



World Health
Organization

WHO report on the global tobacco epidemic, 2023

Protect people from tobacco smoke

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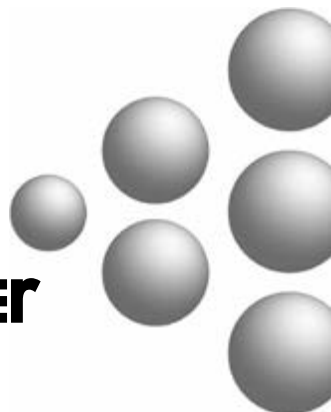
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Made possible by funding from
Bloomberg Philanthropies

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WHO report on the global tobacco epidemic, 2023: protect people from tobacco smoke

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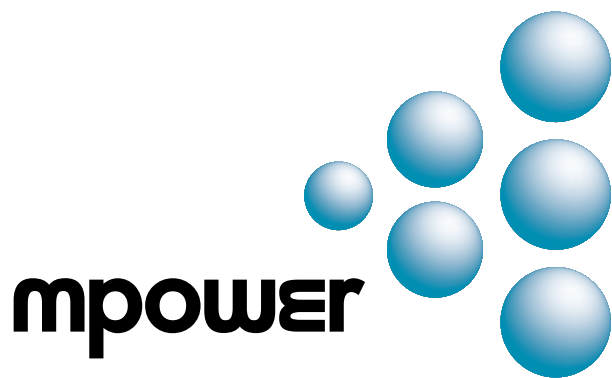
**Second-hand tobacco
smoke kills 1.3 million
non-smokers a year.**

np

**Smoke-free
environments save
lives and benefit
businesses and
economies.**

rip

**Effective smoke-free
laws are comprehensive
and enforced.**



m

Monitor tobacco use and prevention policies

p

Protect people from tobacco smoke

o

Offer help to quit tobacco use

w

Warn about the dangers of tobacco

e

Enforce bans on tobacco advertising, promotion and sponsorship

r

Raise taxes on tobacco

**The general public
supports smoke-free
measures.**

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“The steadfast progress demonstrated by countries over these years is a testament to what can be achieved when a clear global health vision is combined with committed global partnership.”

Dr Tedros Adhanom Ghebreyesus, Director-General, World Health Organization



Foreword

5.6 billion people, 71% of the world population, are now protected by at least one MPOWER measure.

It has been 20 years since the adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC) and 15 years since the introduction of MPOWER, the technical package designed to help countries implement the Convention. The steadfast progress demonstrated by countries over these years is a testament to what can be achieved when a clear global health vision is combined with committed global partnership.

MPOWER provides cost-effective demand-reduction measures to help countries reduce tobacco consumption. Since MPOWER was introduced globally 15 years ago, an estimated 300 million less people are smoking than might have been if smoking prevalence had stayed the same.

The number of countries that have adopted at least one MPOWER measure at the highest level of achievement has grown from 44 in 2008 to 151 in 2022. However, 44 countries remain unprotected by any of the MPOWER measures. It is crucial that tobacco control continues to be a global health priority.

This report focuses on smoke-free environments, a measure that aims to protect people from second-hand smoke. Every year 1.3 million non-smokers die from exposure to second-hand smoke. Smoke-free public environments not only protect bystanders but can also help de-normalize the act of smoking across society.

In 2008, only 5% of the world's population was covered by comprehensive smoke-free laws, but today over one quarter of the world's population is covered. Countries that have not yet done so should ban smoking in all indoor public spaces, workplaces and public transport in line with Article 8 of the WHO FCTC, backed by enforcement mechanisms.

But progress so far is being undermined by the tobacco industry's aggressive promotion of E-cigarettes as a safer alternative to cigarettes. Young people, including those who never previously smoked, are a particular target. In fact, E-cigarettes are harmful to both the people using them and those around them, especially when used indoors.

Tobacco continues to be one of the top preventable causes of premature deaths and it is the only commercial product that kills half its users when used exactly as intended. The past two decades provide us with rich lessons on how to address this global health threat – we must act now to save lives and stop the spread of this preventable killer.



Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

“In 2008, only 5% of the world’s population was covered by comprehensive smoke-free laws, but today over one quarter of the world’s population is covered.”

“Smoke-free laws shield the public from cancer, heart disease and other deadly effects of inhaling tobacco smoke. They also help encourage smokers to quit – and they discourage others, especially young people, from ever starting.”

Michael R. Bloomberg, WHO Global Ambassador for Noncommunicable Diseases
Founder of Bloomberg Philanthropies



Foreword

Latest *WHO report on the global tobacco epidemic* sets out 15 years of meaningful progress around the world and highlights that much more remains to be done.

For the past 15 years, Bloomberg Philanthropies has partnered with the World Health Organization to combat tobacco use and prevent related illnesses. According to the best estimates, these efforts have saved more than 35 million lives. Much of that success is attributable to the spread of MPOWER tobacco control policies, which now protect more than 5.6 billion of the world's 8 billion people. Since this work began in 2007, 107 countries have adopted at least one MPOWER policy at best-practice level.

One of the most effective elements of the MPOWER strategy is “P” – protect people from tobacco smoke through smoke-free laws, which is the focus of this report. Smoke-free laws shield the public from cancer, heart disease and other deadly effects of inhaling tobacco smoke. They also help encourage smokers to quit – and they discourage others, especially young people, from ever starting.

When New York City enacted the Smoke-Free Air Act in 2003, we saw the incredible success of such laws first-hand. The law banned smoking in all indoor workplaces, including bars and restaurants, and protected every New Yorker's right to breathe clean air. Critics – and there were many – argued the ban would scare away visitors and decimate the hospitality industry. They couldn't have been more wrong.

Over the next decade, the number of restaurants and bars in New York City, and the number of people they employed, grew by nearly 50%. At the same time, an estimated 10 000 fewer New York City residents died prematurely due to smoking – proving that when it comes to public health and economic growth, governments aren't facing an either/or proposition. The two go hand-in-hand.

Today, 74 countries have smoke-free policies that cover all indoor places, up from just 10 in 2007. And in 2020, 16 years after Ireland became the first country to pass a smoke-free law, the entire continent of South America became smoke-free. In addition, countries including Brazil, Mauritius, Netherlands (Kingdom of the) and Türkiye are setting new global standards for tobacco control, adopting all six MPOWER measures at the highest possible levels.

It's clear that our work is getting results, but too many lives remain at risk. Smoking is still the leading cause of preventable death in the world. Not enough countries are implementing MPOWER cessation and tobacco taxation policies. And the tobacco industry is relentless, both in its opposition to tobacco control legislation and its targeting of teens and children with e-cigarettes and other heated-tobacco products.

As the tobacco industry finds new ways to push its deadly products, we must push back harder than ever – and we are. National and local governments continue to lead the fight and protect their citizens against the tobacco industry. And Bloomberg Philanthropies is strongly committed to curbing tobacco use in low- and middle-income countries and reducing e-cigarette use among teenagers in the United States of America.

This report recognizes the hard-fought progress that all of us, working together with the World Health Organization, are making – and it highlights how much more remains to be done. I hope it will inspire others to join us.



Michael R. Bloomberg
WHO Global Ambassador for
Noncommunicable Diseases and Injuries
Founder, Bloomberg Philanthropies

“As the tobacco industry finds new ways to push its deadly products, we must push back harder than ever – and we are. National and local governments continue to lead the fight and protect their citizens against the tobacco industry.”

“All people have a fundamental right to breathe clean air and governments are obliged to protect everyone’s health as a fundamental human right.”

Dr Rüdiger Krech, Director, Department of Health Promotion
World Health Organization



Foreword

Seventy-four countries are now covered by comprehensive smoke-free measures.

This ninth WHO report on the global tobacco epidemic demonstrates the remarkable progress of many countries in adopting health-promoting policies and reducing tobacco use – a risk factor that kills an astounding 8.7 million people every year. And even more shocking is that 1.3 million of these deaths are among people who do not use tobacco, including infants and children. Women and children in particular are vulnerable to second-hand smoke exposure.

This is why smoke-free environments are so important. All people have a fundamental right to breathe clean air and governments are obliged to protect everyone's health as a fundamental human right. Smoke-free environments save lives by reducing exposure to second-hand smoke as well as by bringing about changes in social norms. When smoking bans work, private spaces are more likely to become smoke-free, more smokers are motivated to quit and fewer children are tempted to try smoking.

The tobacco and related industries would have people, and especially business owners, believe that smoking bans are detrimental to tourism and the hospitality industry. This is not true – this myth has been debunked over and over again. When effectively enforced, businesses have been shown to thrive and the public, including smokers themselves, support, and even play a role in enforcing, smoke-free measures.

This brings to light the progress the world has seen in the adoption and implementation of smoke-free environments, and acts as a spur to accelerate this progress. It was difficult to imagine 20 years ago that as many as half of all countries would have smoke-free laws already in place to protect people in restaurants and bars. These measures are working but cannot be taken for granted. With the advent of new and emerging products, some of which are marketed to undermine smoke-free environment laws already in place, where they are not banned, countries must stand strong and ensure appropriate regulation of e-cigarettes and heated tobacco products is firmly in place.

We can do so much more to protect everyone from the harms of tobacco and second-hand smoke.



Dr Rüdiger Krech
Director,
Department of Health Promotion
World Health Organization

“When smoking bans work, private spaces are more likely to become smoke-free, more smokers are motivated to quit and fewer children are tempted to try smoking”

“Since the Convention’s entry into force in 2005, there has been significant progress, with 74 countries now completely smoke-free in all indoor public and workplaces, up from 10 in 2007. But we are far from universal implementation of Article 8.”

Dr Adriana Blanco Marquizo, Head of the WHO FCTC Secretariat



Foreword

Today, the Protocol has increased its number of Parties to a total of 66.

The Secretariat of the WHO Framework Convention on Tobacco Control (WHO FCTC) and its protocols welcome publication of the *WHO report on the global tobacco epidemic, 2023*.

This latest edition of the report – the ninth in the series – focuses on the “P” in the MPOWER measures – protect people from tobacco smoke through smoke-free environments. Some 1.3 million people die annually and many more become sick from the effects of exposure to second-hand smoke and the scientific evidence is clear: there is no safe level of second-hand smoke.

Article 8 of the WHO FCTC recognizes that “scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability” and requires Parties to adopt and implement measures “providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places”.

Since the Convention’s entry into force in 2005, there has been significant progress, with 74 countries now completely smoke-free in all indoor public and workplaces, up from 10 countries in 2007. But we are far from having universal implementation of Article 8.

Guidelines for implementation of Article 8 of the Convention, the first set of guidelines adopted by the Conference of the Parties (COP) to the WHO FCTC in 2008, set out the ways in which Parties can meet their obligations in this area, through evidence-based measures and Party experience, key means for tobacco control improvements. The Guidelines urge Parties to strive for universal protection within 5 years of entry into force of the Convention for the Party.

Furthermore, the Eighth session of the Conference of the Parties to the WHO FCTC adopted the Global Strategy to Accelerate Tobacco Control 2019–2025 in order to advance sustainable development through WHO FCTC implementation. Goal 1 of the Strategy calls for implementation of the time-bound measures, including Article 8.

Smoke-free environments – together with highly visible health warnings on tobacco packaging about the effects of tobacco consumption – are basic measures to ensure that people are not exposed to avoidable risks in public spaces and workplaces and that tobacco users are aware of the consequences of such consumption. These measures enjoy wide acceptance among populations, are not costly, and demonstrate a positive return on investment. Most importantly, they save lives.



Dr Adriana Blanco Marquizo
Head of the WHO FCTC Secretariat

“The scientific evidence is clear: there is no safe level of second-hand smoke.”

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Abbreviations

| | |
|-----------------|---|
| COP | Conference of the Parties |
| DSR | designated smoking room |
| ENDS | electronic nicotine delivery systems |
| ENNDS | electronic non-nicotine delivery systems |
| GATS | Global Adult Tobacco Survey |
| GYTS | Global Youth Tobacco Survey |
| HTP | heated tobacco product |
| MOP | Meeting of the Parties to the Protocol |
| NCD | noncommunicable disease |
| SDGs | Sustainable Development Goals |
| SHS | second-hand smoke |
| TAPS | tobacco advertising, promotion and sponsorship |
| THS | third-hand smoke |
| TII | tobacco industry interference |
| WHO | World Health Organization |
| WHO FCTC | World Health Organization Framework Convention on Tobacco Control |



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Summary

With over 8 million tobacco-related deaths a year, tobacco use continues to be one of the biggest public health threats and tobacco control remains a global health priority. This is the ninth *WHO report on the global tobacco epidemic* and the fifteenth year since MPOWER was introduced as a technical package designed to help countries implement the demand-reduction measures of the WHO Framework Convention on Tobacco Control. This report shows that, in 2022, more than 5.6 billion people – 71% of the world’s population – were covered by at least one MPOWER measure implemented at the highest level (Fig. 1).

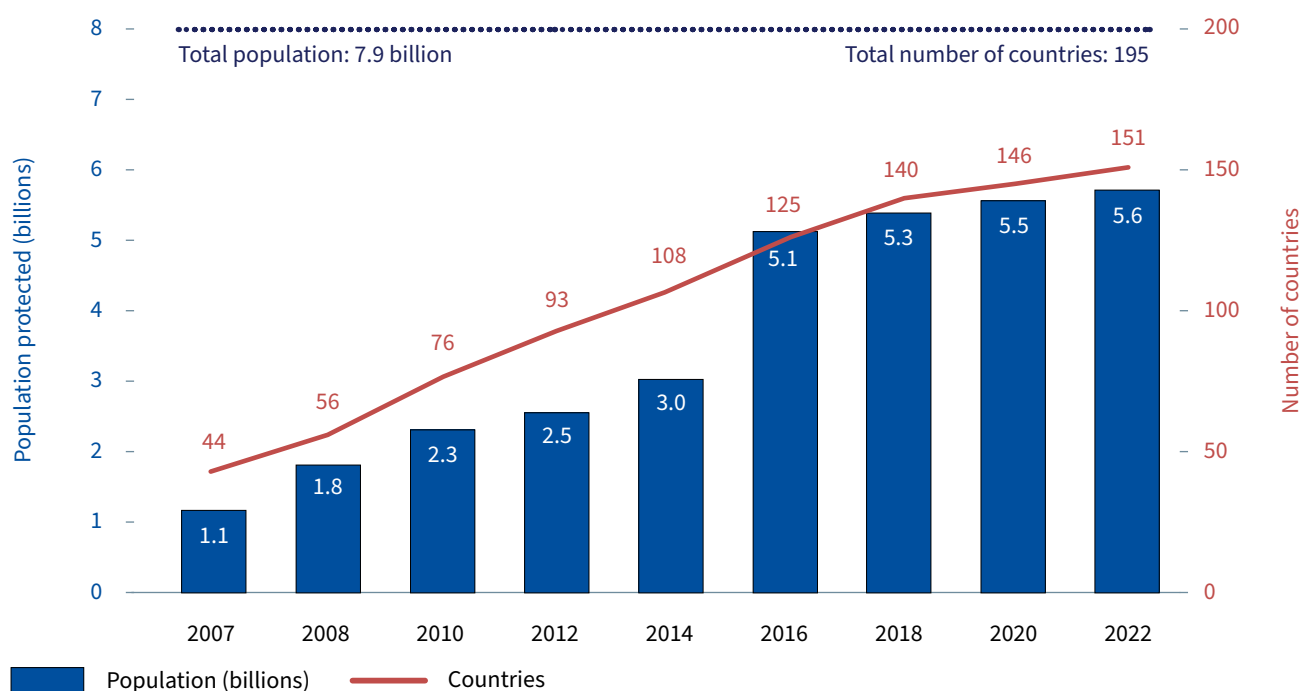
The number of countries with one or more MPOWER measure in place has more than tripled since 2007 – from 44 to 151 countries, and the number of countries with two or more MPOWER measures in place has increased almost 10-fold – from 11 to 101 countries (Fig. 2). Forty-eight countries have at least three policies in place, covering 1.5 billion people (see Annex 1).

Of the 44 countries that have not yet reached the highest level of achievement (or best-practice level, meaning they have achieved the criteria as described in Technical Note 1) for any MPOWER measure, 31 are just one level away from best-practice for one or more of their MPOWER measures.

While progress has been steady since 2007, the pace has certainly slowed since 2018. Since 2020, five countries that previously had no best-practice measures in place (Cabo Verde, Myanmar, Nicaragua, Sudan and Zambia) have reached the highest level of achievement on one or more measures. All five countries are low- or middle-income countries.

5.6 billion people, over 70% of the world’s population, are now covered by at least one MPOWER measure at the highest level of achievement.

Fig. 1. At least one MPOWER measure at highest level of achievement (2007–2022)



Smoke-free measures must be scaled up to protect people from a major cause of health burden

Protecting people from tobacco smoke – the “P” of the MPOWER measures – is the focus of this ninth *WHO report on the global tobacco epidemic* and is a crucial component of the MPOWER package. Smoke-free measures in public indoor areas are highly cost-effective interventions that not only protect non-smokers from the many dangers of second-hand tobacco smoke but also “denormalize” the act of smoking and can increase smokers’ motivation to try to quit.

Complete smoke-free indoor public places, workplaces and public transport now cover 2.1 billion people living in 74 countries. This is a seven-fold increase since 2007 and means that smoke-free environments comprise the second most adopted MPOWER measure in terms of the number of countries covered. Over the

15 years since monitoring MPOWER progress began, almost 2 billion people have been newly protected by laws mandating 100% smoke-free environments.

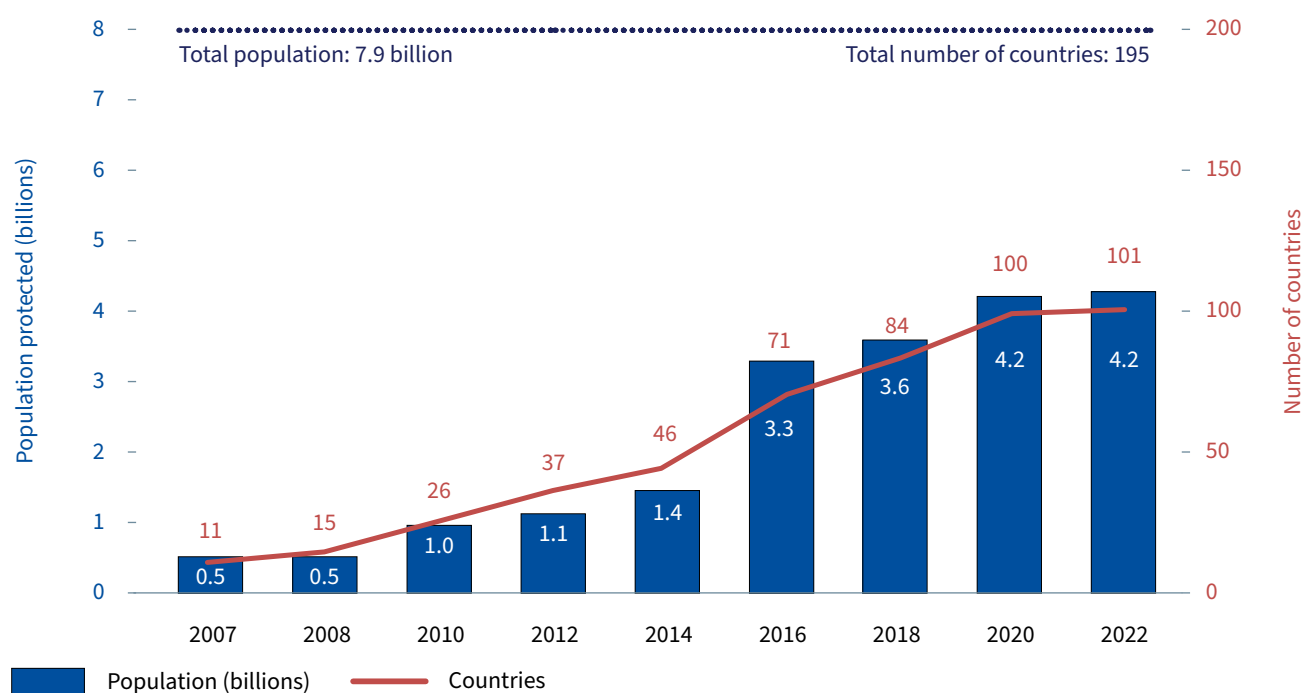
Despite the evidence demonstrating that designated smoking areas or rooms (DSRs) do not help to protect people in public indoor areas, 71 countries continue to allow them in many venues, and especially in hospitality-based venues such as restaurants, bars and cafés. Simply by removing these provisions, 39 of these countries would immediately achieve best-practice status.

Reported compliance is highest in health care and educational facilities and lowest in pubs, bars and cafés, followed by universities and restaurants (see Annex 2.1–2.3). To ensure compliance, countries must ensure enforcement mechanisms are established and followed. While almost all countries (87% or 170 countries) prescribe fines for violations of smoking bans, less than one third of countries have dedicated funds for enforcement.

Eight countries are only one measure away from achieving all MPOWER measures at the highest level of achievement

Of the 101 countries now covered by at least two MPOWER measures, 36 have three measures at the highest level of achievement, and eight countries have four measures at the highest level of achievement (Ethiopia, the Islamic Republic of Iran, Ireland, Jordan, Madagascar, Mexico, New Zealand and Spain). Meanwhile, the total number of countries that have adopted all of the MPOWER measures at best-practice level has increased by two since the last report, which sees Mauritius and the Netherlands (Kingdom of the) welcomed to this rank achieved by Brazil and Türkiye (see Annex 3, Annex 4).

Fig. 2. At least two MPOWER measures at highest level of achievement (2007–2022)



Over the last 15 years, the number of countries covered by comprehensive smoke-free environments has increased from 10 in 2007 to 74 in 2022.

More than two billion people remain unprotected by any of the MPOWER measures at best-practice level

All countries can adopt and implement comprehensive tobacco control policies to prevent the immense burden imposed by tobacco use and exposure to second-hand smoke. Yet, in 2022, 44 countries had not yet adopted a single MPOWER measure at best-practice level, leaving 2.3 billion people vulnerable to the harms of tobacco.

Progress in tobacco control continues but must be accelerated

In 2022, the MPOWER measure that saw the most progress was banning tobacco advertising, promotion and sponsorship (TAPS), with seven countries reaching the highest level of achievement, covering a population of 246 million additional people since 2020. Although TAPS bans remain an under-adopted measure, almost 2 billion people in 66 countries are now covered.

High-income countries are lagging when it comes to reaching best-practice on TAPS bans, with only 15 out of 60 high-income countries reaching this level (25% of all high-income countries). By contrast, 38 out of 106 middle-income countries (36%) and 13 out of 28 low-income countries (46%) have achieved best-practice level.

Graphic health warning policies at the highest level of achievement have been adopted by 103 countries. This means that more than 4.5 billion people (or 57% of the world's population) are now protected by large graphic pack warnings featuring all recommended characteristics, making it the MPOWER measure with both the highest population coverage and the largest number of countries covered. It is also important to note that by the end of 2022, 22 countries had adopted legislation mandating plain packaging for tobacco products and had issued regulations with implementation deadlines. A handful of other countries have required plain packaging by law but have not yet issued rules for implementation.

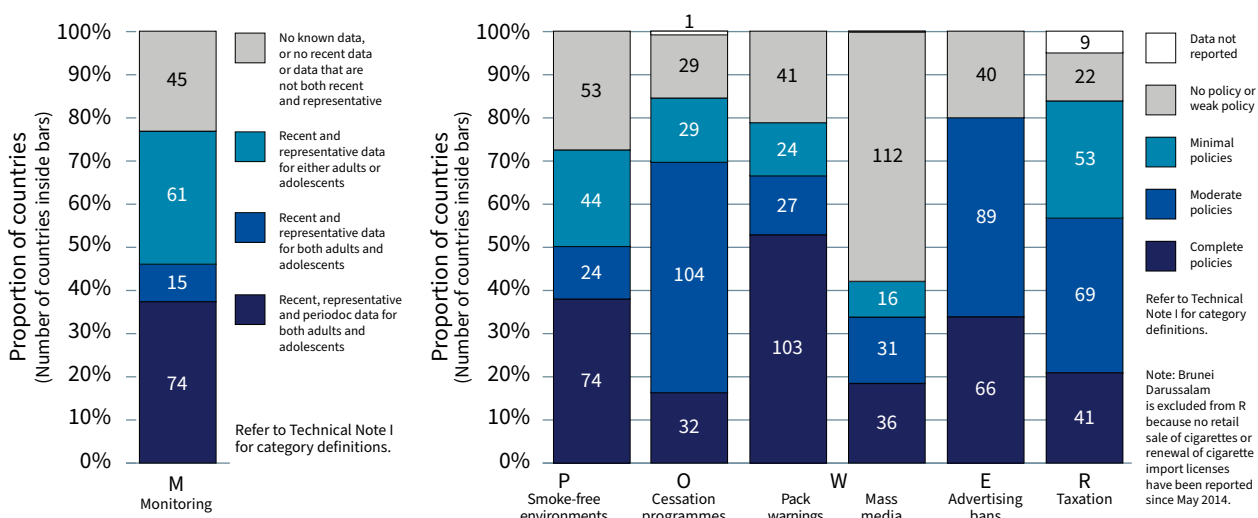
Few countries have policies on cessation services, with only 32 countries providing such services at best-practice level, covering almost 2.8 billion people.

