Going Beyond the World Health Organization Framework Convention on Tobacco Control: An Environmental Scan

by
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Background

In May 2021, Health Canada’s Tobacco Control Directorate (TCD) commissioned an environmental scan and report to determine what measures Parties to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) have implemented, or could implement, that go beyond the WHO FCTC and its guidelines, including measures from other non-Party WHO Member States.

This scan was motivated by Article 2.1 of the WHO FCTC that states:

“In order to better protect human health, Parties are encouraged to implement measures beyond those required by this Convention and its protocols, and nothing in these instruments shall prevent a Party from imposing stricter requirements that are consistent with their provisions and are in accordance with international law.”(1)

Overall, there appears to be at least two interpretations of Article 2.1. The first is the strictly legal basis for the Article, which is to cover Parties who take measures beyond what is explicit or implicit in the treaty and may need to defend such measures in the face of a legal challenge. This type of language is common practice in other similar types of treaty instruments.

However, for many, this seems to be only part of the rationale for Article 2.1. Governments negotiating the treaty also included it to encourage Parties to think beyond the WHO FCTC measures because they knew the measures included in the treaty were of necessity bound in time, specifically 2003 when the negotiations ended and the Convention was signed. Some negotiators believed that as the thinking on tobacco control evolved, new measures would be suggested and/or developed. The treaty was intended to be the ‘floor’ and not the ‘ceiling’. They knew that they could not foresee every development, but wanted to provide an opening for Parties to be creative and introduce new measures that reflected the evolving science upon which tobacco control measures are based.

The following scan focuses solely on this second rationale for Article 2.1. It provides a list of the measures identified, short descriptions and references. This working paper is primarily intended to be a resource for future discussion among Parties to the WHO FCTC and civil society as they consider measures that can aid in accelerating the achievement of WHO FCTC objectives.
Approach

The first step of the scan was an informal consultation process through email and Zoom exchanges with 18 tobacco control professionals who acted as informants. Each were selected by the author of this report because they work on tobacco control at either a regional or global level and could provide a broad perspective. This group was representative of people in governmental organizations, academia and civil society.

Each informant was asked to provide suggestions of ideas, strategies or measures they thought went “beyond” the WHO FCTC, with “beyond” defined as not being found in the WHO FCTC or its guidelines. Where possible, they were asked to share materials or links to support their suggestions. Consultations were stopped when few new ideas were being generated and a literature search was conducted. A draft working paper was shared with ten reviewers to provide feedback, generate additional ideas and fill gaps.

The literature review included both published and grey literature. Initial search terms were drawn from ideas from informants followed by a snowball technique of searches using key words and websites, journal article citations and Google Scholar forward citation searches. Over 200 items were collected and organized for analysis.

Each idea, strategy or intervention was then cross referenced against the WHO FCTC and its guidelines, an analysis was conducted, and a decision was taken as to whether it was explicitly in either the WHO FCTC or its guidelines. This list was presented to the TCD for further discussion and agreement on the parameters of the scan (more information in limitations section below). Based on this agreement, the report includes two categories: (1) items that are deemed explicitly not included in the WHO FCTC or its guidelines and (2) items that are deemed implicitly covered by the WHO FCTC and/or its guidelines but not explicitly mentioned.

Many of the reports, journal articles and websites identified for the scan mentioned more than one type of measure that were classified as beyond the WHO FCTC. However, for ease of reporting, the author has limited analysis and citations to papers that are illustrative of the total and, where feasible, attempted to highlight the people or countries where the measure either originated, was recently contemplated or has been successfully implemented.

Limitations

It is important to highlight that this working paper is meant solely to be a scan and is not an analysis. No attempt was made to assess the value, impact or benefit of any idea, strategy or intervention identified in this scan, nor does its inclusion imply it is a recommendation. In fact, when ideas were suggested by those consulted, it was often with a stated caveat that raising the idea did not mean they agreed with it or recommended it. As well, any legal challenges brought by the tobacco industry against measures included on the list were not considered as criteria for inclusion or exclusion.
Measures such as blanket bans on, or abolition of, tobacco products were deemed out of scope for this report by TCD, including bans on electronic nicotine device systems (ENDS) and heated tobacco products (HTPs). Blanket bans on the sale, possession or use of a product are a well-known supply reduction tool in the area of addictive substances. The rationale for excluding blanket bans from this report is that Parties are already aware of this type of intervention, the WHO FCTC does not preclude Parties from using this tool if they so choose, and if a Party chooses to implement such an approach, theoretically then it does not need the WHO FCTC.

