco) Regulation 2016. Under the new regulation, infringement notice penalties (on-the-spot fines) increased from 360 Australian dollars to 1110 Australian dollars for an individual, and from 1800

Australian dollars to 5500 Australian dollars for a corporation. The new regulations also introduced penalty infringement notices for three existing offences: selling cigarettes in a pack of fewer than 20 cigarettes; placing a tobacco product in a package without a health warning; and selling a tobacco product in packaging without a health warning. Progress also has been made in other parts of Australia (see the text box). For example, in the Australian Capital Territory, in 2022, the Tobacco and Other Smoking Products Act 1927 was amended to allow compliance testing to occur for sales of all smoking products, including electronic cigarettes, to minors. Prior to this, the act only permitted compliance testing for tobacco sales to minors. Tasmania continues to increase the licensing fees for retailers, and Western Australia prohibits tobacco product sales in music festivals.

Nigeria reported that enforcement sensitization programmes have been carried out in some states, and three major radio stations have raised the awareness of the public on the ban of sale to and by minors.

According to 2023 data, 126 Parties (69%) prohibited the sale of cigarettes individually or in small packets and 116 (64%) prohibited the manufacture and sale of sweets, snacks, toys or any other objects in the form of tobacco products.

Queensland (Australia)

Strengthening the protection of the young population over tobacco products

Case study

Over the past few years, various Australian federated states have made significant strides in reducing tobacco sales to minors and by minors. Queensland public health advocates have consistently urged governments to take action in two crucial areas: establishing a licensing regime for tobacco product retailers; and effectively enforcing existing regulations. Following a parliamentary inquiry into licensing and comprehensive stakeholder policy consultation on options for reforms to reduce smoking, on 25 May 2023, the Parliament successfully passed a bill to amend the *Tobacco and Other Smoking Products Act 1998*.[30] The reforms extend efforts to prevent uptake of smoking and promote quit attempts, and will be fully implemented by September 2025. In Queensland, the definition of smoking products includes tobacco products, herbal cigarettes, loose tobacco smoking blends, personal vaporizers and related products (for example, electronic cigarettes and e-liquids), tobacco and other things smoked in hookahs.[31] The proposed changes in Queensland encompass seven key areas, centred around safeguarding children and youth from the harmful effects of smoking and supporting existing smokers to quit.

1. A licensing scheme for all tobacco and e-cigarette suppliers will include stringent vetting of potential suppliers. In deciding whether a supplier is suitable for a licence, previous criminal history of the applicant, including compliance with smoking product regulations in any state or territory, will be considered. Licences can be cancelled or subject to conditions in the instance of non-compliance. Wholesalers will only be able to sell to licenced retailers. All smoking product suppliers must be licensed by 1 September 2024.

2. To counter the normalization of smoking among children involved in the sales of tobacco and e-cigarettes, a new prohibition will be introduced on the supply of smoking products by minors. In Queensland, the definition of smoking products includes e-cigarettes. Previously, the law allowed children working in retail settings to engage in such sales, which will be now prohibited.[32] From 1 September 2024, children must not be employed to supply or handle smoking products. Small businesses with less than 20 staff have until 1 September 2025 to comply with this requirement.[33]

3. Queensland has removed the defence to the offence of supply to a minor where that supply is by a parent or guardian to further de-normalize the supply of smoking products. The enforcement approach will focus on monitoring, education and awareness, rather than fines or prosecution, so as not to criminalise families that may already be disadvantaged. From the 2 June 2023, parents and guardians cannot legally supply smoking products to children.[33]

30 https://www.parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=169&id=4243
31 Section 4, Tobacco and Other Smoking Products Act 1998 (Qld)
32 230331 AMA Qld sub Tobacco and Other Smoking Products Amendment Bill 2023.pdf
33 New smoking reforms | Health and wellbeing | Queensland Government (www.qld.gov.au)

Case study

4. New restrictions on the sale and use of tobacco products in liquor-licensed premises, where pairing alcohol use and nicotine addiction can inhibit quit attempts. From 1 September 2024, liquor licensed premises will only be able to sell tobacco products from one service counter, and a tobacco product vending machine must be located in a staff only area. Further from 1 July 2024, the law will prohibit children from remaining in a designated outdoor smoking area at a liquor-licensed venue and strengthen the requirements for buffers around these areas. These measures further extend protections to reduce access to smoking products and exposure to second-hand smoke by children and contribute to de-normalizing smoking.[32]

5. To combat the availability of cheap, illegally imported or grown tobacco, a new offence will punish retailers who supply or possess illicit smoking products. The laws complement Australia's plain packaging, taxation and importation controls on tobacco products. The new offences came into effect on 2 June 2023.

6. On 2 June 2023, changes were implemented to modernize controls on retail advertising and the display of smoking products including electronic cigarettes and electronic cigarettes-related products. The aim of these changes is to reduce demand for smoking products, by further minimizing advertising, display and promotion of smoking products.

7. New and extended smoke-free public places are also being introduced from 1 September 2023 reducing exposure to second-hand smoke and supporting people to quit in areas where families and children gather. The new smoke-free areas laws include establishing a smoke-free buffer area around commercial outdoor eating or drinking places, making outdoor markets smoke-free (with an allowance for small smoking-only areas) and making school carparks and under-18 outdoor recreational events smoke-free.[34]

The reforms complement Queensland's comprehensive approach to smoking reduction, including campaigns and supportive health measures to aid individuals with their nicotine dependence treatment. Queensland's publicly funded behavioural counselling phone service (Quitline) offers a free 12-week supply of nicotine replacement therapy to eligible clients and recently began supporting people, including children, that are concerned about their e-cigarette addiction.[33]

34 New smoking reforms | Health and wellbeing | Queensland Government (https://www.qld.gov.au/health/staying-healthy/atods/smoking/new-smoking-reforms)

Photo courtesy of Queensland Health

Tobacco growing and support for economically viable alternatives (Article 17) and protection of the environment and the health of persons (Article 18)

Key observations

- Articles 17 and 18 of the Convention continue to be weakly implemented among the Parties.
- Approximately half of Parties reported having tobacco growing in their jurisdiction. Less than one third of these Parties (31%) promote viable alternatives for tobacco growers, a minor increase since 2020 (29%).
- Only 8% of these Parties promote economically viable alternatives for tobacco workers, and 2% of Parties do so for individual sellers.

Tobacco growing. Of all Parties, 85 (47%) reported tobacco growing in their jurisdictions. The proportion was the same as in 2020.

Economically viable alternative activities. Among the tobacco-growing Parties, 26 Parties (31%) promote viable alternatives for tobacco growers, which is two Parties more than in 2020, and only 7 Parties (8%) do so for tobacco workers and two Parties (2%) for individual tobacco sellers (Annex 1: Section K). Colombia reported that in 2022 the Ministry of Agriculture and Rural Development allocated resources worth 3 billion Colombian pesos for tobacco reconversion. The purpose of the initiative was to combine technical, administrative and financial efforts for tobacco reconversion through support for the implementation of the production of corn and beans for former tobacco producers in the departments (administrative subdivisions) of Santander and Boyacá, with the final aim of improving marketing processes and thus improving the quality of life of this group.

Chile noted that initial work began with the Ministry of Agriculture that seeks to collect information regarding the number of tobacco farmers and quality of life in order to subsequently advance a joint work strategy. India reported on the implementation of a Crop Diversification Programme supporting tobacco farmers to shift to alternative crops, and Thailand set up in 2021 a working group on alternative crop production.

Protection of the environment and the health of people. Protective measures in tobacco cultivation and manufacturing have been reported by around one third of tobacco-growing Parties, with no major improvement as compared to 2020 (Annex 1: Section K). Only measures considering the health or persons in respect to tobacco manufacturing were now reported by 33 Parties (39%), with increase from 31 Parties (37%) in 2020.

Andorra, in its first WHO FCTC implementation report, highlighted new regulations and laws in relation to Article 18 of the Convention. In 2021, a new regulation promoting organic production was approved; the regulation calls for additional public resources to promote both the development of organic agricultural production and the development of new economic activities that have as objective the production of organic food products. Law 31/2022 of 21 July 2022 for the development and diversification of the livestock and agricultural sectors was also approved. This is an omnibus law that modifies various existing legislative frameworks and whose main purpose is to promote the development and diversification of the sector.

In the Czech Republic, from 1 October 2022, tobacco products with filters and filters marketed for use in combination with tobacco products have to bear markings on their packaging informing consumers of the following: (a) appropriate waste-management options for the product or waste disposal means to be avoided for that product, in line with the waste hierarchy; and (b) the presence of plastics in the product and the resulting negative impact of littering or other inappropriate means of waste disposal of the product on the environment. Germany reported that in 2021 tolclofos-methyl (a broad-spectrum aromatic hydrocarbon fungicide from the group of triphosphoric acid esters) was banned for cultivation.

Policy options and recommendations in relation to Articles 17 and 18. Among tobacco-growing Parties, 22 Parties (26%) reported having utilized the policy options and recommendations in relation to Article 17, and 18 Parties (21%) in relation to Article 18. (Annex 1: Section Q).

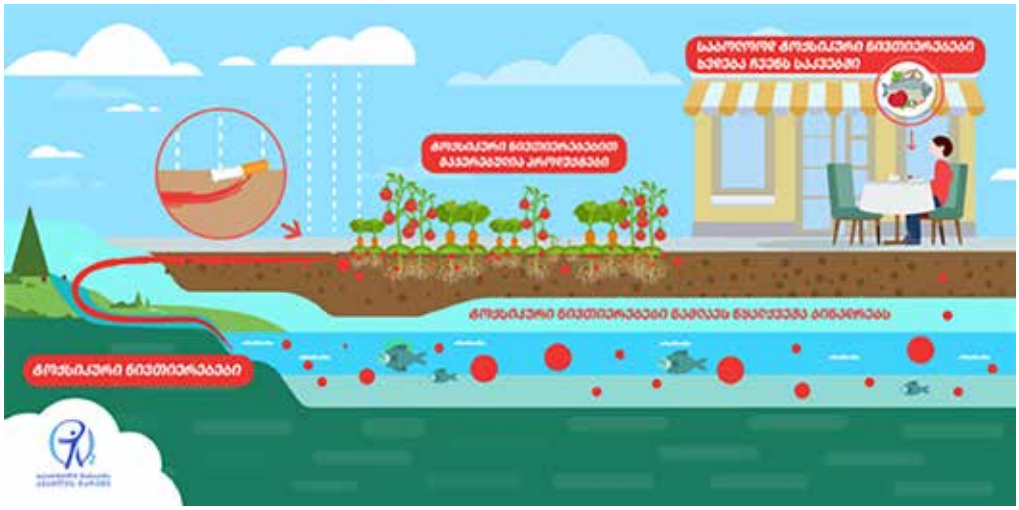
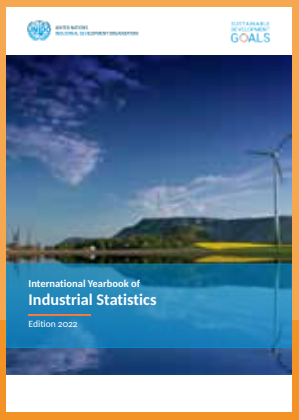


Photo courtesy of the National Center for Disease Control and Public Health, Georgia

Among the tobacco-growing Parties, 26 Parties (31%) promote viable alternatives for tobacco growers, which is three Parties more than in 2020, and only seven Parties (8%) do so for tobacco workers and two Parties (2%) for individual tobacco sellers.

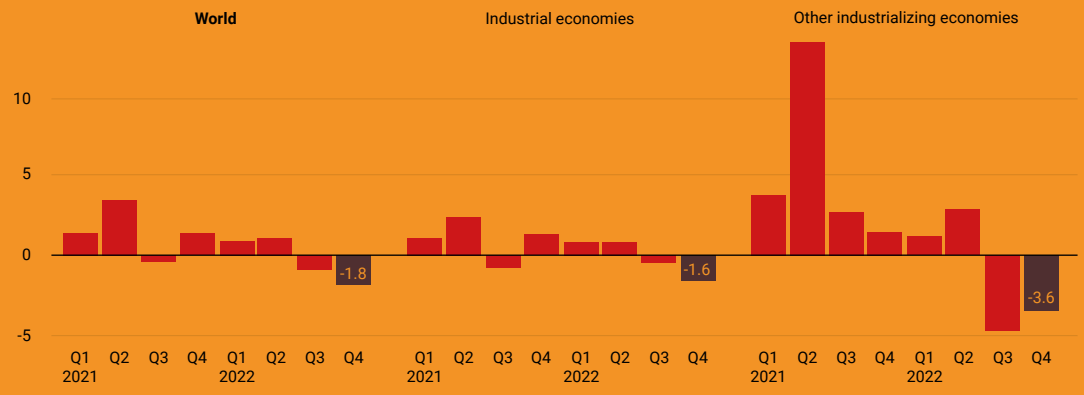
Recent global trends in the manufacturing of tobacco products: report by the United Nations Industrial Development Organization (UNIDO)



The contribution of tobacco products to global manufacturing value added (MVA)[35] further decreased in the past 20 years, as shown in the figure below from UNIDO's *International Yearbook of Industrial Statistics, Edition 2022*.[36] In 2020, this sector was responsible for only 0.9% of global MVA, half of the share registered in 2000 (1.8%). Additional details on the main manufacturers of tobacco products are shown in Table 3.6 of the Yearbook. The United States of America is the leading manufacturer in this industry, even if its world share has decreased significantly (38.2% in 2000 to 22% in 2020). China's share on the manufacturing of tobacco products, on the other hand, increased considerably from 5.1% in 2000 to 21.9% in 2020.

A timelier analysis can be obtained from the latest seasonally adjusted index numbers of quarterly industrial production. However, these figures are based on manufacturing output rather than value added.[37]

Output growth of tobacco products manufacturing
Percentage change compared to the same quarter of the previous year



Source: UNIDO. Quarterly Index of Industrial Production (seasonally adjusted estimates)

On a year-on-year comparison, global manufacturing of tobacco products experienced mostly positive growth rates throughout 2021 and 2022. Notably, the higher increases in 2021, especially in the second quarter of that year, are linked to the COVID-19 pandemic and the subsequent recovery. The containment measures implemented in numerous economies led to lower production levels in the second quarter of 2020. The same quarter in 2021 registered high year-on-year growth rates, explained by the strong recovery and the low base of comparison.

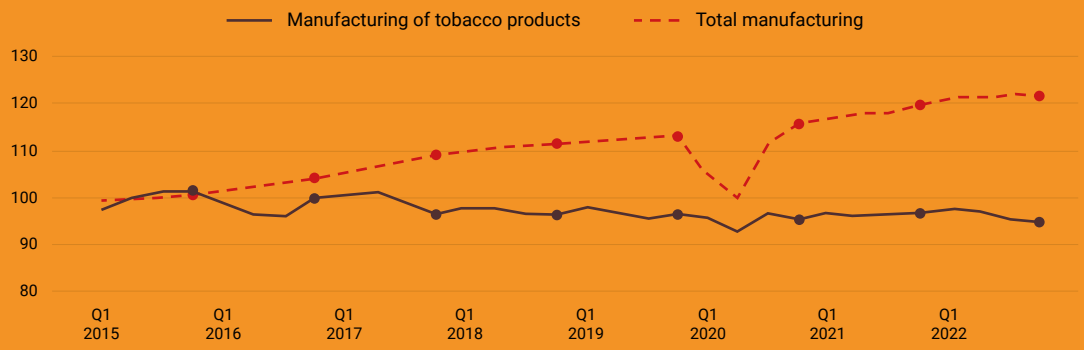
35 Manufacturing value added (MVA) of an economy is the total estimate of net output of all resident manufacturing activity units obtained by adding up outputs and subtracting intermediate consumption, using all firms with primary activity in the manufacturing sector – International Standard Industrial Classification of All Economic Activities (ISIC). Measurement of MVA requires appropriate demarcation of the type of economic activity and of the territory in which the activity takes place. The figures from UNIDO's publication are derived from the annual index of industrial production (IIP), measuring the growth of industrial production in real terms (deflated for sector-specific inflation). For the calculations, the weights for global MVA figures are derived from national MVA data for the base year 2015, and IIP trends are used as an approximation of MVA growth over time.

36 https://stat.unido.org/content/publications/-international-yearbook-of-industrial-statistics-2022

37 World Manufacturing Production - Quarterly Report (Q4 2022). United Nations Industrial Development Organization, available at:https://stat.unido.org/content/publications/world-manufacturing-production---quarterly-report

Nevertheless, the latest seasonally adjusted estimates seem to confirm the return to the downward trend described previously. In the fourth quarter of 2022, global manufacturing of tobacco products experienced a contraction of 1.8%, following a drop of 0.9% in the third quarter. The downward trend was observed across country groups, notably for industrial economies (-1.6%), as well as for other industrializing economies (-3.6%). In annual comparison, a slight drop of 0.2% for global manufacturing of tobacco products was registered in 2022, while in 2021 an increase of 1.4% was reported.

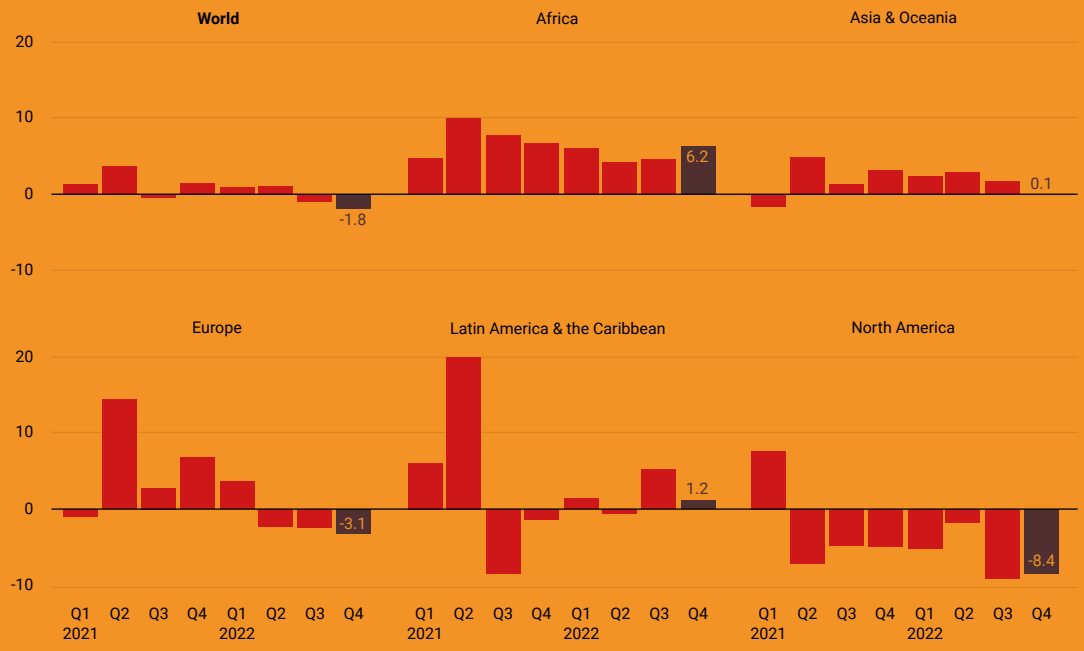
Index of tobacco products manufacturing and total manufacturing
Index 2015 = 100



Source: UNIDO. Quarterly Index of Industrial Production (seasonally adjusted estimates)

Regional data reveal diverging growth patterns over the previous two years. Africa reported the biggest increases during this period, while Europe, Latin America and the Caribbean, as well as Northern America, faced volatile or negative trends in this sector. Manufacturing of tobacco products in Asia and Oceania generally increased during 2021–2022, but showed only a stagnation in the last quarter of 2022. The world's biggest manufacturers of tobacco products, China and the United States of America, reported for the same period diverging trends: 4.8% and -8.8%, respectively.

Output growth of tobacco products manufacturing
Percentage change compared to the same quarter of the previous year



Source: UNIDO. Quarterly Index of Industrial Production (seasonally adjusted estimates)

(Note: UNIDO is an observer to the Conference of the Parties to the WHO FCTC.)

Liability (Article 19)

Key observations

- Approximately two thirds of Parties reported that their tobacco control legislation contains measures regarding criminal liability for violations of that tobacco control legislation.
- The number of Parties with liability actions within their jurisdiction remained stable since the last reporting cycle.
- Legal challenges by the tobacco industry have continued to persist. However, laws or regulations implementing the WHO FCTC have been upheld in all cases where information is available.

According to the 2023 data, around two thirds of Parties reported that their tobacco control legislation contains measures regarding criminal liability for any violations of that tobacco control legislation, while over one-third of Parties have civil liability measures specific to tobacco control. In addition, between 2020 and 2023, there were modest increases in the number and percentage of Parties that reported criminal and civil liability provisions specific to tobacco, as well as general criminal and civil liability provisions that could apply to tobacco control. For example, Ukraine reported new criminal liability provisions for engagement in illicit trade. The Criminal Code in Uzbekistan now includes provisions stating that the illegal production of tobacco products may include penalties such as imprisonment.

However, there has been no increase in the number of provisions for compensation and liability actions. In relation to compensation, less than one third of the Parties reported having civil or criminal liability provisions that provided for it, the percentage remaining the same between 2020 and 2023. The number of criminal or civil liability actions by any person in the jurisdiction of the Parties went down slightly by 2023 as compared to 2020. The proportion of Parties with such ongoing proceedings was 14%. Compared to the 2021 Global Progress Report, one in 10 Parties reported taking legislative, executive or administrative action against the tobacco industry on the reimbursement of costs related to tobacco use.

Liability cases cited in the last report have continued to proceed. Notably, in the Republic of Korea, the National Health Insurance Service's lawsuit against tobacco companies was ruled against the plaintiff in November 2020. However, an appeal by the tobacco companies is in progress. In Canada, class action lawsuits by people affected by tobacco-related diseases, where more than 15 billion Canadian dollars in damages were awarded, were stayed due to settlement negotiations between the companies and their creditors. However, the most recent stay of proceedings will expire in 2023.

Legal challenges to the implementation of the WHO FCTC. Over the reporting period, Nepal and the Philippines reported legal challenges to laws or regulations implementing the WHO FCTC. In both cases, the laws/regulations have been upheld by courts. Laws and regulations implementing the WHO FCTC were upheld by courts despite legal challenges initiated by the tobacco industry, following on from previous reports submitted by the Parties. Notably, legal challenges may span any number of provisions of the WHO FCTC and may be a key barrier to legal implementation in many instances.

Ten years after the trial decision, the Philippines Supreme Court held that the Food and Drug Administration's regulatory powers over tobacco products were constitutional and referred to the Philippines' WHO FCTC obligations (see case study). After eight years, in August 2022, the final verdict of the Nepal Supreme Court ruled in favour of the Tobacco Control Directive 2014 to print 90% pictorial health warnings on all tobacco packs. Cases that upheld tobacco control laws include the Constitutional Court of Austria confirming the constitutionality of the annual fee to be paid by tobacco industry and the Indian Supreme Court ruling that duty free shops at arrival terminals must comply with India's tobacco control laws and not foreign laws.

The Philippines

The Supreme Court upholds tobacco products regulations implementing the WHO FCTC

Case study

A full bench of the Supreme Court of the Philippines overturned a 2012 decision of a trial court that granted a petition filed by the Philippine Tobacco Institute against the Government to declare the tobacco regulations of the Food and Drug Administration (FDA) invalid and unconstitutional for exceeding the Department of Health's (DOH) rule-making powers. The decision upholds the authority of the FDA to regulate tobacco products and clarifies the importance of the Philippines' international obligations under the WHO FCTC as required by the Philippines' constitutional law.

The Philippine Tobacco Institute challenged the authority of the FDA to regulate tobacco products, arguing that tobacco products were under the exclusive regulatory jurisdiction of the Inter-Agency Committee – Tobacco (IATC) under Republic Act No. 9211. The Philippine Tobacco Institute has historically been a member of the IATC. The FDA regulations place tobacco products under the regulatory authority of the FDA.

In a Decision dated 13 July 2021, the Supreme Court upheld the regulatory powers of DOH and FDA over all tobacco products, and declared the FDA Regulations to be valid and constitutional. The Supreme Court ruled that the FDA Act of 2009 (RA 9711) clearly establishes the FDA's regulatory jurisdiction over all products that may have an effect on health, including tobacco products.

The Supreme Court noted that certain contested provisions in the FDA Regulations are aligned with the Philippines' international commitments under the WHO FCTC, citing Article 5.3 of the Convention, which requires State Parties to protect their tobacco control policy-making from tobacco industry interference. The Supreme Court noted that the WHO FCTC has become operative as part of national law in the Philippines in accordance with the Constitution, and that accordingly, as a national health authority, DOH along with the FDA must consider the country's commitments under the WHO FCTC in exercising their regulatory powers over health products. The decision also paved the way for strong tobacco control regulations to be adopted through FDA, including the foundation of regulations to implement Articles 9 and 10 of the WHO FCTC in the country.

Research, surveillance and exchange of information (Article 20)

Key observations

- Several Parties reported having developed a national system for surveillance of the consequences of tobacco consumption, while the training and support for all people engaged in tobacco control activities, including research, implementation and evaluation was improved.
- Compared to 2020, regional and global exchange of publicly available national information on the practices of the tobacco industry improved substantially, but exchange of other kinds of information related to tobacco use and control needs further attention.

National systems for epidemiological surveillance. In 2023, 135 Parties (74%) reported having established a national system for epidemiological surveillance of patterns of tobacco consumption, two Parties less than in 2020 (Annex 1: Section M). In addition, 119 Parties (65%) reported having a national surveillance system for exposure of tobacco smoke, 108 Parties (59%) for determinants of tobacco consumption, and 99 Parties (54%) on social, economic and health indicators. All these indicators have shown a minor increase compared to the previous data. The number of Parties that reported having established a national surveillance system for consequences of tobacco consumption increased from 86 Parties (48%) in 2020 to 93 Parties (51%) in 2023.

Availability of data on the prevalence of tobacco use and exposure to tobacco smoke. Of all Parties, 172 (95%) have provided prevalence data for adult tobacco smoking in the reporting platform. Thirty Parties (16%) reported having new data on adult tobacco smoking collected or published between 2021 and 2023. In addition, 161 Parties have reported prevalence data about youth tobacco use (smoking or smokeless), and 21 Parties (12%) had new data from 2021 to 2023.

Similar to the last reporting cycle, slightly over half of the Parties have reported prevalence data for adult smokeless tobacco use. Only 16 Parties (9%) have reported new smokeless tobacco data published between 2021 and 2023 for adults. Seventy-seven Parties (42%) had data about the use of novel and emerging tobacco products and nicotine products in either adult or youth population. In addition, only 26 Parties (14%) of the Parties indicated that they had data on tobacco use in ethnic groups.

A total of 147 Parties (81%) have reported having data on exposure to tobacco smoke in their populations. Sixteen Parties (9%) had reported having new exposure data published between 2021 and 2023. In spite of this, exposure is still not monitored systematically, with only 119 Parties (65%) reporting that they have included exposure to tobacco smoke in their regular surveillance related to tobacco. Overall, there are no major changes in the proportion of Parties having exposure data.

In addition to the prevalence of smoking and smokeless tobacco use, Parties have the possibility to report on prevalence of water-pipe tobacco use, and since 2020 reporting cycle, on electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS) and heated tobacco products (HTPs). The availability of data on these products varies greatly among Parties.

Availability of data on tobacco-related mortality and economic burden. At the time of this analysis, 91 Parties (50%) reported that they have information on tobacco-related mortality in their jurisdictions. Available data ranged from 2000 to 2022, and 18 Parties have reported mortality data collected in 2020 or after. Some 84 Parties provided

information on the number of annual deaths attributable to tobacco use in the population at any past data point. The reported figures show broad variations depending on the size of the country. Bangladesh, the European Union, Germany, Japan and Senegal reported over 100 000 annual tobacco-related deaths. For the economic burden of tobacco, 74 Parties (41%) indicated that they had information available. Seventy-two Parties provided further details on the data they have. The data collection years ranged from 2008 to 2020. Eleven Parties had data collected from 2020, and no Parties had reported publishing new data between 2021 and 2023.

Some Parties, for example Bahrain, the Philippines and Uganda, reported having ongoing research or published results in past three years about tobacco-related economic burden.

Research topics. The majority, 130 Parties (71%), developed and/or promoted research that addressed the determinants of tobacco use, and it remained at a similar level as in 2020. Of all Parties, 119 (65%) were developing and/or promoting research on the consequences of tobacco use, and 118 Parties (65%) on social and economic indicators related to tobacco consumption. Research on exposure to tobacco smoke was promoted in 108 Parties (59%). Only 83 Parties (46%) reported data on tobacco use among women, particularly pregnant women, and a similar number and percentage on identification of effective programmes for the treatment of tobacco dependence. Developing and/or promoting research on the identification of alternative livelihoods remained the least reported, by 25 only Parties (14%).