Six countries have reached best-practice level since 2020, covering an additional 260 million people. Although this measure is adopted by very few countries, these countries are home to more than one third of the world's population, making it the second most adopted MPOWER measure in terms of population covered.

Monitoring tobacco use, unfortunately, continues to be significantly hampered by the COVID-19 pandemic. Data collection efforts were hindered in many countries during 2020 to 2022, as was the release of results for surveys completed before and during the pandemic. A total of 74 countries achieved the highest level of achievement for monitoring tobacco use in 2022, down from a peak of 82 in 2014.

While raising prices through taxation is the most effective way to reduce tobacco use, this measure has been slow to progress. A large increase in population coverage by this measure was observed between 2016 and 2018 (from 8% in 2016 to 13% in 2018), but since then, the proportion of the world's population protected by taxes at best-practice level has dropped slightly to 12% in 2022. Fig. 3 shows the overall status of selected tobacco control policies globally.

Fig. 3. The state of selected tobacco control policies in the world, 2022



Countries across the world continue to adopt MPOWER measures at a steady pace

Each MPOWER measure has been newly adopted at best-practice level by additional countries since 2020.

- Three countries (Belarus, El Salvador and Mauritius) improved monitoring to best-practice level.
- Five countries (Kyrgyzstan, Mauritius, Mexico, Netherlands (Kingdom of the), and Ukraine) newly adopted complete smoke-free laws covering all indoor public places, workplaces and public transport.
- Six countries (Ethiopia, Iran (Islamic Republic of), Israel, Mauritius, Romania and Zambia) advanced to best-practice level with their tobacco use cessation services.
- Two countries (Benin and Myanmar) adopted large graphic pack warnings.
- Seven countries (Cabo Verde, Kyrgyzstan, Lao People's Democratic Republic, Mexico, Netherlands (Kingdom of the), Sudan and Ukraine) introduced comprehensive bans on tobacco advertising, promotion and sponsorship, including at point-of-sale.
- Four countries (Australia, Lithuania, Nicaragua and Vanuatu) moved to the best-practice group by levying taxes that comprise at least 75% of retail price.

Two billion people are still unprotected by any regulatory restrictions on electronic nicotine delivery systems (ENDS)

The previous *WHO report on the global tobacco epidemic* showed how MPOWER measures could be applied to ENDS and called on countries to regulate ENDS to protect their populations. This new report highlights the fact that 121 countries regulate ENDS in some way. Thirty-four of these countries (covering 2.5 billion people) ban the sale of ENDS, and the other 87 countries have adopted (partially or completely) one or more legislative measures to regulate ENDS, covering 3.3 billion people. The current regulatory options taken by 87 countries include a wide range of measures with no globally common approach to address these products.

Seventy-four countries (seven fewer than in 2020) still have no ENDS ban or regulations in place, leaving over 2 billion people particularly vulnerable to the activities of the tobacco and related industries.

Particularly relevant to smoke-free environments, only 42 countries completely ban the use of ENDS in all indoor public places, workplaces and public transport (although this is an improvement on the 36 countries with the presence of such bans in 2020).

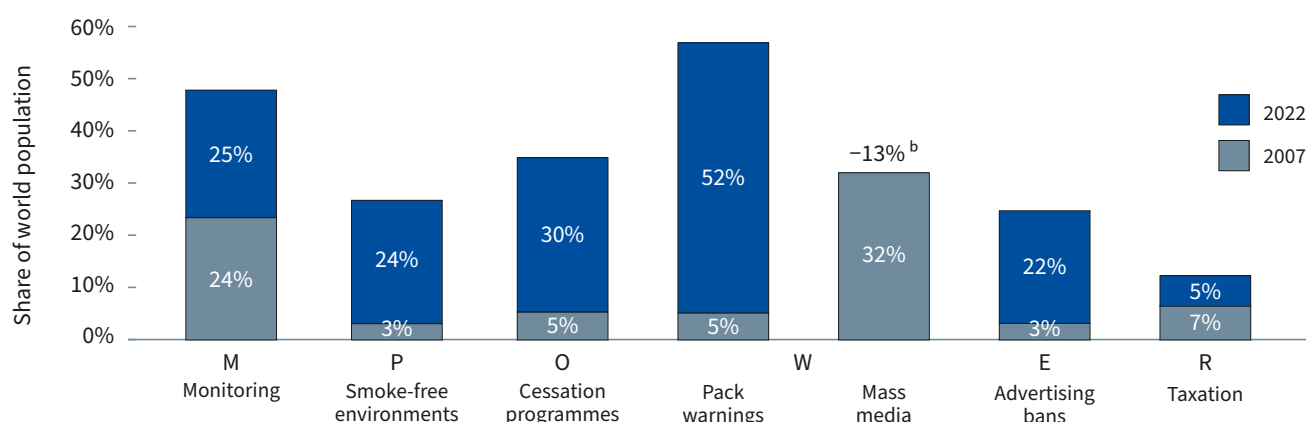
Only 23 countries comprehensively ban the advertising, promotion and sponsorship of both ENDS devices and e-liquids. An additional five countries apply these bans only to the devices, while three countries apply them only to the e-liquids.

ENDS marketing targets children and young people through a number of tactics, including making ENDS available with many enticing flavours. Astonishingly, very few countries have measures in place to protect children from ENDS. Only four countries now ban all flavours while nine others restrict or allow specific flavours, and 88 countries, covering a population of 2.3 billion people, have no minimum age at which ENDS may be purchased.

15 years of MPOWER have made a major impact on global tobacco control

Since 2007 and the launch of the MPOWER technical package, all MPOWER measures have made notable progress. Fig. 4 illustrates how graphic health warnings have made the most progress compared with the other measures, protecting an additional 52% of the world's population since 2007, while offering cessation services, successfully adopted in some populous countries like India, is second with an additional 30% of the global population protected since 2007. Tobacco taxation has been the slowest measure to progress, with only an additional 5% of the population covered in the last 15 years.

Fig. 4. Increase in the world population covered by selected tobacco control policies, 2007^a to 2022



^a 2010 for W mass media, 2008 for R taxation.

^b The share of the world's population covered by mass media campaigns decreased since 2010.

Four countries have now achieved the full MPOWER package at best-practice level, and an additional eight countries need only to attain one more measure before they have the full MPOWER package.



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1. The WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products

Introduction to the WHO FCTC and Protocol

The WHO Framework Convention on Tobacco Control (WHO FCTC) and the Protocol to Eliminate Illicit Trade in Tobacco Products are evidence-based, legally binding international instruments. With 182 and 67 Parties respectively as at June 2023 (Annex 5), these treaties are unifying frameworks for intergovernmental cooperation and are fundamental to combatting the global tobacco epidemic and upholding the right of all people to the highest attainable standard of health.

Since its entry into force on 27 February 2005, the WHO FCTC has included a core set of mutually reinforcing obligations to reduce the demand for, and supply of, tobacco products (see Table 1). The implementation of these measures is supported by an equally important set of general obligations for advancing progress and cooperation on tobacco control locally, nationally, regionally and globally. Of these, Article 5.3 and its Guidelines for implementation provide crucial safeguards against tobacco industry influence over, and interference in, tobacco control policies. These general obligations are reinforced by other measures such as Article 19 on liability, which innovatively targets the industry's deceptive, profit-driven tactics.

The Protocol, which entered into force on 25 September 2018, focuses on eliminating illicit trade in tobacco products. It was developed to build on Article 15 of the Convention in recognition of the complexity of addressing illicit trade, its significant contribution to the global tobacco epidemic, and the threat it poses to key demand-reduction measures (especially price measures and health warnings).

The Protocol provides a framework for international cooperation, including on global tracking and tracing, and prescribes a comprehensive set of measures, such as supply-chain control and due diligence obligations, to combat the illicit tobacco market.

Update on COP9 and MOP2

In November 2021, the Ninth Session of the Conference of the Parties to the WHO FCTC (COP9) and the Second Session of the Meeting of the Parties to the Protocol (MOP2) were held.¹

A major outcome was the Declaration on the WHO FCTC and recovery from the Coronavirus disease (COVID-19) pandemic, which called for measures to prevent tobacco industry efforts to exploit the public health emergency as a means of furthering its own interests and undermining tobacco control measures (1). It emphasized the deadly interplay between tobacco use and COVID-19, with the former having exacerbated both COVID-19 risk and severity during the pandemic, which in turn increased health system vulnerability. It also emphasized the importance of fully implementing the WHO FCTC as a means of addressing the vulnerabilities which underlay the crisis, achieving the Sustainable Development Goals (SDGs) and overcoming the devastation caused by the pandemic. At MOP2, Parties adopted the Decision on assistance and cooperation, which reinforced the indispensability of mutual assistance and international cooperation in enforcement, investigation and prosecution, and also in administrative, legislative and scientific domains for the achievement of the Protocol's objectives. In particular, it mandated the Convention Secretariat to facilitate cooperation

between Parties and offer technical assistance to Parties implementing the Protocol. It also highlighted the need for Parties and the Convention Secretariat to collectively establish mechanisms and procedures for sharing experiences, best practices and other information on the implementation of the Protocol.

At both COP9 and MOP2, the Parties adopted decisions for establishing the WHO FCTC Investment Fund and the Protocol Investment Fund. These new financing mechanisms will provide sustainable funding for the implementation the WHO FCTC and the Protocol in alignment with COP and MOP decisions, workplans and budgets.

WHO FCTC progress report

WHO FCTC implementation is aligned with the COP-adopted Global Strategy to Accelerate Tobacco Control (Global Strategy 2025) and contributes to the achievement of the SDGs. SDG Target 3.a calls for the strengthening of the implementation of the WHO FCTC in all countries to reduce tobacco use and its related health, social, and economic impacts. In line with the strategy, as well as Article 21 of the WHO FCTC and Article 32 of the Protocol, the Convention Secretariat produces a biennial progress report on implementation for each treaty – the Global progress report on implementation of the WHO FCTC – which provides an overview of the status of the Convention's implementation.

¹ The COP and MOP are the governing bodies for, respectively, the WHO FCTC and the Protocol. They are the sole bodies for authoritative interpretations of their respective treaties with responsibilities for reviewing and guiding their implementation, adopting measures in response to emerging issues, and fostering international cooperation.

Table 1. Key WHO Framework Convention on Tobacco Control provisions

| | |
|---|--|
| <p>Demand-reduction measures</p> | <p>Article 6: Price and tax measures to reduce the demand for tobacco</p> <hr/> <p>Article 8: Protection from exposure to tobacco smoke</p> <hr/> <p>Article 9: Regulation of the contents of tobacco products</p> <hr/> <p>Article 10: Regulation of tobacco product disclosures</p> <hr/> <p>Article 11: Packaging and labelling of tobacco products</p> <hr/> <p>Article 12: Education, communication, training and public awareness</p> <hr/> <p>Article 13: Tobacco advertising, promotion and sponsorship</p> <hr/> <p>Article 14: Demand-reduction measures concerning tobacco dependence and cessation</p> |
| <p>Supply-reduction measures</p> | <p>Article 15: Illicit trade in tobacco products</p> <hr/> <p>Article 16: Sales to and by minors</p> <hr/> <p>Article 17: Provision of support for economically viable alternative activities</p> |
| <p>General obligations</p> | <p>Article 4: Guiding principles</p> <hr/> <p>Article 5: General obligations</p> <ul style="list-style-type: none"> ■ 5.1: Comprehensive multisectoral, national tobacco control strategies, plans and programmes ■ 5.2: National coordinating mechanism or tobacco control focal point ■ 5.3: Protecting tobacco control policies from the tobacco industry's commercial and vested interests |
| <p>Other measures</p> | <p>Article 18: Protection of the environment and the health of persons</p> <hr/> <p>Article 19: Liability</p> <hr/> <p>Article 20: Research, surveillance and exchange of information</p> <hr/> <p>Article 21: Reporting and exchange of information</p> <hr/> <p>Article 22: Cooperation in the scientific, technical and legal fields and provisions of related expertise</p> |

The data collection underpinning the report also supports monitoring of progress on the indicators set out in the Global Strategy 2025. By disaggregating progress on each of the core articles of the WHO FCTC (5, 6, 8, 11 and 13) into various indicators, the report illustrates the comprehensiveness of progress made by the Parties. The latest report (2021) shows that while implementation rates of individual measures are high, many measures are not implemented in full. Parties report that Articles 5 and 11 are the most advanced while Article 13 is the least advanced.

The report also highlights challenges in implementation of Articles 17, 18 and 19 on economically viable alternatives to tobacco, environmental protection, and industry liability.

Protocol progress report

The 2021 *Global progress report on implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products* was the first of its kind and provides an overview of progress made by Parties. It also focuses in on key

provisions for evaluation, including those related to licensing, tracking and tracing, law enforcement, and international cooperation. It notes that most Parties remain at early-stage implementation, with progress very uneven among the various Parties and elements of individual articles. With respect to establishing tracking and tracing systems, almost half of respondent Parties confirmed some level of implementation. The greatest level of progress was found in measures relating to licensing and control, proscribing unlawful conduct and establishing prosecution and sanctions.

The most underreported measure was international cooperation. It is important to take this into account since the key barriers to progress reported by Parties, such as insufficient technical capacities and financial resources, could be addressed through improved international cooperation.

Highlights for COP10 and MOP3

To guide and maintain momentum on implementing the WHO FCTC and the Protocol, the upcoming COP10 will take place in Panama in November 2023 under the theme “Together, promoting healthier lives”, which reflects the extent to which success in tobacco control hinges on partnership and cooperation across the whole of society, government, and the world. The theme for MOP3 is “More Parties, greater traceability, less illicit trade”, which emphasizes the significance of rising numbers of Parties to the Protocol and the establishment of a global tracking and tracing regime, and the need for the Protocol’s reach to be expanded further. Key areas of focus at COP10 include tobacco product regulation, forward-looking tobacco control measures in relation to Article 2.1 of the WHO FCTC, and implementation of Article 19 of the WHO FCTC. These and all discussions at the meeting will be guided and informed by the Global Strategy 2025 as well as the findings of the recent WHO FCTC progress report.

Tobacco product regulation to be COP10 highlight

Tobacco product regulation is set to be a highlight with an emphasis on developing and implementing evidence-based measures to reduce the appeal, addictiveness, and toxicity of tobacco products – in line with Articles 9 and 10 as well as the Partial Guidelines for implementation of Articles 9 and 10. As set out in the recent progress report, these two are among the least

implemented of the WHO FCTC’s substantive articles despite evidence of encouraging progress on key measures for each article. Accordingly, this focus will provide an opportunity to bridge the implementation gap.

Additionally, COP10 is scheduled to address forward-looking tobacco control measures in relation to Article 2.1 of the WHO FCTC, which stipulates Parties are not confined to the provisions of the WHO FCTC and are thus not prevented from imposing stricter requirements than those it contains. This encourages and empowers Parties to implement novel measures to accelerate progress in tobacco control such as tobacco-free generation policies, which aim to prevent entire generations from ever initiating tobacco use, and other end-game approaches for eliminating tobacco consumption all together using strategies for de-nicotinization and policies for restrictions on retail availability, among others.

COP10 to raise tobacco industry accountability

It is also anticipated that COP10 will grapple with measures that require tobacco industry accountability for the impact of their products – in line with Article 19. Industry accountability encompasses past, present and future loss of life, detriment to health, loss of productivity, health care expenses, health system fragility, exacerbation of the COVID-19 pandemic, occupational health hazards, and environmental damage.

Finally, the COP’s agenda is likely to feature items on the tobacco industry’s new strategies for evading and undermining tobacco control. Such strategies include novel and redesigned tobacco and nicotine products; and marketing tactics and misinformation campaigns to circumvent regulations, maintain existing customers, and extend reach to younger generations. The ever-evolving nature of tobacco industry tactics will make COP10 oversight over these strategies invaluable.

WHO FCTC and measures to protect people from tobacco smoke

Overview of Article 8 and related articles

The focus of this report, implementing smoke-free environments, aligns with Article 8 of the WHO FCTC. This Article mandates Parties to adopt and implement effective legislative, executive, and administrative measures to protect people from exposure to tobacco smoke. COP decisions to date aim to provide guidance and support for Parties in implementing Article 8 and achieving its objectives. In the 2021 *Global progress report on implementation of the WHO FCTC*, the majority of Parties reported some level of implementation of Article 8 provisions but they reported a much lower rate of implementation when it came to comprehensive implementation of all key measures under Article 8. This shows considerable room for progress.

Retrospective of COP decisions pertaining to “P”

Since the adoption of the WHO FCTC, several decisions have been taken by the COP in relation to Article 8 and the protection of people from exposure to tobacco smoke. The importance of this Article and the high priority it has been accorded is reflected in how –at the first meeting of the COP – the Parties approved templates for the elaboration of guidelines for the implementation of Article 8 and requested the Convention Secretariat to initiate work on these guidelines (2). Consequently, the Guidelines for implementation of Article 8 were the first adopted by the COP (at only its second meeting) for any WHO FCTC article (3).

The Guidelines for implementation of Article 8 provide a comprehensive framework for the design and implementation of measures to universally protect people from exposure to tobacco smoke. They emphasize the importance of adopting a comprehensive approach, including

the establishment of 100% smoke-free environments, public education and awareness-raising campaigns, and monitoring and enforcement mechanisms. They make explicit that the language of Article 8 provides for further evidence-informed measures that extend protections to settings beyond those in its non-exhaustive list.

The Guidelines for implementation of Article 8, alongside the content of other guidelines, make clear the necessity of Article 8's comprehensive implementation alongside other interdependent WHO articles (4). In particular, package and labelling warnings (Article 11) and awareness raising (Article 12) shift behavioural norms to reinforce the effectiveness of regulation in protecting people from exposure to tobacco smoke, while going further to protect people in private spaces who are outside the realm of even the most comprehensive regulatory approaches (4–6). This is important because exposure to tobacco smoke occurs most in private settings, such as homes, with a disproportionate impact on women and children (4). Progress with any of these articles also enables advances

in other articles, since they generally fall within the jurisdiction of ministries of health and are implementable by decree or other executive decision. Both their substantive and procedural interconnection emphasize the need for a comprehensive approach, integrating smoke-free environments with health warnings and labelling regulations, as well as public awareness raising, to strengthen the overall impact of tobacco control measures.

Decisions relating to heated tobacco products (HTPs)

HTPs are tobacco products that produce aerosols containing nicotine and other chemicals by heating tobacco units (7). In 2018, COP8 recognized that HTPs “are tobacco products and are therefore subject to the provisions of the WHO FCTC” (8). Since their emergence, HTPs have been marketed by the tobacco industry with health and cessation claims that are not supported by independent, robust evidence (9). One main health claim is that they do not combust tobacco or produce smoke and that this makes them “reduced risk” products (8). At COP8, the Parties

recognized that these claims and the properties of HTPs “may pose regulatory challenges regarding their definition and classification ... and that these may pose challenges for the comprehensive application of the WHO FCTC”. In the Decision, Parties noted the particular challenge for smoke-free legislation and requested that all Parties prioritize particular measures, including protecting “people from exposure to their emissions” and explicitly extending “the scope of smoke-free legislation to these products in accordance with Article 8 of the WHO FCTC”(8).

In response to the issues around classifying the emissions of HTPs, the Convention Secretariat and WHO were requested to examine and report back at COP9 on the health impacts of HTP emissions for non-users and related challenges for the application of the parts of the WHO FCTC and its guidelines that refer to tobacco smoke (8). The resulting report concluded that the aerosols commonly emitted by HTPs do fall under the definition of tobacco smoke (9). It was further detailed that the evidence shows that non-users are exposed to toxicants from HTP emissions (9, 10).



The plenary discussions during the Ninth Session of the Conference of the Parties (Hybrid format).

Decisions relating to ENDS

ENDS and electronic non-nicotine delivery systems (ENNDS) do not necessarily contain tobacco and instead vaporize a solution composed of numerous compounds, which include nicotine in the case of ENDS, or may not contain nicotine in the case of ENNDS. Their emissions do include toxicants and exposure to them poses risks to non-users (11). COP6 set out the basic objectives to be pursued in addressing ENDS/ENNDS including the protection of non-users from exposure to their emissions (12). At COP7, Parties were also invited to apply regulatory measures to prohibit or restrict the manufacture, import, distribution, presentation, sale and use of ENDS/ENNDS, as appropriate. Parties that have not totally banned those products were invited to follow a non-exhaustive list of regulatory options for pursuing the objectives set out in the COP6 decision – provided in a report prepared by WHO – that were endorsed for consideration by the Parties (11, 12). Such regulation entails the application of many of the WHO FCTC’s measures for ENDS/ENNDS, prominently including minimizing exposure to emissions by prohibiting their use in indoor spaces and other places where smoking is not permitted and requiring health warnings about their risks – in line with Articles 8 and 11 (11).

The growing power of Article 8 to protect from tobacco

Article 8 of the WHO FCTC is a critical element of global tobacco control efforts that protect our right to health and is the focus of the *WHO report on the global tobacco epidemic, 2023*. It corresponds to “MPOWER measure P” – “protect from tobacco smoke” – and extends protection to many of the most vulnerable groups in society. To be fully effective, these protections need to be mandated and enforced across a wide range of settings and need to be implemented as part of a comprehensive package alongside other complementary measures (such as Articles 11 and 12 in the WHO FCTC that correspond to the “W” MPOWER measure – “warn about the dangers of tobacco”). In designing and implementing measures to protect people from tobacco smoke, the WHO FCTC and related COP decisions and guidelines provide a crucial resource and support.

The second *WHO Report on the global tobacco epidemic*, in 2009, also had “P” as its focus. This reflects the importance of the measure for saving and improving lives as well as how feasible and acceptable it is for implementation. However, despite this prominence under both MPOWER and the COP’s own agenda, various challenges and successes have emerged in implementing Article 8, including lack of political will and resources to move

beyond superficial measures and ensure comprehensive enforcement. Recent data, however, show the considerable benefits of implementing MPOWER measures and the demand-reduction provisions of the WHO FCTC, including Article 8, with a rate of return of US\$ 7.11 for every dollar invested (13). This emphasizes the importance of sustained commitment, investment, and support from Member States and Parties in, respectively, using the MPOWER package and in advancing the Convention’s implementation.

Urgent need to do more with Article 8

As has been shown, despite significant progress since the WHO FCTC came into force 18 years ago and since MPOWER was established 15 years ago, implementation of Article 8 and of “P” remains insufficient in many countries as shown by both this report and the 2021 progress report. There is, accordingly, an urgent need to seize the moment to make progress on this foundational measure. It is, out of all the WHO FCTC Articles, evidently among the most feasible to implement at a low-cost across a variety of national settings. It is also among the Articles with the most expansive and rich evidence base to support both the benefits of smoke-free environments and the absence of negative effects. Urgent efforts are crucial to ensure the timely and successful implementation of Article 8 and other related WHO FCTC provisions.

Article 8 of the WHO FCTC is a critical element of global tobacco control efforts that protect our right to health.



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2. 15 years of MPOWER progress

“MPOWER was designed to catalyse global action on tobacco control. In protecting over 5 billion people, I am proud to say that it has delivered on its promise. But it is a promise that must be kept. We must continue to prioritize tobacco control to protect the health of billions more people in the future.”



Dr Margaret Chan
Former WHO Director General (2007-2017)
Dean of Vanke School of Public Health,
Tsinghua University

“The tobacco industry infiltrates our lives from so many doors. MPOWER tools and measures work to close off all doors. That is why the full power of MPOWER is only unleashed when countries fulfill all measures. I urge all to act fast before the tobacco industry reverses all our efforts in protecting our populations and in unburdening our health systems.”



HRH Princess Dina Mired of Jordan
Past President Union For International
Cancer Control (UICC)
Former Director General of the King Hussein
Cancer Foundation (KHCF)

“The original motivation for MPOWER was to obtain change rather than be a monitoring exercise alone. It was designed to measure progress and enable national governments to compare their policies with other countries; to complement the WHO FCTC; and to offer a practical roadmap for implementing key anti-tobacco measures.

Importantly, MPOWER also includes jurisdictions not Parties to the WHO FCTC.

MPOWER has exceeded its initial goals and is an invaluable tool: reader-friendly maps, charts and graphics help translate hundreds of tobacco statistics into easily understood formats.”