Other limitations included varied levels of understanding among key informants of the details of what is included in the WHO FCTC and its guidelines, which resulted in many suggestions from informants that are covered by the WHO FCTC. One point of confusion may have arisen from informants intermixing the concept of “beyond” the WHO FCTC and “endgame” strategies. The goal of endgame strategies is to get to zero, or near zero, prevalence within a specified period. In the literature search, the “beyond” measures outlined below were often found in endgame plans alongside measures that are clear obligations of the WHO FCTC. Nuance in descriptions and language in these endgame strategies made it challenging to decipher if some ideas or plans fell in the “beyond” category.

Another limitation stemmed from a lack of consensus among key informants and reviewers over what policies are explicitly in the WHO FCTC and its guidelines versus policies that are implicitly in the WHO FCTC and its guidelines. Moreover, some thought the paper should only cover the explicit items while others thought it was important to include the implicit ones as by the nature of them being implicit, they might be overlooked by Parties.

Many of the informants also questioned why some Parties consider meeting the minimum requirements set out in the WHO FCTC as being sufficient to fulfil their obligations and do not push “beyond” them as these measures are intended to be a floor and not a ceiling (e.g., minimum taxation levels or minimum size requirements for graphic warning labels). Such discussion, however, was not within the scope of this scan and working paper.

Some informants thought this discussion of “beyond” was premature in their country or region as they are still grappling with trying to implement measures that are explicitly outlined in the WHO FCTC and its guidelines. They thought this discussion was a luxury of countries that are more advanced in their implementation of the WHO FCTC.

Finally, the author acknowledges that while this scan is likely one of the first comprehensive attempts to itemize measures with a focus on what goes beyond the WHO FCTC and its guidelines, the search was conducted in English, so there are unquestionably examples that were not found within the limits of the scope and timelines allocated to this assignment. The examples provided are offered solely to help guide future discussions.
**Items that go beyond the WHO FCTC**