In 2021, the European Union published a study to identify an approach to measure the illicit market for tobacco products and to identify a robust, reliable and independent methodology to measure the illicit market for tobacco products. In December 2021, the European Commission published a study on smoke-free environments and advertising of tobacco and related products; the study identified the gaps of the current regulatory framework, as well as challenges related to its implementation, application, compliance and enforcement. Some Parties such as the Czech Republic, Italy and Latvia have reported participating to the second phase of the project, Joint Action for Tobacco Control (JATC2), a project funded by the European Union that aims to strengthen the collaboration in tobacco control among Member States.

Variety of different research topics was reported by Parties. For example, the Czech Republic had researched relapse prevention in smoking cessation using the eHealth intervention, concluding that the procedure of user reminders to log on to the programme neither increased programme adherence nor the probability of quitting smoking. This suggests that programme developers may save costs by using email instead of SMS text messaging reminders. The Philippines has conducted studies about graphic health warnings and plain packaging, while continuing with research about the economic burden of smoking. The Danish Health Authority and National Institute of Public Health have conducted a study about the national burden of disease in 2022 using data from 2017–2018 in Denmark. Uzbekistan reported on an investment case in tobacco cessation conducted in 2022 with the support of WHO and the United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases (UNIATF).

Exchange of information and training, and support for research. In 2023, 84 Parties (46 %) reported on the regional and global exchange of publicly available national information on the practices of the tobacco industry, a substantial increase from 75 Parties (41%) in 2020 (Annex 1: Section M). The regional and global exchange of national scientific, technical and legal information was reported by 118 Parties (65%). The exchange of information relating to the cultivation of tobacco was reported by 42 Parties (23%) in 2023. 118 Parties (65%) reported providing training for those engaged in tobacco control activities, such as research, implementation and evaluation, an increase from 113 Parties (62%) in 2020.

Nine new Parties reported having regional and global exchanges of publicly available national information on the practices of the tobacco industry, and some practical examples of regional information exchange were reported. As of May 2021, the Costa Rican Ministry of Health, the Ministry of Science, Innovation, Technology and Telecommunications (MICITT) and the National Council for Scientific and Technological Research (CONICIT) signed an agreement about a new fund for research, technological development and innovation in health in the field of tobacco control. Jamaica reported having exchanged information in the public domain increasingly in the past two years, particularly related to laws and regulations on tobacco control and information about the enforcement of laws on tobacco control. Dissemination of the most recent national tobacco data has also been ongoing both locally and regionally through engagement with government ministries, agencies and departments, as well as civil society, academia and other experts. Latvia reported on information exchanges with the other Baltic countries (Estonia and Lithuania), focusing on the regulation of nicotine pouches and electronic cigarettes. Paraguay reported progress in sharing information related to tobacco control among the members of an intergovernmental commission. In Panama, a new information system for the evaluation of the impact of NCDs was developed in 2022.

Database on laws and regulations. The majority of Parties, 131 (72%), reported that they maintain a database of national laws and regulations on tobacco control, up from 128 Parties (71%) in 2020 (Annex 1: Section M). Of all Parties, 93 (51%) reported that the database also contained information on the enforcement of those laws and regulations. Forty Parties (22%) reported establishing a database of pertinent jurisprudence. For example, Palau reported having updated its database that stores all NCD-related policies, including on tobacco control.[38]

38 https://www.pihoa.org/regional-initiatives/health-information-management-systems-surveillance-2/usapi-ncd-surveillance-data/

Of all Parties, 172 (95%) have provided prevalence data for adult tobacco smoking. In addition, 161 Parties have reported prevalence data about youth tobacco use (smoking or smokeless).

Finland

Further development of tobacco-related research

Case study

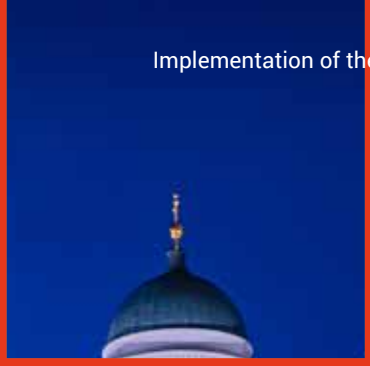
The Tobacco Act was adopted in Finland in 1976, and since then the country has actively engaged in and conducted a range of studies pertaining to smoking and tobacco control.[39]

Evidence has shown that tobacco-related inequalities are prevalent in Western countries, and as one of the contributors to this situation, higher retailer density in a specific area has been associated with higher smoking prevalence in previous studies. New Finnish research about area-level sociodemographic differences in tobacco availability examined compared to nationwide tobacco product retail licence data in Finland was published in 2023. The study reveals that even in a country with small income inequalities, tobacco availability was higher in the areas with lower socioeconomic status. The study suggests that the existing licensing system and supervisory fees in Finland could be complemented by using area-specific criteria to restrict the density of tobacco sales points.[40]

Further, a comprehensive report on the societal costs associated with smoking in the country was released in 2022. The new report was an awaited update of previous estimates based on data from 2012. According to the report, such costs amounted to approximately €1.0 billion to €1.6 billion in 2020, which marked a decrease when adjusted for inflation compared to the figures from 2012. The report covered various aspects related to smoking, including the direct and indirect health-care costs associated with smoking, and the number of transfer payments, such as disability pension, sickness benefits and family pensions attributed to smoking. As the report concludes, smoking causes a major economic burden to the society, regardless of the observed reduction in smoking, while its related sickness, death and other costs are preventable.[41]

Finland has also participated in international research collaboration, including a study on e-cigarette regulations concerning youth e-cigarette use, which utilized cross-country data of the European School Survey Project on Alcohol and Other Drugs (ESPAD) from 32 countries.[42] In addition, Finland has established a new research partnership with the Centers for Disease Control and Prevention (CDC) Foundation, collaborating on a project led by the WHO FCTC Knowledge Hub on Surveillance. This project aims to leverage the WHO FCTC reporting data to explore the implementation of Article 13 of the Convention and its relationship with youth tobacco and e-cigarette use. Under the EU-funded Joint Action on Tobacco Control 2 project, which commenced in October 2021, the Finnish Institute for Health and Welfare leads a work package dedicated to the tobacco endgame. Information has been exchanged and new data collected on the development, implementation and evaluation of tobacco endgame goals and strategies in the WHO European Region, and the first results will be published in 2023.

39 Finnish tobacco control policy and legislation - THL
40 Area-level sociodemographic differences in tobacco availability examined with nationwide tobacco product retail licence data in Finland (bmj.com)
41 Tupakoinnin yhteiskunnalliset kustannukset vuonna 2020 ja vertailu vuoteen 2012 (julkari.fi)
42 Exclusive and dual use of electronic cigarettes among European youth in 32 countries with different regulatory landscapes | Tobacco Control (bmj.com)




Furthermore, a working group appointed by the Ministry of Social Affairs and Health in 2022 for the development of tobacco and nicotine policy made several proposals for strengthening tobacco control monitoring and evaluation.[43] These include regular updates to the societal costs, legislative changes to better utilize industry sales data in the monitoring of tobacco consumption, and inclusion of cotinine analyses in the wastewater surveillance, which is used for monitoring illicit drug use in Finland. Through these proposals, Finland demonstrates its commitment to exploring innovative avenues for comprehensive tobacco control strategies.

43 Development of tobacco and nicotine policy: Proposals for action by the working group 2023

Reporting and exchange of information (Article 21)

Key observations

- At the time of the preparation of this Global Progress Report, 139 Parties (77%) formally submitted their implementation reports for the 2023 reporting cycle, out of which 134 Parties did so by the deadline. The overall number of new full reports has not changed compared to the 2020 reporting cycle.
- A new status report on the implementation of the indicators of *the Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025* is also included in this present report.
- The Convention Secretariat has engaged in a more substantive revision of the WHO FCTC reporting system, including its core questionnaire; this is the first substantive change proposed since the 2012 reporting cycle. The new proposal will be discussed by the Conference of the Parties (COP) at its tenth session in November 2023.

Of the 182 Parties to the Convention required to report in the 2023 cycle, 134 (74%) formally submitted their implementation reports (core questionnaire) in the period designated for the submission of reports for their inclusion in this Global Progress Report.

Most of the remaining Parties updated their data by the cut-off date for the inclusion of their reports in the analyses for this Global Progress Report. The additional questions (voluntary module) that asks Parties about their use of the WHO FCTC implementation guidelines was formally submitted by 10 Parties (5.4%) in the 2023 cycle.

The 2023 reporting cycle used the same reporting instrument and online platform as the previous 2020 reporting cycle, except for a few updates. Updates included the addition of new questions covering topics such as national tobacco control plans and strategies, as well as government expenditures on tobacco control. To help Parties complete their implementation reports, the Convention Secretariat, as in previous reporting cycles, held a webinar accessible to all Parties before the launching of the 2023 reporting cycle. In addition, during the reporting period, the Convention Secretariat provided individualized advice and assisted Parties that requested it.

Revising the WHO FCTC reporting system. In 2019, an external audit of Convention Secretariat operations encouraged the Convention Secretariat to consider incorporating a quality assurance framework in the reporting system of the WHO FCTC, with the aim of improving the quality of data collected periodically from the Parties. Following this recommendation, the Bureau of the Conference of the Parties requested the Convention Secretariat to review the reporting system of the WHO FCTC to explore ways to: 1) improve data quality; 2) reduce the burden of reporting on the Parties; 3) better tailor the collection of data to the current needs of the COP and its subsidiary bodies; and 4) increase the focus on the monitoring the indicators in the *Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025*. The review also included assessing the potential use of official external sources of data to measure global progress in the implementation of the WHO FCTC.

The review of the WHO FCTC reporting system, especially the current reporting instrument, produced several findings. Some of the key findings included the fact that many questions in the reporting instrument could be edited to improve clarity, some questions could be replaced due to the evolution in tobacco control policy, indicators from the Global Strategy could be better captured, and that the reporting instrument could be better harmonized with data collected by official external sources, particularly data included in the *WHO Report on the Global Tobacco Epidemic*. The preparation of the new status report on the indicators of the Global Strategy also found that some of the

current Global Strategy indicators in the reporting instrument could be improved and new indicators could be added. The new status report on the Global Strategy indicators is part of this report.

Following the aforementioned review, a new revised reporting instrument and process was prepared for Parties' consideration at the Tenth session of the Conference of the Parties (COP10) in November 2023. In relation to the reporting instrument, it is proposed that the use of the additional questionnaire, as a separate questionnaire, be discontinued with some key questions integrated into the core questionnaire.

During the review it was observed that data collected by WHO for its report on the global tobacco epidemic could be used to ensure data quality and reduce the reporting burden on the Parties. Moreover, it will also be proposed that data from official external sources, with special regard to data collected by WHO, be used for assessing global progress in the implementation of the WHO FCTC for several articles of the Convention. It will also be proposed that information that is collected by WHO for the biennial WHO reports on the global tobacco epidemic should not be collected in the WHO FCTC reporting instrument, whenever possible, but be obtained instead from WHO by the Convention Secretariat for its analysis.

In relation to the reporting process, it is proposed that the revised reporting instrument be built into a new online reporting platform.[44]

Of the 182 Parties to the Convention required to report in the 2023 cycle, 134 (74%) formally submitted their implementation reports (core questionnaire) in the period designated for the submission of reports for their inclusion in this Global Progress Report.

44 Further details on the review of the reporting system may be found in document FCTC/COP/10/13.

International cooperation (Article 22)

Key observations

- Parties recognize as important sources of assistance WHO, the Convention Secretariat, the Parties themselves, regional organizations, NGOs and the WHO FCTC Knowledge Hubs.
- Parties provided several examples of working with each other and with various partners, including in the most important areas where such projects were implemented.

Fig. 13 presents the responses of Parties about providing or receiving assistance for the implementation of the WHO FCTC in various areas. While the figures overall and by areas have stayed more or less at the same level as in the last reporting cycle, more than three quarters of the Parties provided information – at various level of detail – about the Parties or entities they received assistance from or provided assistance to, or about the assistance itself.

As it can also be seen from Fig. 13 that the provision or receipt of assistance mainly occurred in the development, transfer and acquisition of technology, knowledge, skills, capacity and expertise related to tobacco control and in provision of technical scientific, legal and other expertise to establish and strengthen national tobacco control strategies, plans and programmes.

For example, 69 Parties (38%) reported that they provided expertise for the establishment or strengthening of national tobacco control strategies, plans and programmes, and 116 Parties (64%) reported receiving such assistance. Providing assistance was least common for methods and research related to the affordability of comprehensive treatment of nicotine addiction, reported only by 15 Parties (8%), while double that number, 30 Parties (16%), reported receiving assistance in this area.

Assistance received by the Parties. WHO was mentioned by the highest number of Parties (97) as the organization they received assistance from for the implementation of the WHO FCTC. It was noted that WHO at all levels (from headquarters through regional offices to country offices, and even WHO collaborating centres) were recognized as source of assistance by the Parties. Specifically, the Pan American Health Organization (WHO Region of the Americas) was mentioned by nearly all Parties from the Region. The second most-often mentioned source of assistance was the Convention Secretariat itself, mentioned by 34 Parties. The Convention Secretariat's flagship project, FCTC2030, was mentioned by many Parties that benefited from this project. The WHO FCTC Knowledge Hubs were also mentioned as source of assistance.

In addition, Parties mentioned more than 40 other entities (including United Nations agencies, major international donor organizations, international NGOs, etc.) as sources of assistance. The United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank and the United Nations Interagency Task Force on the Prevention and Control of NCDs (UNIATF) were also mentioned as aiding tobacco control at the country level.

Another broad group providing assistance is the Parties (or non-Parties) themselves. Australia, Brazil, Canada, China, El Salvador, the European Union, Finland, France, Jordan, the Netherlands, Norway, Switzerland, Thailand, the United Kingdom of Great Britain and Northern Ireland, and Uruguay were mentioned at least by one another Party as source of assistance. Some of the Parties mentioned being hosted by other Parties for study tours for learning about implementation of various measures required under the Convention. For

example, Fiji reported that they hosted Samoa and Solomon Islands for study tours related to enforcement of tobacco control measures; Ireland reported hosting delegations from Georgia, Republic of Moldova, Romania and Tajikistan; Finland's Ministry of Social Affairs and Health hosted a delegation from Mongolia to support them and exchange information on research on tobacco retail licensing. Kenya reported hosting Zambia to study tobacco-free farms and some other Parties to share with them Kenya's experience in the implementation of the Protocol and in particular implementation of a tracking and tracing system for tobacco products. Türkiye hosted Jordan as part of a bilateral collaboration on tobacco control.

Additionally, national institutes from various Parties were also listed by other Parties as providers of assistance, among them Expertise France, the Finnish Institute for Health and Welfare, Canada's International Development Research Centre (IDRC), and the United States Centers for Disease Control and Prevention (United States of America is a non-Party) were the most frequently mentioned.

Regional entities, including the East African Community, the Economic Community of West African States (ECOWAS), the Eurasian Economic Union, the Cooperation Council for the Arab States of the Gulf, the Inter-American Drug Abuse Commission and the Southern Common Market (Mercosur) were mentioned as sources of assistance or platforms for collaboration on tobacco control matters. Universities – for example University of Bath, University of California, Los Angeles, and Johns Hopkins University in the United States of America, and University of Lausanne in Switzerland – were also reported by some Parties as sources of assistance.

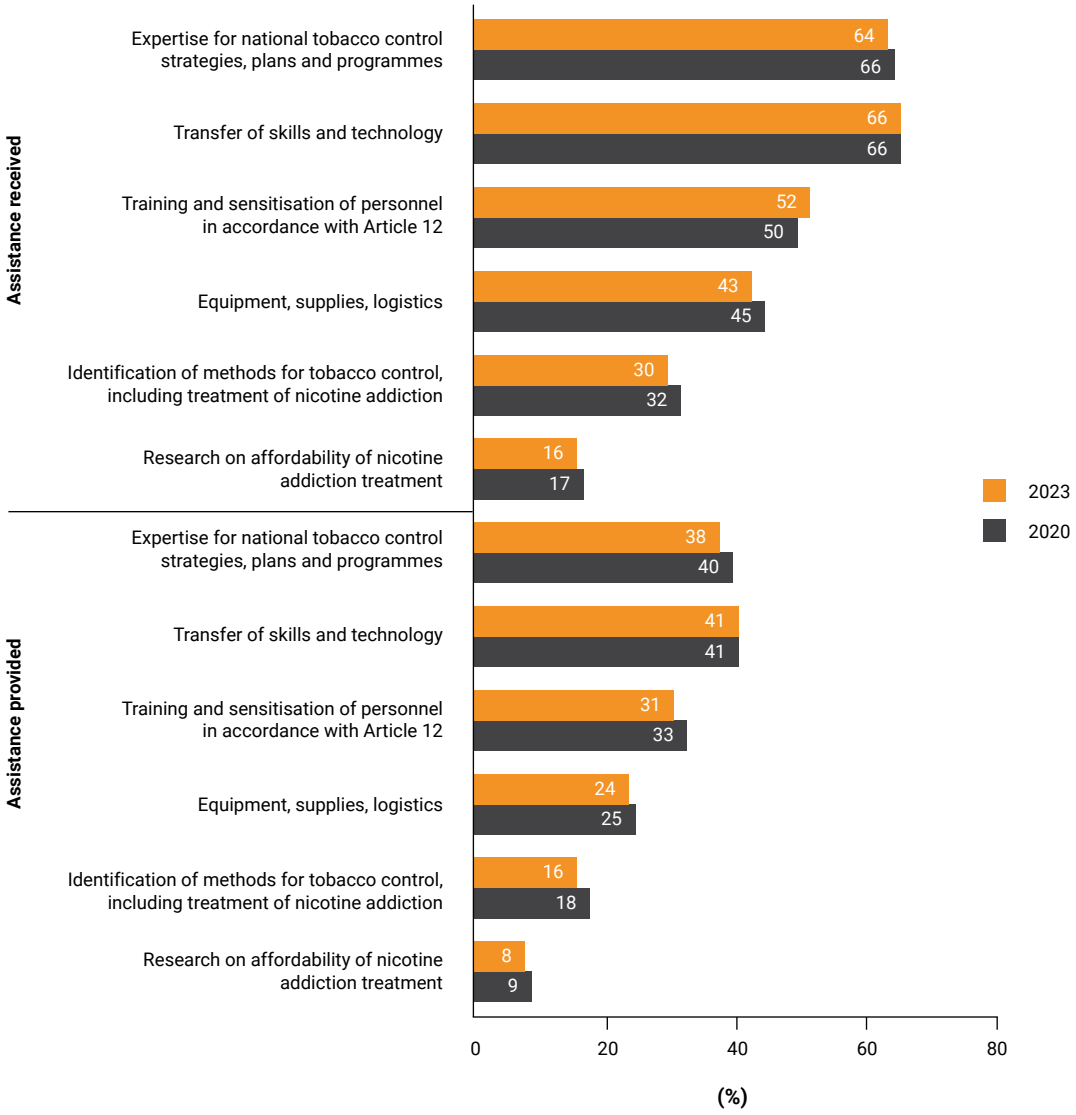
Assistance received from civil society organizations has been recognized by several Parties. NGOs that are observers to the COP – African Tobacco Control Alliance, Corporate Accountability, the Campaign for Tobacco-Free Kids, ENSP, the Southeast Asia Tobacco Control Alliance (including the Global Center for Good Governance in Tobacco Control, which is an entity hosted by SEATCA), the Pacific Community, the Union (and Vital Strategies) – and also NGOs that are not observers to the COP – African Capacity Building Foundation, European Respiratory Society, Lung Cancer Foundation of Australia, Quit Victoria, Vichealth and the World Lung Foundation – were mentioned by the Parties.

Bloomberg Philanthropies and the Bill & Melinda Gates Foundation were also mentioned as providing financial resources for tobacco control work in the Parties; their grants are usually administered – and recognized as such by the Parties – through their partner organizations, including The Bloomberg Initiative to Reduce Tobacco Use – and are implemented through its partner organizations, including Campaign for Tobacco-Free Kids, the Center for Disease Control and Prevention Foundation, the International Union Against Tuberculosis and Lung Disease, Johns Hopkins Bloomberg School of Public Health, the University of Illinois at Chicago, Vital Strategies, and WHO in case of the Bloomberg Initiative and WHO in case of the Bill & Melinda Gates Foundation.

Contributions to the national, regional and global implementation of the WHO FCTC of those NGOs that are accredited as observers to the COP are also highlighted in their biennial reports available on the website of the Convention Secretariat.[61]

It is encouraging to see the high number of partners that could potentially provide support in many areas related to the implementation of the Convention, also in accordance with Strategic Objective 1.1 of the Global Strategy (Give priority to enabling action to accelerate WHO FCTC implementation, including effective forms of technical and financial assistance to support Parties in the identified priority action areas).

Fig. 13. Percentage (%) of Parties that reported providing or receiving assistance, by areas of assistance in 2020 (n=181) and in 2023 (n=182)



The areas in which Parties received assistance, mentioned by many Parties, include the development of national legislation, regulations, policies and tobacco control strategies, plans and programmes; guidance on novel and emerging tobacco products and nicotine products; tobacco cessation; collection of national data related to tobacco use; developing and carrying out communication campaigns; taxation of tobacco products; training and capacity-building; granting licences to use pictures for health warnings, etc. Some examples of projects mentioned in Parties' reports include:

- Colombia highlighted details about its implementation of the FCTC 2030 project. At the closure of the project, on 11 May 2022, the Ministry of Health and Social Protection organized an intersectoral dialogue where the document *Colombia's Advances in Comprehensive Tobacco Control: Achievements and Challenges on the Road to the Sustainable Development Goals* was presented. One of the items which participants agreed in pursuing was the promulgation of a decree formalizing an intersectoral national coordination mechanism for tobacco control.
- El Salvador reported that the International Union Against Tuberculosis and Lung Disease (the Union) and Campaign for Tobacco-free Kids, both observers to the COP, provided technical assistance for the establishment and strengthening of a civil society coalition for tobacco control.

- Development Gateway initiated, in 2020, in a few African countries (Ethiopia, Kenya, Nigeria, South Africa and Zambia) a project supported by the Bill & Melinda Gates Foundation to work with African policy-makers, governments and civil society organizations to use data to promote tobacco control. Tobacco control data dashboards have since been implemented in the mentioned countries to help policy-makers to access and utilize data for effective tobacco control.
- In Panama, members of the national tobacco control team participated in a virtual tax workshop held by the WHO FCTC Knowledge Hub on Taxation based at the University of Cape Town, South Africa, from 21 to 25 March 2022. Panama has not increased their tobacco taxes since 2009. At the workshop, a first estimate was made for a tax increase in Panama. As a result of Panama's team participation in this virtual training, a face-to-face workshop was subsequently held in Panama City in January 2023 with a large participation of representatives from various national entities, including the National Tobacco Control Commission, the General Directorate of Public Health and the Directorate of Health Planning of the Ministry of Health; Consejo Nacional de Salud sin Tabaco (National Customs Authority), the Ministry of Economy and Finance, the Ministry of Education, the Panamanian Coalition against Tobacco, the Foundation for the Prevention of Osteoporosis, National Cancer Association, the General Directorate of Revenue, the National Assembly of Deputies, the National Institute of Statistics and Census, the Faculty of Economics of the University of Panama, the Pan American Health Organization, UNDP and the Convention Secretariat. The meeting served as an important milestone in the process of embarking on the development of a new tobacco taxation policy in Panama.
- Poland reported that it hosted, in Warsaw, Poland, in November 2022, the first Youth Tobacco Control Leadership School organized by the European Network for Smoking and Tobacco Prevention, an observer to the COP. At the meeting, the participants had the chance to develop leadership and advocacy skills to manage tobacco control programmes, and to share and exchange their knowledge on major current and future needs, threats, successes and challenges in tobacco control.
- The Russian Federation reported that the Eurasian Economic Commission's Council in May 2022 approved the form of a report on the composition of tobacco products sold in the Eurasian Economic Union countries and the substances emitted by them. The approved form of the report will allow the Union countries' health-care authorities to obtain information from tobacco product manufacturers on their composition, ingredients added to tobacco, non-tobacco ingredients used and substances emitted by them.
- Seychelles reported that it has received financial and technical support from WHO to conduct a survey to monitor compliance with the country's smoke-free regulations in hospitality premises in 2022.
- A few countries from the European Region highlighted their participation in the Joint Action on Tobacco Control 2 project, which aims to strengthen the cooperation in tobacco control in Europe.

Assistance provided by the Parties. There are many examples of providing assistance in the Parties' reports. For example, the Australian Government Department of Health and Aged Care and the Australian Government Department of Foreign Affairs and Trade provides funding for the McCabe Centre for Law and Cancer (also serving as the WHO FCTC Knowledge Hub on Legal Challenges) Intensive Legal Training Programme. As an example of information sharing, the Australian Government Department of Health and Aged Care regularly responds to requests for licensing of its graphic health warnings, for example, Pakistan reported receiving such assistance. Mauritius also reported sharing its pictorial health warnings with other Parties. Further, the Australian Government Department of Health and Aged Care also provides funding to the Global Alliance for Tobacco Control for their work in supporting the implementation of the WHO FCTC in the Western Pacific Region. Canada reported that its International Health Grants Programme

(IHGP) provided financial assistance to the African Tobacco Control Alliance for a proposal on "Enhancing Health-care Systems, Tobacco Control Amid COVID-19" in the fiscal year 2022–2023. Finland's Lung Health Association assisted with the development of a Central Asian tobacco control network, as a collaborative effort between Kyrgyzstan, Tajikistan and Uzbekistan. This assistance project was planned and carried out in close collaboration with the respective governments and WHO country offices. The Netherlands reported providing assistance in carrying out projects on tobacco product regulation, including by supporting the Convention Secretariat and other Parties.

France's Santé Publique France became the ninth knowledge hub operated by the Convention Secretariat, and assists Parties in relation to Article 12 of the Convention (see more details in the text box). South Africa referred to in its report to the Africa Centre for Tobacco Industry Monitoring and Policy Research (ATIM), a tobacco industry observatory established under the auspices of the Convention Secretariat, and which is aimed at disseminating the latest trends and research on tobacco control to advocates, academics and policy-makers across the African Region. The Centre has provided training to tobacco control advocates from across 11 countries in Africa. South Africa also mentioned in its report the WHO FCTC Knowledge Hub on Tobacco Taxation, housed in the Economics of Tobacco Control Project at the School of Economics at the University of Cape Town, with the full support of the National Department of Health. The hub's work on assisting Parties in establishing their tobacco taxation policies is well known and referred to elsewhere in this report.

In relation to illicit trade in tobacco products, Lithuania reported that Lithuanian customs provided assistance (training, support in drafting strategies, legal instruments, controls, technical equipment, and study visits) to the customs of Parties such as North Macedonia, Republic of Moldova, Ukraine and to the General Administration for Borders and Crossings (GABC), an EU-project. Panama reported assisting Paraguay to ratify the Protocol to Eliminate Illicit Trade in Tobacco Products through virtual participation in sessions of the Paraguayan Congress and also through media interviews. Panama also supported Ecuador in relation to the operation of a tracking and tracing system for tobacco products.

A few Parties referred to the Nordic health cooperation, which has one component of cooperation to improve public health by facilitating exchange and mutual assistance in the areas of alcohol and tobacco control. Iceland reported working with Greenland, Faroe Islands (Denmark) and Aland (Finland) as part of this project.

Other Parties referred to their collaboration under the auspices of the Cooperation Council for the Arab States of the Gulf. For example, Oman reported providing financial and technical support to conduct a study on the economics of tobacco in Council countries. Bahrain reported providing (and receiving) assistance through the Council on updating tobacco product standards and specifications.

Singapore, through WHO TobLabNet and in collaboration with various WHO platforms, continues to support the work requested by the COP in capacity-building by providing technical training and consultation on tobacco testing, in line with decision FCTC/COP7(14) and FCTC/COP8(21) at the seventh and eighth sessions of the COP. During the current reporting cycle, Singapore provided scientific advisory and regulatory testing support to government agencies for countries in the WHO South-East Asia and in Western Pacific regions to help fulfil their obligations under the WHO FCTC. Furthermore, Singapore continues to provide technical support in building the scientific knowledge relating to the harms of tobacco and emerging tobacco products, to countries within and beyond the Western Pacific Region.

The Government of the United Kingdom of Great Britain and Northern Ireland has invested around £15 million of official development assistance (ODA) funds over six years, from 2016 to 2017 and from 2021 to 2022, in order to strengthen the implementation of the WHO FCTC in low- and middle-income countries through the FCTC 2030 project. The United Kingdom of Great Britain and Northern Ireland agreed to extend the project for another three years (2022–2023 to 2024–2025) through ODA funding with a maximum of £3m in total and to include support on ODA-eligible countries to implement the Protocol to Eliminate Illicit Trade in Tobacco Products. The project is due to commence its eight year of support from the United Kingdom of Great Britain and Northern Ireland in April 2023. The governments of Australia and Norway also fund the project. Turkmenistan reported that it allocated, in 2015, about US$ 3 million to the WHO Regional Office for Europe for tobacco control in the European Region.