Dr Judith Mackay
Asian Consultancy on Tobacco Control
Special Advisor to WHO FCTC Secretariat's
Knowledge Hub on Article 5.3
Honorary Professor University of Hong Kong

4 countries

with **all MPOWER measures** at best-practice level

8 countries

with **only one more measure** to go to achieve the full MPOWER package

36 countries

with **only 2 more measures** to go to achieve the full MPOWER package

300 million

fewer smokers today than if the rates in 2007 had never declined

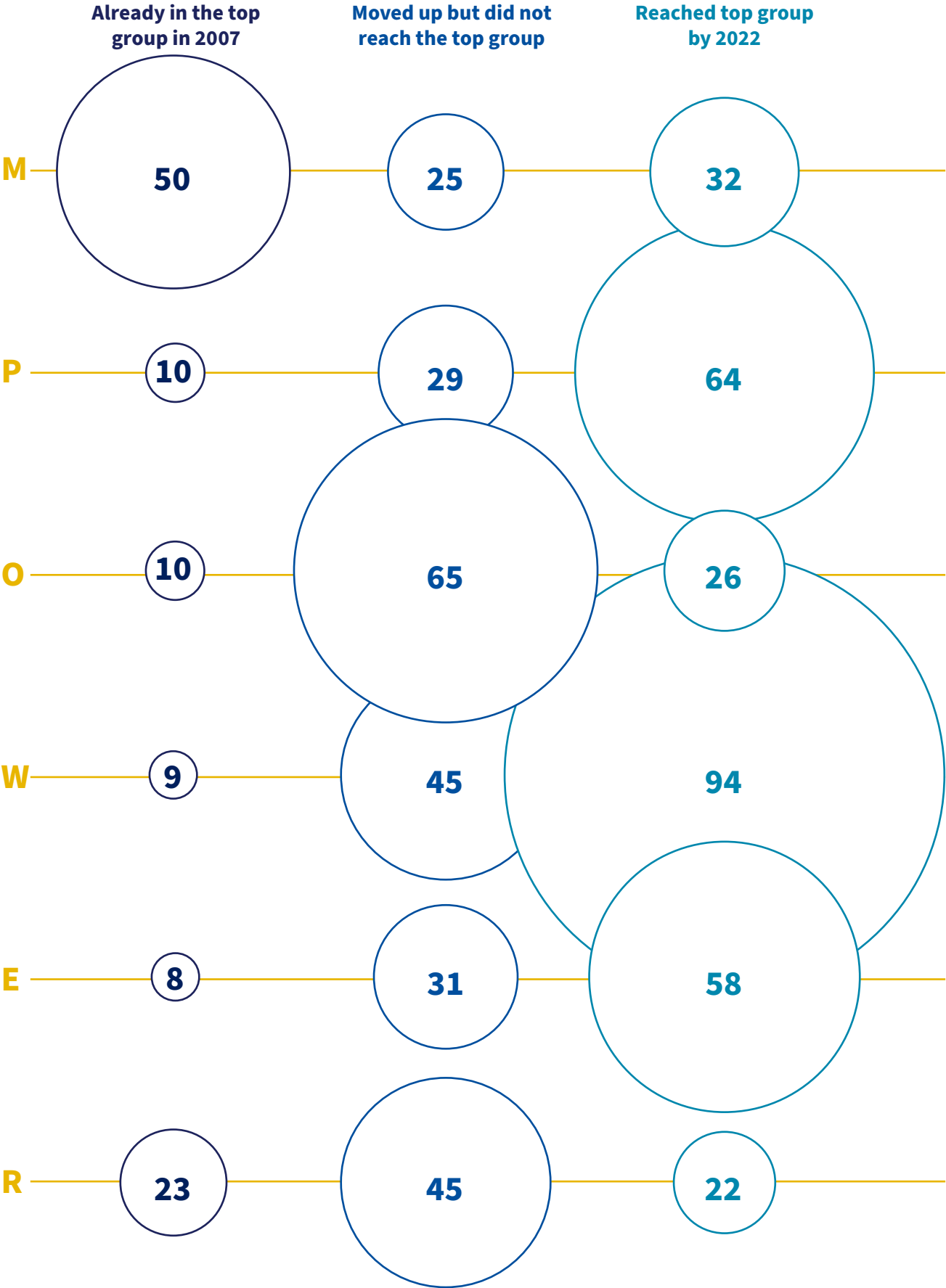
More and more countries are achieving best-practice level across all MPOWER measures. Today, 44 countries only have one or two more measures to adopt before they achieve the full MPOWER package (see Fig. 5 and Fig. 6).



“No treaty, no set of public health solutions, has saved more lives, more quickly than the WHO Framework Convention on Tobacco Control and the MPOWER package designed to help countries implement it. It is because the MPOWER package provides a legally enforceable proven road map of concrete, evidence-based measures whose benefits have been and continue to be demonstrated in the real world across different political systems and cultures and on every continent. Fifteen years after the adoption of the MPOWER package one thing can be said with certainty: MPOWER has saved lives in every country where one or more components of MPOWER have been adopted.”

Matthew L Myers
President
Campaign for Tobacco-Free Kids

Fig. 5. Countries that moved up one or more categories, by MPOWER measure 2007–2022



All MPOWER measures are evidence-based and highly cost-effective across all country income levels. As a result, all MPOWER measures are recognized as NCD Best-Buy interventions in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030 (14).



“In Thailand we use the MPOWER package to communicate effectively the best-buy tobacco control strategies. I feel the global tobacco control community should all express our thankfulness to those who ingeniously created this invaluable communication tool.”

Dr Prakrit Vathesatogkit
Secretary General
Action on Smoking and Health Foundation
Thailand (ASH Thailand)
Recipient of the MPOWER Award 2009



“MPOWER brought needed structure to global tobacco control, guiding what we do and helping to track what we have done. MPOWER’s persistence for 15 years speaks to its utility.”

Dr Jonathan M Samet
Dean and Professor
Colorado School of Public Health

MPOWER MEASURES are designed to work together to reach the goal of reduced tobacco use and healthier populations

Reduced tobacco use and improved health impact

Protecting non-smokers from tobacco smoke

Motivating and supporting smokers to quit

Preventing the uptake and initiation of tobacco use

MPOWER



“We have come a long way and WHO’s global tobacco control report has been there to document our journey toward freeing the world from the harms of tobacco. Today, 5.6 billion people are protected by at least one best-practice WHO MPOWER measure, five times more than 15 years ago. This means fewer children buying cigarettes, fewer people breathing harmful second-hand smoke, and some 35 million lives saved. We are proud to have been part of the team that developed MPOWER and championed it over the years.”

José Luis Castro
President & Chief Executive Officer
Vital Strategies



“MPOWER enabled us to focus attention and resources on high-impact interventions that include advertising and sponsorship bans, bans on smoking in public places, enforcement of warnings on cigarette packs and raising taxes. These are areas that many African countries have now recorded successes and we attribute that to the clarity provided by MPOWER.”

Dr Akinbode Oluwafemi
Executive Director
Corporate Accountability and Public
Participation Africa (CAPPA)
Recipient of the MPOWER Award 2009



“MPOWER, as a means of operationalizing the WHO FCTC, has been instrumental in reducing tobacco use and the massive harm it causes globally. As a recent *Lancet* comment highlights, while the burden of tobacco-related disease remains unacceptably high, progress to date has been enormous. The single greatest barrier to progress remains the tobacco industry.

Fully addressing tobacco industry interference as outlined in Article 5.3 and its Guidelines will be key to enabling full implementation of the MPOWER measures and preventing millions more totally avoidable profit-driven deaths.”

Professor Anna Gilmore
Professor of Public Health & Director
Tobacco Control Research Group (TCRG)
Department for Health, University of Bath

“The tobacco industry has an arsenal of vile tactics to undermine, frustrate and sabotage legitimate and effective tobacco control measures. It refuses to stop. Monitoring the industry is crucial to expose these forms of industry interference in public policy. Evidence is our fire power to protect public health.”

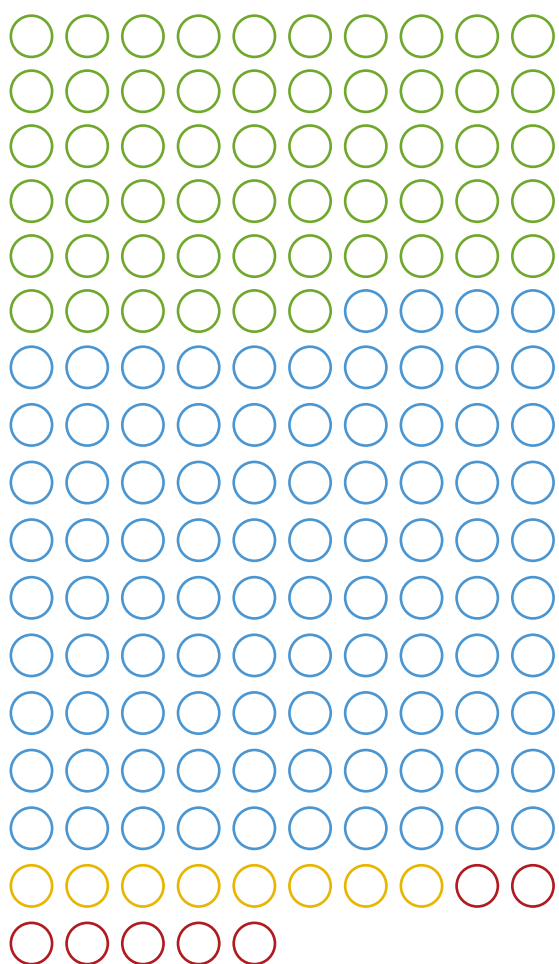


Dr Mary Assunta

Head, Research and Advocacy,
Global Center for Good Governance in Tobacco Control.

Senior Policy Advisor
Southeast Asia Tobacco Control Alliance (SEATCA)

Fig. 6. Countries on track to achieving the global target of a 30% relative reduction in tobacco use by 2025



56

If current trends continue, the **voluntary target of a 30% relative reduction between 2010 and 2025 is likely to be achieved**

94

Likely to achieve a decrease in prevalence between 2010 and 2025 but, if current trends continue, **not likely to achieve the 30% relative reduction voluntary target**

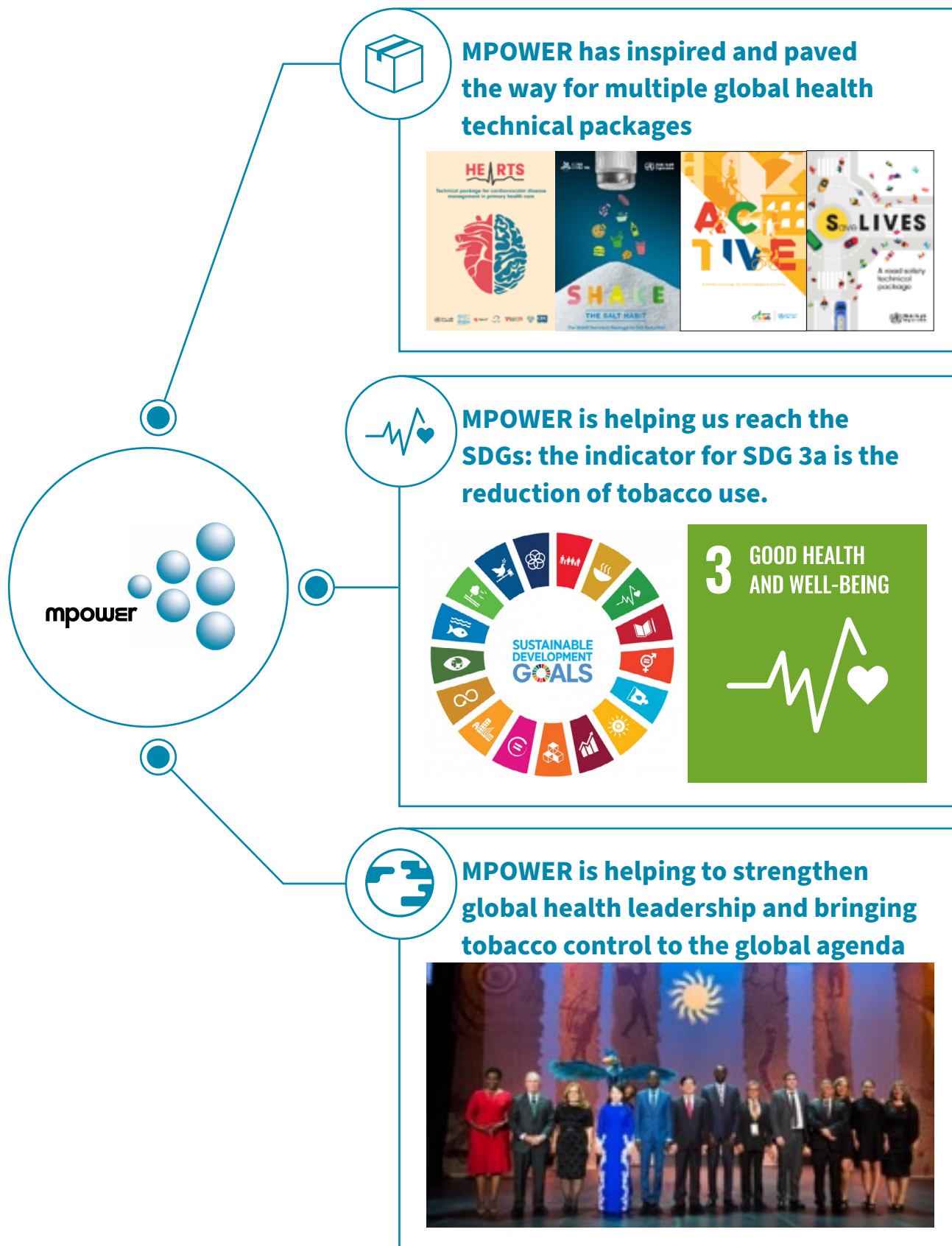
8

If current trends continue, there will be **no significant increase or decrease in prevalence between 2010 and 2025**

7

If current trends continue, there is likely to be an **increase in prevalence between 2010 and 2025**

15 years of MPOWER as a tool of global health leadership



MPOWER accelerating into the future

The ingredients that can help accelerate MPOWER adoption and tobacco control are (15):

- 1 Ensure political will:** One of the most important factors to ensure that the MPOWER technical package is adopted and implemented is the backing and commitment from all levels of government (16). Stakeholders must be made aware of the huge burden imposed by tobacco and the impact it has on their country's health and economic outcomes. Effective tobacco control measures, like MPOWER, save lives and money.
- 2 Encourage multisectoral action:** Tobacco control cannot be effectively implemented through the Ministry of Health alone. For example, tobacco taxes are one of the most effective tobacco control interventions and require collaboration and leadership from the Ministry of Finance. It is crucial to strengthen to use a whole of government approach to ensure policy coherence on tobacco control by supporting the development and adoption of multisectoral strategies and programs and the establishment of coordinating mechanisms for tobacco control.
- 3 Build strong local and global partnerships:** Partnerships across government and with nongovernmental organizations and academia, help to strengthen and magnify the efforts of all. In collaboration partners can leverage each other's strength to reach the common aim of reducing the impact of tobacco on populations globally.
- 4 Maintain a strong stance against tobacco industry interference:** The tobacco and related industries, like that producing electronic nicotine products, utilize a suite of evolving tactics to maintain and grow their consumer base. Countries must remain vigilant in implementing WHO FCTC Article 5.3 and be prepared for the attempts by industry to challenge and undermine tobacco control efforts.
- 5 Commit to evidence generation and knowledge transfer:** Data and evidence not only help to drive policy progress but also policy implementation. Countries should conduct representative surveys and appropriate research to continuously evaluate the effectiveness of adopted policies, and to help adapt implementation to ensure that the whole population is protected from and well-informed about the harms of tobacco.
- 6 Invest in tobacco control:** Develop and use investment cases to demonstrate to decision-makers the cost-effectiveness and the return on investment that is possible with tobacco control as has been conducted by WHO (13, 17, 18) and the WHO FCTC (19). While tobacco control is known for being highly cost-effective, it is important to ensure that countries invest in their human resources with appropriate training to effectively develop legislation, stand up to the tobacco and related industries and ensure compliance with tobacco control measures in place.



“The MPOWER initiative has been a great milestone in global tobacco control. Today, almost three-quarters of the world’s population is now protected by at least one measure.”

Professor Ala Alwan

Former Regional Director for the WHO Eastern Mediterranean Region (2012–2017)
Former Assistant Director General for Noncommunicable Diseases and Mental Health (2008–2012) Former Minister of Health of Iraq (2003–2005)

3. Smoke-free environments: protect people from tobacco smoke

Second-hand smoke (SHS) is harmful and is estimated to cause the deaths of 1.3 million non-smokers each year. Smoke-free environments therefore play a crucial role in tobacco control and public health. They protect people from exposure to known carcinogenic and toxic substances; denormalize smoking in public places; and promote the spread of smoke-free environments even into private spaces. These societal changes can encourage tobacco users to attempt quitting, enhance their success in doing so, and discourage young people from ever starting to use tobacco.

Box 1. Smoke-free environments and the WHO FCTC – the story so far

In 2009 WHO published the *WHO report on the global tobacco epidemic: smoke-free environments*. Each biennial report published since then has either focused on a different MPOWER measure or has addressed the issue of emerging tobacco and nicotine products. Now, in 2023, we revisit the theme of smoke-free environments.

Since 2009, smoke-free environments have gone from being an innovative policy intervention in a handful of high- and middle-income countries to becoming a worldwide feature of tobacco control. Now an almost equal proportion of low-income countries as high-income countries have adopted comprehensive smoke-free legislation to protect people at all times from tobacco smoke in all enclosed public areas and workplaces.

However, there remain many public spaces and workplaces that are not protected by smoke-free laws and many more that do not comply with smoke-free laws. For this reason we need to accelerate efforts to protect all people from SHS. In our first report on smoke-free environments in 2009, we highlighted the effectiveness of smoke-free laws to reduce exposure to SHS; the public support this measure garnered; and the need for smoke-free laws to be comprehensive. In this report we reiterate and build upon many of these important points, as well as review the current evidence on the burden caused by SHS, assess the global progress on the adoption of smoke-free measures, and present up-to-date evidence and recommendations on the implementation and enforcement of smoke-free laws.

Any level of exposure to second-hand smoke is detrimental to the health of children and adults.

Sometimes called “passive smoke”, “environmental tobacco smoke” or “tobacco air pollution”, SHS is the mixture of compounds released by tobacco smoked by others (the “active smoker”). Of the 7000 compounds released, at least 69 can cause cancer. SHS includes both the side-stream smoke from the end of the cigarette and the smoke exhaled by smokers. The smoke produced in one room spreads to other rooms in the building regardless of whether doors are kept closed or windows kept open. Even with open windows and air filters, the toxic compounds from SHS cling to rugs, curtains, clothes, food etc. and remain

in the room months after the active smoking took place – this is known as “third-hand smoke” (THS) – now a recognized consequence of SHS. The evidence suggests that THS, which is also known as “residual tobacco smoke” or “aged tobacco smoke” may be harmful to those exposed (20) (research is underway to explore ways to remediate exposed environments and protect future occupants of those spaces from THS) (21).

In the early 2000s, with limited evidence of SHS harms, the tobacco industry strained to “frame” the problem of SHS as a mere annoyance for non-smokers,

and maintained that refraining from smoking in public places was purely a matter of courtesy (and not a way to protect bystanders from grave danger) (Box 1).

However, the adverse health impact of SHS is now irrefutable. All major medical and scientific organizations, including WHO IARC (22), the US Surgeon General (23), and the United Kingdom Scientific Committee on Tobacco and Health (24) confirm that SHS harms non-smokers and that there is no safe level of exposure. Breathing in even a small amount of SHS can be dangerous to health (25–27).

Smoke-free environments help guarantee the right of non-smokers to breathe clean air, motivate smokers to quit, and allow governments to take the lead in tobacco use prevention through highly popular public health measures.

The burden caused by second-hand smoke is huge

The most recent Global Burden of Disease (2019) (28) estimates that 1.3 million of the 8.7 million tobacco-related deaths each year are among non-smokers exposed to SHS – almost equivalent to the number of people that die in road traffic crashes every year. In addition to deaths, many people suffer ill-health as a consequence of SHS exposure. In adults, SHS exposure is associated with stroke, coronary heart disease, cancer, chronic obstructive pulmonary disease, respiratory infections and other conditions (see Fig. 7).

Foetuses, infants and children cannot choose the environment they are exposed to and are the most vulnerable to SHS

Severe asthma, respiratory tract infections, ear infections, and sudden infant death syndrome are all more common among children exposed

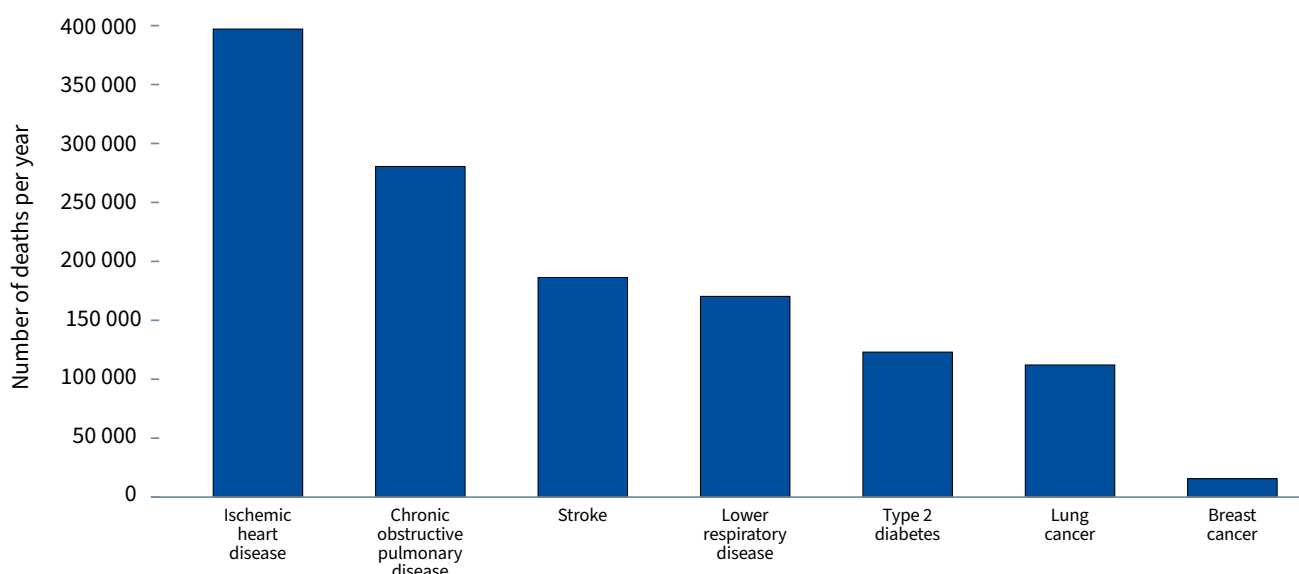
to SHS (29, 30). Young children are particularly vulnerable as they breathe more rapidly than adults, and their lungs and bodies are still developing. Smoking by parents and other household members causes respiratory symptoms and slows lung growth in their children (23). The 2019 Global Burden of Disease (28) estimates that globally about 51 000 children and adolescents under the age of 20 years die every year from SHS exposure. Almost all of these children (almost 47 000) are under the age of 5 years and these estimates do not take account of the health impact on newborns when pregnant woman are exposed to SHS.

Adolescents exposed to SHS were more likely to experience respiratory tract infection symptoms and to seek treatment at an urgent care or hospital emergency department (31). One study found that adolescents aged 12–17 years who self-reported exposure to SHS were more likely to experience difficulty exercising; wheezing during or after exercise; having symptoms

related to transmissible spongiform encephalopathies – including shortness of breath and a dry cough; and to miss school as a result of illness (31). Adolescents exposed to SHS are also more likely to experience symptoms of depression (32).

Increasingly, evidence indicates that SHS exposure during childhood is not only detrimental during childhood but continues to play a negative role in health into adulthood. A recent study conducted in Japan (33) demonstrated that adults who were exposed to SHS during childhood are more likely to die from coronary heart disease than those who were not. These results are supported by another large study conducted over 25 years in Finland showing how adults exposed to SHS as children demonstrate a number of cardiovascular risk factors that are markers of atherosclerosis (34). This large cohort study has also shown the impact of childhood SHS exposure on bone health, including osteoporosis, in adulthood (35).

Fig. 7. Main causes of death due to second-hand smoke exposure



Exposure to SHS during pregnancy is detrimental to fetal growth and development, leading to adverse birth outcomes such as preterm birth, low birth weight, and perinatal and infant mortality. Exposure to SHS during pregnancy is linked to a 23% increased risk of stillbirth and 13% increased risk of congenital malformation (36). Exposure to SHS during pregnancy is particularly relevant to many low- and middle-income countries, where few women smoke but live with men who do.

The burden caused by second-hand smoke impacts some people more than others

As the presence of smoke-free environments has risen globally and the prevalence of smoking has declined in most countries, exposure to SHS would also be expected to decline – and overall, the trend over the last 20 to 30 years suggests that SHS exposure is declining. In the United States for example, between 1988 and 2018, exposure to SHS among non-smokers declined from 87.5% to 24.6% (37).

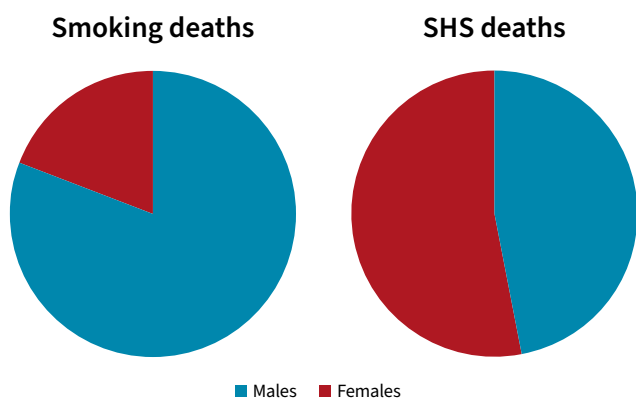
In the United Kingdom, children living in smoke-free homes rose from 63% in 1998 to 93.3% in 2018 (38). However, more recent trends are not as optimistic. The Eurobarometer survey of 28 European countries indicates a stalled trend between 2006 and 2017 (39). One large global study looking at the trends of SHS exposure among adolescents demonstrated that while exposure at home decreased between 1999 and 2018, exposure in public domains may have increased (40).

Furthermore, some people are more likely to be exposed to SHS than others. Of the 1.3 million SHS-related deaths, almost 1.2 million (close to 90%) occur in low- and middle-income countries. Within countries, trends in the prevalence of SHS exposure are complex. Studies show exposure to SHS is generally higher among disadvantaged groups of people (36, 41). In a study of 15 countries, the relationship between socioeconomic status and exposure in low- and middle-income countries suggests that exposure at home is reduced with increasing education (42).