The following\(^1\), in no order of priority or theme, are items found that were deemed not explicit in the WHO FCTC or its guidelines:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Smokefree private spaces (2)(3)(4)(5)(6)(7)(8)(9) These measures regulate or ban smoking in private places. A range of these measures have been implemented and enforced around the world in a variety of different places including: private homes, vehicles, multi-unit housing, government-subsidized housing, balconies, patios and yards belonging to housing complexes.</td>
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<td>2</td>
<td>Restrictions or bans on consumption or possession for vulnerable groups (2)(10)(11)(12) This measure legislates bans on consumption and/or possession of tobacco aimed at protecting vulnerable populations. There are many examples from countries and jurisdictions around the world. Nepal introduced a ban on sales of tobacco to pregnant women as part of its tobacco control legislation. The Republic of Congo has legislation that strictly forbids the consumption, purchase and possession of tobacco to minors, pregnant women and the mentally ill. Burundi has prohibited sale and consumption of tobacco to minors and pregnant women and Chad has prohibited the consumption of tobacco for both these groups.</td>
</tr>
<tr>
<td>3</td>
<td>Tobacco free investment portfolios (13) This strategy involves engaging and educating key leaders in financial institutions globally to reconsider commercial relationships with the tobacco industry and to consider excluding the industry from their investment, lending and insurance activities.</td>
</tr>
<tr>
<td>4</td>
<td>Controlling the marketing of tobacco products through a regulated market model (1)(15)(16) This strategy proposes controlling marketing with a government-owned agency set up to market and distribute tobacco products that are manufactured by free enterprise companies. The agency would be backed by legislation that made tobacco a controlled substance with possession, sale and use only allowed as permitted by the regulations, under the purview of the agency. This “regulated market model” would eliminate most of the incentives and remaining opportunities for commercial promotion of tobacco and create incentives to encourage the development of less harmful tobacco products.</td>
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<tr>
<td>5</td>
<td>Transferring the supply of cigarettes from for-profit This strategy proposes to address the fact that demand side measures in the WHO FCTC are impeded and undermined by private tobacco companies that are, as for-profit companies,</td>
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\(^1\) Numbers in parentheses point to documents referenced at the end of this report
<table>
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<tr>
<th>Corporations to non-profit enterprises with a public health mandate (17)</th>
<th>obligated by law to maximise profits and thus are compelled to maintain and expand cigarette sales. The solution proposed is that tobacco could be supplied through non-profit enterprises that share a public health mandate. The elimination of profit driven behaviour from the supply of tobacco would enhance the ability of public health authorities to reduce tobacco use.</th>
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<tr>
<td>Tobacco price regulation to promote the health of markets, government revenue and the public (1)(18)</td>
<td>This idea explores how the tobacco industry frequently uses tax increases to &quot;over-shift&quot; cigarette prices beyond the tax increase to further maximize firms' profits and shift the focus to the tax instead of their profit-maximization. One proposed solution is a price cap regulation wherein a cap is placed on the pre-tax manufacturers' price but not on the retail price that consumers face. This maximum manufacturers' price would be based on an assessment of the genuine operational costs that firms face and a small profit. The end result would not affect the government's ability to raise taxes or place any limit on retail prices but would significantly limit cigarette firms' profits and market power.</td>
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<td>Restricting the sale of any tobacco product or similar products to state-owned tobacco stores (3)(19)(20)(21)(22)</td>
<td>This strategy involves creating government-owned or licensed retail outlets to sell tobacco. Some suggest these highly regulated outlets could offer cessation services and volume purchases to reduce wholesale prices while allowing high net prices via taxation. Hungary, for example, limits the distribution of tobacco through a network of government-licensed and designated retail outlets nationwide. France’s government-licensed tobacco shops require mandatory training for tobacco retailers on tobacco and public health regulations and the health risks of smoking.</td>
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<td>Designate specific store types to sell tobacco (23)(24)(25)(26)(21)</td>
<td>This strategy involves designating specific store types to sell tobacco. The types of ideas that have been explored include selling tobacco products only in specialist stores or selling in pharmacies only as an option that could provide a strong link with smoking cessation advice. Hungary, for example, has an established network of government-licensed and designated specialty retail outlets called “National Tobacco Shops”. The Dutch government announced a ban on the sale of cigarettes in supermarkets that will come into effect in 2024. The plan is to phase out tobacco sales in store to the point where only specialist retailers will sell cigarettes and tobacco products after 2030.</td>
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<tr>
<td>“Tobacco-Free Generation”. Restrict the acquisition of</td>
<td>This strategy aims to restrict as comprehensively as possible the acquisition of tobacco and/or new forms of tobacco products to all those born in a certain year or after they reach</td>
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<td>10</td>
<td>“Sinking lid” on the volume of tobacco allowed to be sold each year and cap-and-trade system (37)(19)</td>
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<td>The “sinking lid” strategy involves regularly requiring reductions in the amount of tobacco released to the market for sale, sufficient to achieve the desired level of commercial sales by a target date. Tobacco manufacturers would periodically bid to the government for a residual quota (the allowed quantity after considering the reduction imposed by the law). Prices would increase as supply is reduced. The price level would be influenced by demand, which in turn would reflect the impact of other interventions to reduce demand and the changing normality of smoking. Similarly, under a cap-and-trade system, a defined and constant-declining cap is placed on supply. Producers who exceed their cap can, for a fee, trade their overage to other suppliers who were under their cap, ensuring the cap is maintained for the entire industry. (A system that has been used for carbon emissions.)</td>
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<tr>
<th>11</th>
<th>Decreasing the number and density of outlets selling tobacco products (38)(25)(19)(39)(23) (40)(29)(41)(42)</th>
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<td></td>
<td>The idea of decreasing the number and density of tobacco outlets is that it will reduce overall retail availability, decrease initiation, decrease exposure to marketing and increase long-term cessation. A variety of different ways have been proposed to do this including: providing incentives to retailers who agree to end tobacco sales; charging an annual fee for tobacco retailer registration and increasing or decreasing it annually based on sales volume; decreasing and/or capping licences to sell tobacco; capping the number of retailers in a specific geographical area, particularly when they are highly concentrated in more disadvantaged neighbourhoods; banning retailers within certain distances of schools or along routes to schools; and establishing minimum distances between tobacco retailers. Through its system of specialty stores, Hungary has reduced its number of tobacco retailers from 42,000 too 7,000 allowing only one store for every 2000 residents. Finland has implemented a system of high licensing fees to retailers that has reduce outlets by 28%. New Zealand’s Smokefree Aotearoa 2025 strategy is currently requiring certain existing tobacco retailers to transition out of selling tobacco products by a set date.</td>
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<tr>
<td>12</td>
<td>“Polluter pays” approach and extended producer responsibility (EPR) framework to internalize the environmental costs of tobacco production and use back to the tobacco industry or (43)(44)</td>
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<tr>
<td>13</td>
<td>Addressing relative risks of low nitrosamine smokeless tobacco through policy (LNSLT) (45)(28)(46)</td>
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<td>14</td>
<td>Supplemental national transfer dollars from excise taxes to sub national jurisdictions (47)</td>
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<tr>
<td>15</td>
<td>Reducing the exposure to toxic substances from smoking tobacco through a recreational nicotine market (48) and advantaging “clean nicotine” over tobacco products (19)</td>
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<td>16</td>
<td>Retailer incentives changed from earnings per-sale to incentives to promote quitting. (19) (49)(50)</td>
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<td>Page</td>
<td>Description</td>
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<tr>
<td>17</td>
<td>Moratorium on new products (19)(51)</td>
</tr>
<tr>
<td>18</td>
<td>Make tobacco manufacturers responsible for youth tobacco use (19)(52)</td>
</tr>
<tr>
<td>19</td>
<td>Creation of an independent foundation that engages in non-regulatory tobacco control activity (19)(53)(54)</td>
</tr>
<tr>
<td>20</td>
<td>Gradually phase out the sale of commercial combustible tobacco products (55)(56)(57)(58)</td>
</tr>
<tr>
<td>21</td>
<td>Quantifiable Metrics Warranting Industry-Wide Corporate Death Penalties (59)(60)</td>
</tr>
<tr>
<td>22</td>
<td>Smokers’ license (61)(54)(63)(64)(65)</td>
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</table>
user. Financial incentives to permanently relinquish the licence could be offered (with a 6-month “cooling off period” for changing one’s mind), and new smokers seeking a licence would first have to prove that they chose to smoke with full knowledge of tobacco’s health and financial costs by correctly answering a series of questions. In addition, the legal smoking age could be raised annually by one year; given that smoking initiation occurs primarily among those under 23 years of age, new requests for smokers’ licences would presumably decline rapidly after several years.