Some Parties also mentioned that their governments assisted civil society to better contribute to tobacco control efforts, including Chad and Egypt. Guyana reported that the Ministry of Health, pioneering tobacco control, provided assistance to organizations or groups that required training, equipment or materials to enhance their contributions to tobacco control; these included the Ministry of Education and the Ministry of Culture, Youth and Sports, local NGOs, and the general public. Additionally, in El Salvador, the Union and Campaign for Tobacco-Free Kids provided technical assistance for the establishment and strengthening of a civil society coalition for tobacco control. The same NGO observers supported civil society organizations in Uruguay in their advocacy work.

Implementation assistance through membership in regional and international organizations. Overall, 38 Parties (21%) reported having encouraged the provision of financial assistance for low- and middle-income countries and for Parties with economies in transition to assist them in meeting their obligations under the Convention, with no change from 2021.

Several Parties responded to this question by providing details on how they encouraged relevant regional and international organizations and financial, as well as development institutions in which they are represented, to support tobacco control. A few Parties mentioned advocating for tobacco control in WHO and the WHO Regional Office for the Americas, for example, through advocating of inclusion of tobacco control in policy documents. Other organizations within the United Nations system where WHO FCTC Parties mentioned that they are advocating for more presence of tobacco control programmes include UNDP, UNICEF, UNFPA, and the World Bank. Niger specifically mentioned that the needs assessment carried out in their country served as an opportunity to engage with the United Nations system and advocacy for more resources to be devoted by United Nations system entities for tobacco control. Some other Parties mentioned the United States Centers for Disease Control and Prevention, the Bill & Melinda Gates Foundation, ENSP and the Caribbean Public Health Agency (CARPHA).

France

Santé publique France serves as the new WHO FCTC Knowledge Hub on Public Awareness (in relation with Article 12)

Case study

On 5 July 2022, the Convention Secretariat and Santé publique France signed a memorandum of understanding to establish the WHO FCTC Knowledge Hub on Public Awareness, in relation with Article 12 of the Convention. The new Knowledge Hub will develop, analyse, synthesize and disseminate to WHO FCTC Parties knowledge and information concerning education, communication, training and public awareness of the consequences of tobacco consumption and tobacco control issues.

The French national public health agency hosting the Knowledge Hub, S*anté publique France*, is a governmental institution reporting to the Ministry of Health. Created in 2016, *Santé publique France* aims to improve the health of the population. Its missions include but are not limited to: coordinating and implementing public health surveillance programmes; monitoring of the health risks threatening the population and alerting national public health authorities on potential health threats; assisting the public health authorities in disease control, prevention and health promotion; developing prevention and health education campaigns; and contributing to the country's response to health alerts and crises.

Santé publique France can implement the functions of the Knowledge Hub on Public Awareness given its extensive experience in implementing and evaluating media campaigns and interventions related to Article 12 of the Convention. In particular, Santé publique France holds expertise in prevention and communication techniques, of which social marketing in health, a discipline whose objective is the adoption of health-promoting behaviours, covers an important place.

Since 2016, Santé publique France continues to implement and evaluate yearly *Mois sans tabac* (the French version of the English programme "Stoptober"), a programme which challenges smokers to quit tobacco for a month.[45] The cost-effectiveness of this programme was recently evaluated in a study done by the Organisation for Economic Co-operation and Development (OECD). According to the OECD simulations, *Mois sans tabac* is expected to prevent 500 000 cases of NCDs in France from 2023 to 2050 and to reduce health expenditure by €1.42 per capita per year. This will allow to save the annual health-care budget €94 million, a more than seven-fold return on the annual €12.5 million invested.[46] *Mois sans tabac*, like other anti-tobacco programmes, is supported by the national Addictions Fund (*Fonds de Lutte contre les Addictions*).

45 Guignard, R., et al. (2021), "Effectiveness of 'Mois sans tabac 2016': A French social marketing campaign against smoking", Tobacco Induced Diseases, 19(July), 60. https://doi.org/10.18332/tid/139028

46 Devaux, M., et al. (2023), "Évaluation du programme national de lutte contre le tabagisme en France", Documents de travail de l'OCDE sur la santé, n° 155, Éditions OCDE, Paris. https://doi.org/10.1787/b656e9ac-fr

Santé public France, as WHO FCTC Knowledge Hub on Public Awareness, is expected to provide assistance (capacity-building, organization of courses, training programmes, webinars, scientific conferences and other activities) to all Parties to the WHO FCTC, with a special focus towards French-speaking Parties, especially in Africa. Assistance will be provided by using a multisectoral and interdisciplinary approach, in accordance with the *Guidelines for Implementation of Article 12 of the WHO FCTC*, adopted by the COP in 2010.

The team of the Knowledge Hub on Public Awareness
(Photo courtesy of the Knowledge Hub)

Novel and emerging tobacco products[47] and nicotine products

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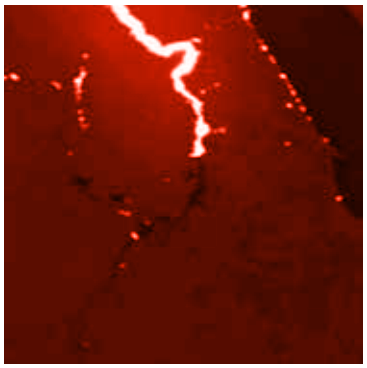


47 According to WHO, "new" or "novel" tobacco products, in addition to containing tobacco, must meet at least one of the following criteria:
- New or unconventional technology is used, such as vaporization of tobacco into the lungs or use of menthol pellets in a cigarette filter.
- The product type has been on the market for less than 12 years; these include dissolvable tobacco products.
- The product type has been on the market for longer, but the market share has increased in areas in which the type was not traditionally used, such as smokeless tobacco products being introduced into countries where they were not previously available.
- The product is marketed, or work has been published to allow it to be marketed, with the claim that it could reduce exposure to harmful chemicals.

WHO study group on tobacco product regulation: report on the scientific basis of tobacco product regulation: fifth report of a WHO study group. Available at: http://apps.who.int/iris/bitstream/handle/10665/161512/9789241209892.pdf?sequence=1

Key observations

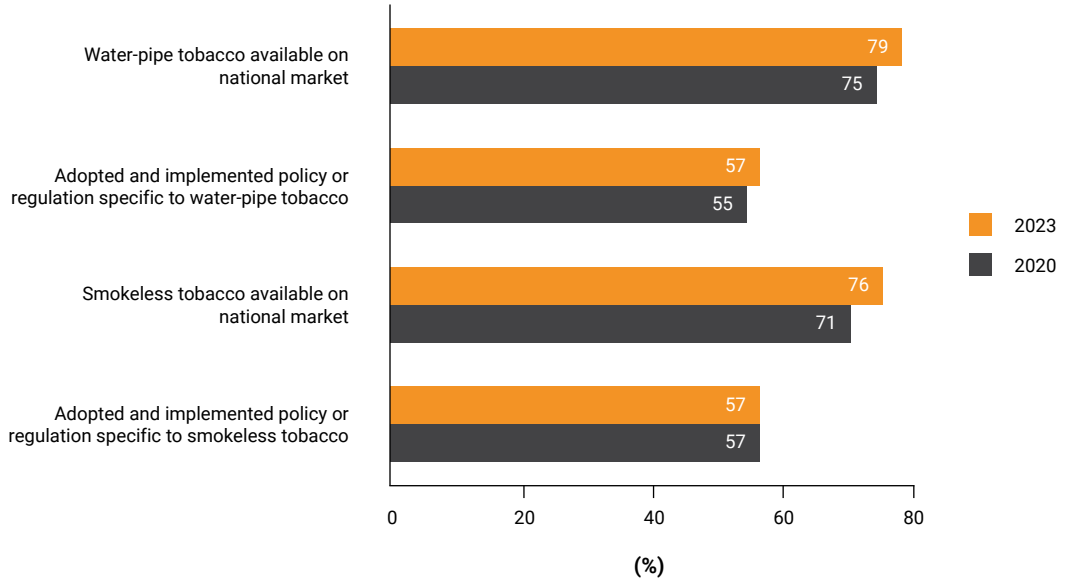
- Smokeless tobacco and water-pipe tobacco are available in more than three-quarters of the Parties. A little more than half of the Parties regulate both categories of products.
- Heated tobacco products (HTPs) can now be found in almost half of the Parties, compared to one-third in the previous reporting cycle. However, less than half of Parties regulate HTPs.
- The presence of novel and emerging nicotine products in more markets has also been observed. The presence of electronic nicotine delivery systems (ENDS) is now reported by three-quarters of Parties, and that of electronic non-nicotine delivery systems (ENNDS) by around half of the Parties. However, only over half of Parties regulate ENDS and approximately one-third of Parties regulate ENNDS.
- Some Parties reported that they regulate ENDS and ENNDS as tobacco products.

Novel and emerging tobacco products

Smokeless tobacco and water-pipe tobacco products

Water-pipe tobacco remains the most common of the emerging tobacco products, and the number of Parties having it available in their national market increased from 136 Parties (75%) in 2020 to 144 Parties (79%) in 2023. Similarly, smokeless tobacco was available in 139 Parties (76%) in 2023. The number of policies and regulations specific to these products have increased as well. Of all Parties, 104 (57%) have implemented policies and regulations specific to water pipes and smokeless tobacco, showing an improvement from the previous reporting period, mainly for water-pipe tobacco laws.

Fig. 14. Percentage (%) of Parties reporting smokeless tobacco and water-pipe tobacco products in national markets, and implementation of product-specific policies and regulations, in 2020 (n=181) and 2023 (n=182)



Many Parties regulate the use of smokeless tobacco in their jurisdictions. The warnings on the packages of nasvay, tobacco snus and nicotine snus are regulated by a new law in Uzbekistan. South Africa has regulated the labelling of smokeless tobacco products. The Ministry of Interior and Municipalities in the United Arab Emirates prohibits the use of any type of chewed tobacco.

Just over half of the Parties (58%) reported having adopted laws to regulate water-pipe tobacco. In Bulgaria, herbal products for smoking are subject to excise duty (including water-pipe tobacco). In the Islamic Republic of Iran, the ban on flavours has been revoked by the Supreme Council, which obliged the Ministry of Health to establish a technical committee to regulate flavour content in water-pipe tobacco. Bahrain has adopted the Gulf Cooperation Council specifications for water-pipe tobacco, which were updated recently. Oman is currently updating the hookah requirements list to be unified for all municipalities, as there are currently specific requirements for each municipality. Additionally, the import and circulation of hookahs are prohibited. Uzbekistan requires the placement of health warnings on the mouthpiece and water-pipe flask.

Pakistan reported having banned the import of shisha (tobacco and non-tobacco) and related substances, in order to protect the youth from using it and being exposed to tobacco smoke. In Türkiye, enterprises offering water pipes are increasingly being inspected, and police officers have started to work in inspection teams. In Uruguay, water pipes are regulated as of March 2021 (Law 18256 and its amendments), which applies to all tobacco products.

Heated tobacco products (HTPs)

A significant increase in the presence of HTPs has been reported in the markets of the Parties. HTPs can now be found in 49% of the Parties, compared to 38% in 2020. However, less than half of Parties regulate HTPs (43%, compared to 31% in 2020).

The Azerbaijan State Standard and Tax Code applies to smokeless tobacco products, water-pipe tobacco and HTPs. In Colombia, HTPs are regulated under the same provisions as other tobacco products; however, in relation to health warnings, only a round of three

health warnings is incorporated, unlike conventional tobacco products which have a round of six health warnings. The Finland Tobacco Act imposed in 2022 a display ban for the devices for HTPs. Iraq reported having rejected a formal request by Philip Morris International to introduce HTPs into its territory and issued Resolution No. 233 for prohibiting the import of heated tobacco, in line with its international obligations under the WHO FCTC. Georgia developed a new reporting form for the disclosures of HTPs and other novel tobacco products, including their content and instructions for use, so importers and manufacturers are obliged to submit information about these products, and not only about traditional tobacco products and electronic cigarettes.

Latvia reported having amended the regulations under the EU Tobacco Products Directive in order to apply the same restrictions to HTPs devices. Through the Peruvian Ministry of Economy and Finance, a rule has been issued that taxes all tobacco items, including HTPs, which will be taxed with 0.27 Peruvian sol per unit, similar to what is applied to conventional cigarettes. In Uruguay, as of March 2021, HTPs are included in the regulation of other tobacco products under Law 18256 and its amendments, which also cover water-pipe tobacco and smokeless tobacco products.

Novel and emerging nicotine products

The presence of novel and emerging nicotine and non-nicotine products in more markets has also been observed. Electronic nicotine delivery systems (ENDS) are now present in 74% of the Parties (compared to 65% in 2020), and electronic non-nicotine delivery systems (ENNDS) are available in 52% of Parties, compared to 38% in 2020. In relation to the adoption and implementation of policies or regulations, only over half of Parties regulate ENDS (60%) and approximately one third of Parties (36%) regulate ENNDS.

Electronic nicotine delivery systems (ENDS). In November 2022, Australia's Health Minister consolidated eight different tobacco related laws, regulations and instruments into a single streamlined act of Parliament. As reported, the reforms are expected to extend advertising and sponsorship restrictions to electronic cigarettes. Australia also reported that the policy and regulation of ENDS/ENNDS is shared by the national and subnational levels of government. The commercial sale of ENDS is prohibited in all states and territories under state and territory legislation. However, regulatory changes introduced by the Therapeutic Goods Administration (TGA) in October 2021, indicate that people who use ENDS must have a prescription.

The Technical Regulation for Electronic Nicotine Products that entered into force in Bahrain in May 2022 regulates the contents and emissions of these products, as well as the device used to consume them. Belgium's modification of the royal decree on electronic cigarettes was reported to enter into force in July 2023. The dispositions for ENDS will be applied to ENNDS as well, including notification, composition and labelling. A resolution from the Brazilian Health Regulatory Agency (ANVISA) prohibits the sale, import and advertising of ENDS. China reported that the e-cigarettes available in the domestic market should pass a technical review, and non-compliance with the technical requirements would mean that the product cannot be introduced in the market for sale.

The restrictions related to the sale and use of ENDS and ENNDS are in line with those applied to tobacco products in Latvia. Lithuania reported having adopted amendments to the Tobacco Control Law in 2022, regulating the content of ENDS and ENNDS, including taxation, and banned flavours in electronic cigarettes, with and without nicotine, except tobacco flavour, to reduce the attractiveness and use of electronic cigarettes, especially among young people. In 2023, the Netherlands regulated the disclosures of contents of electronic cigarettes and of electronic liquids with and without nicotine as part of the flavour ban applied to these products.

Seychelles indicated having amended the Tobacco Control Act to include and regulate ENDS. This includes, among other restrictions, a ban on advertising and promotion; a ban on usage in enclosed public places, workplaces and public transport; a ban on sale by/to minors; the display of prescribed health warnings for ENDS; the display of nicotine content on ENDS packages; and a ban on ENDS that produce attractive flavours, for example, fruit medley and candy-like aromas. The amendments to the Act were approved by the Cabinet in 2022, and they were to be presented to the National Assembly in 2023 for approval.

In Sweden, tobacco-free nicotine products have been regulated in a new legislation from June 2022 with dates of entry into force set for 1 August 2022, 1 January 2023 and January 2024, depending on the measure. The law mandates the inclusion of a content declaration and a health warning as a text that informs about the harmful effects of nicotine. Additional restrictions are adopted on advertising of these products, sponsorship and product placement, with certain exceptions. These products cannot be sold or given to anyone under the age of 18. Moreover, manufacturers, importers and distributors of tobacco-free nicotine products must establish and maintain a system to collect information on all suspected harmful effects that these products have on human health, to be provided to the Public Health Authority upon request.

Thailand reported to be continuing to work to enforce the ban on importation and sales of ENDS. However, the electronic cigarette use group in the country is lobbying policy-makers, politicians and the Government to promote the legalization of ENDS by claiming that these products are a safer option for smokers, especially those who wish to quit smoking. Another tactic reported as being used by the electronic cigarette use group is convincing the Government that legalizing these products will increase the country's income through taxation, as well as to call for additional research to show that ENDS are safe for smoking cessation purposes. Venezuela reported having banned the sale of electronic cigarettes in the country.

Other Parties that had previously banned ENDS are now regulating or planning to amend the regulation to control their use and importation, including Bhutan, Chile and Norway.

Electronic non-nicotine delivery systems (ENNDS). In Australia, the sale and use of ENNDS products that do not contain nicotine may be permitted in some states and territories, subject to state and territory legislation. In the Republic of Korea, if the ENNDS product is approved by the Ministry of Food and Drug Safety as a "quasi-drug product", it can be advertised and sold in the domestic market as a smoking cessation device. Mauritius amended its national tobacco control law in 2022, including the ban on the sale and import of ENDS and ENNDS. In Portugal, ENNDS are covered by the general consumers protection legislation.

Few Parties have reported establishing laws for **nicotine pouches** (Belgium, the Czech Republic, Latvia and Uzbekistan). In Belgium, a ban on allowing nicotine pouches in the market has been signed and will be published, with the expectation of enforcement in 2023. A decree on nicotine pouches without tobacco was being prepared in the Czech Republic. The effectiveness of the decree was set for 1 July 2023. The decree regulates: a) requirements for the composition, appearance, quality and properties of nicotine pouches without tobacco; b) labelling of nicotine pouches without tobacco content, including prohibited elements and features; and c) methods, deadlines and scope of notification obligations of manufacturers and importers.

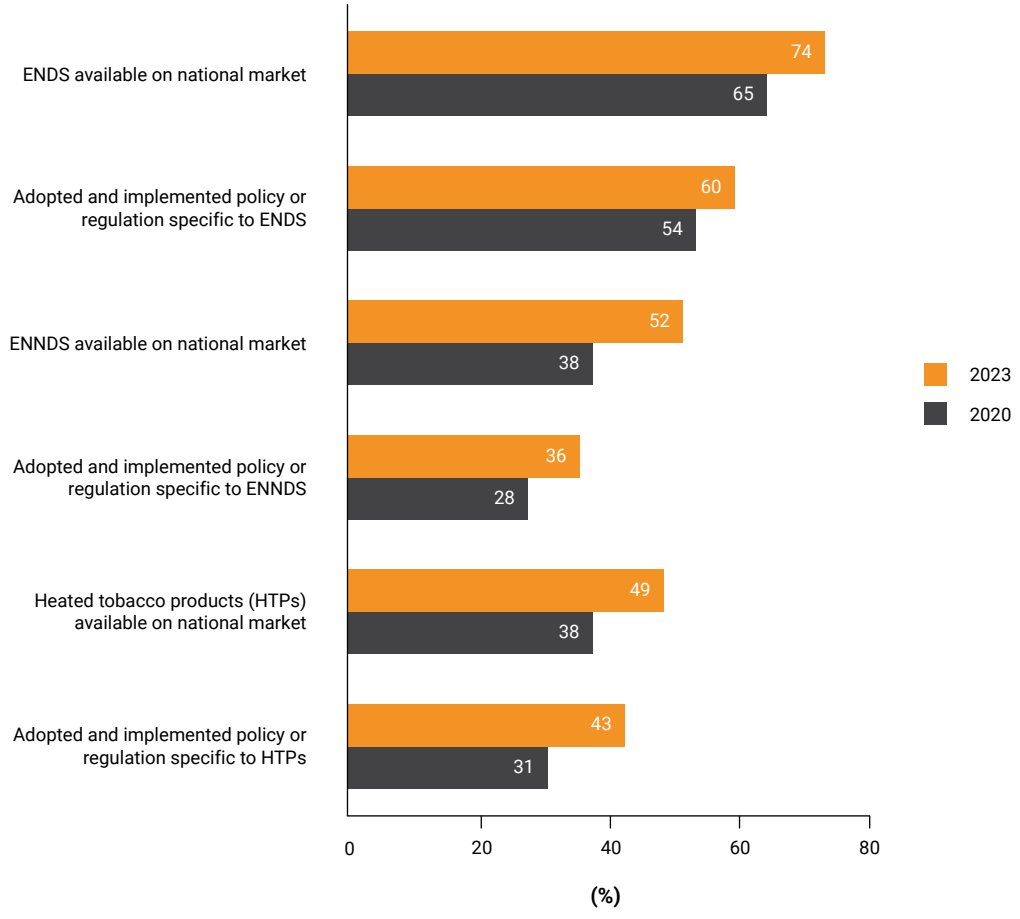
HTPs and ENDS regulated together

Some Parties regulate HTPs and ENDS together.

In November 2021, Bahrain released the Bahraini Technical Regulation for Electronic Nicotine Products, which regulates electronic shisha and HTPs. The Ministry of Health is responsible for the implementation of the new technical regulation, which entered into force in May 2022. Mexico introduced a ban on the sale of electronic cigarettes in 2008. In February 2020, a presidential decree banned the importation of electronic cigarettes, with or without nicotine, and HTPs. On 16 July 2021, a decree modified the banning provisions for alternative nicotine delivery systems, in order to allow import and export of HTPs. On 22 October 2021, a new presidential decree revoked the decree from July 2021, restoring the ban on the import and export of HTPs, and maintaining the ban on ENDS and ENNDS. This new decree also includes a ban on the import and export liquids, blends, cartridges and detachable units. The main arguments are the right to health, the right to a healthy environment, and protecting the best interests of the child over any other vested or commercial interests.

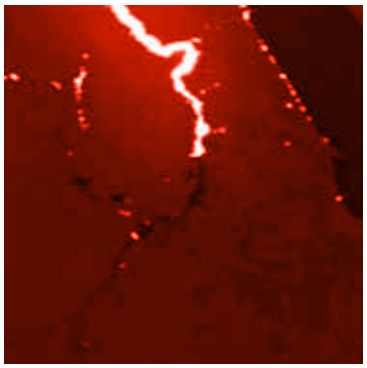
Panama adopted in 2022 a law prohibiting the use, import and sale of electronic cigarettes and HTPs. The Philippines published in 2022 an administrative order containing the first set of graphic health warnings for vapor products, HTPs and other similar products. In 2020, the Russian Federation expanded its ban on tobacco advertising, promotion and sponsorship (TAPS) to nicotine-containing products and devices for its consumption, including ENDS, devices for their use and water pipes.

Fig. 15. Percentage (%) of Parties reporting novel and emerging tobacco products and nicotine products in national markets, and implementation of product-specific policies and regulations, 2020 (n=181)-2023 (n=182)



Prevalence of tobacco use: trends and projections

5



Key observations

- Trends through 2022 and projections to 2025 show that most Parties need to accelerate tobacco control activities in order to achieve the voluntary global NCD target to reduce tobacco use by 30% between 2010 and 2025. Of note, 127 Parties are currently not on track to achieve the reduction target unless effective policies are urgently put in place.
- To enable more accurate trend analyses, as well as estimates and projections, the Parties to the Convention need to continue to strengthen their surveillance and monitoring systems, and more generally, scale up their implementation of Article 20 of the Convention and exchange collected data.

Comparable estimates for prevalence of smoking and smokeless tobacco use.

Under Article 20, Parties shall establish, as appropriate, programmes for national, regional and global surveillance of the magnitude, patterns, determinants, and consequences of tobacco consumption and exposure to tobacco smoke. The progress with surveillance systems and the types of prevalence data reported by the Parties is described in the chapter on Article 20. Additionally, the prevalence of current smoking and smokeless tobacco use among adults and youth, as reported by the Parties in the 2023 reporting cycle, is available in Annex 3.

To further utilize the prevalence data provided by the Parties, global and regional trends in tobacco use were calculated by the WHO Department of Health Promotion using data reported up to the end of 2022 and in earlier reporting cycles, together with other national surveys available in the public domain. The statistical model[48] used to calculate these estimates overcomes issues of comparability due to different age ranges, years and tobacco indicators covered by surveys. WHO-modelled estimates made it possible to compare tobacco use rates in 2022 with rates in 2005, even though many Parties have not conducted national surveys to measure prevalence in those particular years.

Between 2005 and 2022, 179 Parties collected nationally representative data on one or more indicators of tobacco use. In these surveys, 165 Parties reported tobacco smoking indicators, 169 reported cigarette smoking indicators, 133 reported smokeless tobacco indicators, and 156 Parties reported on any tobacco use including both smoked and smokeless types of tobacco. These surveys were combined with earlier surveys back to 1990 to estimate trends in tobacco use. Parties without data on smokeless tobacco use are assumed to have negligible levels of use.

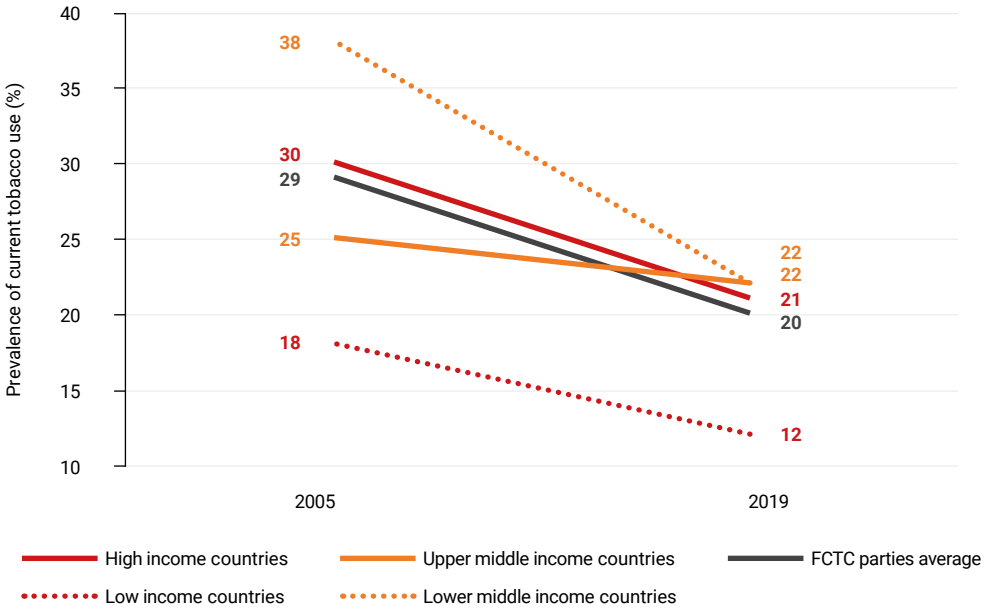
The global average rate of current tobacco use of all Parties in 2005 is estimated at 29% of people aged 15 or older (45% of males and 13% of females). By 2022, tobacco use rates dropped to an average of 20% (33% of males and 7% of females). Tobacco use includes use of smoked and/or smokeless tobacco products, depending on the varieties commonly used in and surveyed by each Party. Current use means either daily or occasional use at the time of the survey.

All World Bank income groups of Parties are trending downwards with average current tobacco use rates (Fig. 16). In 2005, lower-middle-income Parties had collectively the highest average tobacco use rate at 38%, but by accomplishing the fastest decline in average rates, by 2022 a prevalence of 22% was achieved. Slowest progress is occurring among the upper middle-income Parties, with an overall reduction from 25% in 2005 to 22% in 2022. Low-income Parties had on average the lowest smoking rates in both years.

The global average rate of current tobacco use of all Parties in 2005 is estimated at 29% of people aged 15 or older (45% of males and 13% of females). By 2022, tobacco use rates dropped to an average of 20% (33% of males and 7% of females).