Other evidence points to inequalities in exposure based upon geography with rural children in LMICs more exposed to SHS but amongst poorer children, those in urban settings were exposed to higher concentrations of SHS than those in rural settings (43).

The burden of death related to SHS exposure is disproportionately borne by females: around 10% of male tobacco-related deaths, (excluding deaths from chewing tobacco) are among non-smokers who were exposed to SHS, almost one third of all female tobacco-related deaths, (excluding chewing tobacco again) result from SHS exposure (Fig. 8). The inequalities observed in death rates between males and females are apparent where morbidity is concerned as well. Females therefore pay a heavy price for others' smoking. Insufficient protection may be due to the complete absence of comprehensive smoke-free legislation or the existence of partial smoke-free laws; the lack of effective implementation and/or compliance; and/or due to exposure where laws do not apply, for example in private property (see Box 2).

Fig. 8. Global total deaths due to smoking and SHS by sex, 2019



Source: Global Burden of Disease 2019(28)

Box 2. Second-hand smoke exposure may have increased during the COVID-19 pandemic

During the COVID-19 pandemic, many governments implemented “stay at home” policies and people were asked to work from home. In some contexts, this pattern of work persists to this day. Evidence suggests that smoking behaviours in response to the pandemic varied widely across countries, with some smokers finding the motivation to quit due to health concerns while others consumed more than usual. Given that many were confined to their homes however, it is possible that smokers smoked more at home and therefore exposed their families and others sharing their residence to more SHS. It is important to increase awareness about these behaviour changes and their harmful consequences (44-48).

Second-hand smoke imposes major costs on households and the broader economy

While the health burden related to SHS is borne by those exposed to it, the economic burden of SHS is felt much more widely. It is estimated that in the United States in 2018, cigarette smoking cost US\$ 600 billion. Of this total amount, US\$ 7 billion resulted from lost productivity due to premature deaths caused by SHS exposure (49). With almost 70% of the population exposed to SHS in 2018, one study has estimated that the economic burden of SHS in China will cost up to US\$ 321 billion over the period 2015 to 2030 (50). A recent study using data from the Global Burden of Disease estimated that the economic burden imposed by SHS was equivalent to up to US\$ 7 billion among the Cooperation Council for the Arab States of the Gulf countries (comprising Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates) (51) – comprising 20.4% of the total economic burden of smoking and SHS exposure combined in those countries.

The economic burden is also felt by individuals and families. When a family member suffers a chronic health condition, the resulting health care costs can be debilitating, and the death of a working family member can be catastrophic to a family's future financial stability. Given that tobacco use is often higher among those who are economically disadvantaged, SHS exposure is higher among non-smokers in these communities, contributing to a vicious cycle of tobacco use and poverty (52, 53).

Effective smoke-free policies save lives

There is evidence that, whenever smoke-free laws are implemented, they are followed by an almost immediate drop in SHS pollution levels and by marked improvements in respiratory health (54). In one of the earliest studies on SHS conducted on bar workers in Scotland reported a 26% decrease in respiratory symptoms, and asthmatic bar workers had reduced airway inflammation within 3 months after comprehensive smoke-free legislation was enacted (55).

Today there is robust evidence that comprehensive smoke-free laws result in reduced hospital admissions for acute coronary syndrome and reduced mortality from smoking-related illnesses (56). For example, a study in Argentina, where smoke-free measures were at first adopted differently in different provinces and cities, demonstrated the immediate decrease in admissions for acute coronary syndrome following implementation of a smoke-free policy in Santa Fe (a 13% reduction, by -2.5 admissions per 100 000 population), compared with no change in Buenos Aires city where the policy allowed for DSRs and other exceptions. In Santa Fe, the immediate effect was followed by a persistent decrease in acute coronary syndrome admissions (57).

Smoke-free laws also reduce neonatal and infant mortality, as well as adult deaths and illness from respiratory disease and heart disease (58, 59). Within months to a year after being implemented, smoke-free environments reduce the incidence of heart attacks among the general population (60–63).



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Smoke-free laws can denormalize smoking and inspire smoke-free homes

Making indoor public places smoke-free by law also promotes non-smoking as a norm. Evidence shows that when smoke-free policies are implemented, tobacco smoking in public spaces becomes less acceptable and private spaces are also more likely to become smoke-free (e.g. smoke-free homes/cars), resulting in reduced exposure to SHS at home (a major risk for pregnant women and children of all ages who live with smokers) (64–66). People can also be encouraged to make their homes smoke-free through appropriate campaigns to increase knowledge about the harms people are exposed to in their homes and how they can make their homes safer (See Table 2).

Smoke-free laws can encourage people to quit and prevent the initiation of smoking

Another major benefit of effective smoke-free measures is that smokers are more likely to try to quit (67) seek tobacco cessation support (68) and ultimately to successfully quit (69). In 2014, the U.S. Surgeon General concluded that smoke-free laws in workplaces and communities help smokers quit and reduce tobacco use (70). Furthermore, if children and adolescents observe less smoking, they are less likely to initiate tobacco use. One study conducted in China showed that smoking in the home is also linked to children being more likely to take up smoking themselves (71). Another study in the United Kingdom suggested that children who are cared for by smokers are almost 70% more likely to try smoking by the age of 15 (72).

Implementation of smoke-free measures is cost-effective

Smoke-free measures are one of the most cost-effective public health interventions. For every dollar spent implementing a smoke-free measure, significant numbers of lives will be saved and lifespans extended. Properly enforced comprehensive smoke-free policies are found to be highly cost-effective in reducing smoking prevalence to yield positive health outcomes. Analyses conducted for the recently updated Global Action

Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030 (73) listing the NCD best-buys for addressing the NCD burden estimate a very low implementation cost for smoke-free policies relative to the beneficial health impacts they generate 1 international dollar per healthy life year gained (14, 74).

Governments should be reassured that public support for smoke-free measures is high

Decision-makers may be concerned or may be led to believe by the tobacco and related industries, that the general public will be discontented by smoke-free measures. A recent systematic review of data from 33 countries demonstrates that support for smoke-free environments is generally high, especially in areas where children might be exposed, like cars. This study also revealed that where measured, support typically increased after implementation of smoke-free laws. Support was particularly strong among non-smokers and increased over time post-implementation for smokers (75).

Smoking bans have positive economic impacts upon businesses and tourism

Smoking bans are beneficial for businesses, contrary to the arguments put forward by the tobacco and related industries who challenge and undermine them in the hospitality sector and encourage hospitality businesses to join them in their fight. Such arguments claim that smoking bans reduce revenue and increase costs in smoke-free venues such as restaurants and bars, as smokers will visit them less frequently or for shorter periods of time. They also argue that to implement and enforce the policies, businesses have to pay to establish and maintain smoking and non-smoking sections, and that smoking employees will become less productive as they take longer or more frequent breaks for smoking. However, there is now ample and global evidence that counters these claims and clearly demonstrates that smoke-free policies cause no adverse economic outcomes for businesses, including restaurants and bars. In fact, smoke-free policies often have a positive economic impact on businesses (76–82).

To effectively protect people, smoke-free policies must be comprehensive

Comprehensive smoke-free policies mean 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 tobacco smoke. The elimination of smoking and tobacco smoke should be absolute to create a comprehensively smoke-free environment. Other approaches including ventilation, air filtration and the use of DSRs have repeatedly been shown to be ineffective, and conclusive evidence exists that engineering approaches do not protect against exposure to tobacco smoke (see Table 2). Voluntary smoke-free policies are not effective and the adoption of effective legislative, executive or administrative measures is necessary. Partial smoke-free laws simply fail to protect people from the harms of SHS (83,84).

Designated smoking areas or rooms do not protect people from tobacco smoke

Research in a variety of countries demonstrates that the impact of smoke-free laws is maximized when they are comprehensive and allow no exceptions (85). Indeed, this is the only way to ensure that smoke-free laws are enforceable, fair, and effective at protecting everyone from the harms of SHS. DSRs do not protect people from SHS, complicate enforcement, and are likely to reduce compliance. Data over the years demonstrate that in many countries fewer DSRs are allowed in health facilities and educational facilities (10% of those with smoke-free laws as compared with 20% in 2008) but exceptions often still exist for restaurants, pubs and bars, with up to 40% of countries with smoke-free laws still allowing DSRs in cafés and bars (see “Protect people from tobacco smoke” results chapter, page 53, for more information) (see Box 3).

Table 2. Debunking myths associated with second-hand smoke

| Myth | Fact |
|--|--|
| Smoking near a window eliminates SHS | Smoking near or leaning out of an open window does not protect your family. SHS drifts into your house. At the same time, by doing this, you may expose your neighbours to SHS |
| Smoking in one room with closed doors protects from SHS | Designating a specific room for smoking does not offer effective protection from SHS as it drifts into the rest of the house |
| Using ventilation, air conditioning or opening windows removes smoke | These systems do not get rid of SHS and may even distribute it throughout a building. Only avoiding smoking inside or near a house protects from SHS |
| Smoking on a balcony protects from SHS | SHS can get into your home when you open the balcony door. Moreover, THS still persists on a balcony and can be brought inside the home. So this kind of behavior does not protect from exposure |

Source: WHO Regional Office for Europe (86)

Box 3. Governments are obliged to protect their populations' health

Smoke-free air is a human rights issue

All people have a fundamental right to breathe clean air and governments are obliged to protect everyone's health as a fundamental human right. This duty is implicit in the right to life and the right to the highest attainable standard of health as recognized in many international legal instruments, including the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child. These are formally incorporated into the Preamble of the WHO Framework Convention on Tobacco Control, and have been ratified by more than 100 countries. Voluntary agreements, often promoted by the tobacco industry as a "compromise", have proven insufficient to achieve public health goals because they do not eliminate, and at best only reduce, exposure to the harmful health effects of SHS – to which both smokers and non-smokers alike are vulnerable.

Smoke-free air is a child rights issue

Unlike adults, children are unable to regulate their own exposure to tobacco smoke. Children are forced to live in the environment provided for them. International treaties, including the Convention on the Rights of the Child, are clear that States should ensure the survival and development of children. Tobacco use poses a risk to children's survival, health and development. As children are dependent on decisions made by adults about their tobacco use, tobacco control policies to inform the public of the dangers of smoking around children are critical. Children deserve and require clean, safe and secure environments, and the evidence clearly shows that these need to be completely smoke-free, including from before birth.

WHO Framework Convention on Tobacco Control

Article 8 requires that Parties adopt effective measures to protect people from exposure to tobacco smoke in (1) indoor workplaces; (2) indoor public places; (3) public transport; and (4) "as appropriate" in "other public places". This creates an obligation to provide universal protection by 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. No exemptions are justified on the basis of health or law arguments.

Some countries have adopted legislation to extend smoke-free environments into private spaces and outdoor public places

As described in the previous chapter, Article 8 of the WHO FCTC requires that all indoor workplaces, indoor public places, public transport as well as “other public places as appropriate”, are smoke-free. Some countries have taken steps to make outdoor public spaces smoke-free, for example, outdoor places like playgrounds, school campuses and the grounds of health care facilities, as well as quasi-outdoor spaces, such as terraces or doorways, where vulnerable populations, such as children or hospital patients, may be exposed to SHS. Bus stops and train platforms, are examples of outdoor public areas where people who do not want to be exposed to SHS may be forced to wait for transport and consequentially breathe in SHS (see “Protect people from tobacco smoke” results chapter, page 51).

Private spaces can, also be legislated for. Smoking in cars, for example, is known to lead to particularly high levels of SHS exposure for child passengers (87, 88). Countries such as Australia and the United Kingdom have taken steps to ban smoking in cars where there is a passenger under the age of 18 years

and a number of surveys indicate that there is public support for bans in cars (89–91) that can successfully reduce SHS exposure (92). One study across three countries demonstrated that while exposure in cars was falling prior to policy implementation, a 22% relative reduction in addition to this trend was observed one year after policy adoption (93). These findings are consistent with findings in Canada and California (94, 95) although exposure to SHS in cars has remained high in some contexts, particularly among adolescents (96).

Twenty years ago the world began to take serious action against second-hand smoke

In 2004, Ireland became the first country to adopt and implement national smoke-free measures in indoor areas (see Box 4). The policy measure was considered an innovative and radical move at the time and faced push back from the industry and from the hospitality sector where there was significant fear that the ban would result in reduced business. The evidence accumulated over the years however has proven that these fears were unfounded (97).

There have been significant advances in the number of countries adopting smoke-free measures since 2004. High-

income countries were first to show notable progress but some low- and middle-income countries soon followed, with Uruguay becoming the first such country to adopt the measure in 2005 (see “Protect people from tobacco smoke” results chapter, page 51).

Today, 74 countries (21 high-income countries, 45 middle-income countries and 8 low-income countries) have protected their populations with best-practice smoke-free measures. One major recent achievement is that all countries in South America now have smoke-free legislation at best-practice level in place (see Box 5).

Twenty years ago, it was almost unimaginable that restaurants and bars would be covered by comprehensive smoke-free laws. Today, 74 countries are covered by smoke-free measures at best-practice level in all indoor public spaces. This is an outstanding achievement, but it is not enough. Almost 6 billion people are still unprotected by comprehensive smoke-free measures globally.

Governments face specific challenges and obstacles when drafting and adopting smoke-free legislation. Barriers faced in adopting smoke-free environments can be effectively addressed. Table 3 provides some ideas on how to address commonly faced challenges.

Box 4. Smoke-free bars in Ireland: a runaway success

On 29 March 2004, Ireland became the first country in the world to implement smoke-free legislation in workplaces including bars and restaurants. At the time, there was a great deal of negative rhetoric surrounding the initiative in Ireland by vested interests. But by the start of 2005 a programme broadcasted on national television presented market research carried out on the Irish population asking “2004: How was it for you?” and found that the implementation of smoke-free measures was ranked as the top of a list of 30 positive events occurring in Ireland in 2004. “...it [smoke-free measures] was a clear winner – 15% ahead of the second placed event, Ireland’s only 2004 Olympic Games gold medal win” (98, 99).



Irish Examiner

**15 years of the smoking ban -
'None of us dreamed it would
ever happen'**

Newspaper headline from 2019, Ireland

Box 5. Smoke-free South America

The 10 countries of South America constitute the first subregion to achieve full smoke-free status. This was achieved with Paraguay passing the hard-won Decree 4624 in December 2020.

The 10 countries took different paths to adopt this public health measure, either through executive or legislative measures, or a combination of both.

A few countries, including Argentina, Brazil, and Venezuela (Bolivarian Republic of), started implementing smoke-free environments at the subnational level and gradually expanded to the national level (100).



Map of the smoke-free subregion of South America



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Table 3. Challenges and Opportunities: progressing the adoption of smoke-free measures

| Challenges | Potential approaches |
|---|---|
| <p>Tobacco and related industries' interference</p> | <p>The next chapter provides more detail on the ways in which the tobacco industry interferes with smoke-free environments. Some ways to address this challenge are:</p> <ul style="list-style-type: none"> ■ be prepared to counter claims by the industry and front groups that DSRs provide reasonable protection; ■ be vigilant against of research affiliated with the tobacco industry and their front groups; ■ protect indoor smoke-free environments from new and emerging tobacco and nicotine products; ■ ensure high compliance through enforcement so that the industry cannot argue that legislation is ineffective; ■ counter the “loss of business” arguments, and keep the debate focused on health and protecting everyone from SHS; ■ ensure the tobacco and related industries are not involved in legislation and that legal measures are in line with WHO FCTC Article 8 and its implementation guidelines (101). |
| <p>Perceived or real push-back from the business community</p> | <p>Build a strong evidence base for the impact of SHS on the local health and economic burden to inform advocacy efforts.</p> <p>Ensure that evidence on the impact of smoke-free measures on businesses and tourism is carefully and robustly conducted.</p> <p>Consider setting up a coalition or working group to support businesses and address local concerns.</p> |
| <p>Perceived or real lack of political will</p> | <p>Develop and share polling data showing public support for smoke-free laws.</p> <p>Identify business owners who support smoke-free legislation and share their stories.</p> <p>Identify workers employed in smoke-filled workplaces who can speak of the impact on their health.</p> <p>Advocates for tobacco control should use the appropriate evidence to spur action and to identify gaps that must be addressed to protect people from SHS. For example, evidence on the economic costs of SHS and the benefits to businesses of smoke-free legislation can be leveraged to convince decisions-makers.</p> <p>Adopting local and subnational level smoke-free environments is a way to spur national action, gradually building up to 100% comprehensive smoke-free coverage across the country.</p> |
| <p>Limited resources</p> | <p>Some countries are challenged by limited resources to implement public health interventions. Some ways to address this include:</p> <ul style="list-style-type: none"> ■ ensuring that decision-makers are aware of the robust evidence indicating that smoke-free measures are highly cost-effective, and highlighting the health and economic benefits from their implementation (see Tobacco control investment cases and Return on Investment analyses); ■ utilizing existing infrastructure for inspections and enforcement; ■ collaborating with civil society or building a voluntary task force to enforce smoke-free laws; ■ raising and/or using tobacco tax revenue to offset implementation costs. |
| <p>Concerns about public disapproval of smoke-free laws</p> | <p>Evaluate and track public knowledge and opinions of smoke-free measures. Surveys can reveal that a public awareness campaign is needed to reinforce the public's understanding of the harms of SHS or the existence of smoke-free laws. Most often, such surveys also indicate that the public is in favour of smoke-free measures in public places, which often increases after implementation of the measure, and this evidence can be valuable in galvanizing political will.</p> <p>Sensitize the public to the harms of SHS and empower them to demand smoke-free environments. Building public support for smoke-free environments can in turn help strengthen political will.</p> |

Subnational and local-level laws can help protect people from SHS and spur action at national level

Many countries have a government system in which state/provincial and local jurisdictions have significant legislative and administrative power and can enact and enforce smoke-free legislation (and other laws) independently from, and sometimes more effectively than, national governments. Therefore, cities and subnational jurisdictions like provinces and states can protect their citizens even before national legislation is in place. A number of studies have indeed shown that local-level legislation may not only be more feasible for some countries but also allows policy-makers the opportunity to better counter the influence of the tobacco industry which may be focused at national level. Smoke-free measures at the subnational level are common where public health legislation is decentralized, such as Indonesia and India, and progress at subnational level should be encouraged at the same time as supporting and driving national progress. This type of progress often leads to national laws, such as in Argentina and Brazil, where subnational laws ultimately led to national legislation (102).

Many studies, conducted in subnational areas (e.g. states, provinces, cities) of countries in which smoke-free laws have not been enacted nationally, have been able to demonstrate the positive impact of such laws on population health (103,104). One recent study examined the gradual implementation of smoke-free environments and the impact these actions had on infant mortality in Brazil. The study demonstrated that 15 000 infant lives were saved during 2000–2016 as a result of the policy. The study also estimated that an additional 10 000 infant lives could have been saved if the intervention had been implemented comprehensively across all states simultaneously since 2000.

Clear formulation of smoke-free legislation is an important step

Weak legislation can leave loopholes for the tobacco and related industries to exploit or lead to confusion and disagreement in interpretation and therefore weakened implementation. Smoke-free legislation has been formulated differently in different contexts as a result of unique cultural, legal and economic factors. When formulating legislation, some important aspects to note include:

- Carefully consider the definitions of important terms such as “smoking” and “indoor places”. Smoke-free laws should cover use of inhaled tobacco (including HTPs) and inhaled nicotine products, such as ENDS.

- Homes, dwellings and vehicles can also be places of work. For example, prisons and nursing homes. These venues require careful consideration.
- Careful consideration of the specific venues. Some legislation lists the type of venues where the smoking ban is to be applied, but this risks the possibility of unintentional exclusion. If legislation lists the types of venues, it should be indicative and not exhaustive.
- There should be no DSRs allowed regardless of the level of technical requirements associated with them.
- The law should clearly identify and articulate the authority responsible for implementation, who the law applies to and their responsibility for enforcement, such as the responsibility of venue operators to enforce restrictions.
- Mechanisms should be described in the legislation to ensure effective coordination between all relevant agencies, with a clearly designated lead agency responsible for coordination.
- Giving the Minister of Health (or other) the authority to include DSRs in specified or unspecified venues leaves the law vulnerable to subjective influence and vulnerable to private interests.



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Apart from the physical requirements of smoke-free environments (see Fig. 9), the implementation of smoke-free legislation requires strong planning and clearly articulated mechanisms of enforcement. To prepare a strong and effective plan, countries can assess the current smoke-free situation, convene an implementation task force composed of the relevant stakeholders and create an enforcement strategy. Ideally, the public comes to appreciate smoke-free environments such that a smoke-free policy will eventually become self-enforcing.

Informing people of the dangers of SHS is important to ensure support for smoke-free environments and effective protection

If people do not know or do not believe that SHS is a danger to their own and others' health, they will be less likely to support and/or comply with smoking bans or to voluntarily limit their exposure and that of others (105). Global Adult Tobacco Surveys (GATS) have asked people if they believe SHS causes serious illness, heart attacks, and

cancer and responses have varied across countries. In China only 50% of people reportedly know that SHS can cause heart attacks while in Türkiye almost all (95.6%) of those asked were aware (Fig. 10). One recent study conducted in Malaysia revealed that male smokers had limited knowledge about the health risks linked to SHS and that this shaped the men's home-smoking behaviour (106). Gauging people's understanding of the harms associated with smoking and SHS is important for improving support for, and compliance with, smoke-free laws.

Where smoke-free environments exist, sustainable enforcement mechanisms must be developed and applied to ensure people are protected from SHS.

Fig. 9. Physical requirements of a smoke-free environment:



“No smoking” signs

Clear, bold and legible in the appropriate languages



Removal of all ashtrays

Ashtrays can act as cues for smoking



Clearly displayed instructions on how to report a violation

A telephone number and the name of the person on the premises to whom complaints should be directed



The observance of the rules must be supervised

The designated responsible person must take reasonable specified steps to discourage or stop a person from smoking on the premises

It is crucial therefore to raise awareness of the harms of SHS as well as the benefits of smoke-free environments. To bring about the best chances of successful implementation, all stakeholders should be engaged including, but not limited to, the general public, decision-makers, opinion leaders, researchers, the tourist and hospitality sectors, businesses and the media.

Compliance with smoke-free measures is critical and requires sustained enforcement

Enforcement approaches fall into two categories – those that build voluntary compliance (for example, by ensuring that people are aware of the policy and what it entails); mobilizing the community and building support for legislation through education campaigns and public health messaging will increase the likelihood of

developing voluntary compliance and self-enforcement. The other category is active enforcement which includes approaches that monitor compliance and hold people accountable for violations. This includes compliance checks, designated complaints mechanisms, and the issuing of penalties or sanctions to violators of smoke-free laws (107). Successful implementation includes aspects of both of these approaches.

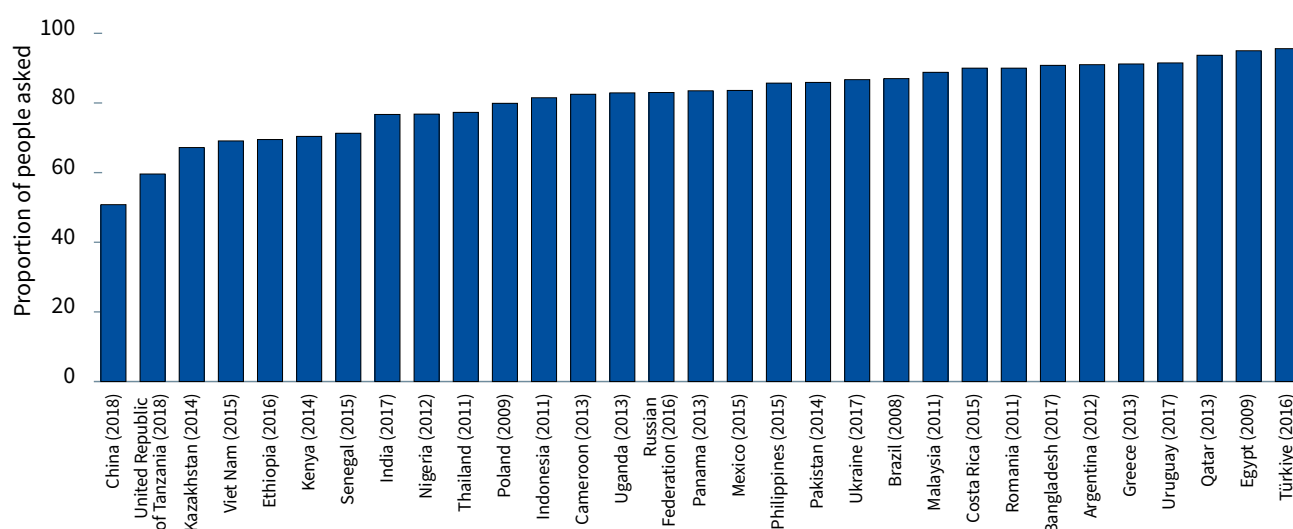
While approaches to strengthening enforcement of, and compliance with, smoke-free laws need to be relevant to the specific context in which the law is implemented, there is a growing literature on the topic that can help guide countries in establishing robust mechanisms (see Table 4). A recent review of evidence published between 1980 and 2017 found that policy promotion and awareness-raising activities, signage, enforcement officers,

and penalties for violations were the enforcement strategies most frequently cited as being associated with successful policy enforcement.