| 23 | Phasing out tobacco growing (66) | This idea suggests going beyond encouraging sustainable alternative livelihoods and phasing out tobacco growing altogether. |
| 24 | Imposing a health levy, solidarity levy, or user fee on the tobacco industry (67) (68) | This strategy seeks to raise financing for tobacco control through innovative methods such as a health levy, solidarity tax or user fee on cigarettes, sales revenues, or wholesale revenues. Examples are numerous with 48 countries that use tobacco tax revenue for health-related programs and/or tobacco control. The United States has a user fee, separate of tobacco taxes, that requires companies to pay fees based on each company’s market share. A proposal in the UK proposed a levy, in addition to high tobacco taxes, of the equivalent of 25 pence (in today’s prices) on a pack of cigarettes. |
| 25 | Ban on incentives to retailers (50) | This strategy bans a manufacturer or distributor of tobacco products from offering any type of benefit related to the sale or retail price of a tobacco product to owners or employees of tobacco retail outlets. There are some jurisdictions in the world with prohibition of incentives to retailers in place. |
| 26 | Litter abatement (69) | This strategy requires cigarette retailers to pay a litter abatement fee per each pack of cigarettes. The City and County of San Francisco has a litter abatement fee of $1.05 per pack as of January 2022. |
| 27 | Mandatory labelling that filters are plastic waste (70) | This measure involves regulation that requires all tobacco products with plastic filters to be marked clearly on the outside of packages that they contain plastic filter waste with the aim of reducing the impact of certain plastic products. This type of regulation has been implemented by the EU. |
Measures that are deemed implicit in the WHO FCTC and its guidelines

There were several items where there was no consensus among informants and reviewers as to whether the idea, strategy or intervention belonged on the list above. This was mainly because the item was believed to be implicitly covered by the WHO FCTC and its guidelines even though not explicitly outlined in either. The following measures were deemed implicit:

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<tbody>
<tr>
<td>1</td>
<td>Reducing nicotine content in cigarettes (71)</td>
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<tr>
<td>2</td>
<td>Health warnings on individual cigarettes (72)</td>
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<tr>
<td>3</td>
<td>Single presentation requirement (73)(74)</td>
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<tr>
<td>4</td>
<td>Incentives for disadvantaged smokers (75)</td>
</tr>
<tr>
<td>5</td>
<td>Prohibit filters in smoked tobacco products (41)</td>
</tr>
<tr>
<td>6</td>
<td>Performance standard for combustible tobacco (76)</td>
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### Next Steps

It is the hope of the author that this environmental scan be used as a working paper on which Parties can continue to build and refine in order to explore all measures that can help strengthen and accelerate country responses “to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke”.(1)
References


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