48 WHO uses the data from national surveys reported by Parties in their 2020 implementation reports to augment the WHO tobacco use prevalence data set in order to calculate comparable trend estimates of tobacco use. The method for the estimation is described in the article “Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control”; Bilano, Ver et al.; The Lancet , Volume 385 , Issue 9972 , 966 – 976; http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60264-1/abstract

Fig. 16. Estimated trend in current tobacco use prevalence, ages 15+, by World Bank income groups, 2005–2022



Source: WHO estimates

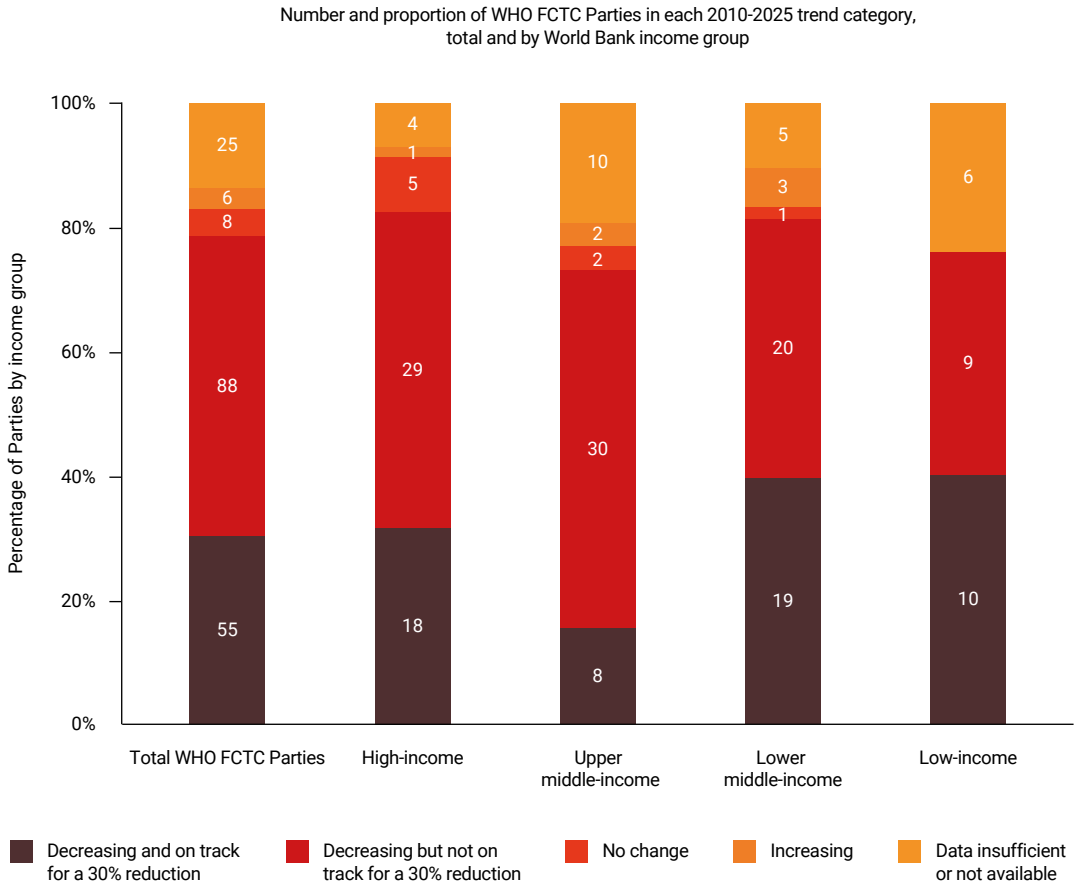
Regarding tobacco use among young people, the majority of Parties are consistently monitoring youth rates over time, particularly among those aged 13–15 years. Some 142 Parties completed a national school-based survey between 2012 and 2022 (the past 10 years) that measured current tobacco use or current cigarette smoking in this age group. Using data from these surveys, the average prevalence of tobacco use among children aged 13–15 years was 9.4% overall (11.8% for boys and 6.8% for girls). On average, boys used tobacco at a rate close to double that of girls. However, in 25 Parties, girls used tobacco at a higher rate than boys. Looking only at cigarette smoking reported in these surveys, the average prevalence among children aged 13–15 was 4.6% overall (6.1% for boys and 3.0 % for girls).

Towards meeting tobacco use reduction targets

The WHO *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (resolution WHA66.10) includes a voluntary target to reduce the prevalence of tobacco use among people aged 15 years and older by 30% in relative terms between 2010 and 2025. Meeting this target will contribute greatly to the overarching target of a 25% reduction in premature mortality from NCDs. The SDGs include Target 3.a that calls for strengthening implementation of the WHO FCTC in all countries, as appropriate, with an indicator to measure age-standardized prevalence of current tobacco use among people aged 15 years and older.

WHO estimates show that 55 Parties (30%) are on track to achieve the target by 2025 (Fig. 17). An additional 88 Parties (46%) have decreasing rates and need only accelerate the work they are already doing. Of note, eight Parties are expected to experience no decrease in smoking prevalence, and another six Parties can expect tobacco use rates to increase unless effective policies are urgently put into place. Trends are unknown in 25 Parties where insufficient nationally representative surveys have been reported. In summary, most Parties need to accelerate tobacco control activities in order to achieve the NCD target.

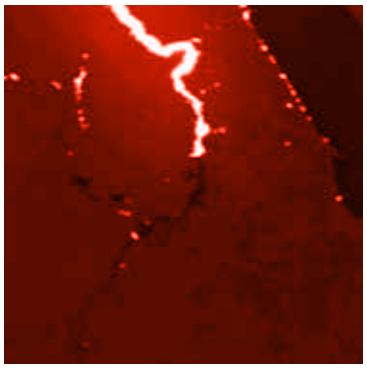
Fig. 17. Projections for WHO FCTC Parties on achieving the target of 30% relative reduction of current tobacco use prevalence ages 15+ in 2025, by World Bank income group*



These trend estimates reflect the effects of tobacco control actions already implemented by the Parties prior to conducting their most recent survey. Where no survey has been conducted since a policy was implemented, the effects of the new policy will not be seen until the next survey has been conducted. These projections, therefore, reflect only what has been captured in surveys to date and will be subject to recalculation as new policies are implemented and new surveys are released. These estimates of tobacco use are therefore not directly comparable with earlier estimates.

Only one in three Parties are likely to achieve the tobacco use target by 2025, therefore, most Parties need to accelerate tobacco control activities in order to reach it, and subsequently, the respective NCD target.

6 Priorities, needs and gaps, and challenges



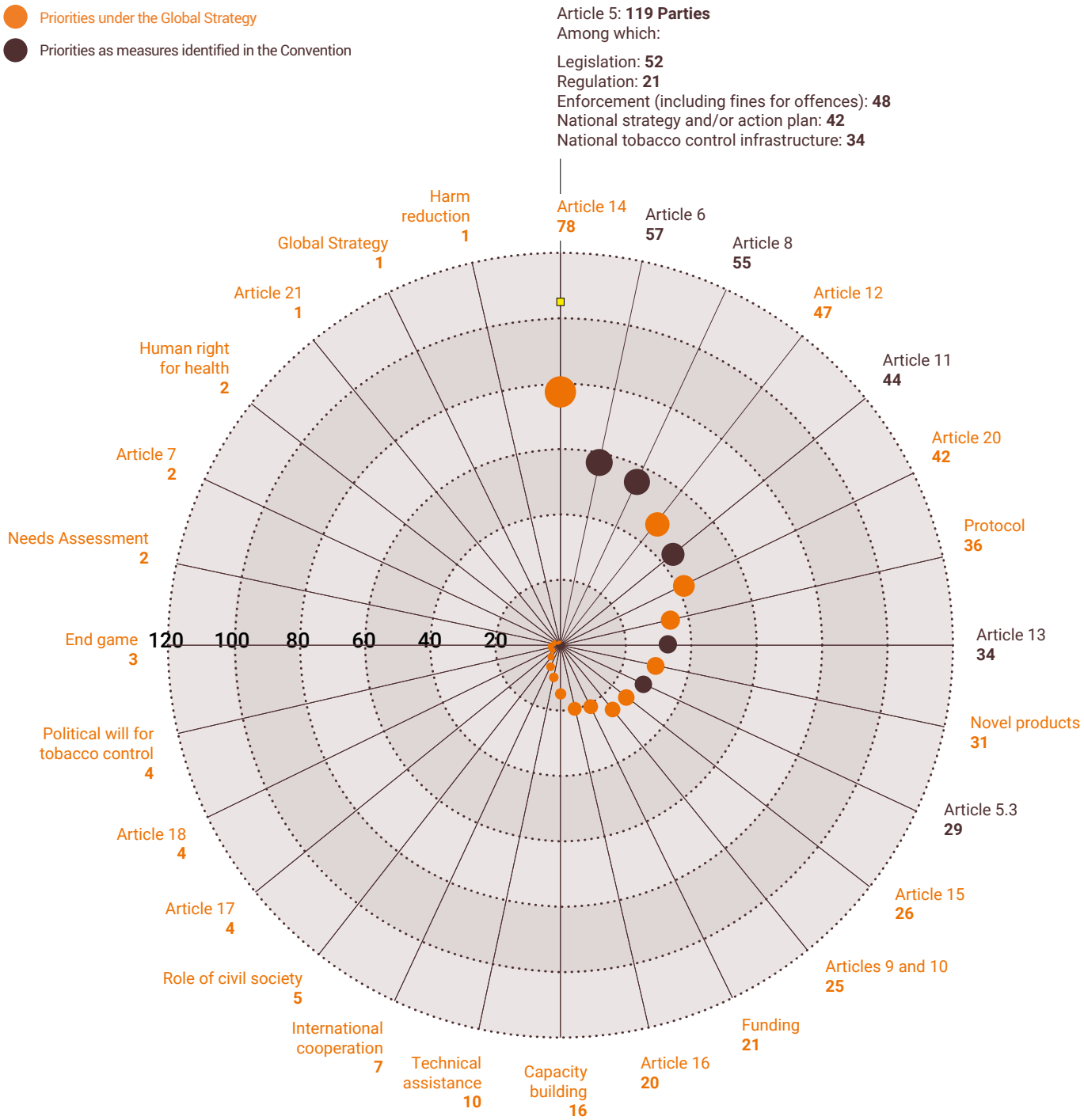
Priorities

Nearly all Parties reported on their national priorities for implementation of the Convention. Obligations under Article 5 (General obligations) were mentioned by most Parties, particularly in relation to the development of legislation, the enforcement of existing regulations including the imposition of fines for offences, the development of a national strategy and/or action plan on tobacco control, the national tobacco control infrastructure, and the elaboration of regulations, in that order. These items under Article 5 were mentioned on 119 occasions, with an increase observed since the 2020 reporting cycle (104 occasions).

The next most mentioned priorities are the measures under Article 14 (Demand reduction measures concerning tobacco dependence and cessation), mentioned by almost half of Parties, followed by those under Article 6 (Price and tax measures to reduce the demand for tobacco) and under Article 8 (Protection from exposure to tobacco smoke). Measures related to Article 12 (Education, communication and public awareness), Article 11 (Packaging and labelling) and Article 20 (Research, surveillance and exchange of information) were also mentioned by a good number of Parties among their national priorities. The third time-bound article, Article 13 (Tobacco advertising, promotion and sponsorship), was mentioned on 34 instances, while Article 5.3 (Protection of public health policies from commercial and other vested interests of the tobacco industry) was recognized as a priority by 29 Parties.

The priorities that have been reported by an increased number of Parties fall under the following categories: the Protocol, novel products, funding and technical assistance. As for the newly mentioned priorities, reporting Parties highlighted the need for capacity-building in tobacco control, support through a needs assessment exercise and Article 2.1 (Measures beyond those required by the Convention and its protocols). Fig. 18 below presents the various priorities mentioned by the Parties, also reflecting the number of times the respective priorities were mentioned.

Fig. 18. Priorities highlighted in the reports of the Parties



Gaps between the resources available and the needs assessed for implementing the WHO FCTC. A total of 114 Parties (63%) responded that they have identified specific gaps between the resources available and the needs identified in the implementation of the Convention, three percentage points more than in 2020. Of those Parties, 106 (93%) provided details on the gaps they identified.

The three most frequently mentioned gaps were: a lack of financial resources; a lack of human resources and expertise for tobacco control; and the need for more training and capacity- building in tobacco control.

The lack of financial resources was mentioned by more than two thirds of Parties that reported on gaps. This included Parties at all levels of economic development. The areas where Parties would like to see more financial resources devoted include the following:

- education, communication, training and public awareness activities, including public education campaigns;
- tobacco cessation activities;
- monitoring compliance, inspections and other enforcement activities, including at the borders;
- research activities, including monitoring of the tobacco industry.

The second most frequently mentioned gap is a lack of human resources and expertise for tobacco control, mentioned by more than one third of Parties that reported on gaps. A few Parties specifically mentioned the frequent changes in trained officers as an implementation gap. The third-most reported gap is a lack of training and capacity-building among those who work in tobacco control.

In addition to the above, Parties reported another 23 implementation gaps. They are listed in the Table 6, categorized by articles to the Convention and with some details on those gaps as reported by the Parties.

A total of 114 Parties (63%) responded that they have identified specific gaps between the resources available and the needs identified in the implementation of the Convention.

Table 6. Gaps reported by the Parties in relation to technical areas under various WHO FCTC articles

Article 4.7	• No NGOs dedicated to work in tobacco control, insufficient involvement and participation of NGOs in the implementation of the WHO FCTC, lack of involvement of professional associations in tobacco control.
Article 5	• Lack of or weak political commitment. • Lack of or gaps in national legislation (the legislation is not WHO FCTC-compliant; Article 5.3 is not included in the national legislation). • Lack of national comprehensive tobacco control strategy or plan, or a plan in the process of updating. • Lack of a national coordinating mechanism for tobacco control. • Lack of or limited collaboration among stakeholders. • Lack of a dedicated tobacco control unit. • Lack of or ineffective enforcement.
Article 6	• Absence of a taxation policy.
Articles 9 and 10	• Lack of laboratory testing capacity.
Article 11	• Need for support on plain packaging.
Article 12	• Lack of a media strategy for tobacco control.
Article 14	• Lack of activities to help quit tobacco use. This includes a lack of a national quit line, promotion of tobacco cessation services, pharmaceutical products to assist those who wish to quit are not available, a lack of inclusion of cessation services in primary health care and a lack of inclusion of nicotine replacement therapy in the essential medicines list.
Article 15	• Need to address illicit tobacco trade. • Implementation of tracking and tracing systems for tobacco products.
Article 16	• Sale of individual sticks are still allowed • Shelves are directly accessible to buyers
Article 17	• No viable alternative livelihood programmes are available.
Article 20	• More research is needed, in areas such as tobacco control investment cases, epidemiological studies, surveillance and monitoring.
Article 26	• Lack of technical assistance. • Lack of basic office needs.

The needs and gaps reported by the Parties under this question of the reporting instrument will inadvertently present overlaps with the constraints and barriers section.

Constraints and barriers encountered in implementing the Convention. Among all Parties to the Convention, information on constraints and barriers to implementation of the Convention was available from 158 Parties (87%).

Among those Parties that reported on constraints and barriers, the most reported implementation barrier continues to be interference by the tobacco industry and those working to further its interests. This was reported by around one third of the Parties. Challenges include interference by the tobacco and nicotine industry with the policy-making process, primarily through legal challenges, including litigation. One Party reported that tobacco manufacturing has recently been established in the country, while another Party underlined the fact that the local tobacco industry is considered an important contributor to the local economy, which acts as a barrier to the implementation of the Convention.

The second-most often indicated barrier, mentioned by one in six Parties, is a lack of intersectoral cooperation and coordination, including bureaucratic and administrative barriers. The next most cited constraints (by one in 10 Parties) are a lack of enforcement, which results in poor implementation of tobacco control legislation, as well as the limited knowledge, in particular of decision-makers, about the WHO FCTC, including Article 5.3. Ten Parties noted the introduction of novel and emerging tobacco products and nicotine products in their markets, a lack of regulation of these products and their increasing popularity as an implementation barrier.

It is to be noted that more than 10 Parties cited political issues as barriers to the implementation of the Convention. These include political instability, such as emergency situations or “unsuitable” political conditions, international sanctions, ongoing political reforms or economic crises.

There is a series of implementation barriers reported by few Parties each; these include competing legislative priorities; insufficient involvement/interest of decision-makers and of public authorities and communities, including slow decision-making, the feeling of “job done”; difficulties in working with partners, including lack of interest from academia; lack of compliance with the requirements of the law; lack of support for tobacco taxation from the finance ministry; lack of inclusion of Article 5.3 in the national legislation; insufficient knowledge on the effects of tobacco use and social acceptance of smoking; lack of coordination with local governments; the presence of tobacco growing and a tobacco cottage industry and the need to explain to legislators the meaning of diversification from tobacco growing; lack of interest of donors and technical and financial partners (with the exception of WHO) in supporting tobacco control; the negative impact of influencers and social networks; and marketing through the social media to young people. The COVID-19 pandemic was also referred to as an implementation barrier by a few Parties.

The are some very specific constraints and barriers referred to by some Parties. For example, Bhutan mentioned that its tobacco sales ban was lifted in 2020 after being in force for 18 years. Micronesia reported that the public is less concerned by the impact of tobacco than that of communicable diseases; this warrants more effective communication efforts aligned with Article 12 of the Convention. Saint Kitts and Nevis reported on a connection between the perception of use of marijuana and tobacco. Decriminalization of marijuana use in 2019 led policy-makers to deprioritize tobacco control measures. It seems that the changing prevalence of marijuana use and changing public attitude towards its use also impact public perceptions of tobacco use. If marijuana is viewed as a less harmful alternative to tobacco, it could undermine efforts to control tobacco use and will make it harder to build support for WHO FCTC policies.

7 Global Strategy to Accelerate Tobacco Control

Indicators of the Global Strategy to Accelerate Tobacco Control: a status report

The progress made on the 20 indicators of the Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025 were reviewed and, where appropriate, compared to the baseline data collected in the previous reporting cycle. Some highlights of the findings are presented below.

Under Strategic Goal 1, the progress of Parties is addressed in the previous sections of the present report. In addition, eight of the nine WHO FCTC Knowledge Hubs that had provided a report on their work assisted more than 150 Parties. This represents a significant increase in the provision of support by WHO FCTC Knowledge Hubs, as compared to the previous reporting cycle. It should be noted, however, that during the COVID-19 pandemic most of the assistance was provided through online means, which permitted outreach and support on a broader scale. In relation to the indicator on the number of Parties involved in South–South and Triangular (SST) Cooperation programmes, even though specific SST projects existed in the past, no such projects have been implemented since 2020. The Convention Secretariat facilitated SST between Parties through the FCTC 2030 project. When a Party expresses the need for support in a particular area, the Convention Secretariat identifies Parties or entities from other Parties that could provide such support. For example, Georgia assisted Armenia in the development of tobacco regulations. Fiocruz (Brazil), which also serves as the WHO FCTC Knowledge Hub for Articles 17 and 18 of the Convention, supported Mozambique with tobacco control capacity- building.

Under Strategic Goal 2, the Convention Secretariat reiterated to Parties the importance of including implementation of the WHO FCTC in the voluntary national reviews (VNRs) of their domestic implementation of the SDGs. The Convention Secretariat promoted its publication on this matter during a webinar [49] in November 2022, following a first webinar in June 2021. On that occasion, new research was carried out to study how many Parties included implementation of the WHO FCTC in their VNRs. In 2021–2022, in 83 VNRs analysed, 37% of Parties listed SDG Target 3.a in their reports, and 35% of Parties reported on SDG Target 3.a. Furthermore, 39% of Parties listed the indicator of SDG Target 3.a (indicator 3.a.1) in their reports, and 48% of Parties reported on data related to it. Despite the positive fact that some Parties have covered SDG Target 3.a and/or indicator 3.a.1 in their VNRs, the percentages have still not changed significantly as compared to earlier research that analysed VNRs from 2016 to 2019. From the 2023 reporting cycle, for the first time, reference to VNRs was included in Party responses to an open-ended question under Article 20 of the Convention. The inclusion of a question on this matter in a revised WHO FCTC reporting instrument is proposed for consideration at the Tenth session of the COP (COP10) (document FCTC/COP/10/13).

Under Strategic Goal 3, an implementation review mechanism for the WHO FCTC is proposed to for consideration at COP10 (document FCTC/COP/10/14). In addition, an indicator to measure the gap in global funding for implementation of the WHO FCTC was developed, and a calculation of the global funding gap was undertaken. As the current cycle of the Global Strategy is scheduled to end in 2025, a possible extension of the Global Strategy is proposed for consideration at COP10 (document FCTC/COP/10/16).

The Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO FCTC 2019–2025 was adopted by the Eighth session of the Conference of the Parties (COP8) through decision FCTC/COP8(16). The decision also required the Convention Secretariat: 1) to collect baseline data for the range of indicators identified in the Global Strategy; and 2) to report, on a biennial basis, on the progress in implementation of the Global Strategy, as part of its regular biennial global reports on the implementation of the Convention.

49 https://fctc.who.int/newsroom/events/item/2022/11/17/default-calendar/showcasing-sdg-target3.a-in-parties-voluntary-national-reviews

The Global Strategy contains 20 indicators that are expected to measure progress in the implementation of the objectives under its three strategic goals. These indicators are described in the Indicator Compendium for the Global Strategy.[50] Baseline data for the Global Strategy indicators were published as part of the *2021 Global Progress Report on the Implementation of the WHO FCTC*.

This report intends to capture the progress in the implementation of the Global Strategy measures. This second status report is based on information reported by the Parties in the 2023 reporting cycle, and on information from other sources. For those indicators related to Parties' implementation work for which information is not collected through the reporting instrument of the WHO FCTC, as was the case for the 2021 report, proxy indicators and/or additional data sources were used according to the methodologies defined in the Indicator Compendium.

In the case of indicators that are not directly related to the implementation of the Convention by the Parties, a cut-off date of 31 December 2022 was used. For the latter, the information was collected through desk research and ad-hoc questionnaires sent out to the relevant stakeholders.

Also, it is important to note that lessons learned on data collection from the first report on the Global Strategy indicators were already utilized this time to improve the quality of data presented in this second report. For example, new questions, reflecting more precisely the indicators in the Global Strategy, were added to the WHO FCTC reporting instrument, and the information collected through them was used in the 2023 cycle. They facilitated, among other activities, data analysis on costed national tobacco control strategies, on measures that go beyond the requirements of the Convention in line with Article 2.1 (for example endgame strategies, smoke-free generations) or on the assistance provided by the WHO FCTC Knowledge Hubs to Parties.

This second status report will continue to make suggestions on how to further develop indicators of the Global Strategy, or what additional resources and data should be collected or used to assess progress in these indicators.

50 Global Strategy to Accelerate Tobacco Control Advancing Sustainable Development Through the Implementation of the WHO FCTC 2019 – 2025: Indicator Compendium. May 2023. See: https://fctc.who.int/publications/m/item/indicator-compendium-global-strategy-to-accelerate-tobacco-control

Status by strategic goals and indicators

The current status for each indicator will be presented in the order these indicators appear in the Global Strategy.

Strategic Goal 1

Strategic Goal 1: Accelerating Action

Indicators under Strategic Goal 1 refer to the implementation work carried out by the Parties, specifically in the areas covered by Article 5 (General obligations), Article 6 (Price and tax measures), and the time-bound provisions with respect to Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship) of the Convention.

To assess the number of Parties with strengthened national tobacco control measures related to the time-bound articles (Articles 8, 11 and 13) of the Convention, a comparison had to be made between the responses of the Parties in the 2020 and 2023 reporting cycles, respectively (where available).

Other indicators under Strategic Goal 1 refer to the number of Parties that received or provided financial and/or technical support to each other and the number of Parties that have received assistance from the WHO FCTC Knowledge Hubs, or through South–South and Triangular projects.

Indicators under Strategic Objective 1.1

1. Number of Parties reporting having received or provided financial and/or technical support

This indicator corresponds to several questions in the section entitled “International cooperation and assistance” of the reporting instrument of the WHO FCTC used in the 2023 reporting cycle. As in the first report on Global Strategy indicators we already presented figures for this indicator from the 2018 and 2020 datasets, a trend seems to be identifiable.

According to information collected in the 2023 cycle, 87 Parties reported having provided and 133 Parties reported having received financial and/or technical support in at least one of the following six areas:

- development, transfer and acquisition of technology, knowledge, skills, capacity and expertise related to tobacco control;
- provision of technical, scientific, legal and other expertise to establish and strengthen national tobacco control strategies, plans and programmes;
- appropriate training or sensitization programmes for appropriate personnel in accordance with Article 12;
- provision of the necessary material, equipment and supplies, as well as logistic support, for tobacco control strategies, plans and programmes;
- identification of methods for tobacco control, including comprehensive treatment of nicotine addiction; and
- promotion of research to increase the affordability of comprehensive treatment of nicotine addiction.

The corresponding figures for this indicator presented in the first report were 86 Parties that reported having provided and 130 Parties that reported having received technical and/or financial support in at least one of the six areas in 2018, and 86 Parties that reported having provided and 134 Parties that reported having received technical and/or financial support in at least one of the six areas in 2020. This means no significant change occurred in 2023 as compared to the previous two reporting cycles.

This Global Progress Report includes examples of the Parties providing or receiving assistance, and examples of assistance provided by non-Party stakeholders (for example, IGOs and NGOs) to Parties. In the case of the latter, the biennial reports submitted by the NGOs that are observers to the COP – as part of their reaccreditation process – serve and could continue to serve in the future with additional information on the areas where these organizations assisted the Parties in their implementation of the Convention.[51]

There continue to be signs of underreporting of this information by the Parties. For example, there are assistance mechanisms operated by the Convention Secretariat and its partners, such as needs assessments and related activities, that are not mentioned in Parties' implementation reports. Efforts should be made to further encourage Parties to provide more complete and detailed information on the assistance they provided or received, as well as any financial or technical assistance that may be needed to address existing implementation gaps.

2. Number of Parties that have submitted a costed national tobacco control plan as part of their regular WHO FCTC reports

As a novelty in the reporting instrument utilized in the 2023 cycle, a new question asked Parties whether they have a "costed" national tobacco control plan or strategy. In 2023, out of the 135 Parties that submitted a report, 23 responded that they have a costed national tobacco control action plan or strategy. Out of these 23 Parties, 12 confirmed that this is fully funded.

In the first report on Global Strategy indicators, as suggested in the Indicator Compendium, proxy indicators[52] were used to measure this indicator. They referred to Parties having:

1. reported the development and implementation of a comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the Convention; and
2. established or reinforced and financed a focal point for tobacco control and/or a tobacco control unit and/or a national coordinating mechanism for tobacco control.

To enable a comparison with data presented in the first status report, we could still consider that in the 2023 cycle the following number of Parties provided affirmative responses to any items under points 1 and 2 above:

- 34 Parties reported that they developed and implemented comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the Convention (versus 128 Parties in 2020 and 121 in 2018);
- 157 Parties reported having established or reinforced and financed a focal point for tobacco control (versus 155 in 2020 and 151 in 2018);
- 125 Parties reported having established or reinforced and financed a tobacco control unit (versus 121 in 2020 and 115 in 2018); and
- 133 Parties reported having established or reinforced and financed a national coordinating mechanism for tobacco control, compared to 131 in 2020 and 134 in 2018.

51 https://www.who.int/fctc/cop/observers_ngo/

52 Indirect measure or sign that approximates or represents a phenomenon in the absence of a direct measure or sign.

Considering that under the first point above, 134 Parties reported that they have national tobacco control strategies, plans and programmes in place, but responding to the new question of the 2023 reporting instrument only 23 Parties confirmed that they have a costed national plan or strategy, a significant discrepancy is exposed. In future reporting cycles, there should be more attention devoted to collecting additional data that explain this discrepancy, including through further fine-tuning of the existing questions or adding supplementary questions. But for the time being, we might need to admit that most Parties' national tobacco control strategies and plans do not have an appropriate budget attached to them.

In a related new question in the reporting instrument, Parties were requested to provide their government's expenditure on tobacco control, for the latest year available. In the 2023 cycle, 66 Parties answered this question, out of which 23 Parties provided details on government expenditure on tobacco control, while the balance of 43 Parties indicated having no expenditure or facing difficulties to calculate the expenditure.

On a similar note, the WH*O Report on the Global Tobacco Epidemic 2021* also contains information on countries' tobacco control budgets. In that report WHO found that 60 Member States have allocated a budget for tobacco control strategies, plans and programmes.[53]

3. Number of Parties implementing price and tax measures

The reporting instrument of the WHO FCTC, in relation to Article 6 of the Convention, utilizes a qualitative indicator identifying Parties "that have adopted and implemented tax policies and, where appropriate, price policies on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption".

Considering the new information collected from the Parties in the 2023 reporting cycle, 152 Parties have indicated that they adopted tax and price policies.

To illustrate those policies, the questionnaire of the WHO FCTC also collects quantitative information on tobacco taxes and prices. See the Article 6 section of this Global Progress Report for information on tobacco taxes and prices reported by the Parties. In that section, examples of practices in implementing price and tax measures are also presented.

4. Number of Parties with strengthened national tobacco control measures

Due to the complexity of this indicator, we used the methodology proposed in the Global Strategy Indicator Compendium for measuring it. The Indicator Compendium states that the "number of Parties with strengthened national tobacco measures is defined as those Parties that have implemented the time-bound measures (Articles 8,11 and 13) of the Convention". The *Guidelines for Implementation of Article 8* of the Convention require Parties to put in place certain measures according to a particular timeline, while the time-bound requirements for Articles 11 and 13 are included in the text of the Convention.

To assess this indicator, a comparison had to be made between the responses of the Parties to specific reporting instrument indicators in the 2020 and 2023 reporting cycles, respectively. Policy changes were considered improvements ("strengthening"), but "voluntary agreements" were not. Those Parties that have not given new information in 2023 were not included in drawing the observations below, as a comparison could not be made.

53 Table 6.14 - National tobacco control programmes (https://www.who.int/tobacco/global_report/en/)

A total of 126 Parties reported progress in implementing at least one measure under Articles 8, 11 or 13 in the 2023 cycle, a very slight increase from 124 Parties in the 2020 cycle. Of these, 111 Parties reported progress on at least one measure under one of these three articles, 12 Parties have reported progress under two articles, and three Parties reported progress under all three articles.

More details on the progress made in time-bound measures are described below.