Monitoring and evaluating smoke-free policies will help implement them more effectively

As with most public health interventions, policy monitoring and evaluation allows for strengthening and improving the programme over time. Monitoring policies to track where they have been implemented (or not) and where they are successful (or not) can help adapt and amend the approach to strengthen the implementation of the intervention and strengthen the public health impact. It is also useful to monitor the knowledge and attitudes of the public and key populations to help target messaging and media campaigns (see Table 4).

Fig. 10. Percentage of adults (≥15 years) who believe that exposure to SHS causes heart attacks in non-smokers, selected countries (GATS 2008–2018)



Source: GATS 2008–2018

Table 4. Approaches to implementing smoke-free environments

| | Approach | Description and evidence-base |
|--|--|---|
| Inform, consult and involve the public | Raise awareness about the harms of second-hand smoke | The more public support there is for smoke-free measures, the more effective they are likely to be. Ensuring that people are aware of the harms caused by second-hand smoke and the benefits of banning smoking public areas can help to build this support. Mass media campaigns and graphic health warnings on tobacco packaging can help lay the foundations for smoke-free environments. |
| | Raise awareness about the measures in place | It is crucial that business owners and the public are on board and understand the measures in place, and what the consequences are of failing to meet the requirements. If awareness and support for the law is low then compliance will be low and enforcement will be more challenging to implement. The public should be empowered to demand smoke-free environments and to lodge complaints where violations occur. |
| | Support businesses and the tourist industry | Countries can help support businesses by providing capacity building opportunities (e.g. workshops on ways to implement smoke-free policies) and recognizing those that have demonstrated commitment to smoke-free environments (e.g. through awards schemes). Develop and disseminate materials (print or digital, depending on resources) that business can use for signage, patron education, etc. as the law goes into effect. |
| Enforcement and Compliance | Penalties for noncompliance | Fines and sanctions on the individual can be effective when vigilantly enforced but by applying fines on the establishment, the accountability lies with the business/venue and this can help ensure that enforcement is enacted by those who are most likely to observe violations. |
| | Recruit and train key staff as enforcement officers | Empowering people in society that are in positions of oversight or authority (such as health care workers, social workers and teachers) to enforce smoke-free laws can be a highly cost-effective approach. |
| | Establish citizen complaint mechanisms | Expanding the authority to report on smoke-free violations to citizens and bystanders through clear and simple mechanisms can help to improve compliance (108). Instructions on how to report smoking ban violations should be clearly displayed on no-smoking signage and digital tools, like mobile apps, may help facilitate citizen reporting (see Box 6) (109, 110) |
| | Ensure enforcement capacity | Legislation should address enforcement processes and structures and assign enforcement authority to the appropriate agencies, with clear powers and duties. Having dedicated human resources and capacity for smoke-free enforcement is a major factor of success. Enforcement officers should be well-trained. Assigning “duty of compliance” and responsibility to enforce smoke-free laws to a broad range of stakeholders, such as business owners, teachers and health care workers can expand capacity for enforcement. |

Table 4. (continued) Approaches to implementing smoke-free environments

| | Approach | Description and evidence-base |
|-----------------------------------|--|---|
| Enforcement and Compliance | Plan for sustainability | <p>Countries can develop a sustainable source of funding for enforcement (potentially using income gained from fines imposed for breaking smoke-free laws or from earmarked tobacco taxes).</p> <p>Utilizing existing networks and mechanisms, such as existing food safety inspectors, to take on enforcement activities can save resources and improve sustainability.</p> |
| | Strategize enforcement for best effect | <p>Ideally, after the smoke-free law is adopted, all stakeholders will support smoke-free laws and the measure will become self-enforcing. To achieve this a combination of active and soft enforcement approaches may be necessary. For example, if the law is in force it may be recommended to begin with a period where violators are cautioned, giving the community a chance to adapt before strengthening enforcement and meting out penalties.</p> <p>High-profile prosecutions can help to relay the message that the noncompliance will not be tolerated.</p> |
| | Remove all designated smoking areas/ rooms | <p>Studies show that DSRs not only reduce the effectiveness of smoke-free areas but also reduce the likelihood that the law will be enforced effectively, and compliance is likely to suffer (111).</p> |
| | Monitor and evaluate enforcement and compliance | <p>A better understanding of where measures have, or have not, penetrated, where they are succeeding and how they are being managed can help to improve and strengthen enforcement and compliance and can also help to build the evidence base for advocacy.</p> <p>Consider engaging civil society partners in compliance monitoring and reporting.</p> <p>Use monitoring mechanisms to ensure equitable protection from SHS.</p> |
| Monitoring and Evaluation | Monitor public knowledge and attitude about SHS and smoke-free measures | <p>Monitor the knowledge and attitude of stakeholders, including the general public, on SHS and to garner opinions on the implementation of smoke-free measures. This information will help to strengthen implementation approaches and can help target messaging.</p> |
| | Monitor outcomes of smoke-free measures | <p>Some of the key questions to monitor are:</p> <ul style="list-style-type: none"> ■ Does the smoke-free law lead to a reduction in SHS exposure and air pollution in indoor places and in private homes? ■ Does the smoke-free law lead to a reduction in SHS-related deaths and illness? ■ Does the smoke-free law lead to a reduction in smoking prevalence? ■ What is the economic impact of implementing of the smoke-free law? |

Addressing inequalities should be part of every implementation plan

Ensure adoption, implementation of, and compliance with, smoke-free laws across all geographies and contexts: Smoke-free measures cannot effectively protect people from SHS if compliance with the law is not upheld, and there are a number of factors that affect compliance. Even in contexts where there are comprehensive laws and high compliance, smoke-free laws may not penetrate all parts of society. Rural and remote areas, for example, are less likely to be monitored for enforcement and therefore more likely to demonstrate lower rates of compliance (112).

Ensure awareness of the impact of SHS in private spaces: Inequalities related to SHS exposure within countries can arise from exposure in private spaces (113, 114). Global Youth Tobacco Survey

(GYTS) surveys show that young females are more likely than young males to be exposed in both home and public environments. People living in disadvantaged communities are more likely to be exposed to SHS (115). Women, who are more likely to be non-smokers compared with men, are often exposed to high levels of SHS in their homes and carry a larger health burden from SHS relative to their consumption (116). Females in the Western Pacific countries, for example, carry a large portion of the burden due to SHS exposure. Pregnant women in low- and middle-income countries also report higher levels of exposure to SHS than women who are not pregnant as they are more likely to spend more time at home (117). In some contexts, non-urban youth are more likely to be exposed to SHS in their homes and in vehicles than urban youth (118).

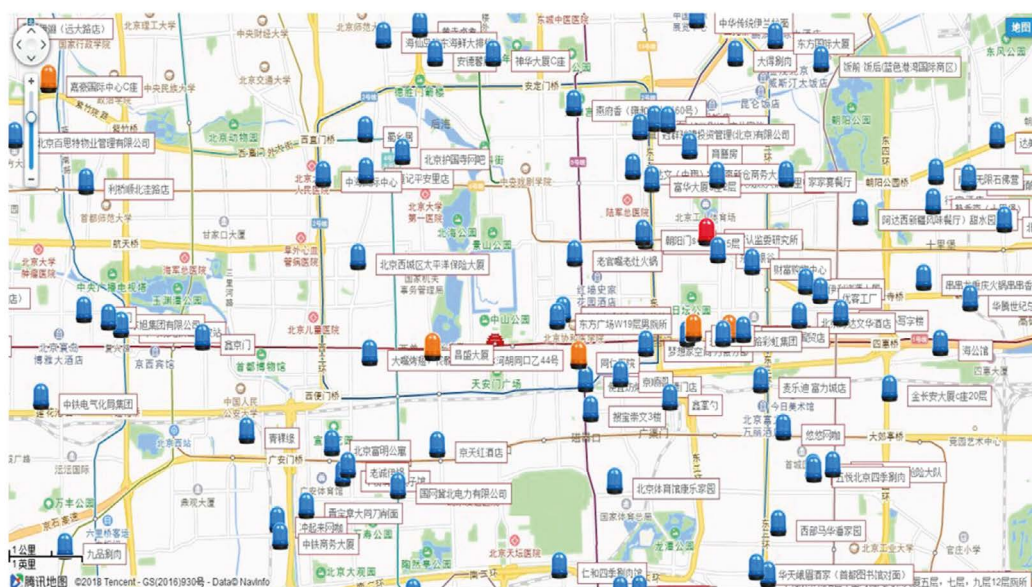
New and emerging tobacco and nicotine products pose a serious threat to smoke-free measures

Tobacco and related industries market e-cigarettes and other new and emerging nicotine and tobacco products as alternatives and/supplementary products to conventional cigarettes that can be used in indoor public areas, even where smoking bans exist (119). These products include, nicotine pouches, e-shishas, e-pipes and e-cigars. Through such marketing tactics, these industries explicitly or implicitly implies that the emissions that result from the use of these products are harmless to those exposed. The use of these products poses several risks. The exposure to smoke or aerosols is harmful (although the extent of that harm is still under investigation) and breathing clean air that has no additional toxicants compared with the ambient air is every citizen's right (Box 7).

Box 6. Digital solutions for enforcement

Digital approaches have been developed in recent years to help improve enforcement of smoke-free areas. Digital technologies can be employed to send people messages about the smoke-free policy of the venue they are in, thus increasing awareness, while apps that allow for quick and easy reporting of smoke-free violations by citizens can help provide the capacity where enforcement officers are in short supply. One example is the Complaint Map in Beijing:

“The Complaint Map visually displays the reported violations on a map of Beijing in real time. The general public can access the Complaint Map at any time to see which venues and locations have been reported. It is used by tobacco control volunteers, who are recruited and trained to address complaints and promote compliance. It is also used by the government's enforcement team for targeted inspections.” (110)



Visual display of violation on the Complaint Map

Also, the difficulty associated with distinguishing the different products and the aerosols that result from these products makes enforcement of smoke-free laws intended to protect the bystander almost impossible.

There is also significant and legitimate concern that new and emerging products have the potential to renormalize the act of smoking, thereby undermining progress made in protecting people through smoke-free policies (120). The act of using some of these products is very similar to that of smoking and the more they are seen as acceptable, particularly in indoor environments, the more likely smoking itself will become more socially acceptable. It is also important to note that some newer products that look very much like ENDS (and could be confused with ENDS, like HTPs) contain tobacco

and emit tobacco smoke (7, 121–123). Therefore, it is often a challenge to determine which product is being used, making the enforcement of smoke-free laws difficult, where they exist. Thus, for the purpose of their use in public places, they should fall under existing smoking restrictions or bans. Lastly, although the evidence on the negative health effects of newer products is still mounting, we know they are harmful.

Countries need a strong response to those pushing for the use of ENDS, ENNDS and HTPs in indoor spaces. In a recent survey of European attitudes towards tobacco and e-cigarettes, about one quarter of respondents reported having seen people using e-cigarettes in drinking establishments (124). In a study in 12 European countries, moreover, the self-reported prevalence of exposure

to second-hand aerosols was 16%, ranging from 4.3% in Spain to 29.6% in England (125). Smoking bans adopted before the advent of e-cigarettes often do not include emerging products, such as e-cigarettes and their use in public places, so their use may, by law, be permitted. And because of the way “smoking” was defined in older laws, their use may also be unintentionally excluded from long-standing smoke-free laws. It is important to note that even if the sale, manufacture and import of these products are banned, measures are still required to ensure use in public places is also banned. However, it is to be noted that many countries apply their existing policies, including smoke-free laws, to HTPs (Box 8).



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Box 7. SHS, second-hand aerosols (SHA) and their health effects

- Waterpipes are increasing in popularity and create large volumes of SHS. They are often used in communal spaces and very often indoors. Studies have demonstrated that the air quality in rooms where waterpipes have been used is just as bad as those where cigarettes have been smoked (126–128).
- HTPs heat tobacco to produce a nicotine-infused vapor. Evidence shows that HTPs contain hazardous chemicals, and some of these compounds may even be found in higher quantities than found in conventional cigarettes. Recent evidence has indicated that exposure to SHS from HTPs is associated with asthma and asthma-like symptoms, as well as sore throat, headache and chest pain in bystanders (129, 130).
- When used indoors, ENDS and ENNDS, like e-cigarettes, raise airborne concentrations of particulate matter above background levels (131, 132). The levels of nicotine (for ENDS but not ENNDS); particulate matter and potential carcinogens in second-hand aerosols exceed the maximum recommended levels set out in the WHO FCTC Guidelines (101). This is of concern, as studies evaluating human exposure to particulate matter generated by the use of ENDS – including fine and ultrafine particles (which may penetrate the alveoli), volatile organic compounds, heavy metals and nicotine – suggest an increased risk of heart and lung disorders. Although the health risks associated with second-hand aerosols (SHA) from ENDS/ENNDS are not yet well understood, a systematic review concluded that ENDS “vapour” has the potential to cause harm to bystanders. Further research is needed to fully understand the health effects of second-hand aerosols (121, 133–135).

If we continue at the current rate of policy adoption, it will be another 50 years before the rest of the world is protected from second-hand smoke. Acceleration of progress is critical.

Box 8. Smoke-free legislation must cover new and emerging nicotine and tobacco products and be future-proofed against tobacco industry tactics

- ENDS, ENNDS and HTP non-users should be protected from the emissions of these products.
- Smoke-free legislation should encompass new and emerging nicotine and tobacco products and specific products, like ENDS, should never be excluded from its provisions.
- WHO FCTC Decision FCTC/COP8 (22) asks Member States to “ban the use of HTPs where smoking is prohibited, making sure that legislation for smoke-free environments complies with all recommendations of Article 8 Guidelines for implementation and treats HTP use as smoking”.
- In drafting legislation, terminology used to describe smoking is critical and should cover the use of new and emerging products. The industry attempts to argue that HTPs are not “smoked”, “burned” or “combusted”. Therefore, if the definition of “smoking” in smoke-free legislation is restricted to the use of these terms it may result in the exclusion of HTPs from the law and expose bystanders to harms.

Recommendations for adopting and implementing smoke-free environments

Legislation should be comprehensive and align with WHO FCTC Article 8 and its implementation guidelines to effectively protect people from SHS exposure. Countries should adopt legislation that mandates completely smoke-free environments with no DSRs. Physically separating smokers from non-smokers (for example by establishing DSRs providing ventilation of smoking areas) does not eliminate the health risk resulting from exposure to SHS.

Smoke-free legislation should be simply and clearly articulated. Laws should be written in clear language with the aim to limit misinterpretation, ensure the inclusion of novel and emerging tobacco and nicotine products and, as far as is possible, provide sufficient opportunity for countries to cover any foreseeable future scenarios.

Smoke-free legislation should be enforceable and mandatory because voluntary policies are not effective substitutes to legislation.

Authority to enforce the law must be clearly designated and articulated clearly where possible in the legislation.

Legal action should be adopted at any and all jurisdictional level(s) where effective legislation can be achieved.

Anticipating and responding to the tobacco industry's opposition, often mobilized through third parties, is crucial. The next chapter will discuss some of the key actions that can be taken to address the many ways the industry tries to hinder progress.

Involving civil society is central to achieving effective legislation. Effective partnerships and stakeholder engagement can be very powerful tools to coordinate advocacy efforts and bolster political will.

Raising awareness, and consultation with stakeholders are necessary to ensure early adoption and smooth implementation of smoke-free legislation.

Enforcement must be sustainable. An implementation and enforcement plan, together with effective awareness-raising campaigns, a well-coordinated enforcement infrastructure (involving all relevant agencies) and ensuring high-profile prosecutions include fines or the closing down of businesses that repeatedly violate the law, are critical for successful implementation.

Monitoring of implementation and compliance is essential, as is measurement of the impact of smoke-free environments; ideally, people's experiences should also be documented and the results made available to other jurisdictions, and others in the tobacco control community, to support their efforts to successfully introduce and implement smoke-free legislation. Robust research is encouraged to better inform enforcement strategies in different contexts.



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4. Tobacco industry interference:

Protecting people from tobacco and related industries

Tobacco use is responsible for causing over 8 million deaths every year and causes more disability and ill health than any behavioural risk factor. Yet still the tobacco industry aggressively market its products worldwide and, goes out of its way to undermine the implementation of the WHO FCTC and the MPOWER package. Some of the tactics the industry deploys are (136):

TACTIC 1

Building increasingly elaborate alliances and front groups to represent its case- the “third party technique”

TACTIC 2

Attempting to fragment and weaken the public health community

TACTIC 3

Disputing and suppressing public health information

TACTIC 4

Producing and disseminating misleading research and information

TACTIC 5

Directly lobbying and influencing policy-making

TACTIC 6

Influencing “upstream” policies, including trade and investment agreements, to make it harder to pass public health regulations

TACTIC 7

Litigating or threatening litigation

TACTIC 8

Facilitating and causing confusion around tobacco smuggling, and using this confusion to undermine tobacco control

TACTIC 9

Seeking to manage and enhance its own reputation by rebranding themselves as environmentally and socially responsible to increase the ability to influence policy

The tobacco industry’s latest efforts to bolster its reputation and expand its reach into both policy and the commercial markets is to seek to transform itself towards wellness and health care areas by investing and acquiring ownership of pharmaceutical and well-being companies.



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Countering tobacco industry tactics

The tobacco industry attempts to present itself as a partner in tobacco control, while simultaneously blocking regulatory efforts.

Therefore, partnerships with tobacco and related industries should be rejected, and there should be clear rules regarding conflicts of interest for government officials and government employees.

WHO FCTC Guidelines for implementation of Article 5.3 – adopted by the Conference of Parties in 2008. to help countries meet their legal obligations to the Article – are based on both scientific evidence and the countries’ experiences. These guidelines continue to be instrumental in combatting industry interference and should be applied in relation to both conventional and emerging nicotine and tobacco products.

Effectively addressing and countering tobacco industry interference requires a whole-of-government approach which ensures all sectors, including, for example, ministries of trade or commerce, are engaged in the enforcement of tobacco control policies and upholding Article 5.3. Government action to counter tobacco industry interference should include the following:

- Requiring disclosure of, and clearly communicating, funding sources for research institutions, academics, and scientific studies to prevent unseen biases in science on which policy may be based, as well as to clarify the motivations of nongovernmental

organizations, business and trade associations, consumer groups, think tanks, professional associations and others seeking involvement or input in tobacco control policies.

- Rejecting partnerships and non-binding or non-enforceable agreements with the tobacco industry and those working in its interests, including financial support, incentives and endorsement of tobacco industry activities related to tobacco control.
- Raising awareness about the known addictive and harmful properties of tobacco and nicotine-containing products, and about tobacco industry interference with tobacco control policies.
- Denormalizing and, to the extent possible, regulating and banning publicity around activities described as “socially responsible” by the tobacco industry.
- Prohibiting the dissemination of misleading information relevant to tobacco control policies.
- Requiring that information from the tobacco industry on marketing, lobbying and philanthropic activities is disclosed and that the information provided by them be transparent and accurate, with regular, truthful, complete and precise information on tobacco industry activities. All government interactions with the industry should be recorded and made available to the public.

- Putting in place and enforcing effective conflict of interest policies for policy-makers and officials engaged in developing, implementing and enforcing tobacco control policies.

- No government privileges or influence should be afforded to any tobacco and nicotine companies and state-owned tobacco enterprises should be treated the same as other tobacco companies.
- Ensuring that health and non-health agencies take consistent action, adhering to Article 5.3 and applying the Guidelines for implementation.
- Blocking interaction between government and front groups that are funded by tobacco and related industries “purporting to work for a smoke-free world” (speech by Dr Tedros Ghebreyesus)

Governments should also encourage and empower civil society to play a role in preventing and addressing tobacco and related industries’ interference (such as those that are involved in the production or sale of nicotine products like ENDS). Effective advocacy against the tobacco and nicotine industries requires skills training, capacity building and longer-term investments from donors to ensure sustainability.

There are also significant global efforts to expose and curb tobacco industry interference and tactics (see Box 9). For example, the Global Tobacco Industry Interference Index is a global scorecard highlighting how governments are resisting tobacco industry interference.

Box 9. Helpful resources to address tobacco industry interference

Global and regional partnerships and alliances:

- Stop Tobacco Organizations and Products (STOP): this global tobacco industry watchdog is a network of academic and public health organizations working to expose and counter the industry's relentless efforts to sell harmful, addictive products ([STOP](#)). As part of this initiative, national surveys of industry activity and government efforts to protect policy are collated and analyzed by the Global Center for Good Governance in Tobacco Control (GGTC) to produce the Global Tobacco Industry Interference Index (GTI)
- Some regional partnerships like the Southeast Asia Tobacco Control Alliance ([SEATCA](#)) and the African Tobacco Control Alliance ([ATCA](#)) are multisectoral non-

governmental alliances assisting countries in their respective regions to address and stand up to tobacco industry interference (e.g. see [SEATCA resources](#) and [ATCA resources](#))

WHO technical reports:

- Tobacco industry interference with tobacco control. Geneva: World Health Organization; 2008. ([Tobacco industry interference with tobacco control](#))
- Tobacco Industry Interference: A Global Brief. Geneva: World Health Organization; 2012. ([Tobacco Industry Interference - A Global Brief](#))
- Tobacco Industry Interference in the WHO European Region. Copenhagen: World Health Organization; 2012. ([Tobacco Industry Interference in the WHO European Region](#))

- “Implementing article 5.3 of the WHO FCTC: From policy to practice”: an online course coordinated by the Convention Secretariat and the Global Centre for Good Governance in Tobacco Control. ([LEARN – Simple. Practical. Empowering.](#))

Research institutions:

- TobaccoTactics: a source of research on the tobacco industry hosted by the Tobacco Control Research Group within the University of Bath ([TobaccoTactics](#))
- Centre for Tobacco Control Research and Education at University of California San Francisco ([WHO Collaborating Centre on Tobacco Control](#))

Effectively addressing and countering tobacco industry interference requires a whole-of-government approach.



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Tobacco industry tactics used to undermine smoke-free environments

Discrediting scientific information and manufacturing alternative science

The tobacco industry is known for creating scientific controversy in order to challenge, undermine and counter restrictions to tobacco use (137). Similarly, over the years the tobacco industry has worked to refute evidence of the health effects of second-hand smoke (138). In the early years of the 21st century, as the evidence on the health impact of SHS was still accumulating, the industry hired scientists and epidemiologists to promote the message that SHS was not a danger to non-smokers. They tried to portray the hazard of SHS as a “mere annoyance” for bystanders (139) or just a matter of courtesy on the part of smokers to reduce the exposure of smoke to non-smokers.

Today, evidence on the harms of SHS is overwhelming and there is no denying the impact SHS has on the health of non-smokers. So, the industry today deploys a new strategy to create the impression that products like ENDS do not produce second-hand smoke and that they are “clean” alternatives to cigarettes (140). They claim that aerosols of these new and emerging products are “mainly composed of water, glycerin and nicotine”, and therefore not harmful to bystanders. However, this is not true, as the aerosols generated by ENDS typically raise the concentration of particulate matter in indoor environments and contain nicotine and other potentially toxic substances that are harmful to both users and non-users exposed to the aerosols second-hand (141–143). Additionally, there is evidence that ENDS aerosols can lead to respiratory symptoms (144). The full extent of risk posed by new and emerging products like ENDS and ENNDS have not yet been quantified and are not fully understood (145). In the meantime, we must not let the tobacco industry repeat their lies and no credit should be given to their false claims.

Building alliances and front groups to pressure governments and delay implementation of smoke-free measures through litigation

As early as the 1980s, tobacco manufacturers financially backed existing hospitality groups and even created them from scratch in order to lend them an appearance of independence. The tobacco industry manipulated hospitality owners and their representatives into believing that their businesses would suffer gravely or indeed fail as a result of a smoking ban. This continues today, with the tobacco industry and its allies mounting numerous legal challenges to prevent or delay smoke-free legislation from being enacted. Usually when the industry attempts to use litigation (either directly or through front groups) or threatens litigation in the context of smoke-free policies, the main claims used are (146–149):

- They claim that smoking is a fundamental right of individuals;
- They stoke anger by claiming that smokers and business owners are not being supported;
- They claim that procedural due process to the passing of smoke-free laws has not been met;
- They argue that voluntary restrictions are sufficient; and
- They make out that smoke-free laws are very difficult or expensive to enforce.

It is important to note, however, that the vast majority of such cases do not succeed, but they often delay implementation of smoke-free policies and cast doubt in the minds of policy-makers elsewhere.

Conflating product categories to confuse the general public and the regulators, and slip through the smoking bans

Today, the number and types of tobacco and nicotine products sold are prolific, diverse, and rapidly evolving – and some can be very difficult to distinguish from one another. This complexity leads to confusion about product categories and makes regulation and enforcement, especially in resource-limited environments, extremely challenging. The industry uses this confusion to get around legislative loopholes. For example, in countries where ENDS regulation is weak, tobacco companies pitch HTPs as electronic products “similar to ENDS”. Yet, where ENDS are banned, HTPs are pitched as tobacco products that do not fall within existing categories (150, 151). Alternatively, HTPs might be introduced to the market in one country as a smokeless tobacco product (because the regulation on smokeless tobacco products is weak or nonexistent), yet be introduced as a smoking product in country B (because smokeless tobacco products are banned in this country); this creates confusion about these products, both among the general public and for regulatory purposes, and can influence whether these products are permitted or banned in indoor smoke-free environments (150, 152). Indeed, if HTPs are categorized as a smokeless tobacco product, “smoking” bans do not necessarily apply to them. Regulators should therefore not fall into these tobacco industry traps and should always include ENDS, ENNDS and heated tobacco products in the scope of smoke-free legislation.

Attempting to coopt tobacco control language

New and emerging nicotine and tobacco products, like ENDS and HTPs, have enabled the industry to appropriate the term “smoke-free” for its own gain (153). In the case of HTPs, the device heats the tobacco to temperatures below those reached by burning cigarettes (154). Consequently, they market HTPs as “alternatives” to smoked tobacco products and argue that they can be used in indoor spaces (121, 155). Through this marketing tactic the industry intends to weaken any comprehensive smoke-free provisions that currently exist in countries. Research, however, demonstrates that exposure to particulates, nicotine and other components of HTP aerosols pose risks to non-users (156,157). The report of the 9th session of the Conference of the Parties to the WHO FCTC on “Challenges posed by and classification of novel and emerging tobacco products”, noted that novel and emerging tobacco products, in particular HTPs, emit pyrolysis products, such as volatile aldehydes, in their aerosols which clearly fall within the scientific definition of smoke. Therefore, any smoke emitted by HTPs is unambiguously “tobacco smoke” (9, 122, 158).

Directly lobbying and influencing policy-making

The tobacco industry influences policy-making while legislation is being drafted or amended (162,163), for example by suggesting changes that weaken the outcome of the legislation, or influencing the process through political donations and lobbying. The industry may also target legislation that is being reviewed and amended, looking to create loopholes that allow new and emerging tobacco products to fall through existing or potential regulatory gaps, for example where smoke-free environments are involved (See Box 10).

Undermining existing tobacco control measures

The industry argues that HTPs and ENDS are less harmful to both the user and the bystander and therefore, restrictions, such as indoor smoking bans, should not be applied to them or should be less stringent than for conventional tobacco products. However, as noted above, evidence suggests that ENDS do indeed produce airborne particles that may be harmful to non-users and,

as noted above, HTPs do by definition produce smoke. In addition, the use of products like these in public areas poses the potential to undermine current tobacco control efforts by renormalizing smoking (See Box 11 and Box 12).

ENDS have created new ways for the tobacco industry to sidestep laws governing not only smoke-free environments but also advertising bans (ENDS have been openly advertised), health warning requirements and bans on sale to minors. After decades of marketing restrictions, the tobacco industry is once again using traditional media channels such as television and print media, which were previously used to target youth and young adults (164,165), in addition to flooding social media with direct and indirect advertising on ENDS (166–168). Where countries do not prohibit brand stretching (the use of tobacco brands on non-tobacco products) companies can use tobacco product brand names on ENDS, thereby advertising tobacco products and seeking to create brand loyalty. While the vast majority of countries in the world ban the sale of tobacco products to minors, a much smaller number of countries ban the sale of ENDS to minors (169), thus facilitating their first contact with, among other things, nicotine.

Box 10. Attempt to return smoking to public indoor places in wartime, Ukraine

Between July and August 2022, there were two attacks on Ukraine’s smoke-free legislation (strengthened by the newly adopted law No. 1978-IX). The first one appeared in the shape of registered draft law No. 7597 (159), which intended to allow smoking and the use of tobacco and nicotine products in designated places in cafés, bars and restaurants. The registered draft law was justified by the claim that it would provide “economic support” to the hospitality sector during a time of crisis due to ongoing war. The parliamentary health committee rejected the draft law in February 2023 on the basis that it was an attempt to discredit the newly improved tobacco control legislation, particularly smoke-free norms.

Parallel to this, in August 2022, a group of MPs again attempted to diminish Ukraine’s smoke-free norms by registering amendments to draft law No. 5616, which aimed to return smoking and tobacco use to the premises of restaurants, cafés, bars, hotels and other indoor workplaces. Such actions were deliberately hidden from the public, misled parliamentarians from other committees, and became a serious public health threat (160).

A coalition of NGOs organized a public campaign to disclose policy-makers’ vested interests and expose the negative consequences of the amendment. WHO’s country office in Ukraine issued a letter to parliament and the Ministry of Health, warning of the threat and urging public health policy protection, and participated in public events to advocate against harmful policy changes. The NGOs organized an information campaign and collected signatures from international organizations under an open letter to parliament. As a result, even with substantial MPs’ support, the majority in parliament dismissed the harmful amendments and protected the smoke-free legislation.



WHO - NGO Life press conference to advocate against weakening the smoke-free legislation

Box 11. ASA Adjudication on Imperial Tobacco Ltd

In the United Kingdom, a poster for a smartphone app stated: “Smoke Spots: The Smoker’s Social Home. You chose where you drink, why not where you smoke?” Find the best spots to smoke by location or event. Results matched specifically to your needs.” Cancer Research United Kingdom challenged this advertisement through the Advertising Standards Authority (ASA) alleging that the advertisement (a) promoted a tobacco product and (b) normalized smoking and could encourage non-smokers to start smoking or existing smokers to continue. Imperial Tobacco UK Ltd. responded by claiming that the “smoke spots” service being promoted

did not fall within the definition of “tobacco products” and only provided information about locations where it was legal and appropriate to smoke.

The ASA held that the ads did not include any reference to tobacco products but related directly to a service that provided information about locations where smoking was permitted. Therefore, the ads did not promote tobacco products. However, elements of the ad presented smoking in a positive light and the overall impression of the ad was normalizing of smoking. It was held that the ad was harmful and irresponsible on that point.

Box 12. Driving Addiction: Netflix, F1 and Tobacco Advertising

STOP, a network of academic and public health organizations operating globally to expose and counter the tobacco industry, has published three Driving Addiction reports to expose the problematic collaboration between tobacco companies and Formula 1. The 2023 report focuses on the impact of the Netflix docuseries, *Formula 1: Drive to Survive*, which enjoys a younger audience than that for F1 races. Through this programme, viewers are inundated with tobacco company branding, like that of BAT’s Vuse brand (an e-cigarette) on McLaren team cars, including in countries where tobacco advertising and sponsorship are expressly prohibited. For instance:

- Brazil has banned the import, sale and advertising of e-cigarettes since 2009, but F1 and Drive to Survive fans are still exposed to e-cigarette advertising due to broadcast coverage of races in other countries, the Netflix and F1-related social media content.
- India, home to an estimated 31 million F1 fans, has prohibited e-cigarettes and nicotine products, and there is a comprehensive prohibition on tobacco advertising. However, viewers are still exposed to tobacco company messaging and e-cigarette branding while watching the *Drive to Survive* series and F1 races.

Research conducted for the report estimates that a staggering 1.1 billion minutes of Drive to Survive, Season 4 content, viewed globally, contained tobacco company-related branding. Given Netflix’s global reach, in order to protect consumers from tobacco advertising and sponsorship, the report calls upon governments to ask Netflix to remove the programme where it violates national restrictions and to strictly enforce national legislation with respect to violations.



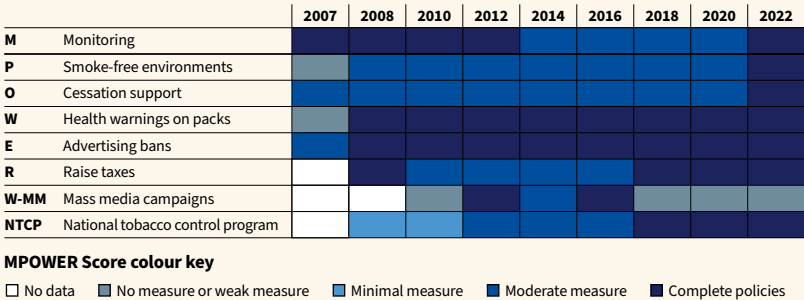
The STOP Report on the collaboration between tobacco companies and Formula 1

Mauritius – an MPOWER success story

History of tobacco control in Mauritius

- Mauritius’ achievements in tobacco control began in 2003, when the Ministry of Health and Wellness began work towards implementing tobacco control laws. Soon after, on February 27, 2005, Mauritius was among the first countries to become Party to the WHO FCTC.
- In 2008, the first tobacco control regulation was published under the Public Health (Restrictions on Tobacco Products) Regulations. These regulations mandated a set of eight pictorial and written warnings to be displayed on 65% of the surface areas of cigarette packaging. Health messages were also required on cigar, cigarillo and pipe tobacco packaging. A comprehensive ban on advertising, promotion and sponsorship of tobacco products was also implemented, and tax was introduced.
- Armed with data compiled through the ITC survey, Mauritius was in a stronger position to further strengthen its commitment to tobacco control, and in 2018 became a Party to the Protocol to Eliminate Illicit Trade in Tobacco Products
- From 2018 to 2022, the Ministry of Health and Wellness worked with WHO to revise and strengthen the 2008 Public Health (Restrictions on Tobacco Products) Regulations. This was achieved with the strong support and close collaboration of the Mauritius Attorney General’s Office and engagement across relevant government agencies.
- Amended Public Health (Restrictions on Tobacco Products) Regulations were put in place in 2022 (See Fig. 11).
- The new regulations comprehensively strengthened Mauritius’ tobacco control framework by introducing plain tobacco packaging and eight new larger pictorial health warnings with provision to rotate images every 2 years. The regulations also introduced a complete smoking ban in all indoor workplaces as well as in many outdoor public spaces. Additionally, a ban was imposed on the manufacture, import, distribution and sale of waterpipes, ENDS and ENNDS (including e-liquids), and heated tobacco products (including tobacco products for their use). The regulations impose the same ban on smokeless tobacco products; tobacco products with a characterizing flavour; roll-your-own tobacco and accessories; any other product containing nicotine; and any device used for tobacco consumption that may be manufactured or marketed to replace or imitate a tobacco product, not including products prescribed by medical practitioners (e.g. nicotine replacement therapy). The new regulations also imposed stringent reporting requirements for tobacco importers and introduced new tobacco product regulations, including reduced ignition propensity for cigarettes.

Fig. 11. MPOWER progress since 2007: Mauritius



Tobacco use in Mauritius is declining

- National noncommunicable disease surveys show the impact of Mauritius’s tobacco control measures since efforts began. The 2009 survey showed that 21.7% of Mauritians were currently smoking, and by 2015, this rate had fallen to 19.7%. The 2021 survey showed a further decrease to 18.1%.
- The Global Youth Tobacco Survey carried out in 2016–2017 provided insight on the tobacco epidemic among adolescents aged 13 to 15 years. The current tobacco use rate was around 18%, which indicated more effort was needed to prevent youth uptake.

MPOWER measures in Mauritius

Protecting people from tobacco smoke

As stated by the WHO FCTC, voluntary smoke-free policies alone are not as effective as mandatory ones, and enforceable legislation needs to be expedited. Following an initial ban on smoking in public places and public transport in 2008, the new regulations released in 2022 banned smoking in all outdoor and indoor spaces, but also within a radius of 10 m of any opening in a building. This also covers the outdoor areas of restaurants and drinking facilities.

- Mauritius has gone a step further, too, banning smoking in gardens to which the public has access, as well as when while driving or travelling in a vehicle carrying passengers; or while stationary in a vehicle carrying passengers.
- By broadening its definition of what is considered a “public place”, Mauritius aims to become a “smoke-free” country.

Offering help to quit

- Since 2010, tobacco cessation services have been free of charge through eight cessation clinics around the island. One more clinic was inaugurated in April 2023. The tobacco cessation clinics dealt with more than 10 000 cases between 2018 to 2022.
- Cessation support started in 2010 in one primary care facility and has since been extended to all regional hospitals, two community hospitals and the Diabetic & Vascular Health Centre.
- Since 2011, a toll-free quit line has been available for those who wish to stop smoking. The number is advertised through public campaigns.

Warning about the dangers of tobacco

- Since 2008, under the initial regulations, a set of eight pictorial health warnings were designed for and required on

packets of cigarettes and the percentage display was set at of 60% on the front and 70% at the back. The graphic health warnings depicted health-related consequences of tobacco consumption such as oral cancer, impotence, stroke, and addiction.

- Health warnings on the harmful effects of tobacco consumption on packaging of cigars, cigarillos and pipe tobacco were also imposed in 2008.
- In 2018, a new set of eight pictorial warnings were designed and tested, based on health risks that had not previously been addressed, such as miscarriage, ageing, toxicity of cigarette consumption, and cardiovascular diseases.
- On 31 May 2023, plain packaging was implemented on tobacco products and a new set of health warnings, both graphic and text, were enforced. The combination of health warnings has now a percentage display comprising 100% of the available area on the back of the pack, 80% on the front and 75% on the lateral sides of packets of cigarettes.
- The new regulations mandate the display of warning signs prohibiting the sale of tobacco products to minors at all points of sale, together with increased penalties for non-compliance.
- Mauritius has taken many opportunities to share its graphic health warnings with numerous countries such as Cambodia, Ethiopia, Pakistan, Seychelles and Sudan, and to provide assistance and share its experience in the field of tobacco control.

Enforcing bans on advertising, promotion and sponsorship

- Bans on advertising, promotion and sponsorship of tobacco products have been in place since 2008. There is rigorous monitoring through the various enforcement bodies.

- No advertisement or promotion of tobacco products is permitted at points of sale, including promotion through price lists, as the prices of tobacco products on sale are required to be displayed according to a prescribed, standardized layout.
- Sale of tobacco products at retail outlets or through vending machines was prohibited in 2008, and online sales were banned in 2022.
- Online advertising and promotion of tobacco products has also been expressly banned.

Raising taxes

- The total tax share as a proportion of the retail price of the most sold brand in Mauritius stood at 78.2% in 2022.
- Mauritius applies a uniform specific excise tax on cigarettes, a best-practice policy. The excise rate amounted to 6188 Mauritian rupees per 1000 pieces in 2022. When compared with 2008, the first year with relevant data in the *WHO Report on the global tobacco epidemic*, excise tax doubled in real terms over a period of 12 years, making cigarettes less affordable over time to discourage consumption.
- For each of the financial years 2022–2023 and 2023–2024, a 10% tax increase on tobacco products has been imposed as Mauritius is aiming to achieve the 30% reduction in the prevalence of tobacco consumption in adults aged 15 years and above by 2030.



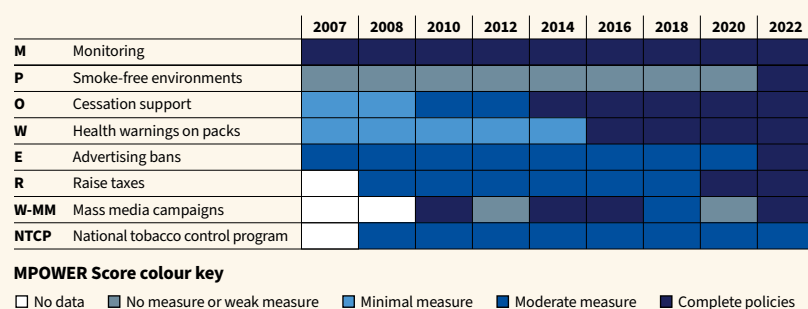
Poster promoting the tobacco quitline in Creole 2018

The Kingdom of the Netherlands: making MPOWER history

History of tobacco control in Netherlands (Kingdom of the)

- In 1957 the Dutch Health Council published an advisory report, *Smoking and health*, which confirmed the association between smoking and lung cancer. In response, health organizations such as the Dutch Cancer Society became actively involved in tobacco control.
- There were further influential Health Council reports during the 1970s, including *Measures to reduce smoking*, which stated at the outset, “public health interests must prevail above economic interests”, and contained a comprehensive and integrated set of policy proposals, most of which were not translated into policy at that time.
- By 1975 a national institute for tobacco control was formulated and this led to the foundation of the Netherlands Expertise Center for Tobacco Control (STIVORO), which became responsible for implementing tobacco control interventions such as educational campaigns and for providing smoking cessation support. The following year an advisory report by the Meulblok Committee on tobacco advertising was published, and in 1977 the Tobacco Memorandum was presented, which recommended gradual implementation of the measures proposed by the Health Council.
- Netherlands’ (Kingdom of the) first health warnings appeared on cigarette packs in 1982 (with the legend “Smoking threatens health”), alongside the first mandatory information about tar and nicotine content. And in 2005 Netherlands (Kingdom of the) became a Party to the WHO Framework Convention on Tobacco Control.
- Following the 2014 rise in the legal age of purchase of tobacco (from 16 to 18 years of age, as provided for in the 2002 amendment to the Tobacco Act), in November 2015 the “Smoke-free Generation” campaign was launched by the Dutch Alliance for a Smoke-free Society. It received wide support from the general public and later transformed into the “Smoke-free Generation movement”. A year later, Netherlands (Kingdom of the) started implementing EU Tobacco Products Directive II, restricting the use of flavourings and dangerous additives in tobacco.
- In 2018 a National Prevention Agreement (NPA), which included an extensive package of policy measures to address excessive alcohol use, overweight and obesity, and tobacco use, was signed, and a year later adopted by the House of Representatives. This partial agreement on smoking was signed by the government and 70 organizations with the aim that by 2040, Netherlands (Kingdom of the) would have less than 5% of its population as smokers, as well as no children or pregnant women smoking (170).
- In 2020 Netherlands (Kingdom of the) became a Party to the Protocol to Eliminate Illicit Trade in Tobacco Products and started implementation of track and trace system to combat illicit tobacco trade, and in the same year a ban on tobacco vending machines was also implemented. In 2021, many longstanding tobacco control gaps were closed, such as banning advertising of tobacco products at points of sale and allowing no DSRs in public places, workplaces and public transport (Fig. 12).

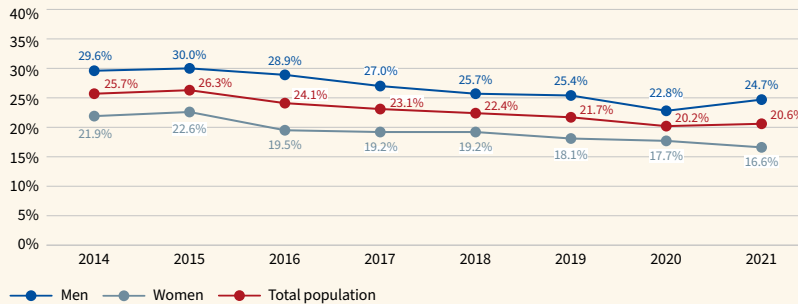
Fig. 12. MPOWER progress since 2007, Netherlands (Kingdom of the)



- Smoking prevalence among adults in Netherlands (Kingdom of the) has declined over time. Current smokers were 25.7% of the population in 2014 and by 2021 this rate had fallen to 20.6% (Fig. 13).
- While fewer women smoke compared with men, the prevalence of smoking among both men and women has been declining at comparable rates.

Tobacco use in Netherlands (Kingdom of the) is declining

Fig. 13. Prevalence of smoking in Netherlands (Kingdom of the)



Source: Nominal values were adjusted by inflation rates from the IMF's World Economic Outlook database of April 2023 (172).

Protecting people from tobacco smoke

- In 1990 the Tobacco Act, adopted in 1988, came into effect. It included a smoking ban for indoor venues in government-owned buildings and properties open to the general public. However, the ban was not comprehensive as the law allowed introduction of smoking areas.
- In 2002 an amendment to the Tobacco Act was adopted, requiring smoke-free workplaces (with the exception for hospitality sector) and public transport, except in DSRs.
- In 2008 the smoking ban was extended to the hospitality sector. However, smoking was still allowed in designated areas with closed doors where personnel did not serve, and on covered terraces as long as one side was open. Over the next few years, there were several suspensions of smoking bans in small bars without personnel, which resulted in smoking being allowed again in this type of establishment since 2011. In 2014, however, small cafés and bars were included again in the general smoking ban, except in smoking rooms.
- In 2020 the grounds of all educational premises in Netherlands (Kingdom of the) – from primary schools to universities – became smoke-free, and by 2022 a ban on DSRs came into force. Smoking areas are no longer allowed in any indoor public places, workplaces, and public transport.

Offering help to quit

- A national quitline has been available in Netherlands (Kingdom of the) since 2002. When the first health warnings appeared on the tobacco packaging one of the messages included was: "Ask for help with smoking cessation: DEFACTO 0900-9390 (0,10 Euro cent/min) or www.stoppen-met-roken.nl or consult your physician or chemist". DEFACTO's 0900 number was the national quit line but it was not yet toll-free (171).
- In 2016, a new, toll-free, national smoking quit line was established and in 2019 a chat service was added. By 2021, the national smoking cessation telephone quit line and chat service had answered more than 3200 questions about smoking cessation.
- And Netherlands (Kingdom of the) Expertise Centre for Tobacco Control initiated a network for tobacco quit lines in Europe, which since 2020 has enabled them to exchange best-practice, new insights, and latest developments in the field of smoking cessation and tobacco products.

Warning about the dangers of tobacco

- In 2002, four months earlier than required, Netherlands (Kingdom of the) implemented health warning provisions set out by the EU Tobacco Products Directive (TPD-1) stipulating that cigarette packs had to carry warnings

covering 30% of the front of the pack and 40% of the back, with rotating texts.

- And a large-scale campaign to support smokers who wanted to quit ("Netherlands (Kingdom of the) starts quitting") was run by STIVORO in 2004, linked to the implementation of the smoking ban.
- Implementation of the EU Tobacco Products Directive II began in 2016, which included pictorial health warnings covering 65% of the front and the back of tobacco packs, and by 2020, plain packaging for cigarettes and roll-your-own tobacco.

Enforcing bans on advertising, promotion and sponsorship

- In 2002 the Tobacco Act was strengthened by an amendment incorporating new bans, including on advertising tobacco products in media, on billboards and outdoors, as well as indirect advertising bans such as free distribution or promotional offers, and a ban on sponsorship.
- And as a complementary measure to these bans, Parliament adopted an amendment to the Tobacco Act in 2019 that included a ban on the advertising and display of tobacco products at point of sale. In 2021 this ban was extended to all selling venues, with the exception of specialized tobacco stores.

Raising taxes

- Over recent years Netherlands (Kingdom of the) has increased excise tax on tobacco products and this has been followed by real price increases over time. These tax increases led to the total tax share as percent of the price of the most sold brand to reach the highest level of achievement by 2020 – a situation that remained the case in 2022 (172).

rip

5. Effective tobacco control measures



m

Monitor tobacco use and prevention policies



p

Protect people from tobacco smoke



o

Offer help to quit tobacco use



w

Warn about the dangers of tobacco



e

Enforce bans on tobacco advertising, promotion and sponsorship



r

Raise taxes on tobacco

Monitoring tobacco use and prevention policies

Article 20 of the WHO FCTC states:

“...Parties shall establish ...surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke... Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at the regional and international levels...” (173)

Monitoring supports and enhances all tobacco control efforts

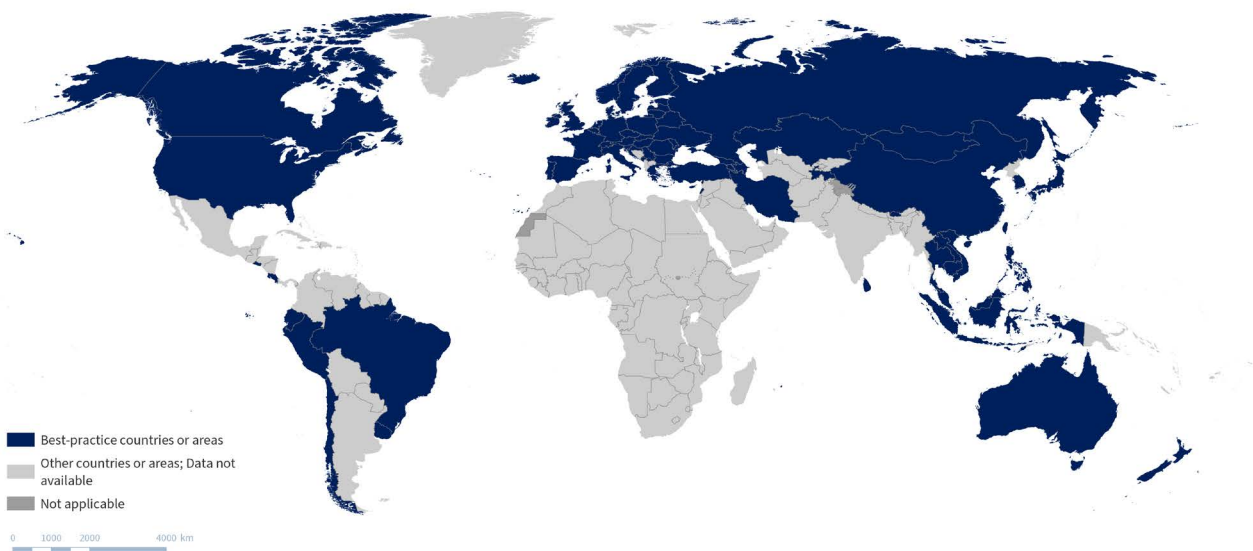
Monitoring patterns and trends in tobacco use and exposure generates reliable, timely data that are fundamental to helping countries understand the impact of tobacco control policy interventions and thereby combat the tobacco epidemic

(see Box 13 and Box 14). Data on trends in tobacco use and exposure give policy-makers the evidence they need to advocate for more tobacco control efforts and implementation resources, thereby strengthening the role of the WHO FCTC (173, 174).

Key elements to track include use of:

- cigarettes and other forms of smoked tobacco (e.g. cigar, pipe, bidis, water pipe, HTPs);
- smokeless tobacco products (oral or nasal tobacco);
- novel and emerging tobacco products such as tobacco vaporizers;
- non-tobacco forms of nicotine (e.g. ENDS);
- tobacco industry activities, where feasible.