Article 8 (Protection from exposure to tobacco smoke)

In case of this article, we considered an "improvement" if the response of a Party changed from "no" to "yes" or from "none" to "partial" or "complete", or from "partial" to "complete", compared to information contained in the previously available datasets, in relation to having adopted and implemented legislative, executive, administrative or other measures banning tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

Improvements were considered if:

- There was an increase in the number of Parties that reported the "adoption and implementation, where appropriate, of legislative, executive, administrative or other measures on any of the following: banning tobacco smoking in indoor workplaces, public transport, indoor public places and, as appropriate, other public places".
- There was an increase in the number of the settings and in the extent/comprehensiveness of measures applied in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.
- There was an increase in the number of responses specifying that the type/nature of the measure providing for the ban is national law or subnational law(s) or administrative and executive orders, but a "voluntary agreement" was not considered an "improvement".

When looking at the specific settings and the extent/comprehensiveness of measures, examples of "improvements" that can be made for indoor workplaces, public transport and indoor public places include:

- Indoor workplaces: Ten Parties reported progress in adopting measures for private workplaces, seven Parties for governmental buildings, nine Parties for universities, six Parties for educational facilities and eight Parties for health-care facilities.
- Public transport: Four Parties reported progress in adopting measures for ferries, one Party for trains, zero Parties for airplanes and five Parties for ground public transport.
- Indoor public places: Seven Parties reported progress adopting measures for nightclubs, five Parties for pubs and bars, six Parties for restaurants, ten Parties for shopping malls and five Parties for cultural facilities.

Article 11 (Packaging and labelling of tobacco products)

For Article 11, "improvement" refers to a response change from "no" to "yes" (compared to previous data from the respective Party) for any of the following measures:

- "requiring that packaging and labelling do not promote a product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions";
- "requiring that each unit packet and package of tobacco products and any outside packaging and labelling of such products carry health warnings describing the harmful effects of tobacco use";

- "ensuring that the health warnings are approved by the competent national authority";
- "ensuring that the health warnings are rotated";
- "ensuring that the health warnings are clear, visible and legible"; and
- "ensuring that the health warnings occupy no less than 30% of the principal display areas".

Examples of improvements could be seen in the following areas:

- four more Parties reported requiring that packaging and labelling do not promote a product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions;
- one additional Party reported requiring that the health warnings are rotated;
- one more Party reported ensuring that the health warnings are clear, visible and legible;
- there was a reduction by one in the number of Parties reporting to require that the health warnings occupy no less than 30% of the principal display areas, and eight more Parties reported progress by ensuring that the size of the health warnings increase to above 50% of the principal display areas; and
- five more Parties reported that their health warnings are now in the form of, or include, pictures or pictograms.

Article 13 (Tobacco advertising, promotion and sponsorship)

For Article 13, "improvement" refers to a response changing from "no" to "yes", compared to a previous report, for any of the following measures: "instituting a comprehensive ban on all tobacco advertising, promotion and sponsorship" (and the different areas covered by the ban) and/or on "cross-border advertising, promotion and sponsorship originating from your territory".

Examples of progress was detected in the following specific areas under this article, by comparing 2020 and 2023 datasets:

- eight Parties reported progress on having instituted a comprehensive ban on all tobacco advertising, promotion and sponsorship;
- four more Parties reported having banned cross-border advertising, promotion and sponsorship originating from their territory; and
- six additional Parties reported banning cross-border advertising, promotion and sponsorship entering their territory.

5. Number of Parties that have identified WHO FCTC implementation as a development priority, including in their United Nations Development Assistance Framework (UNDAF)

In accordance with the Indicator Compendium, this indicator refers to countries that have implemented the WHO FCTC as a development priority by indicating activities as part of their domestic engagement with the United Nations Development Assistance Framework (UNDAF).[54]

Searching the most recent UNDAFs extracted from the corresponding database (documents between 2012 and 2022) for keywords, 61 hits were found for "tobacco" and only one for "WHO FCTC".

54 The core data source is the UNDAF database: https://unsdg.un.org/resources/cooperation-framework. The Cooperation Framework dashboard on UNSDG knowledge portal has given additional insight into the Cooperation Framework cycle of different countries: https://unitednations.sharepoint.com/sites/DCO-WG-UNSDG_CF/SitePages/Cooperation%20Framework%20Dashboard.aspx.

Indicators under Strategic Objective 1.2

6. Number of Parties that have received assistance from the WHO FCTC Knowledge Hubs

This indicator is defined as the number of Parties that have received any form of assistance from at least one of the WHO FCTC Knowledge Hubs on matters under their expertise in relation to the Convention.

The measurement of the indicator was based on the information collected from the WHO FCTC Knowledge Hubs. In 2022, for the first time, each Knowledge Hub submitted to the Convention Secretariat their yearly activity reports by using an online reporting platform and by using a standard questionnaire.

One of the questions was built upon the Global Strategy indicator aiming to identify the "number of Parties that have received assistance from the WHO FCTC Knowledge Hubs".

According to the reports submitted by eight out of the nine existing Knowledge Hubs, by the end of 2022, the WHO FCTC Knowledge Hubs had provided assistance to 126 Parties in 151 instances.

The three Knowledge Hubs that reported providing assistance to the highest number of Parties were the Knowledge Hub for Article 5.3, the Knowledge Hub on Legal Challenges and the Knowledge Hub on Tobacco Taxation. The WHO FCTC Knowledge Hub for Article 5.3 reported providing assistance to 82 Parties, either one-to-one or through workshops, webinars and regional activities. The WHO FCTC Knowledge Hub on Legal Challenges reported aiding 50 Parties through workshops and online training courses. Such group training programmes are followed, in some cases, by country workshops or one-to-one assistance to Parties. The Knowledge Hub on Tobacco Taxation reported providing assistance to more than 15 Parties.

Parties that wish to learn more about specific programmes carried out by the Knowledge Hubs, and any of their activities, should consult the Knowledge Hub newsletters.[55]

7. Number of Parties involved in South–South and Triangular cooperation programmes, either as a provider or recipient

South–South and Triangular (SST) cooperation is a potential tool for promoting collaboration among the Parties in accordance with Article 22 of the Convention. Parties might face similar challenges, and identifying and addressing them through peer support could serve as the basis of mutual assistance projects. There were specific SST projects in the past; however, no such projects were implemented in the past two years.

The Convention Secretariat facilitated SST between Parties through the FCTC 2030 project. When a Party needs support in a particular area, the Convention Secretariat looks for providers of support. For example, Georgia assisted Armenia in the development of tobacco regulations. Fiocruz (Brazil), which also serves as the Knowledge Hub for Articles 17 and 18 of the Convention, helped Mozambique with tobacco control capacity-building.

55 https://fctc.who.int/coordination-platforms/knowledge-hubs/news

Strategic Goal 2

Strategic Goal 2: Building international alliances and partnerships across sectors and civil society to contribute to WHO FCTC implementation

Indicators under Strategic Goal 2 highlight the ways Parties engage with partners while implementing the Convention. These include IGOs and NGOs, as well as engagements under the *2030 Agenda for Sustainable Development*.

8. Number of development agencies, intergovernmental organizations, international organizations or initiatives that include WHO FCTC implementation in their strategies or plans

The Indicator Compendium defined this indicator as the number of agencies or organizations within the United Nations system, and other relevant international agencies and initiatives that integrate WHO FCTC implementation in their strategies, plans and programmes.

As for the baseline report, information was extracted from working documents, communication and reports of country work carried out by various Convention Secretariat teams. Furthermore, the Convention Secretariat contacted by email the organizations with observer status COP to seek additional information. Finally, desk research to find additional information was carried out on the websites of relevant organizations. Complimentary information was found on webpages of the United Nations Ad Hoc Interagency Task Force on Tobacco Control (which was incorporated in the work of the United Nations Inter-Agency Task Force on the Prevention and Control of NCDs, UNIATF)[56] and those of the UNDP.[57] The information collated is presented in the table below.

56 https://www.who.int/tobacco/about/partners/un_taskforce/en/
57 https://www.undp.org/content/undp/en/home.html

Agencies, organizations and initiatives that include WHO FCTC implementation (or any aspect of it) in their strategies or plans	Details of WHO FCTC implementation inclusion in strategies/plans
Inter-agency and Expert Group on SDG indicators (IAEG-SDGs)	The Convention Secretariat participated in the Thirteenth meeting of the Inter-agency and Expert Group on Sustainable Development Goal Indicators (IAEG-SDGs) in November 2022. These meetings are platforms for information exchange and joint programming between United Nations agencies. This meeting was used to identify tobacco-related data sources that are relevant to assessing global progress in implementation of the WHO FCTC and the Protocol in which the Convention Secretariat is currently engaged.
League of Arab States (LAS)	Through the Arab Health Ministers' Council, LAS could potentially pass resolutions to support implementation of the WHO FCTC. LAS through its Technical Committee is currently working with health ministries to develop a model legislation to guide its Member States on how to bridge existing legislative gaps.[58]
United Nations Development Programme (UNDP)	UNDP's corporate strategy on health and development – *The HIV, Health and Development Strategy 2016-2021: Connecting the Dots* – elaborates UNDP's work on HIV and health in the context of the *2030 Agenda for Sustainable Development*.[59] It includes references to WHO FCTC, most prominently under Action Area 2 (Promoting effective and inclusive governance for health) and its Priority 2.2: Strengthening governance to address NCDs and accelerate tobacco control). In line with UNDP's *Strategic Plan 2018–2021*, and *its HIV, Health and Development Strategy 2016–2021*, UNDP and the WHO FCTC Secretariat have jointly developed the Toolkit for Parties to Implement Article 5.1 of the WHO FCTC to support Parties in developing effective national tobacco control strategies. The toolkit is intended primarily for governments, particularly ministries of health, national tobacco control focal points and national coordinating mechanisms for tobacco control. UNDP's interest lies in scaling up its work with WHO and the Convention Secretariat, among other relevant partners, to support countries to analyse the costs and benefits of sugar, alcohol and tobacco taxes in terms of health, health equity, revenue raised and return on investment, building on work to develop national investment cases for NCDs/tobacco control. Working closely with the Convention Secretariat, UNDP is the lead agency in supporting countries to implement Article 5 of the Convention, specifically national planning, multisectoral governance, and protection against tobacco industry interference in policymaking.
United Nations Interagency Task Force (UNIATF) on the Prevention and Control of NCDs	Work is ongoing as part of the workplan of UNIATF in the area of promoting tobacco control among school-aged children involving UNIATF, the United Nation Children's Fund (UNICEF), the United Nations World Food Programme (WFP), UNODC, WHO and the Convention Secretariat. WHO, in partnership with WFP and the Food and Agricultural Organization of the United Nations (FAO), launched an initiative for alternative livelihoods for tobacco farmers in Kenya in 2022. Under this initiative, over 1500 tobacco farmers have changed their crops from tobacco to high-iron beans. The initiative is planned to reach at least 4000 farmers by the end of 2024 and will soon expand to Zambia.
World Health Organization (WHO)	WHO has included WHO FCTC in its *Thirteenth General Programme of Work* (GPW13) 2019–2023 as its normative function (Promote Health, Keep the World Safe, Serve the Vulnerable), under Platform 2: Accelerating action on preventing noncommunicable diseases and promoting mental health. Decision WHA74(10) (2021) requested the WHO Director-General to submit "an implementation road map 2023–2030 for the global action plan for the prevention and control of NCDs 2013–2030, through the Executive Board at its 150th session, and subsequent consultations with Member States and relevant stakeholders, for consideration by the Seventy-fifth World Health Assembly". The purpose of the implementation road map is to guide and support Member States to take urgent measures, in 2023 and beyond, to accelerate progress and reorient and accelerate their domestic action plans with a view to placing themselves on a sustainable path to meeting the nine voluntary global NCD targets and SDG target 3.4. The road map focuses on the *4 by 4 NCD Agenda*, which includes tobacco use, the harmful use of alcohol, unhealthy diets, physical inactivity, cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, as per the mandate, but to be implemented in full alignment with the commitments to reduce air pollution and promote mental health and well-being (the *5 by 5 NCD Agenda*). The Updated Appendix 3 of the *NCD Global Action Plan 2013–2030* contains seven very cost-effective interventions for the prevention and control of tobacco, including the inclusion of mCessation into population-wide tobacco cessation interventions to all tobacco users and a new intervention capturing pharmacological interventions for tobacco cessation.[60]
Food and Agriculture Organization of the United Nations (FAO)	Please see reference under the United Nations Interagency Task Force (UNIATF) on the Prevention and Control of NCDs.

58 https://fctc.who.int/publications/m/item/league-of-arab-states-helping-arab-nations-to-implement-the-who-fctc
59 https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv--health-and-development-strategy-2016-2021.html
60 https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_10Add8-en.pdf

United Nations Environment Programme (UNEP)	The Convention Secretariat is working with UNEP to show how the tobacco production system and tobacco products damage the environment. In February 2022, UNEP launched a partnership with the Secretariat of the WHO FCTC to raise awareness and drive action on the extensive environmental and human health impacts of microplastics in cigarette filters. The partnership is facilitated through UNEP's Clean Seas campaign – a global coalition comprised of 63 countries devoted to ending marine plastic pollution.[61] The Convention Secretariat is also engaging in the Intergovernmental Negotiating Committee to develop an international legally binding instrument on plastic pollution, including in the marine environment. This is following the adoption in February 2022, at the resumed Fifth session of the United Nations Environment Assembly (UNEA-5.2), of a historic resolution (5/14) to develop an international legally binding instrument on plastic pollution, including in the marine environment with the ambition to complete the negotiations by end of 2024. The instrument is to be based on a comprehensive approach that addresses the full life cycle of plastic.[62]
Organization of Islamic Cooperation (OIC)	The OIC has continued to implement a Tobacco Free OIC Capacity-Building Programme (TF-CaB), developed under its Statistical, Economic and Social Research and Training Centre for Islamic Countries (SESRIC) programme, which aims to foster an OIC-wide coordinated approach to curb and control the spread of tobacco epidemic in the OIC Member States by raising awareness on the serious effects of its consumption and bringing legally binding obligations. Within the framework of TF-CaB, SESRIC organized an online training course on "Packaging, labelling and pictorial health warnings on tobacco products" in March 2021. On 30–31 May 2022, ESRIC organized a training course on "Developing Impactful Awareness Raising Campaigns towards Reducing Tobacco Consumption" in collaboration with the Turkish Green Crescent Society (YE LAY) and the Ministry of Agriculture and Forestry of the Republic of Türkiye. On 9–10 May 2023, SESRIC organized an orientation workshop on "Tobacco Questions for Surveys of Youth (TQS-Youth)" in Collaboration with the Centers for Disease Control and the CDC Foundation.
World Customs Organization (WCO)	In November 2021, WCO Secretary General addressed the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products, stressing that the WCO's 183 Members remain committed to fighting illicit tobacco trade by supporting the implementation of the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products. The Secretary General also highlighted the WCO's regional and international operations that had been organized to strengthen regional and international customs networks to assist anti-smuggling efforts addressing illicit tobacco trade. Alongside these initiatives, WCO had created a global closed virtual expert group called TobaccoNet, recently renamed ExciseNet, to cover other high-excise goods such as alcohol, set up to facilitate the exchange of information and intelligence on seizures and suspicious consignments, as well as on new smuggling trends and modi operandi. The WCO Customs Risk Management Compendium was also regularly updated to help Customs in the fight against commercial fraud, such as illicit trafficking in tobacco products. WCO's 2021 illicit trade report contains information on illicit trade in tobacco products.[63] The Convention Secretariat connected with WCO also in relation to the update of the reporting instrument of the Protocol to Eliminate Illicit Trade in Tobacco Products, specifically to look for synergies in monitoring illicit tobacco trade.

9. Number of Parties where WHO country offices included WHO FCTC implementation in the country cooperation strategies

This indicator is defined as the number of Parties where WHO country offices successfully integrated WHO FCTC implementation in the WHO Country Cooperation Strategies agreed upon with the respective governments.

The WHO report, *WHO presence in countries, territories and areas, 2021*, details WHO's principal instruments for planning and includes Country Cooperation Strategy (CCS), the Country Support Plan (CSP), and the Biennial Work Plan(BWP)/Biennial Collaborative Agreement (BCA). The report indicates that as of 31 August 2020, 75 WHO country offices reported having a valid CCS, 34 reported that a CCS is under development or being updated, and 40 did not have a CCS. The African, South-East Asia and Western Pacific regions are the regions that have the largest proportion of CCSs. WHO country offices in the European Region use biennial collaborative agreements for engagement, but some have a BCA or a CCS. At the time of data collection for this report, not all of the CCSs were available online in the WHO Country Cooperation Strategies database, while very few BCA are available online (all available ones are outdated and not relevant for inclusion in this report).

61 https://fctc.who.int/newsroom/news/item/01-02-2022-unep-secretariat-of-the-who-fctc-partner-to-combat-microplastics-in-cigarettes

62 https://www.unep.org/about-un-environment/inc-plastic-pollution

63 https://www.wcoomd.org/-/media/wco/public/global/pdf/topics/enforcement-and-compliance/activities-and-programmes/illicit-trade-report/itr_2021_en.pdf?db=web

To get information on the inclusion of support for WHO FCTC implementation in CCSs, a manual search was conducted in the WHO Country Cooperation Strategies and Briefs" database,[64] by keywords: 1. FCTC; 2. Tobacco; 3. Smoking; 4. Cigarette; 5. SDG 3.a. Thirty-nine valid CCSs and 110 Briefs Strategies were reviewed from the database at the time of the preparation of this report.

Out of the 110 Briefs Strategies reviewed, 73 Parties made reference to either tobacco, the WHO FCTC or SDG Target 3.a in their latest CCS or brie: 18 Parties in the African Region, 10 Parties in the Eastern Mediterranean Region, three Parties in the European Region, 19 Parties in the Region of the Americas, eight Parties in South-East Asian Region and 15 Parties in the Western Pacific Region.

Overall, 39 CCSs were reviewed, out of which 38 Parties referred to either tobacco, the WHO FCTC or SDG Target 3.a in their latest CCSs compared to 93 Parties in the first report on the Global Strategy indicators. There was a limited number of CCSs valid and available online at the time of the review.

A new question on whether the Parties included tobacco control, the WHO FCTC or SDG Target 3.a in their CCS/CSP/BCAs could be included in the reporting instrument in the future.

10. Number of Parties that include WHO FCTC implementation in their voluntary reports on their domestic implementation of the SDGs, in relation to Target 3.a.

This indicator is defined in the Indicator Compendium as Parties that reported in their voluntary national review (VNR) on how they implement the WHO FCTC (in relation to SDG Target 3.a). In general, progress towards reaching the SDGs by the countries is reported in VNRs, a report that allows countries to describe their priority actions and the lessons they have learned. The VNRs are available online.[65]

For this report, the core data source was a study conducted by the Reporting and Knowledge Management team of the Convention Secretariat. The study included an analysis of the VNRs available online for 2021 (n=40) and 2022 (n=43). The VNRs were reviewed only where a full report was available, and also the statistical annexes were reviewed if published separately. It is worth noting that the countries submitting reports each year varies; for example, out of the 83 submissions in 2021 and 2022, only one country submitted a VNR in both 2021 and 2022. The majority of countries that submitted the VNRs were Parties to the WHO FCTC, with only eight VNRs submitted by countries who were not Parties to the Convention. In 2021, three countries that submitted VNRs were not Parties, and in 2022 five countries that submitted VNRs were not Parties.

The reports were reviewed for inclusion of SDG Target 3, the listing of Target 3.a, data reports on Target 3.a., listing of indicator 3.a.1, any data on 3.a.1, and other considerations on tobacco control. The search was conducted by looking for keywords, but also scanning for sections that the keyword search may have missed.

The report found that the vast majority of VNRs covered SDG 3 to some extent (95%). But, overall, less than half (between 30% and 42%) listed and/or reported on SDG Target 3.a and indicator 3.a.1. While the majority included SDG 3, under half listed Target 3.a, respectively, 45% in 2021 and 30% in 2022. This is because the target was sometimes listed but not reported on. Next, the indicator 3.a.1 was similarly listed in less than half of the reports, respectively, 48% in 2021 and 30% in 2022. However, unlike Target 3.a

64 https://www.who.int/country-cooperation/what-who-does/strategies-and-briefs/
65 https://sustainabledevelopment.un.org/vnrs/

reporting, reporting data on indicator 3.a.1 was more common, respectively, 55% in 2021 and 42% in 2022. The higher number of VNRs including data on 3.a.1. versus listing 3.a.1 is due to some countries including smoking prevalence data, but not naming the indicator. There was wide variation in listing and reporting on Target 3.a and indicator 3.a.1 across the VNRs: reporting on Target 3.a ranged from detailed paragraphs on tobacco control to single-sentence statements, while data on indicator 3.a.1 ranged from limited data on tobacco prevalence on a specific age to trends on age-standardized prevalence of current tobacco use among people aged 15 years and older.

The percentage of VNRs with references to indicator 3.a and Target 3.a.1 was similar to the review done for the 2016–2019 period.[66] Reporting on Target 3.a was less frequent than reporting on indicator 3.a.1, the depth of reporting on 3.a varied, with some VNRs listing Target 3.a but focusing their report on indicator 3.a.1.

In addition to this topical research, in the 2023 reporting cycle, for the first time, Parties were requested to provide information if they included WHO FCTC implementation in their VNR under the section on Article 20 of the Convention (Research, surveillance and exchange of information). Based on information provided by the Parties in the 2023 reporting cycle, and cross-checked with the United Nations VNR database,[67] nine Parties were found to have made reference to the WHO FCTC implementation in their VNRs.

11. Number of Parties that include civil society participation in the development and implementation of national tobacco control approaches

According to the Indicator Compendium for the Global Strategy, "the term civil society includes a wide range of nongovernmental, non-profit and volunteer-driven organizations, plus social movements, which organizes people to pursue shared interests, values and objectives in public life".

For measuring this indicator, the Indicator Compendium suggests considering "the number of Parties whereby civil society has reported being included or participated in the development and implementation of national tobacco control strategies, plans and programmes". Currently, no such information could be derived from the questionnaire utilized by the NGO observers to the COP in their reaccreditation reports.

An indicator that could be used as proxy, also taken into account in 2020 for the same purpose, is currently included in the WHO FCTC reporting instrument under Article 12 (Education, communication, training and public awareness). This indicator elicits the civil society's involvement in tobacco control activities at the country level, based on the responses given by the Party in their implementation reports, as it considers the "awareness and participation of the nongovernmental organizations not affiliated with the tobacco industry in the development and implementation of intersectoral programmes and strategies for tobacco control".

In the dataset extracted after the 2023 reporting cycle, 152 Parties have reported awareness and participation of the NGOs not affiliated with the tobacco industry in development and implementation of intersectoral programmes and strategies for tobacco control, relatively stable since 2020 (151 Parties).

In the future, consideration should be given to including this indicator, if appropriate, in the questionnaire that NGOs with the status of observer to COP[68] complete as part of their reaccreditation process.

66 https://fctc.who.int/publications/i/item/9789240014046
67 https://hlpf.un.org/countries
68 https://fctc.who.int/who-fctc/governance/observers/nongovernmental-organizations

12. Number of nongovernmental organizations that are accredited as Observers to the Conference of the Parties participating in COP sessions

Out of the 21 NGOs that were accredited as observers to the COP at the time of opening of Ninth session of the Conference of the Parties (COP9), 18 participated in COP9 according to the list of participants of the meeting.[69]

At the same time, the COP, in decision FCTC/COP9(6)[70] renewed the accreditation of 21 NGOs and in decision FCTC/COP9(3) approved accreditation of five additional NGOs.[71]

13. Financial and technical support from civil society organizations to advance WHO FCTC implementation

The reports of NGOs that have the observer status to the COP contain information on the work carried out by these organizations in supporting implementation of the Convention. The most recent such report is available as part of the documentation for COP10.

According to the report, Article 5 (General obligations) continues to be the article that attracts most attention from the NGO observers, followed by Article 12 (Education, communication, training and public awareness). As compared to the previous submission of reports for review of accreditation, more NGOs have contributed to the work of the Parties in implementation of Article 13 (Tobacco advertising, promotion and sponsorship) and Article 14 (Demand reduction measures concerning tobacco dependence and cessation). On another note, it seems that Article 6 (price and tax measures to reduce the demand for tobacco) and Article 8 (Protection from exposure to tobacco smoke) received fewer contributions in this reporting cycle.

The submitted reports suggest that there are areas where less support was provided by NGO observers to the Parties. Such articles include Article 19 (Liability) and Article 16 (Sales to and by minors), followed by Articles 9 and 10 (Regulation of the contents of tobacco products, and of tobacco product disclosures) and Articles 17 and 18 (Provision of support for economically viable alternative activities, and protection of the environment and the health of persons).

In addition to the reports of NGO observers, in the WHO FCTC reporting instrument, under the section on “International cooperation and assistance”, the Parties also mentioned in their responses the financial and technical contributions they received from civil society organizations. Twenty-four Parties have indicated, in the 2023 dataset, that they received such support from civil society organizations.

To enable a more complete assessment of the progress for this indicator, the questionnaire used for NGO observer reaccreditation reports should be completed with a question on the number of Parties to which they provided technical assistance, and the amount of financial support they provided for the implementation of the WHO FCTC at the national, regional and global levels.

69 https://fctc.who.int/publications/m/item/cop-9-div-1-list-of-participants
70 https://fctc.who.int/publications/i/item/fctc-cop-9-6
71 https://fctc.who.int/publications/i/item/fctc-cop-9-3

Strategic Goal 3

Strategic Goal 3: Protecting the integrity and building on the achievements under the WHO FCTC

Indicators within Strategic Goal 3 focus on the effectiveness and the sustainability of WHO FCTC-related activities, while ensuring they are protected from tobacco industry interference.

14. An Implementation Review Mechanism has been established

This indicator refers to the establishment of a future Implementation Review Mechanism to be decided by the COP.

The Convention Secretariat has conducted, through the voluntary participation of 12 Parties, a pilot project exercise for an implementation review mechanism. The report, submitted to COP9, but for which the discussion was postponed to COP10, describes the outcome of the pilot project and contains a costed strategy, and related terms of reference for a future Implementation Review and Support Mechanism (IRSM).[72]

15. Workplans and budget of the Convention Secretariat aligned with the Global Strategy

Since the workplan and budget presented for consideration by COP9, the Convention Secretariat aligns them with the structure and indicators of the Global Strategy.

16. An indicator that measures the gap in global funding for WHO FCTC implementation to be developed

The Global Strategy (through this indicator) required the development of a global funding gap indicator.

The Convention Secretariat engaged an external company in July 2022 to develop the indicator to measure the global funding gap. As a result of this work, the Indicator Compendium for the Global Strategy was updated to include the new indicator.[73]

In addition to the description of the new indicator, the company also made a first calculation of the global funding gap. This information will be made available to Parties at COP10.

17. Number of Parties that reported implementation of any measures relating to Article 5.3

This indicator is defined as Parties that have reported implementation of any measures pertaining to WHO FCTC Article 5.3, respectively the number of Parties that have responded “yes” to the following question within the WHO FCTC reporting instrument: “Have you adopted and implemented, where appropriate, legislative, executive, administrative or other measures or have you implemented, where appropriate, programmes on protecting public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry?”

In the dataset of the 2023 reporting cycle, 131 Parties reported that they have put in place measures under Article 5.3 of the Convention, as compared to 133 Parties in the 2020 dataset.

72 https://fctc.who.int/publications/i/item/fctc-cop9-11
73 https://fctc.who.int/docs/librariesprovider12/default-document-library/gs-2025-indicator-compendium.pdf?sfvrsn=b62bc98c_8&download=true

Details about the measures Parties have taken in implementing Article 5.3 of the Convention can be found under the respective section of this report.

18. Number of Parties having an operational national multisectoral coordinating mechanism for tobacco control

This indicator measures the number of Parties that have gone beyond the implementation of domestic health-based tobacco control programmes to a coordinated national approach that encompasses a whole-of-government approach in addressing tobacco control, specifically the number of Parties that have responded "yes" to the following question within the WHO FCTC reporting instrument: "Have you established or reinforced and financed a national coordinating mechanism for tobacco control?"

In the 2023 cycle, 133 Parties reported to have established or reinforced and financed a national coordinating mechanism for tobacco control, a slight increase versus 131 Parties in the 2020 cycle.

More information about Parties' national multisectoral coordinating mechanisms can be found in the section on Article 5 of this report.

19. Number of Parties that reported tobacco industry interference as the main barrier to WHO FCTC implementation

This indicator is defined as the number of Parties that have reported in their official WHO FCTC implementation reports tobacco industry interference being one of the barriers in the implementation of the WHO FCTC.

In the WHO FCTC reporting instrument, Parties are required to report on constraints or barriers, other than lack of resources, they encountered in implementing the Convention.

Based on the analysis of responses to this open-ended question in the 2023 dataset, 62 Parties confirmed that they consider tobacco industry interference a constraint/barrier in implementing the Convention. A more detailed analysis of implementation barriers, including in relation to tobacco industry interference, can be found under the discussion of constraints and barriers, earlier in this report.

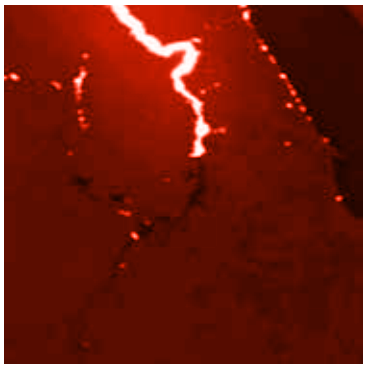
20. Number of Parties that fully fund their costed national tobacco control plans or strategies

This indicator measures the number of Parties that have reported funding their national tobacco control plans or strategies and is related to the indicator "Number of Parties that have submitted a costed national tobacco control plan as part of their regular WHO FCTC reports" under Strategic Objective 1.1 of the Global Strategy.

In the 2023 cycle, responding to a new question, 23 Parties confirmed that they have a costed national tobacco control plan or strategy. Of these 23, 12 Parties reported that their plans or strategies are fully funded.

As a reminder, for a related indicator of the WHO FCTC reporting instrument, under Article 5, 134 Parties reported that they developed and implemented comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the Convention (see details under the Article 5 section of this report).

8 Conclusions



The analysis conducted for this Global Progress Report shows that comprehensive implementation of Articles 5, 8 and 11 varies between WHO regions, and comprehensive implementation of Article 13 is significantly lower in all WHO regions. Overall, Article 11 tends to be implemented in the most comprehensive manner, globally and in the WHO regions, followed by Article 5, 8 and 13 of the Convention.

Data reported under Article 6 show significant improvement since the previous reporting cycle. Minimum cigarette prices have increased in five WHO regions, while the average tobacco tax burden has increased in four WHO regions.

Even though these results are encouraging and show some positive developments, there is a need for Parties to devote more attention to the comprehensive implementation of the treaty, with particular attention to priority articles listed in the Global Strategy, including Articles 5, 6, 8, 11 and, most importantly, Article 13.

New developments were detected in relation to Article 2.1 (Measures beyond those required by the Convention and its protocols), as several Parties reported on plans to reduce tobacco use prevalence under 5% or achieve a smoke- or tobacco-free generation by a certain date through various mechanisms. This is why the Convention Secretariat developed, for the first time in a Global Progress Report, a new chapter focusing on Article 2 of the Convention. The chapter also provides examples of Parties that announced working towards the goal of achieving tobacco- or smoke-free societies through various mechanisms.

Parties seem to have devoted particular attention to the implementation of Articles 9 and 10 of the Convention and to the regulation of novel and emerging tobacco products and nicotine products. More Parties reported that these products appeared in their national markets and more, but not all, Parties also engaged in their regulation. There is a variety of ways in which Parties regulate these products. Also, more Parties reported that they used the Partial guidelines for implementation of these articles in the development of their tobacco product regulation.

The fight against illicit trade in tobacco products has drawn more attention among the Parties; 10 Parties to the WHO FCTC have become Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products since the previous reporting cycle. Further information on the implementation of the Protocol is contained in the *2023 Global Progress Report on Implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products*.

Article 5 and related measures were the most mentioned priorities for the implementation of the WHO FCTC. To reach a comprehensive implementation of the Convention, Parties reported that the most frequent gaps between available resources and their needs in the implementation of the Convention were insufficient financial and human resources and expertise for tobacco control, and they also highlighted the need for training and capacity-building in tobacco control. The most cited implementation barrier reported by Parties continues to be the interference by the tobacco industry and those working to further its interests.

With respect to global tobacco use prevalence, averaged across all Parties, the prevalence of current tobacco use among people aged 15 or older is estimated to have reduced from 29% in 2005 to 20% in 2022. Regarding the expansion of novel and emerging tobacco products and nicotine products, the increasing appearance in Parties' markets has continued since the previous report. HTPs were reported to be present in 89 of 182 Parties. Among the nicotine products, ENDS were reported to be available in 135 Parties, while ENNDS were present in 95 Parties.

Nearly all Parties reported implementation priorities; the list is led by measures required under Article 5, including the development of legislation. Almost two thirds of the Parties reported on gaps; the three most frequently mentioned gaps were: a lack of financial resources; a lack of human resources and expertise for tobacco control; and the need for more training and capacity- building in tobacco control. Similarly, nearly all Parties reported on constraints and barriers to implementation; the two most reported constraints and barriers are the interference by the tobacco industry – for many reporting cycles in a row – and a lack of intersectoral cooperation and coordination, including bureaucratic and administrative barriers.

On the other hand, many Parties reported engaging in assistance projects, either as recipients or providers, mostly in the areas of development, transfer and acquisition of technology, knowledge, skills, capacity and expertise related to tobacco control and in provision of technical scientific, legal and other expertise to establish and strengthen national tobacco control strategies, plans and programmes. Parties provided specific

examples of working with each other and with various partners, as envisaged in the Global Strategy to Accelerate Tobacco Control, including the most important areas where such projects were implemented. Among the providers of assistance, the role of WHO FCTC Knowledge Hubs is increasing. In July 2022, the Convention Secretariat launched a new knowledge hub focusing on Article 12 of the Convention at Santé Publique France.

Efforts have been made to further raise awareness about the Convention internationally and to make it part of the global health policy narrative. The integration of the Convention with global NCD and tuberculosis control efforts has been strengthened, and its implementation in compliance with SDG Target 3.a has also been promoted. The Convention Secretariat presence in the work of the United Nations Interagency Task Force on NCDs and of the Inter-agency and Expert Group on SDG Indicators (IAEG-SDGs) created by the United Nations Statistical Commission, as co-custodian of Target 3.a, contributed to the inclusion of tobacco control in global NCD policies, as well as in the exchange among national statistical offices, statistical teams of United Nations entities and related international organizations.

Even though these results are encouraging and show some positive developments, there is a need for Parties to devote more attention to the comprehensive implementation of the treaty, with particular attention to priority articles listed in the Global Strategy, including Articles 5, 6, 8, 11 and, most importantly, Article 13.

Annex 1.
Progress in the implementation of the WHO FCTC between 2020 and 2023 reporting cycles, as of 5 May 2023

Article/indicator name	2023		2020	
SECTION A				
Article 5. General obligations	**Number of countries**	**%**	**Number of countries**	**%**
Comprehensive national tobacco control strategy	134	74	128	71
Focal point for tobacco control	157	86	155	86
Tobacco control unit	125	69	121	67
National coordinating mechanism for tobacco control	133	73	131	72
Article 5.3. Protection of public health policies from vested interests of the tobacco industry	**Number of countries**	**%**	**Number of countries**	**%**
Measures to prevent tobacco industry interference	131	72	133	73
Public access to a wide range of information on the tobacco industry	76	42	69	38
SECTION B				
Article 6. Price and tax measures to reduce the demand for tobacco	**Number of countries**	**%**	**Number of countries**	**%**
Information on tobacco-related mortality in the population	91	50	90	50
Information on the economic burden of tobacco use in the population	74	41	72	40
Only specific tax levied	56	31	57	31
Only ad valorem tax levied	32	18	31	17
Combination of specific and ad valorem taxes levied	94	52	95	52
Tobacco tax earmarking	36	20	34	19
Tax policies to reduce tobacco consumption	152	84	153	85
Tobacco sales to international travellers prohibited/restricted	88	48	88	49
Tobacco imports by international travellers prohibited/restricted	115	63	115	64
SECTION C				
Article 8. Protection from exposure to tobacco smoke	**Number of countries**	**%**	**Number of countries**	**%**
Availability of data on exposure to tobacco smoke	147	81	152	84
Tobacco smoking banned in all public places	172	95	170	94
National law providing for the ban	162	89	160	88
Subnational law(s) providing for the ban	49	27	47	26
Administrative and executive orders providing for the ban	90	49	84	46
Voluntary agreements providing for the ban	37	20	39	22
Mechanism/infrastructure for enforcement	149	82	148	82

Article 8. Coverage of the smoking ban	Number of countries	%	Number of countries	%
in government buildings				
Complete	145	80	138	76
Partial	25	14	30	17
in health-care facilities				
Complete	155	85	147	81
Partial	15	8	20	11
in educational facilities				
Complete	157	86	151	83
Partial	11	6	15	8
in universities				
Complete	133	73	124	69
Partial	34	19	39	22
in private workplaces				
Complete	101	55	91	50
Partial	58	32	65	36
in airplanes				
Complete	165	91	165	91
Partial	4	2	5	3
in trains				
Complete	120	66	119	66
Partial	16	9	17	9
in ferries				
Complete	112	62	108	60
Partial	29	16	32	18
in ground public transport				
Complete	155	85	150	83
Partial	13	7	19	10
in private vehicles				
Complete	na	na	30	17
Partial	na	na	38	21
in cultural facilities				
Complete	134	74	129	71
Partial	31	17	37	20
in shopping malls				
Complete	125	69	115	64
Partial	39	21	49	27
in pubs and bars				
Complete	88	48	83	46
Partial	60	33	64	35
in nightclubs				
Complete	88	48	81	45
Partial	54	30	60	33
in restaurants				
Complete	102	56	96	53
Partial	62	34	68	38
in motor vehicles used for work				
Complete	na	na	140	77
Partial	na	na	28	15

SECTION D				
Article 9. Regulation of the contents of tobacco products	**Number of countries**	**%**	**Number of countries**	**%**
Testing and measuring the contents	95	52	88	49
Testing and measuring the emissions	88	48	88	49
Regulating the contents	na	na	103	57
Regulating the emissions	87	48	87	48
Article 10. Regulation of tobacco product disclosures	**Number of countries**	**%**	**Number of countries**	**%**
Requiring disclosure on the contents to government authorities	127	70	124	69
Requiring disclosure on the emissions to government authorities	112	62	110	61
Requiring public disclosure on the contents	106	58	102	56
Requiring public disclosure on the emissions	86	47	85	47
SECTION E				
Article 11. Packaging and labelling of tobacco products	**Number of countries**	**%**	**Number of countries**	**%**
No advertising or promotion on packaging	146	80	144	80
Misleading descriptors banned	153	84	149	82
Health warnings required	163	90	163	90
Health warnings approved by the competent national authority	157	86	155	86
Rotated health warnings	141	77	140	77
Large, clear, visible and legible health warnings required	161	88	160	88
law mandates, as a minimum, a style, size and colour of font[a]	146	91	145	91
Health warnings occupying no less than 30% required	146	80	147	81
Health warnings occupying 50% or more required	126	69	118	65
Health warnings in the form of pictures or pictograms required	132	73	127	70
copyright to pictures owned by the governmentb	67	51	62	49
granting of license for the use of health warnings[b]	71	54	63	50
Information on constituents required on packages	92	51	95	52
Information on emissions required on packages	65	36	72	40
Warning required in the principal language(s) of the country	155	85	153	85
SECTION F				
Article 12. Education, communication, training and public awareness*	**Number of countries**	**%**	**Number of countries**	**%**
Implemented educational and public awareness programmes	167	92	167	92
Implemented programmes targeted to adults or the general public	157	86	157	87
Implemented programmes targeted to children and youth	162	89	160	88

Implemented programmes targeted to men	132	73	128	71
Implemented programmes targeted to women	134	74	130	72
Implemented programmes targeted to pregnant women	124	68	123	68
Implemented programmes targeted to ethnic groups	54	30	48	27
Implemented programmes reflecting age differences	157	86	153	85
Implemented programmes reflecting gender differences	140	77	135	75
Implemented programmes reflecting educational background differences	108	59	106	59
Implemented programmes reflecting cultural differences	82	45	71	39
Implemented programmes reflecting socioeconomic differences	83	46	86	48
Implemented programmes covering the health risks of tobacco consumption	164	90	167	92
Implemented programmes covering the risks of exposure to tobacco smoke	162	89	164	91
Implemented programmes covering the benefits of cessation of tobacco use	158	87	157	87
Implemented programmes covering economic consequences of tobacco production	81	45	81	45
Implemented programmes covering economic consequences of tobacco consumption	133	73	134	74
Implemented programmes covering environmental consequences of tobacco production	90	49	83	46
Implemented programmes covering environmental consequences of tobacco consumption	111	61	109	60
Public agencies involved in programmes/strategies for tobacco control	166	91	163	90
Nongovernmetnal organizations involved in programmes/strategies for tobacco control	152	84	151	83
Private organizations involved in programmes/strategies for tobacco control	106	58	108	60
Programmes guided by research	137	75	132	73
Training programmes addressed to health workers	159	87	156	86
Training programmes addressed to community workers	116	64	111	61
Training programmes addressed to social workers	101	55	96	53
Training programmes addressed to media professionals	110	60	107	59
Training programmes addressed to educators	133	73	136	75
Training programmes addressed to decision-makers	117	64	116	64
Training programmes addressed to administrators	98	54	98	54

SECTION G				
Article 13. Tobacco advertising, promotion and sponsorship	**Number of countries**	**%**	**Number of countries**	**%**
comprehensive ban on all tobacco advertising, promotion and sponsorship instituted	145	80	137	76
Ban on display of tobacco products at points of sales	99	54	89	49
Ban covering the domestic internet	97	53	93	51
Ban covering the global internet	43	24	38	21
Ban covering brand stretching and/ or sharing	98	54	89	49
Ban covering product placement	132	73	125	69
Ban covering the depiction/use of tobacco in entertainment media	110	60	104	57
Ban covering tobacco sponsorship of international events/activities	123	68	117	65
Ban covering corporate social responsibility	101	55	97	54
ban covering cross-border advertising originating from the country	89	49	85	47
Ban covering cross-border advertising entering the country	98	54	92	51
Precluded by constitution from undertaking a comprehensive banc	1	3	3	7
Cooperation on the elimination of cross-border advertising	54	30	53	29
Penalties imposed for cross-border advertising	70	38	74	41

SECTION H				
Article 14. Demand reduction measures concerning tobacco dependence and cessation*	**Number of countries**	**%**	**Number of countries**	**%**
Evidence-based comprehensive and integrated guidelines	118	65	115	64
Media campaigns on the importance of quitting	138	76	134	74
Programmes to promote cessation designed for girls and young women	53	29	55	30
Programmes to promote cessation designed for women	56	31	54	30
Programmes to promote cessation designed for pregnant women	71	39	70	39
Telephone quit lines	80	44	71	39
Local events to promote cessation	150	82	147	81
Programmes to promote cessation in educational institutions	107	59	105	58
Programmes to promote cessation in health-care facilities	141	77	142	78
Programmes to promote cessation in workplaces	101	55	100	55
Programmes to promote cessation in sporting environments	59	32	56	31

Diagnosis and treatment included in national tobacco control programmes	127	70	125	69
Diagnosis and treatment included in national health programmes	128	70	122	67
Diagnosis and treatment included in national educational programmes	74	41	67	37
Diagnosis and treatment included in the health-care system	127	70	125	69
Programmes for diagnosis and treatment in primary health care	104	57	101	56
Programmes for diagnosis and treatment in secondary and tertiary health care	87	48	81	45
Programmes for diagnosis and treatment in specialist health-care systems	60	33	60	33
Programmes for diagnosis and treatment in specialized centres for cessation	75	41	72	40
Programmes for diagnosis and treatment in rehabilitation centres	40	22	37	20
Physicians involved in programmes and counselling	115	63	113	62
Dentists involved in programmes and counselling	72	40	70	39
Family doctors involved in programmes and counselling	89	49	85	47
Practitioners of traditional medicine involved in programmes and counselling	31	17	26	14
Nurses involved in programmes and counselling	106	58	101	56
Midwives involved in programmes and counselling	52	29	52	29
Pharmacists involved in programmes and counselling	66	36	60	33
Community workers involved in programmes and counselling	51	28	47	26
Social workers involved in programmes and counselling	66	36	65	36
Training on tobacco dependence treatment in the curricula of medical schools	103	57	100	55
Training on tobacco dependence treatment in the curricula of dental schools	54	30	53	29
Training on tobacco dependence treatment in the curricula of nursing schools	74	41	71	39
Training on tobacco dependence treatment in the curricula of pharmacy schools	48	26	47	26
Accessibility and/or affordability of pharmaceutical products facilitated	110	60	110	61
Nicotine replacement therapy available	99	54	99	55
Bupropion available	72	40	71	39
Varenicline available	63	35	71	39

Article 14.2(b). and (c). Services and treatment costs provided covered by public funding or reimbursement schemes	Number of countries	%	Number of countries	%
Programmes in primary health care[d]				
Fully	57	55	53	53
Partially	39	38	43	43
Programmes in secondary and tertiary health care[e]				
Fully	45	52	40	49
Partially	34	39	35	43
Programmes in specialist health-care systems[f]				
Fully	29	50	25	45
Partially	22	38	22	39
Programmes in specialized centres for cessation[g]				
Fully	33	45	30	42
Partially	30	41	32	45
Programmes in rehabilitation centres				
Fully	17	43	16	43
Partially	17	43	16	43
Nicotine replacement therapy[i]				
Fully	28	28	26	26
Partially	23	23	28	28
Bupropion[j]				
Fully	20	28	17	24
Partially	22	31	23	32
Varenicline[k]				
Fully	13	21	13	19
Partially	20	32	26	37

SECTION I

Article 15. Illicit trade in tobacco products	Number of countries	%	Number of countries	%
Information on the percentage of illicit tobacco products on the national market	44	24	39	22
Marking that assists in determining the origin of product required	122	67	122	67
Marking that assists in identifying legally sold products required	121	66	122	67
Statement on destination required on all packages	72	40	74	41
Tracking and tracing regime developed	83	46	77	43
Legible marking required	121	66	122	67
Monitoring of cross-border trade required	98	54	97	54
Information exchange facilitated	111	61	118	65
Legislation against illicit trade enacted or strengthened	132	73	137	76
Requiring that confiscated manufacturing equipment be destroyed	134	74	134	74
Measures to monitor, document and control the storage and distribution	125	69	124	69

Confiscation of proceeds derived from illicit trade enabled	132	73	132	73
Cooperation to eliminate illicit trade promoted	122	67	124	69
Licensing/other actions to control production and distribution required	126	69	128	71

SECTION J

Article 16. Sales to and by minors	Number of countries	%	Number of countries	%
Sales of tobacco products to minors prohibited	166	91	163	90
Clear and prominent indicator required	130	71	125	69
Required that sellers request for evidence of having reached full legal age	125	69	123	68
Ban of sale of tobacco in any directly accessible manner	114	63	107	59
Manufacture and sale of any objects in the form of tobacco products prohibited	116	64	114	63
Sale of tobacco products from vending machines prohibited	114	63	114	63
Tobacco vending machines not accessible to minors	27	40	28	43
Distribution of free tobacco products to the public prohibited	150	82	147	81
Distribution of free tobacco products to minors prohibited	160	88	156	86
Sale of cigarettes individually or in small packets prohibited	126	69	124	69
Penalties against sellers provided	150	82	147	81
Sale of tobacco products by minors prohibited	136	75	137	76

SECTION K

Article 17. Provision of support for economically viable alternative activities	Number of countries	%	Number of countries	%
Tobacco growing in jurisdiction	85	47	85	47
Viable and sustainable alternatives for tobacco growers promoted[m]	26	31	24	29
Viable and sustainable alternatives for tobacco workers promoted[m]	7	8	8	10
Viable and sustainable alternatives for tobacco sellers promoted[m]	2	2	4	5
Article 18. Protection of the environment and the health of persons	**Number of countries**	**%**	**Number of countries**	**%**
Measures considering the protection of environment in respect to tobacco cultivation within territory[m]	29	34	30	35
Measures considering the health of persons in respect of tobacco cultivation within territory[m]	28	33	30	35
Measures considering the protection of the environment in respect of tobacco manufacturing within territory[m]	33	39	33	39
Measures considering the health of persons in respect to tobacco manufacturing within territory[m]	33	39	31	37

SECTION L				
Article 19. Liability	**Number of countries**	**%**	**Number of countries**	**%**
Measures on criminal liability in the tobacco control legislation	114	63	107	59
Separate liability provisions on tobacco control outside of the tobacco control legislation	66	36	59	33
Civil liability measures that are specific to tobacco control	65	36	62	34
General civil liability measures that could apply to tobacco control	80	44	77	43
Civil or criminal liability provisions that provide for compensation	40	22	40	22
Criminal and/or civil liability action launched by any person	26	14	27	15
Actions taken against the tobacco industry on reimbursement of costs related to tobacco use	18	10	18	10
SECTION M				
Article 20. Research, surveillance and exchange of information	**Number of countries**	**%**	**Number of countries**	**%**
Research on determinants of tobacco consumption promoted	130	71	129	71
Research on consequences of tobacco consumption promoted	119	65	120	66
Research on social and economic indicators promoted	118	65	117	65
Research on tobacco use among women, with special regard to pregnant women, promoted	83	46	84	46
Research on the determinants and consequences of exposure to tobacco smoke promoted	108	59	107	59
Research on identification of effective programmes for tobacco dependence treatment promoted	83	46	83	46
Research on identification of alternative livelihoods promoted	25	14	26	14
Training and support for those engaged in tobacco control activities	118	65	113	62
National system for surveillance of patterns of tobacco consumption	135	74	137	76
National system for surveillance of determinants of tobacco consumption	108	59	105	58
National system for surveillance of consequences of tobacco consumption	93	51	86	48
National system for surveillance on social, economic and health indicators	99	54	96	53
National system for surveillance of exposure to tobacco smoke	119	65	117	65
Regional and global exchange of national scientific, technical and legal information	118	65	121	67

Regional and global exchange of national information on tobacco industry practices	84	46	75	41
Regional and global exchange of national information on cultivation of tobacco	42	23	44	24
Updated database of laws and regulations on tobacco control	131	72	128	71
Updated database of information about the enforcement of laws	93	51	92	51
Updated database of the pertinent jurisprudence	40	22	43	24
SECTION N				
Articles 22 and 26. International cooperation and assistance	**Number of countries**	**%**	**Number of countries**	**%**
Assistance on transfer of skills and technology provided	74	41	75	41
Assistance on transfer of skills and technology received	120	66	119	66
Expertise for national tobacco control strategies, plans and programmes provided	69	38	72	40
Expertise for national tobacco control strategies, plans and programmes received	116	64	120	66
Assistance on training and sensitisation of personnel in accordance with Article 12 provided	57	31	60	33
Assistance on training and sensitisation of personnel in accordance with Article 12 received	95	52	90	50
Assistance on equipment, supplies, logistics provided	43	24	46	25
Assistance on equipment, supplies, logistics received	78	43	81	45
Assistance on identification of methods for tobacco control, including treatment of nicotine addiction, provided	29	16	32	18
Assistance on identification of methods for tobacco control, including treatment of nicotine addiction received	55	30	58	32
Assistance on research on affordability of nicotine addiction treatment provided	15	8	17	9
Assistance on research on affordability of nicotine addiction treatment received	30	16	31	17
Regional and intergovernmental organizations and development institutions encouraged to provide financial assistance for developing country Parties	38	21	39	22
Specific gaps between available resources and needs assessed for the implementation of WHO FCTC	114	63	108	60

SECTION O				
Novel and emerging products	**Number of countries**	**%**	**Number of countries**	**%**
Smokeless tobacco available in national market	139	76	128	71
Water-pipe tobacco available in national market	144	79	136	75
Electronic nicotine delivery systems (ENDS) available in national market	135	74	118	65
Electronic non-nicotine delivery systems (ENNDS) available in national market	95	52	69	38
Heated tobacco products (HTPs) available in national market	89	49	68	38
Adopted and implemented policy or regulation specific to smokeless tobacco	104	57	103	57
Adopted and implemented policy or regulation specific to water-pipe tobacco	104	57	99	55
Adopted and implemented policy or regulation specific to ENDS	109	60	97	54
Adopted and implemented policy or regulation specific to ENNDS	66	36	51	28
Adopted and implemented policy or regulation specific to HTPs	78	43	57	31
SECTION P				
Global Strategy and Article 2.1 (New in 2023 reporting instrument)	**Number of countries**	**%**	**Number of countries**	**%**
Costed national tobacco control plan or strategy	23	13		
Measures beyond WHO FCTC in line with Article 2.1 (e.g. tobacco endgame strategies, smoke-free generations)	20	11		
SECTION Q				
Use of guidelines (voluntary questions)	**Number of countries**	**%**	**Number of countries**	**%**
Guidelines for Implementation of Article 5.3	128	70	130	72
Guidelines for Article. 6	112	62	110	61
Guidelines for Article 8	136	75	133	73
Guidelines for Articles 9 & 10, used for Article 9	102	56	96	53
Guidelines for Articles 9 & 10, used for Article 10	103	57	93	51
Guidelines for Article 11	130	71	125	69
Guidelines for Article 12	122	67	123	68
Guidelines for Article 13	123	68	119	66
Guidelines for Article 14	111	61	107	59
Policy options and recommendations for Articles 17 and 18, used for Article 17 (among tobacco growers)	22	26	23	27
Policy options and recommendations for Articles 17 and 18, used for art. 18 (among tobacco growers)	18	21	17	20

The percentage (%) has been calculated from Yes (or Complete/Partial; Fully/Partial) among all Parties (n=182 in 2023, n=181 in 2020) except if the indicator is marked with a superscript letter. Indicators marked with a superscript letter are calculated among selected respondents, more specifically: [a] Among those with Yes to C256. [b] Among those with Yes to C2510. [c] Among those with No to C271. [d–h] Among those with Yes to the respective structure in C286[1]–C286[5] [i-k] Among those with Yes to the respective medicine in C2812[1]–C2812[3] [l] Among those with No to C326 [m] Among those with Yes to B71.

* As a change from the 2021 report, the indicators under these articles have been calculated among all Parties, except if specifically indicated with superscript letters explained above.

na marks the indicators where the 2023 data is not available due to technical issue in the reporting platform.

Annex 2.