Fig. 14. Monitoring the prevalence of tobacco use – highest achieving countries, 2022



Countries with the highest level of achievement: Armenia, Australia, Austria, Azerbaijan, Belarus^a, Belgium, Bhutan, Brazil, Brunei Darussalam, Bulgaria, Cambodia, Canada, Chile, China, Cook Islands, Costa Rica, Croatia, Cyprus, Czechia, Denmark, Ecuador, El Salvador^a, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Indonesia, Iran (Islamic Republic of), Ireland, Italy, Japan, Kazakhstan, Lao People’s Democratic Republic, Latvia, Lebanon, Lithuania, Luxembourg, Malaysia, Malta, Mauritius^a, Mongolia, Montenegro, Netherlands (Kingdom of the), New Zealand, Norway, Palau, Peru, Philippines, Poland, Portugal, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Serbia, Singapore, Slovakia, Slovenia, Spain, Sri Lanka, Sweden, Switzerland, Tajikistan, Thailand, Türkiye, Ukraine, the United Kingdom, the United States, Uruguay, Viet Nam.

^aCountry newly at the highest level since 2020.

15 years of MPOWER has helped reduce the global prevalence of tobacco smoking from 22.8% to 17.0% in 2021. If the prevalence in 2007 had not reduced there would be 300 million more smokers today.

The majority of countries (83%) asked respondents about tobacco use in a recent population survey

Since 2007, an additional 2 billion people in 24 countries are now covered by tobacco use monitoring at best-practice level (Fig. 14).

Almost half of the world's population – 3.8 billion people in 73 countries – are regularly asked about their tobacco use in nationally representative surveys among adults and adolescents. Most of these countries (41 out of 73) with comprehensive monitoring are high-income countries, while no low-income countries achieved this best-practice level in 2022. Despite having adequate

resources, 32% of high-income countries have not completed best-practice-level monitoring of their populations over the last 5 years. A total of 46 of the world's countries have not completed any recent national surveys since 2016 (Fig. 15, Fig. 16).

The COVID-19 pandemic has delayed many population-level surveys

Since 2020, the number of countries monitoring at best-practice level has increased by just 3 countries, and the population living in countries who monitor at best-practice level remained static at 3.8 billion (Table A1).

Owing to the challenges of running national population-based surveys during the COVID-19 pandemic, many surveys planned in 2020 and 2021 were delayed or cancelled. In this report we have made allowances for delayed survey implementation by extending the 5-year “interval between surveys” criterion to 7 years, but despite this, COVID-19 has contributed to a stagnation in progress on the “M” measure.

Ninety two percent of high-income countries and 75% of middle-income countries have completed at least one national survey among adults or youth in the past 5 years. However, under 50% of low-income countries (12 countries) have done so.

Fig. 15. Progress in monitoring (2007–2022)

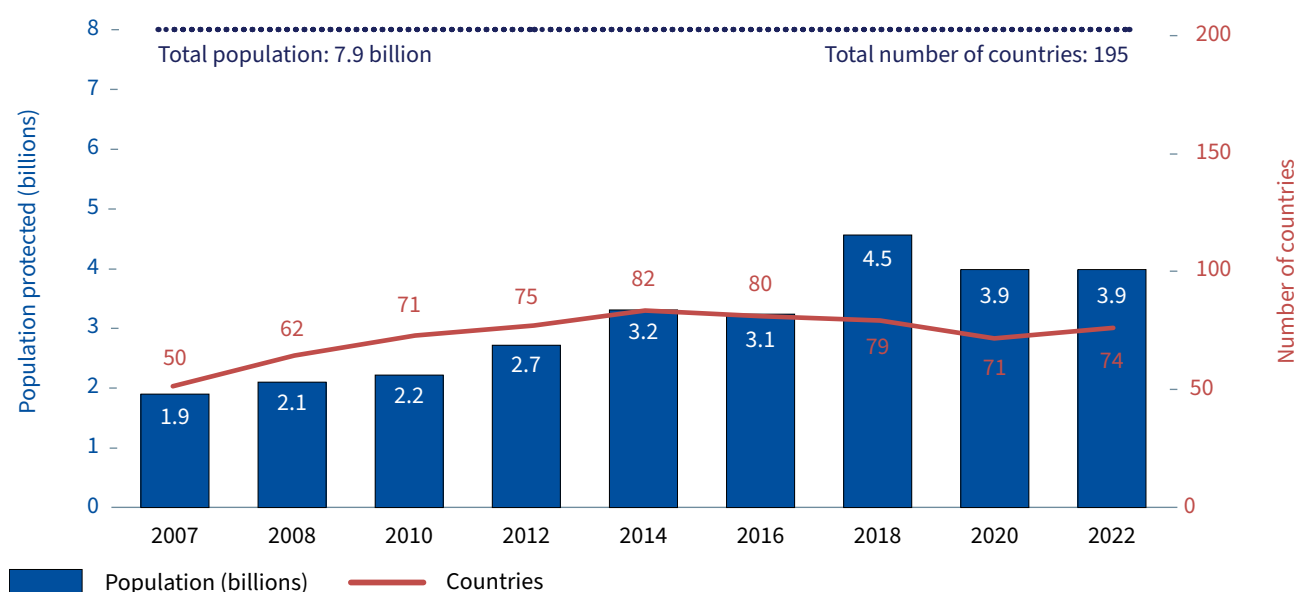
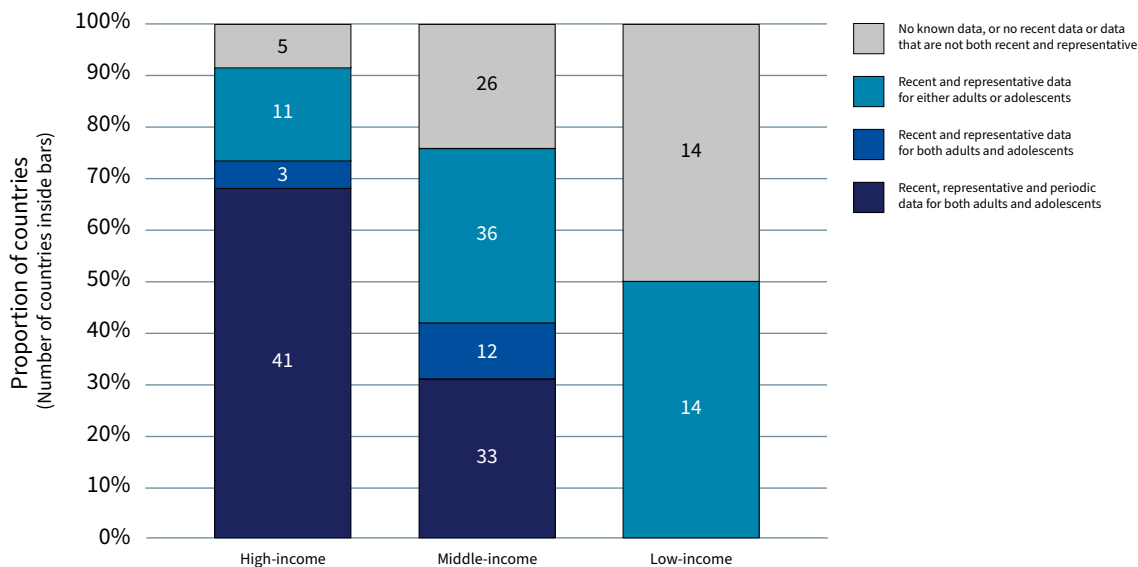


Fig. 16. Monitoring, by country income group, 2022



Smoking prevalence reduces as MPOWER ramps up

Between 2007 and 2021, the global average smoking prevalence has reduced from 22.8% to 17.0%. This is a relative reduction of 25% over 14 years. Smoking rates have been falling in all income groups of countries (see Technical Note II). The relative reduction in average prevalence over 14 years was 24% for high- and middle-income countries, and was 28% for low-income countries.

As 76% of the world’s smokers live in a middle-income country, the global smoking prevalence is strongly influenced by the smoking rates of middle-income countries, where the average is also 17%. High-income countries, where 20% of the world’s smokers live, have the highest average rate at 21% of adults smoking. Only 4% of the world’s smokers live in low-income countries, where the average prevalence of smoking is also lowest at 10%.

Among men, the global prevalence of smoking in 2021 was 29%, down from

38% in 2007. In relative terms, smoking rates among men reduced by 23% over the period. Among women, the global average rate reduced by 35% – from 8% of women smoking in 2007 to 5% in 2021.

Currently there is no WHO estimate of global ENDS use among adults because the data are still scant in many regions of the world.

Despite most countries banning sales to minors – an estimated 24 million children aged 13–15 years around the world smoke.



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Box 13. Surveillance helps drive a decline in tobacco use, Philippines

Over the past two decades the Philippines has conducted repeated national surveys to monitor tobacco use and evaluate progress in tobacco control, including the Global Adult Tobacco Survey (GATS) in 2009, 2015, and 2021; and the Global Youth Tobacco Survey (GYTS) in 2000, 2003, 2007, 2011, 2015, and 2019. Completing six rounds of GYTS and three rounds of GATS to date, the Philippines has invested in sustainable monitoring and surveillance systems to enable the formulation, tracking, and implementation of evidence-

based tobacco control policy and interventions.

Since the launch of the Philippines' first National Tobacco Control Strategy in 2012, sustainable surveillance and monitoring systems (including regular funding and use of evidence for policy action) have formed one of the country's key strategies to advance tobacco control. Strengthening surveillance data was also one of the priority areas of the second National Tobacco Control Strategy 2017–2022.

The landmark Sin Tax Law 2012 used the findings from the 2009 GATS as evidence of the high rates of smoking (28.2%) in the Philippines, particularly among men (47.6%), and kickstarted a series of tax reforms adopted between 2012 and 2020 that increased tax rates and made tobacco products less affordable. As a result, the prevalence of tobacco use among adults fell from 29.7% to 19.5% between 2009 and 2021, while tobacco smoking among adults fell from 28.2% to 18.5% during the same period (See Fig. 17a and Fig. 17b).

Fig. 17a. Overall prevalence of current tobacco use and tobacco smoking among adults, 2009, 2015, and 2021

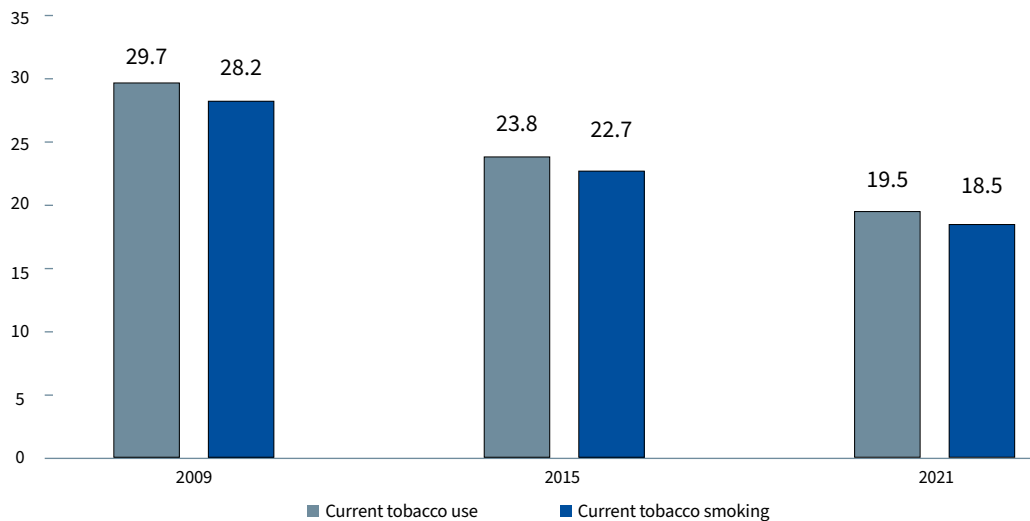
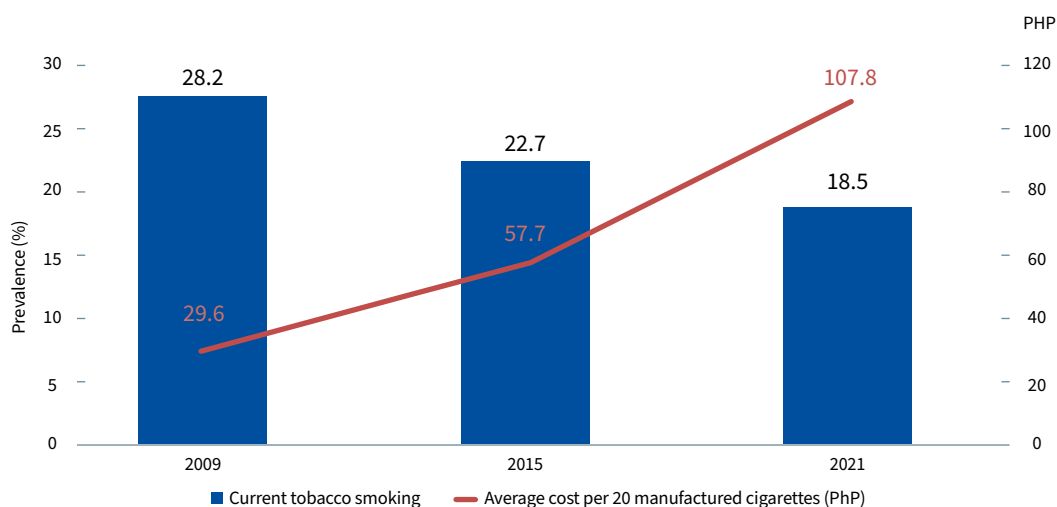


Fig. 17b. Overall smoking prevalence among adults, and average cost of 20 cigarettes



Box 14. Kazakhstan continues to track and monitor tobacco use and key tobacco control measures

Kazakhstan conducted its first Global Adult Tobacco Survey (GATS) in 2014 and has used the findings as the baseline for monitoring tobacco use in the country ever since. The survey also informed the development and adoption of a number of important legislative tobacco control measures, including:

- a ban on the sale of the tobacco product *nasvay*;
- a ban on the display of misleading or false information on tobacco packaging and labelling that creates a false impression of the product being less harmful, or that leads to any association with fruits, berries and/or confectionery; and

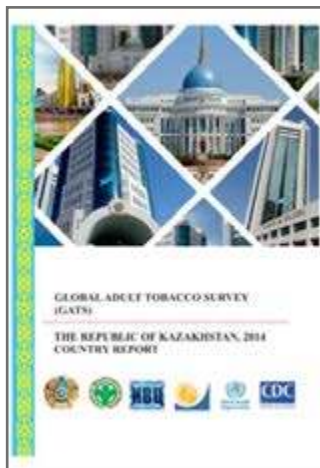
- a partial ban on the sponsorship of tobacco and tobacco products.

In 2019 Kazakhstan conducted its second GATS to assess the implementation of tobacco control policies over the prior 5 years. The survey showed that overall, prevalence of current tobacco use in Kazakhstan (smoking or the use of smokeless and/or heated tobacco) did not change significantly between the two surveys, falling only slightly from 22.9% in 2014 to 21.5% in 2019. However, a significant relative decrease among males (11.8%) and a significant relative increase among females (42.3%) were observed over the same 2014–2019 period. It also showed that tobacco control measures were actively supported

by adults, including by smokers – similar to survey outcomes in other countries.

Infographics with key 2019 GATS results in the Russian and Kazakh languages were developed and posted across different media channels, increasing the visibility of this work.

And in relation to monitoring youth tobacco use, Kazakhstan successfully completed surveys in 2004, 2009 and 2014, and is planning a fourth round in 2024. Data from multiple GATS, GYTS and other national surveys present opportunities for Kazakhstan to reduce and prevent the burden of tobacco use and enforce existing laws and policies to keep its citizens tobacco-free.



Tobacco use survey reports from Kazakhstan (175)

Protect people from tobacco smoke

Article 8 of the WHO FCTC states:

“... [S]cientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability ... [Parties] shall adopt and implement ... measures providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places”. WHO FCTC Article 8 guidelines are intended to assist Parties in meeting their obligations under Article 8 of the WHO FCTC and provide a clear timeline for Parties to adopt appropriate measures (within 5 years after entry into force of the WHO FCTC for a given Party) (173).

Over one quarter of the world’s population are protected by complete smoking bans in public places, workplaces and public transport

In 2007 only 10 countries in the world had a comprehensive smoking ban in place, covering 244 million people. Over the ensuing 15 years, 1.9 billion additional people in 64 additional countries are now covered by best-practice smoke-free laws. This means that there is now a total of 2.1 billion people (over one quarter of the world’s population) living in 74 countries where they are protected by smoking bans at best-practice level (Fig. 18 and Fig. 19).

While around one third of countries in each World Bank income group are covered by comprehensive smoke-free bans, 60% of countries (45 out of 74 countries) with comprehensive smoking bans are middle-income countries (see Box 15). The complete absence of smoking bans, or minimal bans that do not adequately protect people from the dangers of second-hand smoke, are remarkably common in high-income countries: 16 countries, with almost 50% of the total population of high-income countries, provide either no public

places that are smoke-free, or just one or a maximum of two. Together with 25 out of 106 middle-income countries and 12 out of 28 low-income countries, a total of 2.8 billion people are not protected by life-saving smoke-free environment laws (Fig. 19).

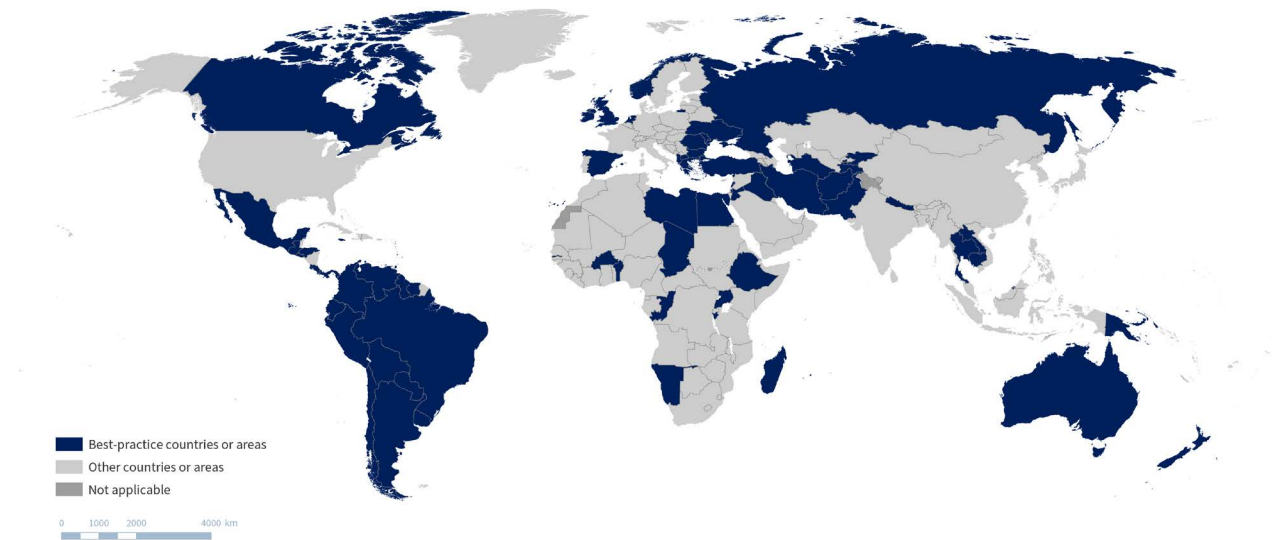
However, in the past 2 years, five countries, with a combined population of almost 200 million, have joined the group of countries providing protection at best-practice level, with all public places now completely smoke-free in 2022 (Fig. 20). All of these countries improved their earlier, more lenient laws: Mexico (see Box 15) and Netherlands (Kingdom of the) achieved this by disallowing DSRs in all venues where they were previously allowed; Kyrgyzstan by adding indoor offices and workplaces to the list of places where smoking is banned, and disallowing DSRs in venues where they were previously allowed; and Mauritius and Ukraine by adding indoor offices and workplaces to venues with a smoking ban, which had been the only provision missing from their earlier smoke-free laws.

Three countries, with 7 million people in total (Cabo Verde, Georgia, and Qatar) have improved their smoke-free laws since 2020 but did not reach best-practice level in 2022 (Table A1).

If 24 countries completely banned smoking in just one or two more places, an additional 22% of the world’s population would be protected by comprehensive smoke-free laws

There are nine countries, home to 81 million people, that need only to cover one more place with a 100% smoking ban to join the 74 countries with comprehensive smoke free laws. A further 15 countries with 1.6 billion people need only to cover two more places with a 100% smoke-free ban to achieve a comprehensive ban on smoking in public places. Of the 546 million people (6.9% of the world’s population) who live in one of the world’s 100 largest cities, 327 million people (in 53 cities) are protected by a comprehensive smoke-free law (see Table A4). Five of these cities (Bandung, Beijing, China, Hong Kong Special Administrative Region (Hong Kong SAR), Jakarta and Medan) are covered by city-level smoke-free laws (as in 2020); seven are covered by state- or province-level smoke-free laws (Brisbane, Hyderabad, London, Los Angeles, Melbourne, Sydney and Toronto); and the remaining 41 are covered by national laws. The remaining 47 cities currently not protected by a national best-practice policy could – instead of waiting for a national policy to be put in place – move ahead with a city, state or provincial level policy to more swiftly protect their large populations.

Fig. 18. Smoke-free environments, highest achieving countries and territory, 2022



Countries and territories with the highest level of achievement: Afghanistan, Albania, Antigua and Barbuda, Argentina, Australia, Barbados, Benin, Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Canada, Chad, Chile, Colombia, Congo, Costa Rica, Ecuador, Egypt, El Salvador, Ethiopia, Gambia, Greece, Guatemala, Guyana, Honduras, Iran (Islamic Republic of), Iraq, Ireland, Jamaica, Jordan, Kyrgyzstan^a, Lao People’s Democratic Republic, Lebanon, Libya, Madagascar, Malta, Marshall Islands, Mauritius^a, Mexico^a, Namibia, Nauru, Nepal, Netherlands (Kingdom of the)^a, New Zealand, Niue, North Macedonia, Norway, occupied Palestinian territory, including East Jerusalem^b, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Republic of Moldova, Romania, Russian Federation, Saint Lucia, Seychelles, Spain, Suriname, Tajikistan, Thailand, Trinidad and Tobago, Türkiye, Turkmenistan, Uganda, Ukraine^a, the United Kingdom, Uruguay, Venezuela (Bolivarian Republic of).

^aCountry newly at the highest level since 2020.

^bHereinafter referred to as “occupied Palestinian territory”.

Fig. 19. Progress in smoke-free legislation (2007–2022)

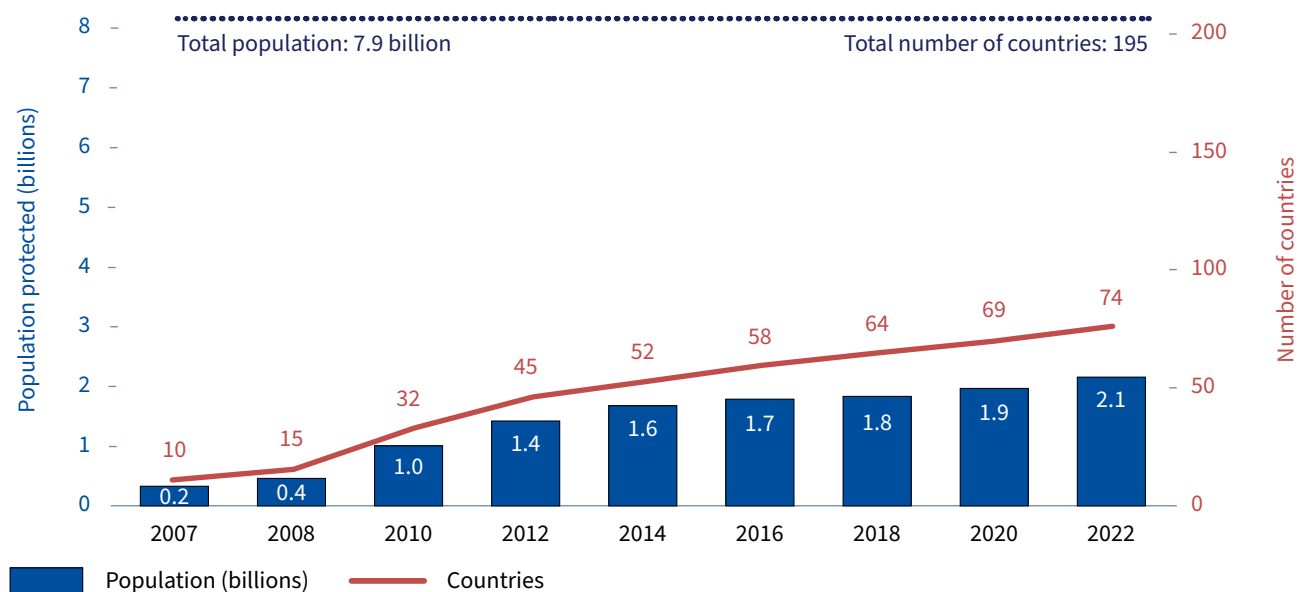
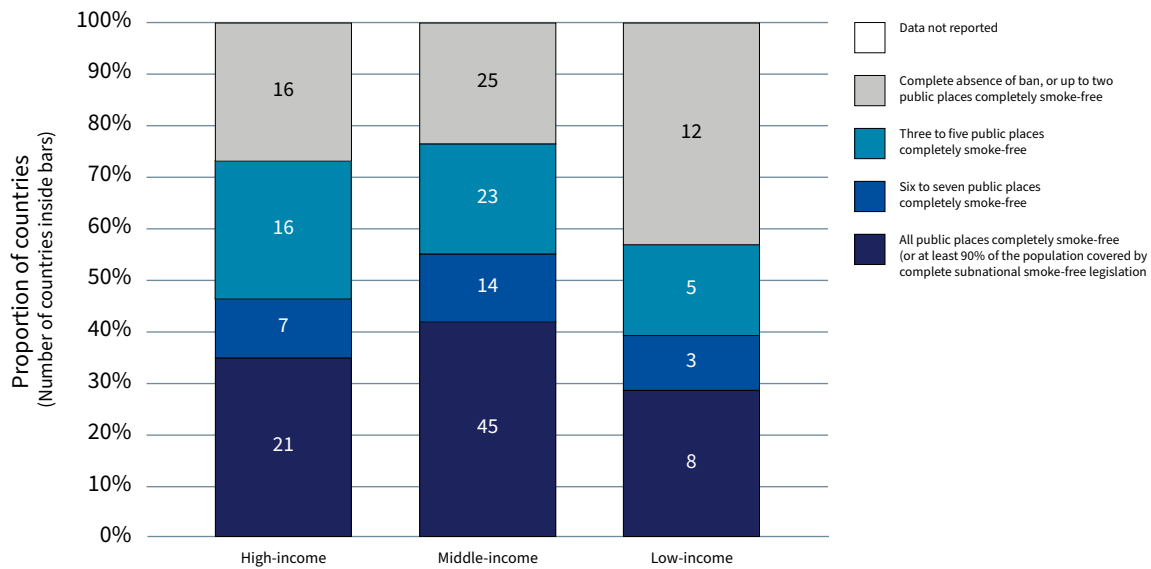


Fig. 20. Smoke-free legislation, by country-income group 2022



Almost 40% of countries, making up over one quarter of the world’s population, are now protected by comprehensive smoke-free legislation.