The count of the implemented measures reported under respective WHO FCTC articles, by each Party, in the 2023 reporting cycle

Party	Article number															
	5*	5.3*	6	8*	9**	10	11	12	13*	14	15	16	17***	18***	19	20
Maximum count by article	4	2	3	11	3	4	8	12	10	20	13	11	3	4	7	19
WHO African Region																
Algeria	4	1	2	5	1	2	5	7	6	9	10	4	0	2	1	9
Angola	3	1	1	9	3	4	5	12	0	11	6	4	0	0	0	7
Benin	2	1	1	9	3	1	5	12	8	5	12	10	0	0	4	12
Botswana	2	0	1	5	0	0	1	6	1	7	7	9			1	0
Burkina Faso	4	2	1	11	2	4	8	11	9	9	10	9			3	15
Burundi	2	0	1	2	0	0	0	10	5	2	5	0			5	3
Cabo Verde	4	1	3	9	1	3	7	11	5	9	9	8			4	11
Cameroon	4	0	0	6	0	0	8	12	6	15	1	2	1	0	0	14
Central African Republic	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chad	4	2	1	11	0	0	8	11	7	7	13	10	0	0	4	12
Comoros	3	2	1	11	0	4	8	11	8	14	10	10			2	2
Congo	3	1	3	10	0	4	8	7	7	8	13	10			3	7
Côte d'Ivoire	3	0	3	11	0	2	8	12	8	11	13	11			5	10
Democratic Republic of the Congo	3	2	1	2	3	4	7	2	10	3	8	6	0	0	2	0
Equatorial Guinea	0	0	0	3	0	0	0	11	0	0	0	2			0	4
Eswatini	4	2	1	8	0	1	0	12	0	5	13	5			1	2
Ethiopia	3	1	1	11	3	2	7	9	10	4	6	10	0	0	2	7
Gabon	3	1	1	5	0	0	6	6	5	0	11	3			1	1
Gambia	4	2	3	9	0	0	3	12	8	13	11	11			3	3
Ghana	4	2	3	10	2	4	8	11	7	8	13	11			3	13
Guinea	3	1	0	1	0	2	0	7	4	0	3	1	0	2	3	9
Guinea-Bissau	1	0	0	0	0	2	0	2	0	1	0	0			0	0
Kenya	4	2	3	11	3	4	7	10	9	8	13	11			6	15
Lesotho	3	0	0	0	0	0	0	7	0	15	0	0			0	11
Liberia	4	2	1	0	0	0	0	0	0	1	0	0			4	0
Madagascar	4	2	3	11	0	0	8	9	8	10	8	9	0	2	2	15
Mali	3	2	1	6	0	2	5	12	6	11	11	7			1	11
Mauritania	2	2	1	11	2	2	7	11	4	7	4	7			2	0
Mauritius	4	2	3	10	3	4	8	12	8	19	13	11			3	12
Mozambique	1	0	1	5	2	4	5	6	3	9	11	6			1	6
Namibia	1	1	1	11	3	1	8	12	5	10	13	10			1	9
Niger	2	0	1	1	1	2	8	11	9	0	9	10	0	0	5	2
Nigeria	3	2	1	9	3	4	8	12	9	14	10	11	2	2	7	16
Rwanda	2	2	2	11	0	0	6	8	4	4	12	5			5	12
Sao Tome and Principe	2	2	0	7	0	2	7	1	3	0	0	4			0	0
Senegal	4	2	3	11	1	4	8	12	8	11	11	7			3	16
Seychelles	4	1	3	11	0	4	8	12	9	11	13	11			1	7
Sierra Leone	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
South Africa	1	2	2	7	0	2	4	12	4	6	4	7	0	0	1	15
Togo	3	1	3	11	1	0	7	11	10	1	8	11			2	15
Uganda	3	0	1	7	3	4	5	12	0	2	3	0	1	0	6	14
United Republic of Tanzania	4	1	0	7	0	4	4	3	0	0	7	5			1	3
Zambia	4	2	0	9	0	1	4	11	0	12	13	3	1	0	0	5
Zimbabwe	3	0	3	6	0	0	5	12	0	17	7	8	0	4	1	17

WHO Region of the Americas																
Antigua and Barbuda	3	1	0	8	0	4	8	6	1	8	0	9			0	2
Bahamas	0	0	3	0	0	0	3	0	0	4	11	1			0	3
Barbados	1	1	3	11	0	0	7	8	0	4	0	8			0	0
Belize	3	0	3	9	0	0	7	12	0	11	12	11			7	0
Bolivia (Plurinational State of)	2	2	0	7	2	3	8	4	5	2	8	5	0	2	0	7
Brazil	4	2	1	11	3	2	7	5	4	9	11	9	1	2	5	19
Canada	4	2	3	11	2	2	8	12	8	20	11	9	0	2	5	17
Chile	3	2	1	11	0	3	8	5	6	6	4	7	0	2	2	12
Colombia	2	1	1	11	0	0	7	11	10	8	10	11	1	2	1	15
Costa Rica	1	0	2	11	1	3	8	12	9	18	8	11	0	2	3	14
Dominica	1	0	1	0	0	0	0	10	0	1	0	0			0	1
Ecuador	3	1	1	10	1	4	8	7	0	11	6	10	0	2	5	8
El Salvador	1	0	2	11	0	2	8	5	0	14	8	11			1	15
Grenada	2	0	3	5	0	2	3	0	0	0	4	0			0	1
Guatemala	0	1	1	11	0	0	3	6	0	6	3	7	0	0	0	3
Guyana	4	2	2	11	3	4	8	11	10	12	10	10			3	4
Honduras	2	2	3	11	3	4	8	12	5	18	12	11	1	4	5	19
Jamaica	3	1	2	11	0	4	8	11	0	16	13	4	2	0	2	17
Mexico	4	1	2	11	0	4	8	11	10	14	13	11	1	0	5	15
Nicaragua	3	0	3	9	1	2	8	11	6	4	11	11	0	4	3	3
Panama	3	2	3	11	0	0	8	12	10	19	10	11	0	2	2	17
Paraguay	4	1	3	11	0	4	7	9	9	17	10	11	0	0	3	16
Peru	0	0	1	11	0	0	7	8	0	10	5	8	0	0	0	4
Saint Kitts and Nevis	1	0	0	0	0	0	0	0	0	0	0	2			0	0
Saint Lucia	3	1	1	11	0	2	8	11	0	15	7	3			1	14
Saint Vincent and the Grenadines	1	0	0	0	0	0	0	4	0	1	0	0	0	0	0	3
Suriname	2	1	2	11	0	0	8	0	6	3	7	11			0	10
Trinidad and Tobago	4	2	3	11	0	3	8	12	8	19	12	10			2	16
Uruguay	3	0	3	11	2	2	8	5	8	11	8	11	0	0	0	9
Venezuela (Bolivarian Republic of)	4	1	3	11	3	4	8	12	9	19	8	11			2	16
WHO Eastern Mediterranean Region																
Afghanistan	4	2	1	5	0	0	2	9	0	11	0	2	1	0	5	10
Bahrain	4	2	3	7	3	4	8	12	8	16	13	11			6	14
Djibouti	3	1	3	9	0	4	8	3	10	0	13	11			3	3
Egypt	3	1	1	1	1	0	8	11	7	11	8	6			3	10
Iran (Islamic Republic of)	4	1	3	10	3	4	8	11	10	18	11	10	0	4	2	17
Iraq	4	2	1	11	3	3	7	11	7	17	11	7			4	15
Jordan	4	0	3	1	3	2	6	12	8	15	5	9			2	12
Kuwait	2	1	2	10	1	2	7	7	6	15	7	8			2	12
Lebanon	3	1	2	11	0	2	6	3	8	5	5	10	0	0	6	0
Libya	3	1	1	3	1	0	1	3	4	2	0	0			1	0
Oman	4	1	2	11	0	1	8	11	0	7	12	4	0	0	0	13
Pakistan	4	1	2	10	0	0	8	12	5	5	7	9	0	4	1	2
Qatar	4	1	3	11	3	4	8	12	9	16	13	11			3	11
Saudi Arabia	4	1	3	9	3	4	8	6	10	13	12	11			2	9
Sudan	4	2	2	5	1	3	8	12	9	13	12	7	0	0	1	10
Syrian Arab Republic	4	2	1	6	3	4	5	12	7	9	6	9	0	0	4	1
Tunisia	4	2	3	5	3	4	8	11	6	20	10	6	0	4	1	15
United Arab Emirates	4	1	1	9	3	2	8	9	6	18	5	11	0	4	4	19
Yemen	3	1	3	5	3	3	8	8	6	11	4	8	1	0	0	10

WHO European Region																
Albania	4	2	3	11	2	3	8	12	9	11	9	11			2	15
Andorra	1	1	3	11	0	0	1	4	0	1	6	6	1	1	2	0
Armenia	3	0	3	11	3	4	6	12	0	14	9	11	0	0	4	14
Austria	2	1	2	5	3	4	8	11	8	15	12	9			2	14
Azerbaijan	1	1	2	6	1	4	5	9	0	6	12	8	0	4	2	7
Belarus	3	2	3	8	3	4	7	10	6	16	12	11			2	14
Belgium	4	0	3	11	2	3	8	10	6	20	11	8	0	0	2	14
Bosnia and Herzegovina	1	2	0	8	3	4	7	3	6	7	0	11			3	2
Bulgaria	3	2	3	11	3	4	8	12	0	18	10	9	1	4	3	15
Croatia	4	2	1	10	3	4	8	10	10	13	11	11	0	0	2	11
Cyprus	4	1	0	9	1	4	8	9	5	14	13	7			1	3
Czech Republic	3	1	3	6	3	4	8	9	0	12	12	9			2	13
Denmark	4	1	3	3	3	4	8	0	6	10	12	7			3	14
Estonia	4	0	3	3	3	4	7	6	2	12	10	10			2	10
European Union	4	2	2	0	3	4	8	4	5	6	11	7	1	2	0	17
Finland	3	1	3	2	3	4	8	8	9	20	13	10			4	14
France	4	2	2	6	3	4	8	7	6	13	13	10			4	15
Georgia	4	1	3	11	3	2	8	11	10	10	7	11	0	0	1	13
Germany	4	1	2	4	3	4	8	9	0	12	10	8	0	4	1	15
Greece	3	0	0	11	3	4	7	3	5	10	1	11			1	9
Hungary	3	1	3	10	3	4	8	7	7	15	13	10	1	1	1	15
Iceland	3	1	3	8	2	2	6	2	7	14	1	11			0	9
Ireland	4	1	3	11	3	4	8	12	7	19	12	9			2	17
Israel	3	2	3	5	2	4	7	6	7	15	11	9			2	15
Italy	4	0	3	3	3	4	8	5	7	18	13	9	0	4	1	17
Kazakhstan	1	1	0	9	3	2	8	8	9	12	2	11			2	13
Kyrgyzstan	4	2	3	10	1	4	8	11	7	18	11	10	1	3	6	14
Latvia	3	2	1	9	2	4	8	7	9	8	13	11			5	14
Lithuania	4	1	2	8	1	1	7	6	8	9	12	11			4	10
Luxembourg	2	2	0	8	1	4	8	5	8	15	12	9			2	14
Malta	3	2	0	11	1	4	8	10	10	14	12	10			3	13
Montenegro	3	1	0	11	3	2	7	6	7	10	11	11	0	4	4	13
Netherlands	3	2	1	11	3	4	8	5	6	17	13	8			6	13
Norway	3	0	3	11	3	4	7	7	9	12	11	10	0	0	4	13
Poland	4	1	0	0	3	4	0	4	0	15	5	0	1	0	0	18
Portugal	4	1	2	9	3	4	8	8	8	15	13	10			2	14
Republic of Moldova	4	2	3	11	3	4	7	9	8	10	11	11	1	4	5	14
Republic of North Macedonia	2	1	3	11	3	4	7	12	7	12	12	11	0	4	5	14
Romania	1	1	1	11	3	4	8	3	5	8	12	11	0	0	4	2
Russian Federation	2	1	1	11	3	3	8	6	9	11	10	10	0	2	6	10
San Marino	2	2	0	8	0	0	0	8	2	2	0	9			0	2
Serbia	2	1	3	8	2	0	6	6	5	10	12	10	0	0	3	13
Slovakia	3	1	3	9	3	4	8	5	7	12	11	11	0	0	1	8
Slovenia	3	2	2	11	3	4	8	9	10	14	13	11			3	14
Spain	3	2	3	11	3	4	8	10	8	18	12	10	0	3	5	18
Sweden	4	0	3	2	3	3	7	11	7	10	12	8			3	14
Tajikistan	0	2	3	2	0	0	8	11	2	12	9	4			1	0
Türkiye	4	1	3	11	3	4	8	12	10	17	11	11	3	4	3	14

Turkmenistan	4	2	3	11	3	3	7	11	9	15	10	11			5	15
Ukraine	2	1	2	11	3	4	8	6	6	4	10	10	0	0	3	11
United Kingdom of Great Britain & Northern Ireland	4	2	2	11	3	2	8	9	8	16	13	9			2	16
Uzbekistan	4	2	1	11	1	0	8	9	3	8	11	10	1	4	1	16
WHO South-East Asia Region																
Bangladesh	4	0	0	5	0	0	8	7	4	1	4	6	0	0	2	11
Bhutan	4	0	2	11	1	2	8	12	10	13	10	3			0	15
Democratic People's Republic of Korea	3	1	3	10	3	4	5	7	6	12	11	8			4	9
India	4	1	3	9	2	0	8	12	5	17	9	8	2	4	0	18
Maldives	4	1	2	8	0	0	8	9	7	10	7	7			4	6
Myanmar	4	1	3	11	0	0	8	9	8	10	3	9	0	0	1	12
Nepal	3	2	3	8	0	2	8	12	9	15	6	9			2	11
Sri Lanka	4	2	3	9	1	0	8	12	6	13	0	10			4	9
Thailand	4	2	3	11	2	4	8	12	9	20	13	11	1	0	2	18
Timor-Leste	2	2	3	4	1	4	8	12	7	20	10	9			1	8
WHO Western Pacific Region																
Australia	4	2	3	11	0	0	8	12	7	20	10	9			6	13
Brunei Darussalam	3	1	3	10	1	2	7	4	8	12	7	11			2	6
Cambodia	4	2	2	11	0	0	8	10	9	10	4	8	0	4	7	19
China	4	1	3	8	3	2	6	12	4	14	12	10	1	4	0	19
Cook Islands	3	2	3	7	0	4	8	12	8	18	2	10			0	15
Fiji	3	0	3	7	0	2	8	12	7	14	9	11	0	0	0	14
Japan	4	1	1	6	2	2	7	11	0	13	9	6	2	4	4	12
Kiribati	3	2	1	6	3	4	8	12	6	15	13	11			1	5
Lao People's Democratic Republic	3	1	3	11	0	4	8	10	7	0	2	8	0	0	0	13
Malaysia	4	1	2	9	3	2	8	12	0	20	9	10	3	0	0	13
Marshall Islands	3	1	2	8	0	0	3	11	3	6	1	9			2	13
Micronesia (Federated States of)	4	1	3	7	0	0	0	11	5	18	0	9			0	16
Mongolia	2	2	1	7	0	2	7	5	10	7	11	10			3	9
Nauru	2	0	2	6	2	2	4	2	1	1	5	8			0	4
New Zealand	4	2	3	11	3	4	8	6	7	19	9	9			3	9
Niue	2	1	3	6	2	4	7	6	4	6	0	11			0	2
Palau	4	0	3	7	0	0	0	10	3	10	8	11			5	6
Papua New Guinea	2	0	1	8	0	0	5	2	9	0	0	10	0	0	0	7
Philippines	4	2	3	6	3	4	8	12	0	15	12	7	2	2	1	15
Republic of Korea	4	1	3	8	2	2	8	10	1	20	4	9	0	1	4	16
Samoa	4	1	2	11	3	4	8	12	7	13	8	9	0	2	2	13
Singapore	4	1	2	9	2	1	8	12	8	17	10	11			1	13
Solomon Islands	3	2	3	10	3	2	8	10	4	9	12	8	0	2	1	7
Tonga	4	0	3	10	3	4	8	12	8	20	7	11	0	0	1	17
Tuvalu	1	0	3	5	1	1	7	4	2	3	0	9			0	2
Vanuatu	2	1	2	11	0	4	8	12	7	4	5	9			0	0
Viet Nam	4	0	3	10	2	2	8	12	6	8	8	9			2	14

Methodological notes:

Unless otherwise stated, the indicators selected for this analysis under each WHO FCTC article correspond to the list of key indicators in Annex 1. For each Party, the count of "Yes" responses to the key indicators was calculated using the latest available data as of 5 May 2023. The first row of the table presents the maximum count available for each article in this analysis.

* For Articles 5, 8, 11 and 13, the analysis covers the same indicators and response options selected for the comprehensiveness analyses, presented in the footnotes of the respective chapters. Only for Article 5, these indicators have been split here to present Article 5.3 separately.

** Under Article 9, the indicator for regulating contents (C233) was excluded from this analysis due to a technical issue in the reporting platform.

***For Articles 17 and 18, the count has been calculated only among those Parties that respond "Yes" to tobacco growing in B71.

Annex 3.
Tobacco use prevalence reported by Parties

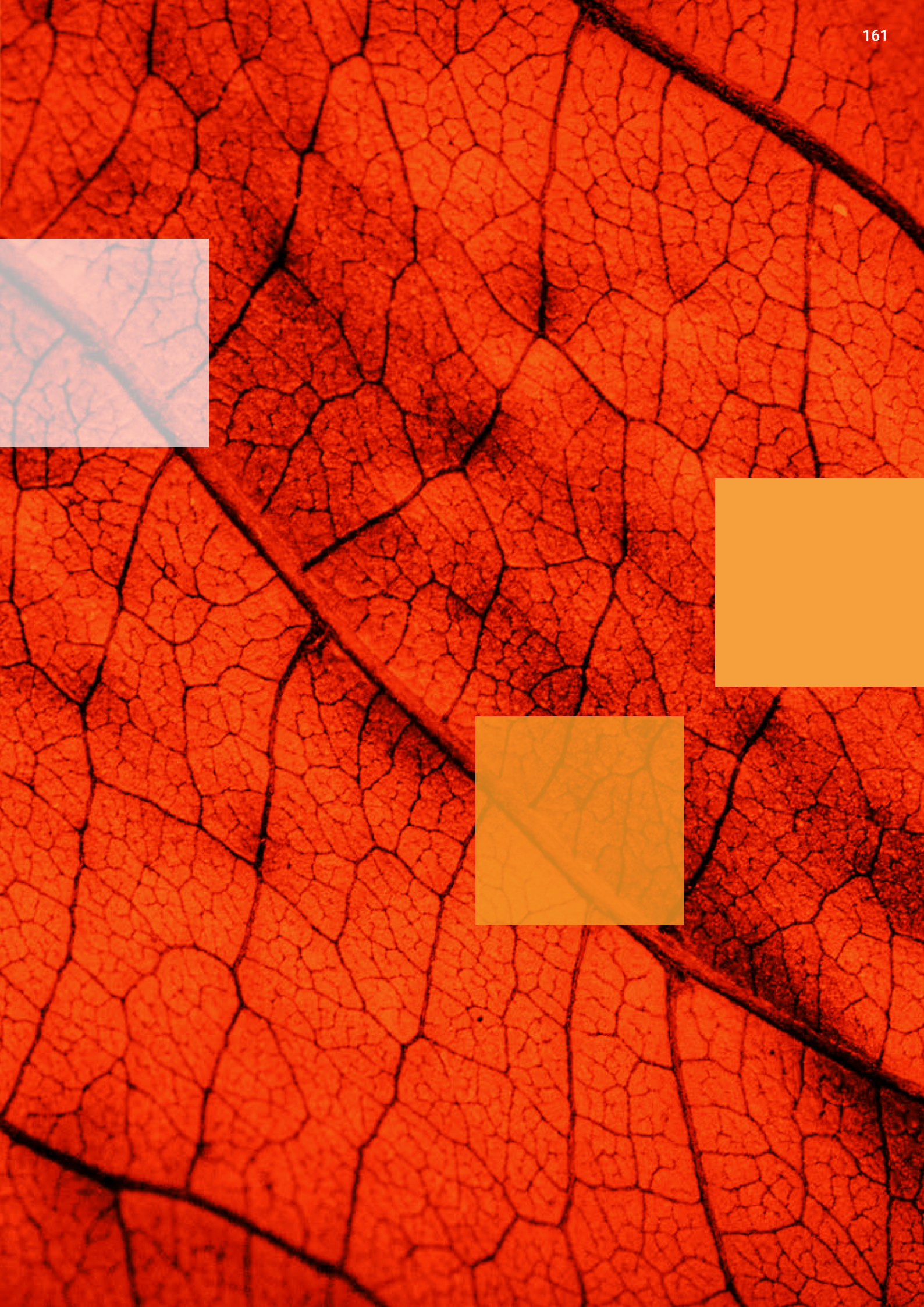


Table A3.1. Adult smoking and smokeless tobacco use prevalence. For definitions and additional information, see the bottom of the table.

	Current tobacco smoking			Current smokeless tobacco use						
	Reported prevalence (%)			Reported prevalence (%)			Age range		Year	Survey/source (full survey and source names appear at the end of the figure)
Party	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**From**	**To**		
Afghanistan	14.2	2.6	8.6	33.7	3.7	19.3	18	69	2019	STEPS
Albania	35.9	4.6					15	59	2017/2018	STEPS
Algeria	32.2	0.4	16.5	17.3	0.4	8.9	18	69	2017	STEPS
Andorra	35.9	35.3	35.6				12	75	2017/2018	Enquesta nutricional d'Andorra
Angola	14.3	1.8		3.0	2.0	5.0	15	49 (*65)	2015/2016 (*2013/2014)	Demographic and Health Survey (*CardioBengo –survey/STEPS)
Antigua and Barbuda										
Armenia	51.5	1.8	27.9				18	69	2016	STEPS
Australia	14.0	9.7	11.8				18	100	2020	Australian Bureau of Statistics National Health Survey
Austria	24.3	23.0	23.7	5.1	1.7	3.4	15	99	2020	General Population Survey on substance use
Azerbaijan	31.9		15.3	0.2		0.1	15	100	2020 (*2017)	Household Budget Survey (*STEPS)
Bahamas	32.4	3.6	17.4	0.9	0.1	0.5	18	69	2019 (*2012)	STEPS
Bahrain	28.0	6.0	18.9				18	100	2017-19	National Health Survey
Bangladesh	46.6	1.0	23.5	16.2	24.8	20.2	18 (*15)	69 (*100)	2018 (*2017)	STEPS (GATS)
Barbados	15.5	3.7	9.2				25	86	2012	Health of the Nation Survey
Belarus	43.2	10.1	23.7	0.2		0.1	16 +		2022 (*2016)	выборочное обследование домашних хозяйств по уровню жизни (Sample survey of households living standards) (*STEPS)
Belgium	31.0	22.0	27.0				15+ (*18)	(*69)	2021	Enquête sur le tabagisme/ Smoking Survey
Belize	16.4	2.1	0.0				15	49	2015	MICS
Benin	7.2	1.4		8.0	3.2	5.7	15 (*18)	49 (*69)	2017/2018 (*2015)	Demographic and Health Survey in Benin (*STEPS)
Bhutan	15.2	3.7	10.6	26.5	11.0	19.7	15 (*18)	69	2019 (2014)	STEPS
Bolivia (Plurinational State of)	29.8	5.6	17.7				18	69	2019	STEPS
Bosnia and Herzegovina									2012	Subnational surveys reported: Study of the Health status of adult population (2012), Survey on health status of Republic of Srpska' citizens (2010)
Botswana	25.7	3.6	14.2	2.1	6.3	4.3	15+		2017	GATS
Brazil	15.9	9.6	12.6	0.5	0.2	0.3	18+		2019 (*2013)	Pesquisa Nacional de Saúde (National Health Survey) (*GATS)
Brunei Darussalam	36.3	3.7	19.9	1.7	2.1	1.9	18	69	2016	STEPS
Bulgaria	45.9	27.5	36.2				15+		2019	EHIS
Burkina Faso	18.2	0.5	9.1						2021	STEPS
Burundi	13.7	1.4					15	59	2016/2017	Demographic and Health Survey
Cabo Verde	15.7	3.2	9.6	3.5	5.8	9.3	18 (*15)	69	2020 (*2013)	STEPS

Cambodia	28.4	2.4	14.6	0.3	6.5	3.6	15+		2021	National Adult Tobacco Survey
Cameroon	9.3	0.3		2.2	3.8	3.0	15	64	2018 (*2013)	Demographic and Health Survey (*GATS)
Canada	11.8	8.5	10.2	0.8		0.4	15	100	2021	Canadian Tobacco and Nicotine Survey 2021: https://www.canada.ca/en/health-canada/services/canadian-tobacco-nicotine-survey.html
Central African Republic	22.8	0.1					22		2009	Unknown
Chad**	20.2	1.2	11.2				25	64	2008	STEPS
Chile	36.7	28.5	32.5				15	100	2016/2017	Encuesta nacional de Salud
China	48.8	2.3	25.8	1.6	0.1	0.9	15+		2020	China Adult Tobacco Survey
Colombia	13.8	6.0	9.8				12	65	2019	Estudio Nacional de Consumo de Sustancias Psicoactivas en Colombia
Comoros	23.8	2.0	12.9	19.5	17.4	18.4	25	64	2012 (*2011)	STEPS
Congo	22.9	2.3	12.6	18.7	2.7	15.4	15+	(*49)	2021 (*2014/2015)	WHO report on the global tobacco epidemic, 2021 (* MICS5 Congo multiple indicator cluster survey 2014–2015)
Cook Islands	34.6	24.5	29.4				15+		2021	Cook Islands Population Census
Costa Rica	13.0	4.0	8.9	0.1	0.0	0.0	15	100	2015	GATS
Côte d'Ivoire	14.2	1.6		0.1			15	49	2021	Preliminary data from the 2021 Demographic and Health Survey
Croatia	41.2	35.7	38.4	5.9	5.1	5.4	15	64	2014/2015	General Population Survey (GPS) on Substance Use (2019, EMCDDA)
Cyprus	49.9	26.8	37.8				15	64	2019	Cyprus national addictions authority general population survey for 2019
Czech Republic	30.0	19.1	24.4	5.3	1.4	3.3	15+		2021	National Research on Tobacco and Alcohol Use in the Czechia (NAUTA)
Democratic People's Republic of Korea	46.1	0.0	22.0				15		2017	National Adult Tobacco Survey
Democratic Republic of the Congo	26.5	4.1	30.6	20.6	20.1		15	49	2013/2014	Demographic and Health Survey
Denmark	22.0	16.0	19.0	6.0	3.0	4.0	15	79	2022	Monitoring smoking habits in the Danish population
Djibouti										
Dominica	16.6	3.2	10.2	16.0		0.8	15	64	2008	STEPS
Ecuador	23.8	4.0	13.7				18	69	2018	STEPS
Egypt	43.6	0.6	20.0	5.5	0.6	3.0	15	65	2016 (*2010)	STEPS (*GATS)
El Salvador	12.8	3.1	7.4				18	100	2022	Encuesta Nacional de Alcohol y Tabaco (ENAT)
Equatorial Guinea**	24.0	2.0	26.0				15	49	2011	Encuesta Demografica y de Salud
Estonia **	25.7	12.6	17.9	6.4	1.4	3.3	16	64	2020	Health Behaviour among Estonian Adult Population
Eswatini	11.7	2.5	6.0	2.7	1.8	2.2	15	69	2014	STEPS
Ethiopia	6.2	1.2	3.7			2.0	15+		2016	Global Adult Tobacco Survey (GATS)
European Union	28.0	22.0	25.0	2.0	1.0	2.0	15+		2017	Eurobarometer

Fiji	40.3	12.3					15	49	2021	Multiple Indicator Cluster Survey (MICS)
Finland**	12.0	9.0	11.0	9.0	1.0	5.1	20+		2020/2021	National FinSote Survey
France	34.7	29.2	31.9				18	75	2021	Baromètre santé
Gabon										
Gambia	25.4	0.7	13.1	0.8	1.4	1.2	15 (*25)	100 (*64)	2018 (*2010)	Demographic Health Survey (*STEPS)
Georgia	55.5	7.8	30.7	0.0	0.0	0.0	18	69	2019	National tobacco survey
Germany	25.7	19.6	22.7	4.5	2.0	3.2	18	64	2021(*2020)	German Health Update (GEDA 2019/2020-EHIS)
Ghana	3.5	0.2		1.9	0.3	0.8	15	49	2017/2018	Multiple Indicator Cluster Survey (MICS)
Greece	36.0	21.8					18	74	2019	Health Interview Survey
Grenada	30.7	6.5	18.7				25	64	2010/11	STEPS
Guatemala	23.9	3.4	11.2				18		2003	World Health Survey
Guinea	12.9	0.9					15	59	2018	Demographic and Health Survey
Guinea-Bissau	17.0	1.0					15	49	2014	MICS
Guyana	26.6	3.3	15.4	3.0	2.0	5.0	18 (*15)	69 (*49)	2016 (*2009)	STEPS (*Demographic Health Survey)
Honduras	22.9	1.8					15	49	2019	Multiple Indicator Cluster Survey (MICS)
Hungary	30.4	24.1	27.1	0.1	0.1	0.1	15+		2019	EHIS
Iceland			10.1	11.5	3.0	7.3	18+		2021	Tóbakskönnun by Gallup
India	19.0	2.0	10.7	29.6	12.8	21.4	15		2016/2017	GATS
Iran (Islamic Republic of)	25.88 (25.02–26.74)	4.44 (4.08–4.8)	14.01 (13.56–14.47)	0.82 (0.65–1)	0.08 (0.03–0.12)	0.41 (0.33–0.49)	18	100	2021	STEPS
Iraq		1.5		0.4	0.0	0.2	15	49	2018	Multiple Indicator Cluster Survey (MICS)
Ireland	21.0	15.0	18.0				15+		2022	Healthy Ireland Survey
Israel	25.6	14.8	20.1				21+		2020	National Health Interview Survey (INHIS-4)
Italy	22.9	15.3	19.0				14	100	2021	Social Survey on Aspects of daily life
Jamaica	16.8	5.3	11.0				12	65	2016	National Drug Use Prevalence Survey
Japan	27.1	7.6					20		2019	National Health and Nutrition in Japan
Jordan	66.1	17.4	42.0	0.0	0.0	0.0	18	69	2019	STEPS
Kazakhstan	38.3	6.4	21.5	1.4	0.0	1.3	15		2019	GATS
Kenya	19.7	0.9	10.1	5.3	3.8	4.5	18	69	2015	STEPS
Kiribati	44.9	20.4		7.6	1.4	4.2	18	69	2018/2019 (*2015/2016)	Multiple Indicator Cluster Survey (MICS) (*STEPS)
Kuwait	39.2	3.3	20.5				18	69	2014	STEPS
Kyrgyzstan	48.0	3.0	26.0	10.0		5.0	25	64	2013	STEPS
Lao People's Democratic Republic	43.5			0.5	8.6	4.3	15 (*15+)	49	2017 (*2015)	Lao Social Indicator Survey (*National Adult Tobacco Survey)
Latvia	40.2	13.2	26.1	0.0	0.0	0.0	15	74	2020	Health behaviour among Latvian adult population
Lebanon	47.6	29.0	38.0				18	100	2016/17	WHO STEPwise approach for Non-Communicable Diseases Risk Factors Surveillance
Lesotho	40.4	0.7		3.8	17.1	10.5	15	49	2018	Multiple Indicator Cluster Survey (MICS)
Liberia	17.2	2.8	9.9				25	64	2011	STEPS
Libya	49.6	0.7	25.1	2.2	0.1	0.7	25	64	2009	STEPS
Lithuania	49.0	22.2	35.6				15	64	2021 (*2016)	General population survey

Luxembourg	29.0	27.0	28.0				16+		2021	Le tabagisme au Luxembourg
Madagascar	30.8	1.2		24.6	9.6		15	59	2021	Demographic and Health Survey
Malaysia	40.5	1.2	21.3	12.1	0.7	6.5	15	75	2019	National Health Morbidity Survey
Maldives	35.6	7.6	23.1	3.9	1.4	2.6	15	69	2020/2021	STEPS
Mali	12.7	0.7		33.0	12.0	45.0	15	59	2018	Demographic and Health Survey
Malta			20.0				15+		2020	Eurobarometer
Marshall Islands	13.3	47.7	9.3			21.6	18		2014 (*2017/2018)	RMI Behavioural Profile (*Hybrid Household Survey of NCD risk factors and substance use)
Mauritania	34.1	5.7	17.3	5.7	28.3	9.0	15	64	2006	STEPS
Mauritius	35.3	3.7	18.1				18	65	2021	Mauritius Noncommunicable Disease Survey
Mexico	29.6	9.4	19.1	0.9	0.4	0.6	20+		2021	Encuesta Nacional de Salud y Nutrición
Micronesia (Federated States of)	49.7	17.0	31.6	28.3	10.2	18.3	12	98	2012	National Outcome Measure Survey
Mongolia	43.7	5.0	24.2	3.0	0.8	1.9	15	69	2019	STEPS
Montenegro	36.2	34.5	35.4				15	64	2017	Research on the quality of life, lifestyles and health risks of the inhabitants of Montenegro
Mozambique	21.9	2.9		2.5	7.9	5.6	15 (*25)	64	2011 (*2005)	Mozambique Demographic and Health Survey (*STEPS)
Myanmar	40.9	3.8		62.2	24.1	43.2	15	49	2015/2016	Demographic and Health Survey
Namibia	20.9	5.3		1.8	2.3		15	49	2006/2007	2006/2007 Namibia Demographic and Health Survey
Nauru	47.4	45.3	46.3	0.2		0.1	18	69	2015/2016	STEPS
Nepal	28.0	7.5	17.1	40.0	3.3	22.0	15	69	2019	STEPS
Netherlands	24.7	16.6	20.6				18+		2021	Health Survey/Lifestyle Monitor, Statistics the Netherlands (CBS) in collaboration with National Institute for Public Health and the Environment (RIVM) and Trimbos-institute
New Zealand	11.6	10.2	10.9				15+		2020/2021	New Zealand Health Survey
Nicaragua		5.5					15	49	2001	Encuesta Nicaraguense de Demografía y Salud
Niger	11.5	0.2	6.2	9.0	5.0	7.0	18	69	2021 (*2016)	L'Enquete Nationale sur les facteurs de risque des maladies non transmissibles (*Enquête Institut National de la Statistique(INS) 2016)
Nigeria	7.3	0.4	3.9	2.9	0.9	1.9	15	100	2012	GATS
Niue	22.6	13.0	17.7	0.3	0.2	0.2	15+		2012 (*2011)	STEPS
Norway	15.0	16.0	16.0	24.3	10.5	17.6	16	74	2021	Statistics Norway Smoking Habits Survey (Reise- og ferieundersøkelse)
Oman	14.7	0.0	7.7	1.7	0.0	0.9	15	100	2017	National Health Survey
Pakistan	22.6	4.7	13.7	11.4	3.7	7.7	15	49	2017/18	Demographic and Health Survey
Palau	30.9	9.7	20.6			38.3	18 (*18+)	64	2016 (*2012)	Palau Hybrid Survey (*Behavioural Risk Factor Surveillance Survey (BRFSS))
Panama	8.0	1.8	4.9	1.0	0.5	0.8	15+		2019	Encuesta Nacional de Salud

Papua New Guinea	60.3	26.0					15	49	2016/2018	Demographic and Health Survey
Paraguay	22.8	6.1	14.5	3.0	1.6	2.3	15	74	2011	Primera Encuesta Nacional de Factores de Riesgo
Peru	13.7	3.1	8.2				15	100	2021	Encuesta Demográfica y de Salud Familiar
Philippines	33.3	3.7	18.5	2.3	0.7	1.5	15+		2021	GATS
Poland	28.1	19.1	23.4			1.0	18+		2021	Public Opinion Research Centre (CBOS) nicotine consumption survey
Portugal	23.9	10.9	17.0				15+		2019	Inquérito Nacional de Saúde
Qatar	20.2	3.1	12.1	1.3		0.7	15	65	2013	GATS
Republic of Korea	30.7	5.8	18.2				19		2021	Korea National Health & Nutrition Examination Survey
Republic of Moldova	28.9	6.3	27.6				18	69	2021	STEPS
Romania	40.8	13.7	26.8	2.2	1.3	1.7	15		2019	Health Status of Romanian Population
Russian Federation	34.9	8.3	19.3	3.0	3.8	3.3	15+		2022	осстат. Состояние здоровья населения Selective monitoring of the health of the population survey (Rosstat)
Rwanda	10.4	3.7	7.1				18	69	2021	STEPS
Saint Kitts and Nevis	16.2	1.1	8.7				25	64	2008	STEPS
Saint Lucia	25.2	3.4	12.9	1.3	0.2	0.8	18+		2019	STEPS
Saint Vincent and the Grenadines	21.9	2.5	12.2						2013/14	National Health and Nutrition Survey
Samoa	25.6	12.5		1.3	0.5	0.9	15 (*18)	49 (*64)	2019/2020 (*2013)	Multiple Indicator Cluster Survey (MICS)(*STEPS)
San Marino	16.1	14.4	15.2				15	100	2013	Sample survey
Sao Tome and Principe	11.6	1.6	4.7			3.5	15	69	2019	STEPS
Saudi Arabia	27.5	3.7	17.9	0.6	0.2	0.4	15+		2019	GATS
Senegal	13.1	0.7		0.3	1.0	0.7	15	59	2017	Enquête Démographique et de Santé à Indicateurs Multiples (EDS-MICS)
Serbia	36.9	32.1	34.4				18	100	2019	Survey of the effects and attitudes related to the Law on Protection of the Citizens from Exposure to Tobacco Smoke
Seychelles	34.1	7.7	20.9	0.3	0.4	0.3	25	64	2013/14	STEPS
Sierra Leone	43.1	10.5	25.8	2.9	12.1	7.8	25	64	2009	STEPS
Singapore	21.1	3.4	12.0				18	69	2017	National Population Health Survey
Slovakia	25.0	17.6	21.2	1.6	1.0	1.3	15+		2022	Survey of health awareness and behaviour of residents of the Slovak Republic
Slovenia	20.6	16.2	18.4	2.0	0.2	1.1	18+		2021	National Survey on the Impact of the Pandemic of Life
Solomon Islands	54.5	21.0	36.6	4.0	2.9	3.4	18	69	2015	STEPS
South Africa	41.2	11.5	25.8	6.4	1.3	3.9	15+		2021	GATS
Spain	25.9	18.5	22.1				15+		2019/2020	European Health Interview Survey (EHIS)
Sri Lanka	19.7	0.0	9.1	26.0	5.3	15.8	15+		2019/2020	GATS
Sudan	17.1	0.7	9.6	14.3	0.2		18	69	2016	STEPS
Suriname	34.0	6.5	20.1				15	64	2013	STEPS

Sweden	10.0	10.0	10.0	22.0	6.0	14.0	16	84	2022	Nationella folkhälsoenkäten (National Survey on Public Health)
Syrian Arab Republic	51.0	10.0	29.0				15	65	2000	National Survey on Tobacco Use
Tajikistan		0.5					15	49	2017	Demographic and Health Survey
Thailand	34.7	1.3	17.4	1.5	2.7	2.1	15+		2021	Health Behaviour of the Population Survey
Timor-Leste	53.3	4.1	48.6	16.1	26.8	19.8	15 (*18)	59 (*69)	2016 (*2014)	Demographic Health Survey (*STEPS)
Togo	10.0	0.6	3.3	4.9	2.4	3.7	18	69	2021	STEPS
Tonga	52.9	16.1					15	49	2019	Multiple Indicator Cluster Survey (MICS)
Trinidad and Tobago	33.5	9.4	21.1	0.5	0.3	0.4	15	64	2011	STEPS
Tunisia	48.3	2.6	25.1	3.0	0.7	1.8	15	100	2016	Enquête nationale "THES"
Türkiye	41.8	21.7	31.7				15+		2021	GATS
Turkmenistan	6.6	0.2	3.4	0.4	0.0	0.2	18	69	2018	STEPS
Tuvalu	48.0	16.9					15	49	2019/2020	Multiple Indicator Cluster Survey (MICS)
Uganda	10.1	0.8					15	54	2016	Demographic and Health Survey
Ukraine	42.3	13.7	26.6	0.4	0.0	0.2	18+		2020	Kyiv International Institute of Sociology face-to-face survey
United Arab Emirates	15.7	2.4	9.1				18	50	2018	STEPS
United Kingdom of Great Britain and Northern Ireland	15.1	11.5	13.3				18+		2021	Annual Population Survey
United Republic of Tanzania	12.9	1.1	6.8	2.1	2.3	4.4	15	64	2018	GATS
Uruguay	21.3	13.9	17.4	0.3	0.0	0.1	15+		2022 (*2017)	Encuesta Continua de Hogares (*GATS)
Uzbekistan	18.8	0.5	9.4	23.0		12.0	18	64	2019	STEPS
Vanuatu	49.0	5.3	27.0				15+		2020	National Population and Housing Census
Venezuela (Bolivarian Republic of)	21.6	12.7	17.1	5.7	0.9	3.3	12		2011	Estudio Nacional de Drogas en Poblacion General
Viet Nam	41.1	0.6	20.8	1.1	1.2	1.1	15+		2021 (*2020)	STEPS (*Provincial Global Adult Tobacco Survey)
Yemen	25.8	7.4	16.4	17.0	5.9	11.3	15	100	2013	Demographic Health Survey
Zambia	19.6	0.9	9.7	3.0	70.0	16.0	15	59	2018	Demographic and Health Survey
Zimbabwe	20.4	2.4	22.8				15	54	2015	Demographic and Health Survey

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Survey name abbreviations: EHIS = The European Health Interview Survey; Eurobarometer = The Special Eurobarometer 458 on Attitudes of European Towards Tobacco and Cigarettes; GATS = Global Adult Tobacco Survey; MICS = Multiple Indicator Cluster Survey; STEPS = The WHO STEPwise Approach to Noncommunicable Disease (NCD) Risk Factor Surveillance.

(*) Marks different age group, year or survey for the data reported for smokeless tobacco. **Indicates Parties where the reported prevalence refers to daily use instead of current use. Current use is most often described by Parties as daily or occasional use, often past 30 day use, but can also entail other definitions. Detailed definitions should be verified against original survey documents of the respective Party.

Table A3.2. Youth smoking and smokeless tobacco use prevalence. For definitions and additional information, see the bottom of the table.

	Current tobacco smoking			Current smokeless tobacco use						
	Reported prevalence (%)			Reported prevalence (%)			Age range		Year	Survey/source (full survey and source names appear at the end of the figure)
Party	Boys	Girls	Total	Boys	Girls	Total	From	To		
Afghanistan	8.0	3.7	8.3	4.8	3.3	4.1	13	15	2017	GYTS
Albania	18.9	8.6	14.0						2020	GYTS
Algeria	16.0	3.1	8.8	7.0	0.8	3.5	13	15	2013	GYTS
Angola			19.0				8	12	2016	Encuesta de la Asociação Nacional de Luta Contra as Drogas
Antigua and Barbuda	6.3	5.9	6.1	2.6	1.6	2.1	13	15	2017	GYTS
Armenia	3.4	4.2	3.8	9.6	2.0	5.8	15	15	2022	HBSC
Australia	6.0	5.0	6.0				15	15	2017	Australian Secondary Students Alcohol and other Drug survey
Austria	20.6	22.7	21.6	15.7	4.6	10.2	15	15	2019	ESPAD
Azerbaijan	11.6	2.3	7.3	2.4	1.1	1.8	13	15	2016	GYTS
Bahamas	13.8	6.9	10.7	4.0	1.6	2.8	13	15	2013	GYTS
Bahrain	21.1	5.0	13.4	5.2	2.2	3.7	13	15	2016 (*2015)	Global school-based student health survey (*GYTS)
Bangladesh	4.0	1.1	2.9	5.9	2.0	4.5	13	15	2013	GYTS
Barbados	15.7	9.3	12.6	2.9	3.0	2.9	13	15	2013	GYTS
Belarus	6.1	9.0	7.6	0.9	0,2	0.6	13	15	2021 (*2015)	GYTS
Belgium	16.1	7.2					15	19	2018	Belgian Health Interview Survey
Belize	15.7	7.5	12.3	2.9	1.7	2.3	13	15	2014	GYTS
Benin	5.1	1.3	3.8	5.8	0.8	2.9	13 (*18)	15 (*21)	2016 (*2015)	GSHS (2016), STEPS (2015)
Bhutan	25.4	9.5	17.3	25.0	18.9	21.6	13	15	2019 (*2013)	GYTS
Bolivia (Plurinational State of)	13.6	8.1	10.9	3.6	2.0	2.8	13	15	2018	GYTS
Bosnia and Herzegovina	27.5	20.8	24.2						2018	Subnational results available: GYTS Republic of Srpska (2018); GYTS Federation of BiH (2018/2019)
Botswana	23.3	16.2	14.3				13	15	2008	GYTS
Brazil	7.1	6.5	6.8				13	17	2019	Pesquisa Nacional de Saúde do Escolar (PENSE)
Brunei Darussalam	12.8	3.7	8.4	2.1	0.3	1.2	13	15	2019	GYTS
Bulgaria										
Burkina Faso										
Burundi										
Cabo Verde	0.4	0.3		17.6	3.8	11.3	18	29	2020	Segundo Inquérito dos Fatores de Riscos das Doenças Não Transmissiveis – IDNT II

Cambodia	3.4	1.7	2.5	2.1	1.7	1.9	13	15	2022	GYTS
Cameroon	10.3	4.0	7.4	5.0	2.3	3.7	13	15	2014	GYTS
Canada	3.8	2.7	3.3			0.6	All grades 7–12		2021	CTNS 2021 https://www.canada.ca/en/health-canada/services/canadian-tobacco-nicotine-survey.html
Central African Republic										
Chad	8.0	7.7	8.1				13	15	2019	GYTS
Chile	13.1	17.3	15.2				13	17	2019	Décimo Segundo Estudio Nacional de Drogas en Población Escolar
China	2.9	1.4	2.2				First grade of junior high school		2021	China Youth Tobacco Survey
Colombia	9.2	8.6	9.0	4.2	3.5	3.9	13	15	2017	Estudio Nacional de Tabaquismo en Jóvenes en Colombia
Comoros	10,5	3,2	6,5				13	15	2017	GYTS
Congo	10.4	7.4	9.5	18.4		16.4	13	15	2019 (*2009)	GYTS
Cook Islands	28.1	13.9	20.7				13	15	2016	GYTS
Costa Rica	3.4	1.8	2.6	1.7	1.6	1.6	GRADE 7 (*13)	GRADE 11 (*15)	2018 (*2013)	Encuesta Nacional sobre Consumo de Drogas en población de Educación Secundaria (*GYTS)
Côte d'Ivoire	3.7	1.2					15	19	2021	Preliminary data from the 2021 Demographic and Health Survey
Croatia	1.6	0.9	1.3				15	15	2018	HBSC 2018; European School Survey on Alcohol and Other Drugs, 2019
Cyprus							15	16	2015	(data available from ESPAD)
Czech Republic	20.8	26.5	23.6	6.4	2.8	4.7	13	15	2019 (*2016)	ESPAD (*GYTS)
Democratic People's Republic of Korea	1.3						13	15	2009	Central Bureau of Statistics
Democratic Republic of the Congo	11.5	3.7					14 boys, 17 girls	22 boys, 23 girls	2013/2014	Demographic and Health Survey
Denmark	19.2	16.3	10.5	15.1	6.2	10.1	15	29	2021	Smoke a survey of tobacco, behaviour and regulations. Selected trends in 2021
Djibouti	8.0	4.2		8.1	4.0		13	15	2013	GYTS
Dominica	4.2	4.0	4.4				13	15	2016	GYTS
Ecuador	1.3	0.5	0.9				10	17	2018	Indicadores Encuesta Nacional de Salud y Nutrición (ENSANUT)
Egypt	16.3	3.1	10.1	2.7	5.4	4.1	13	15	2014	GYTS
El Salvador	1.0	0.9	0.9	0.2	0.0	0.1	13	15	2021	GYTS
Equatorial Guinea										

Estonia	2.4	2.2	10.5			11.3	15 by gender, 11 total	15	2021	HBSC
(ex-Swaziland) Eswatini	15.8	8.6	11.5	6.0	5.0	5.4	13	15	2009	GYTS
Ethiopia	6.3	0.5	3.3				13	15	2003	GYTS
European Union	25.0	18.0	21.0			1.0	15	24	2020	Special Eurobarometer 506 on Attitudes of European Towards Tobacco and Cigarettes: https://europa.eu/eurobarometer/surveys/detail/2240
Fiji	9.6	5.5	7.6	2.6	1.5	2.1	13	15	2016	GYTS
Finland	14.0	13.0	13.0	11.0	4.0	8.0	8 grade (*14)	9 grade (*16)	2021	National School Health Promotion Survey
France	17.0	14.2	15.6	1.0	0.0	0.5	17 (*14)	(*15)	2021 (*2017)	Enquête ESCAPAD 2022 (*Enquête EnCLASS)
Gabon	7.9	7.0	7.6	1.9	2.9	2.4	13	15	2014	GYTS
Gambia	15.9	4.2	9.2	2.3	0.9	1.5	13	15	2017	GYTS
Georgia	17.0	7.0	12.0	5.0	3.2	4.4	15 (*13)	16 (*15)	2019 (*2017)	ESPAD (*GYTS)
Germany	6.1	7.2	6.6	2.9	1.8	2.4	12	17	2018	Alkoholsurvey
Ghana	3.2	2.3	2.8	2.5	3.7	3.1	13	15	2017	GYTS
Greece	16.9	12.9	15.0	2.5	1.3	1.9	13	15	2014	Health Interview Survey
Grenada	12.5	7.1	9.7	2.0	1.6	1.8	13	15	2016	GYTS
Guatemala	18.0	13.2	15.7	3.0	1.8	2.4	13	15	2015	GYTS
Guinea										
Guinea-Bissau	7.7		5.4				13	15	2008	GYTS
Guyana	16.1	7.5	11.7	4.6	3.0	4.1	13	15	2015	GYTS
Honduras	9.6	6.4	7.9	2.2	1.9	2.2	13	15	2016	GYTS
Hungary	15.0	15.0	15.0	1.0	1.0	1.0	13 (*Grade 7–8–9 students)	15	2019/2020 (*2016)	GYTS
Iceland	3.0	3.0	3.0	6.0	5.0	6.0	15	16	2019	Ungt fólk
India	8.3	6.2	7.3	4.5	3.4	4.0	13	15	2019	GYTS
Iran (Islamic Republic of)	4.8	2.1	3.4	3.1	0.8	1.9	13	15	2016	GYTS
Iraq	18.7	10.4	14.8	1.6	2.1	1.9	13	15	2019	GYTS
Ireland	0.7	0.0	5.3				15	17	2018	HBSC
Israel	4.6	1.5	3.0				11	11	2019	HBSC
Italy	18.5	22.8	20.5	1.2	1.4	1.3	13	15	2022	GYTS
Jamaica	25.5	13.4	19.3				13	15	2017	GSHS
Japan	0.2	0.1	0.2				13	15	2021	Survey on underage smoking and drinking
Jordan	32.8	13.4	23.2	3.9	1.1	2.5	13	15	2014	GYTS
Kazakhstan	4.9	3.2	4.0				11	15	2018	HBSC
Kenya	9.6	4.0	9.9	4.3	3.3	7.0	13	15	2013	GYTS
Kiribati	37.0	22.5	29.2	42.5	35.3		13	15	2018	GYTS
Kuwait	24.2	9.8	16.7	3.1	2.3	2.7	13	15	2016	GYTS

Kyrgyzstan	6.8	2.0	4.4	8.0	3.0	5.0	13	15	2019 (*2014)	GYTS
Lao People's Democratic Republic	10.7	2.1					13	15	2016	GYTS
Latvia	22.8	20.0	21.5	6.8	3.7	5.3	13	15	2019 (*2018)	GYTS
Lebanon	17.7	6.0	11.3				13	15	2011	GYTS
Lesotho	25.0	20.0					14	16	2008	Unknown
Liberia										
Libya	11.0	5.0	8.1				13	15	2010	GYTS
Lithuania	9.0	7.1	8.0				15	16	2019	ESPAD
Luxembourg	15.0	15.0	NA				13	14	2018	Le tabagisme au Luxembourg
Madagascar	16,7	6,8	11.3	1,1	2.0	1,1	13	15	2019	GYTS
Malaysia	25.3	6.7	15.9	8.2	4.3	6.3	13	17	2017	National Health and Morbidity Survey - Adolescent Health Survey
Maldives	12.0	4.4	8.3	9.2	2.9	6.2	13	15	2019 (*2011)	GYTS
Mali	18.0	2.0	9.0				13	15	2008	GYTS
Malta	12.0	18.0	15.0				15	16	2015	ESPAD
Marshall Islands	31.3	5.4	17.6	29.6	9.5	19.0	unk	unk	2020	RMI Rapid Youth High School Survey
Mauritania	19,6	16,2	19,8	6.5	6,8	6,8	13	15	2018	GYTS
Mauritius	21.2	6.6	13.6				13	15	2016	GYTS
Mexico	7.5	1.6	4.6				10	19	2021	Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco (ENCODAT)
Micronesia (Federated States of)	27.5	20.1	23.5	20.0	12.7	16.0	13	15	2019	GYTS
Mongolia	11.6	3.2	7.5	11.8	4.5	8.2	13	15	2019	GYTS
Montenegro	18.0	12.0	15.0				16	16	2016	ESPAD
Mozambique	15.1	14.6	14.9	8.3	6.5	7.5	13	15	2016	WHO Report on the Global Tobacco Epidemic, 2021
Myanmar	21.0	2.0	11.0	11.0	1.5	6.0	13	15	2016	GYTS
Namibia	12.3	11.3	11.9				13	15	2008	GYTS
Nauru	19.5	24.5	22.1				13	17	2011	GSHS
Nepal	5.5	0.8	3.1	24.6	16.4	20.4	13	15	2011	GYTS
Netherlands	8.7	10.2	9.5				12	16	2021	HBSC
New Zealand	2.9	4.8	3.8	-			15	17	2019	New Zealand Health Survey
Nicaragua	14.7	10.4	12.6	4.0	2.9		13	15	2014	GYTS
Niger	6,8	0,6	3,5	5,9	5.0	5,4	14	17	2009	Unknown
Nigeria	5.6	1.3	3.5				13	15	2008	GYTS
Niue	22.8	19.2	21.1	2.8	2.9	2.8	13	15	2019	GYTS
Norway	6.0	3.0	5.0	12.0	6.0	9.0	15	15	2014	HBSC
Oman	5.1	2.5	3.7	4.2	1.8	2.9	13	15	2016	GYTS
Pakistan	9.2	4.1	7.2	6.4	3.7	5.3	13	15	2013	GYTS
Palau	20.1	19.5	20.0	7.6	10.2	8.9	13	15	2022	GYTS
Panama	6.2	5.4	5.9	2.2	2.4	2.3	13	15	2017	GYTS

Papua New Guinea	34.9	18.2	25.4	10.9	13.6	12.2	13	15	2016	GYTS
Paraguay	7.4	6.8	7.2	2.0	1.3	1.7	13	15	2019	GYTS
Peru	7.1	5.6	6.4	2.2	1.5	1.9	13	15	2019	GYTS
Philippines	16.2	5.6	10.8	4.3	1.7	3.0	13	15	2019	GYTS
Poland	21.9	18.2	20,0	7.9	3.3	5,6	13	15	2016	GYTS
Portugal	19.3	16.0	4.5				13	18	2019	ECATD-CAD
Qatar	13.8	7.7	10.7	9.4	3.2	6.1	13	15	2018	GYTS
Republic of Korea	0.9	0.7	0.8				13	13	2021	Korea Youth Risk Behaviour Web-based Survey
Republic of Moldova	17,5	9.5	13,6	2,1	1.4	1,7	13	15	2019	GYTS
Romania	49.0	50.0	49.0				15	16	2019	GYTS
Russian Federation	8.9	9.8	9.5	3.8	1.6	2.7	13	15	2021 (*2015)	GYTS
Rwanda	23.5	9.5	33.0				13	15	2008	GYTS
Saint Kitts and Nevis	10.4	7.8	9.2				13	15	2011	GYTS
Saint Lucia	9.4	6.4	7.9	4.5	2.4	3.5	13	15	2017	GYTS
Saint Vincent and the Grenadines	8.9	7.9	8.4				13	15	2018	GYTS
Samoa	42.2	25.3	33.8	2.9	1.5	2.1	13	15	2017	GYTS
San Marino	7.0	7.1	7.0	0.7	0,4	0.6	13	15	2018 (*2014)	GYTS
Sao Tome and Principe										
Saudi Arabia	7.6	5.7	6.8	4.4	2.6	3.6	13	15	2022	GYTS
Senegal	9.8	4.5	7.1	6.6	1.8		13	15	2020 (*2013)	GYTS
Serbia	15.5	15.2	15.3	2.4	1.2	1.8	13	15	2017	GYTS
Seychelles	19.6	10.3	14.7	2.8	0.6	1.7	13	15	2015	GYTS
Sierra Leone	14.5 20.3	9.7	12.1				13	15	2017	GYTS
Singapore			4.3				13	20	2016	Students Health Survey 2014–2016
Slovakia			19.0			4.0	12	21	2022	Public opinion poll, Focus agency
Slovenia	14.3	17.1	15.6	3.1	1.6	2.4	15	15	2018	HBSC
Solomon Islands	24.3	23.4	24.2				13	15	2008	GYTS
South Africa	16.9	13.1	14.8	8.9	8.1	8.5	15	15	2011	GYTS
Spain	21.2	26.7	23.9				14	18	2021	Encuesta sobre Uso de Drogas en Estudiantes de Enseñanzas Secundarias
Sri Lanka	2.9	0.0	1.5	4.2	0.5	2.4	13	15	2015	GYTS
Sudan	10.6	5.0	8.3				13	15	214	GYTS
Suriname	16.1	7.0	11.1	1.7	0.6	1.1	13	15	2016	GYTS
Sweden	8.0	10.0	9.0	14.0	8.0	11.0	15	16	2022	Alcohol and drug use among students (Skolelevers drogvanor)

Syrian Arab Republic	45.0	26.0	36.0				13	15	2007	GYTS
Tajikistan	1.8	1.4	1.7				13	15	2019	GYTS
Thailand	17.2	5.2	11.3	4.1	1.3	2.7	13	15	2015	GYTS
The former Yugoslav Republic of Macedonia	56.3	42.0	40.2				15	34	2017	Use of psychoactive substances among the general population in the Republic of Macedonia (GPS)
Timor-Leste	37.0	9.8	22.5	7.7	9.3	8.4	13	15 (*17)	2019 (*2015)	GYTS (*GSHS)
Togo	5.5	1.1	3.5	4.9	3.5	4.3	13	15	2019 (*2013)	GYTS
Tonga	22.1	6.8	14.6				13	15	2017	GSHS
Trinidad and Tobago	13.6	8.6	11.0	5.0	3.2	4.1	13	15	2017	GYTS
Tunisia	14.2	1.4	7.7	3.8	2.0	2.9	13	15	2017	GYTS
Türkiye	23.2	12.1	17.9				13	15	2017	GYTS
Turkmenistan	0.1	0.2	0.1						2015	(GYTS available)
Tuvalu	30.4	11.2	19.8	2.3	3.3	2.8	13	15	2018	GYTS
Uganda	6.8	4.3	5.5	11.5	9.9	10.5	13	13	2018 (*2011)	GYTS
Ukraine	4,9 (1+ cigarettes daily)	2 (1+ cigarettes daily)	3.4 (1+ cigarettes daily)			6.3 ever	14	14	2019	ESPAD
United Arab Emirates	16.4	8.4	16.4	5.6	4.4	5.6	13	15	2013	GYTS
United Kingdom of Great Britain and Northern Ireland	4.0	3.0	3.3				15	15	2021	Smoking, drinking and drug use among young people in England
United Republic of Tanzania	4.8	1.8		2.9	0.9		13	15	2016	GYTS
Uruguay	8.3	12.7	10.4	2.0	1.5	1.7	13	15	2019	GYTS
Uzbekistan	2.3	0.9	1.7	1.5	0.6	1.1	13	15	2021	GYTS
Vanuatu	16.7	11.7	14.1	5.9	4.6	5.2	13	15	2017	GYTS
Venezuela (Bolivarian Republic of)	11.0	9.0	10.1	2.3	0.3	1.6	12	15 (*14)	2019 (*2011)	GYTS (*Estudio Nacional de Drogas en Poblacion General)
Viet Nam	4.0	1.6	2.7				13	15	2022	Viet Nam Youth Tobacco Survey
Yemen	19.4	7.9	15.1	6.7	2.6	5.1	13	15	2014	GYTS
Zambia	24.9	25.8	25.6				13	15	2011	GYTS
Zimbabwe	17.3	12.8	16.2	6.5	4.6	5.6	13	15	2014	GYTS

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