© WHO/Christopher Black

Complete smoking bans have progressed globally across all indoor venues

Progress in adopting smoke-free measures has been made across all indoor venues during the past 15 years. In 2007, only 15 countries had 100% smoke-free cafés, pubs and bars – a figure that increased to 88 countries by 2022 (although these types of venues remain the least-protected of all under national smoke-free laws). And in 2007, 81 countries had 100% smoke-free health care facilities and 78 countries

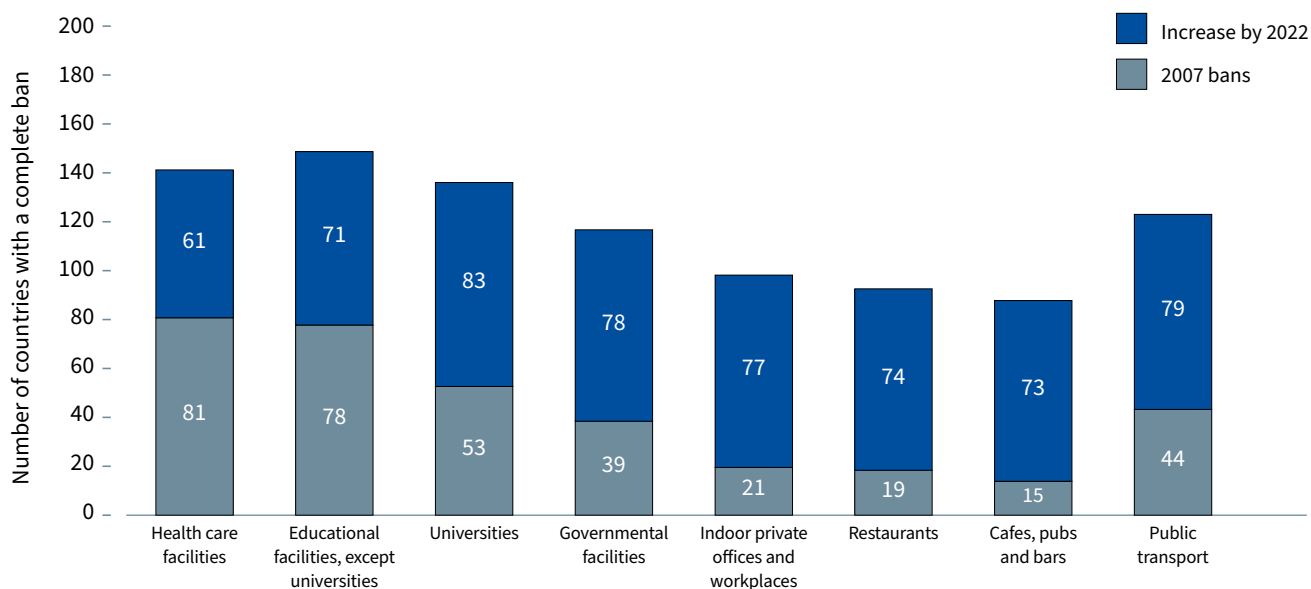
had smoke-free educational facilities. By 2022, the number of countries with 100% smoke-free educational facilities reached 149, and the number of countries with smoke-free health care facilities reached 142 (Fig. 21).

Compliance with smoke-free laws in hospitality settings is weak

Compliance with smoke-free laws varies according to the type of venue.

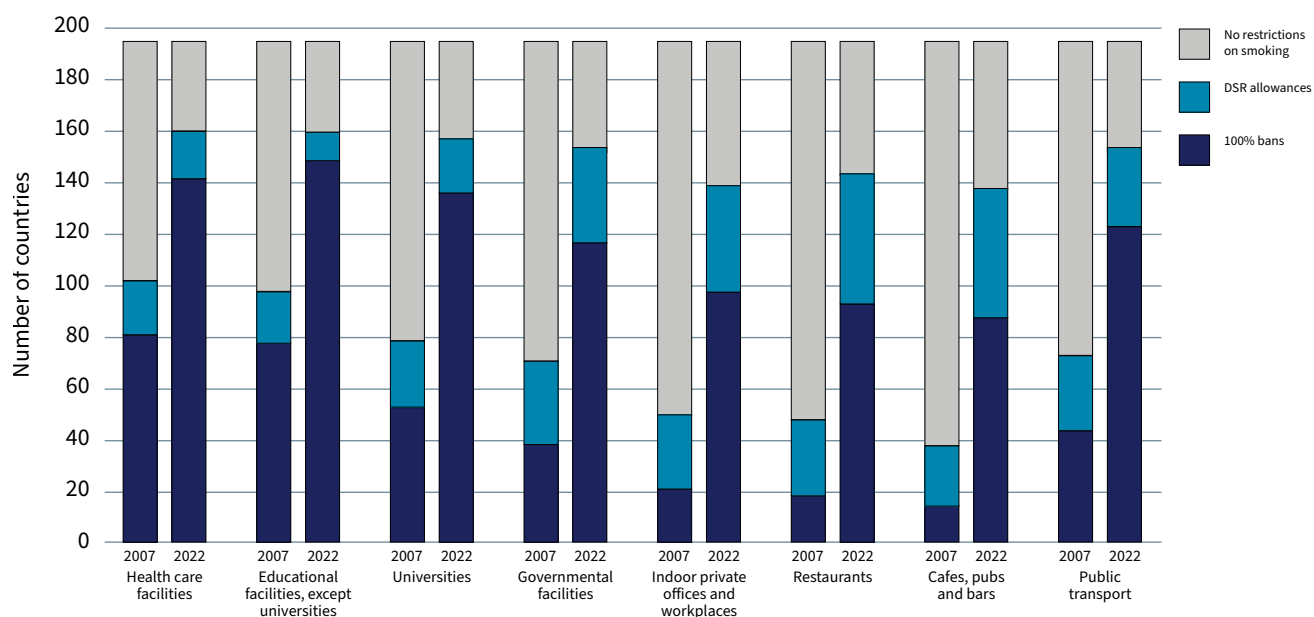
Compliance is reported highest in health care and educational facilities and lowest in cafés, pubs and bars, followed by universities and restaurants (Table A2). To encourage high compliance, countries should establish and fund enforcement mechanisms. While almost all countries (87%) issue fines to the patron or the establishment or both for smoking ban violations, less than one third of countries have dedicated funds for enforcement.

Fig. 21. Complete smoke free legislation, by venue, 2022



Health care facilities in 53 countries and educational facilities in 46 countries still do not have complete smoking bans.

Fig. 22. Comprehensive smoking bans and those with DSRs allowed, by venue, 2022



Designated smoking areas or rooms should be disallowed under smoke-free legislation

Despite evidence that DSRs do not fully protect people in indoor public areas, 71 countries continue to allow them in many venues, especially hospitality venues such as restaurants, cafés, pubs, and bars (Fig. 22). While DSRs can be found around the world, over 50% of high-income countries allow them in some venues, and over 30% allow them in restaurants, bars, and cafés. By contrast, under the law, only 32% of middle-income countries and 21% of low-income countries allow DSRs in any venue. By simply removing allowances for DSRs in smoke-free legislation, an additional 39 countries globally would achieve best-practice level.

Since 2007, 25 countries have amended their laws to disallow DSRs in one or more venues where they were previously allowed. The venues benefiting most from the removal of DSRs in the past 15 years are educational facilities and universities, with nine fewer countries allowing DSRs in educational facilities and five fewer allowing DSRs in universities. Unfortunately, 46 other

countries have newly allowed DSRs in one or more venues under their smoke-free legislation. Cafés, pubs, and bars have seen the biggest increase in DSR provisions, with 50 countries now allowing them, compared with only 23 in 2007. In contrast to these 50 countries, 88 countries have legislated for 100% smoke-free cafés, pubs, and bars to better protect staff and patrons alike.

Countries are increasingly extending smoke free laws to other public venues and outdoor spaces

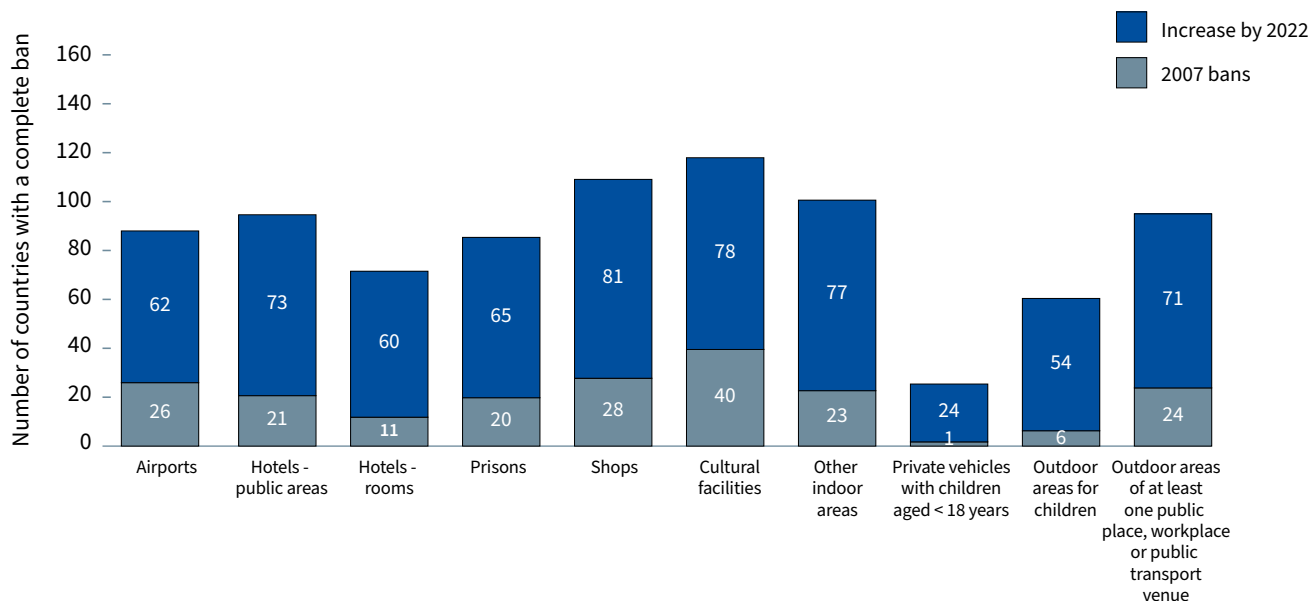
Cultural facilities, such as theatres and cinemas, are the most covered venues (118 countries) followed by shops (109 countries) and public areas of hotels (94 countries). While most countries now prohibit smoking on aircraft, only 88 have adopted 100% smoking bans with no DSRs in airports, meaning 107 countries do not fully protect airport staff and passengers from second-hand smoke.

Recognizing that children are a vulnerable population for second-hand smoke exposure, a total of 25 countries now make smoking in cars with

passengers under the age of 18 years illegal, and 60 countries ban smoking in children’s outdoor areas such as playgrounds.

Even in 2007, many countries realized that going beyond the minimum requirements of WHO FCTC Article 8 would improve the impact of their smoke-free laws. Fifty-two countries already had legislated smoking bans covering at least one of the other venues listed in Annex 2.2, or outdoors at venues specified in Article 8. The most protected type of additional venue in 2007 was that of cultural facilities, with 40 banning smoking in such spaces. Twenty-eight countries already banned smoking in shops, and 26 banned smoking in airports (Fig. 23).

Fig. 23. Additional indoor and outdoor smoke-free venues, 2007 and 2022



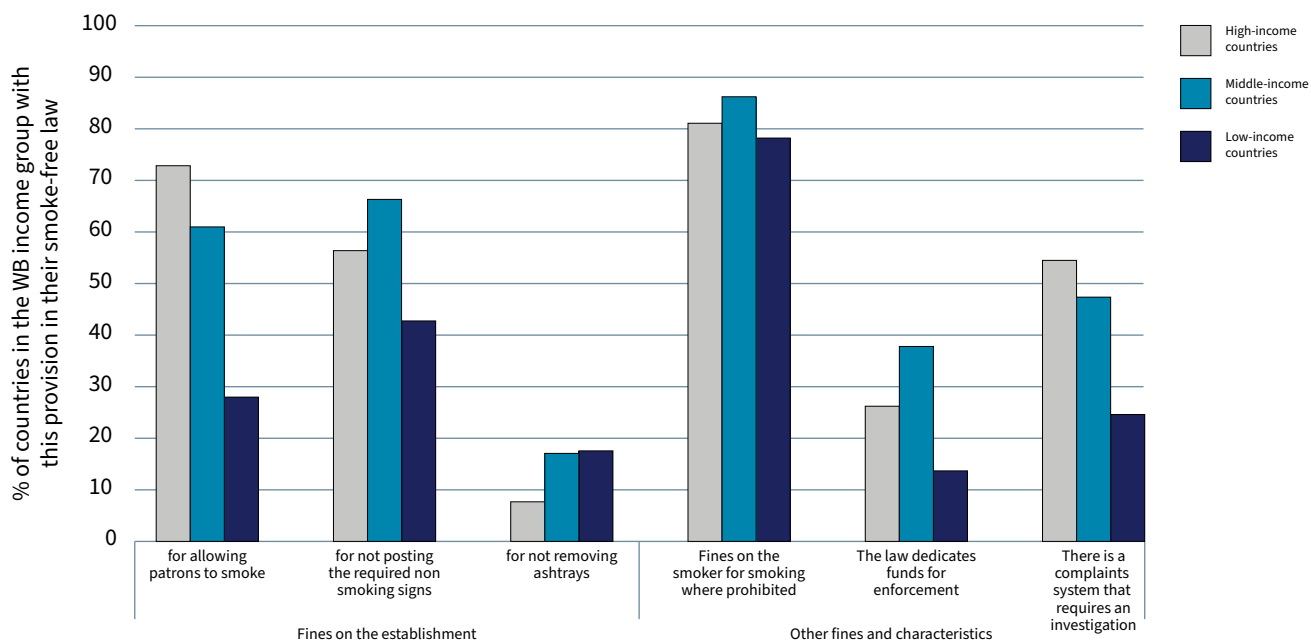
Almost all countries (170 countries or 87% of all countries) prescribe fines for the patron, the establishment or both in cases of smoking ban violations, yet less than one third of countries have dedicated funds for enforcement.

While fining the smoker may help build compliance, fining the establishment is important for ensuring compliance. Despite this, over 80% of countries

mandate penalties for the smoker while only 60% mandate penalties for the establishment not requiring a person to stop smoking where prohibited. Among low-income countries, 80% apply fines on the smoker violating the smoking ban, but under 30% apply fines to the establishment. Very few countries, a total of 29, apply penalties for not removing ashtrays from the smoke-free vicinity (Fig. 24).

Just over half of high-income countries have an established complaint system that requires an investigation and just over one quarter have dedicated funds for enforcement. This is below what is observed for middle income countries where almost 40% have dedicated funds set aside for enforcement.

Fig. 24. Smoke-free environment enforcement mechanisms, 2022



Subnational smoke-free legislation can be a way forward

Among the large number of countries that have not enacted comprehensive smoke-free legislation at the national level, some subnational jurisdictions

have been successful in enacting their own comprehensive smoke-free legislation (Table 5). Often, it is more politically feasible to enact smoke-free legislation that covers a smaller population, such as a specific city or province.

Currently, 27% of the world's population are covered by comprehensive smoke-

free legislation at national level (see examples in Box 16 and Box 17), and an additional 2% are covered at the subnational level. If all subnational jurisdictions with the legal authority to implement comprehensive smoke-free policies were to do so, an additional 4 billion people would be protected from second-hand tobacco smoke.

Table 5. Complete smoke-free bans in subnational jurisdictions, 2022

| COUNTRY | COMPLETE SMOKE-FREE LEGISLATION IN SUBNATIONAL JURISDICTIONS, 2022 | | PERCENTAGE OF NATIONAL POPULATION COVERED (%) |
|----------------------------------|--|---------------------------|---|
| | NUMBER OF JURISDICTIONS | POPULATION COVERED ('000) | |
| Australia | 7 | 26 013 | 99 |
| Canada | 11 | 38 718 | 99 |
| India | 1 | 49 577 | 3 |
| Indonesia | 3 | 16 021 | 6 |
| Micronesia (Federated States of) | 3 | 79 | 69 |
| United Republic of Tanzania | 1 | 735 | 1 |
| United States | 3 | 45 452 | 14 |



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Box 15. Hard-won success in going smoke-free, Mexico

In 2004, Mexico became the first country in the WHO Region of the Americas to ratify the landmark WHO FCTC. Four years later, in 2008, it took the major step of approving its General Law on Tobacco Control – though measures relating to smoke-free environments and TAPS bans adopted through this process only partially complied with the WHO FCTC. Next, in 2009, Mexico instituted policies to implement graphic health warnings on tobacco packaging in alignment with WHO FCTC Article 11.

In the years following the enactment of the 2008 law, over 100 bills relating to tobacco control were presented in Congress – some aimed at making the law more WHO FCTC compliant, while others included provisions supporting the interests of the tobacco industry and allies. During the following 13 years, strategic partnerships of key stakeholders worked to avoid any erosion of progress enabled by the General Law, and to amend the General Law so that it fully aligned with the WHO FCTC. This involved promoting the amendment

in the House of Representatives, and securing its assignment in the Senate's agenda and, ultimately, its approval.

The amendment was successfully passed in December 2021, and the new regulations were enacted in December 2022. These efforts represent a significant milestone in Mexico's progress towards tobacco control and have culminated in Mexico becoming an entirely smoke-free country (smoke-free measures also apply to ENDS/ENNDS), with a complete ban on TAPS, including a ban on the display of tobacco products at points of sale (176, 177).

This success is the result of several crucial factors: the commitment and persistence of various actors, including collaboration and coordination between the executive and legislative branches of national authorities in Mexico, civil society organizations, academia and international organizations. Over 10 years, these actors have provided technical and legal assistance; showcased the health and economic benefits of tobacco

control measures to policy-makers; coordinated communication strategies that included working closely with the local press; and engaged in subnational efforts to garner support for national reform (178). A supportive letter and the World No Tobacco Day 2022 Special Award was also presented by WHO's Director-General to the President of Mexico [DECM1] (179).

This coalition of actors played a decisive role in engaging political leaders who supported the process and countered the tobacco industry's substantial interference, particularly during the final stages of the amendment's approval in Congress.

The Region of the Americas now boasts 24 countries with 100% smoke-free environments, the highest of all WHO regions, as well as nine countries achieving total TAPS bans (6). Today, at least 647 million and 430 million persons in the region are protected from second-hand exposure to tobacco smoke and TAPS, respectively.



Campaign for smoke-free environments, Mexico

Box 16. Collaborating and focusing on smoke-free legislation, Kyrgyzstan

In July 2021, Kyrgyzstan's Supreme Council adopted the Law entitled "On protecting the health of citizens of the Kyrgyz Republic from the consequences of tobacco consumption, nicotine and exposure to second-hand tobacco smoke and aerosol". This law requires all workplaces and public places – including public transport, stations and taxis – to be 100% smoke-free.

In a country where half of all men smoke, effective measures to combat tobacco use and protect the population from the harmful consequences of exposure to second-hand smoke are hugely important. Over the past few years, Kyrgyzstan has taken steps to promote smoke-free environments as part of wider measures to reduce tobacco consumption – one of the most notable examples being the Smoke-free III World Nomad Games, held in Kyrgyzstan in September 2018. The Games were a success, attracting over 70 000 spectators from across the world, and more than 2300 athletes from

74 countries. Initiatives such as the smoke-free Games are rare in Kyrgyzstan, and have not remedied the issue of widespread exposure to tobacco smoke in public places. As a result, and through meticulous work and joint efforts of various stakeholders, a tobacco control law was developed, and adopted in 2021.

Kyrgyzstan's new smoking ban is very comprehensive as it also includes the use of hookahs, e-cigarettes and HTPs. Article 5 of the Law specifically states that its provisions apply to e-cigarettes and e-liquids, and that the use of e-cigarettes and HTPs is considered as smoking under the Law.

In a separate by-law, a new no-smoking sign has been approved that depicts a cigarette, a hookah, an HTP and an e-cigarette. All these graphics are crossed out with a red line, meaning a complete ban. In accordance with the legislation in force in Kyrgyzstan, the sign will be placed at the entrance to buildings and in areas where smoking is prohibited. While the

new law met with resistance from tobacco companies, the government has stood firm in its commitment to protecting public health. Furthermore, several other factors have contributed to the successful adoption of a strong and comprehensive law (with TAPS now completely banned), including the mobilization of civil society; creation of a support group that includes decision-makers; strong international support; and continuous pressure maintained to secure the process without interruption.



A new no-smoking sign that depicts a cigarette, a hookah, an HTP and an e-cigarette, Kyrgyzstan

Box 17. Bengaluru makes strides to comply with state-level and national smoke-free laws, India

Since 2017, the Karnataka state capital Bengaluru has worked to reduce smoking in public places across the city, with support from the Partnership for Healthy Cities.

Local enforcement plays a significant part in ensuring that national law, the Cigarette and Other Tobacco Products Act (COPTA), is able to deliver its intended benefits on the ground, by ensuring that citizens comply with the laws in practice. A major part of Bengaluru's effort has been its focus on increasing city-level compliance with national and state-level smoke-free regulation – a critical component of local action in tobacco control. Between 2017 and 2023, Bengaluru's authorities – coordinated by the municipality's "tobacco control cell" – conducted 102 enforcement drives with 36 enforcement officer training sessions in a bid to significantly increase capacity for enforcing

the regulation. Alongside these drives, Bengaluru's authorities also bolstered existing legislation by removing illegal designated smoking areas within the city, towards creating new 100% smoke-free spaces.

To complement the emphasis on enforcement capacity, the city also prioritized citizen awareness. New "No Smoking" signs were displayed in public places, clearly indicating that smoking was not permitted and that those violating the law would be fined. A series of communication campaigns was also run, covering both the risks of tobacco use and the effects of second-hand smoke, thereby reinforcing the need for 100% smoke-free environments.

A local study conducted by Vital Strategies demonstrated that Bengaluru's focused efforts resulted in a near 27% reduction of smoking in public places (down from a rate of 18% in 2017 to 13% in 2021) and a

225% increase in the display of "No Smoking" signages in public venues (from a rate of 23% in 2017 to 75% in 2021).

In March 2023, Bengaluru received an international award for its efforts to reduce smoking in public places and improve compliance with existing smoke-free laws. And as a city, Bengaluru will continue to work towards becoming 100% smoke-free by 2025.



Smoke-free enforcement team in Bengaluru, India



© WHO/Maria Gutu

Offer help to quit tobacco use

Article 14 of the WHO FCTC states:

“Each Party shall ... take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence... Each Party shall ... design and implement effective programmes aimed at promoting the cessation of tobacco use”. WHO FCTC Article 14 guidelines are intended to assist Parties in meeting their obligations under Article 14 of the WHO FCTC) (173).

Help for tobacco users to quit is vital to their success

New tobacco users (usually adolescents) can become dependent after smoking only four cigarettes (180). And while many may eventually want to quit (the health benefits can be felt within hours), only around 4% will succeed without adequate support (181). Established, evidence-based and cost-effective interventions to help people quit include the following.

Behavioural interventions can help people decide to quit and help increase their chances of success

- “Brief advice” from health professionals – given as part of a routine consultation or interaction – makes efficient use of existing health care services and is an opportunity to reach people who might not yet have considered quitting and provide them personalized counselling (182).

- Toll-free quit lines help potential tobacco quitters to access brief and potentially intensive behavioural counselling. They can increase the absolute quit rate by 4% – a doubling of success. “Proactive” quit lines, where counsellors make follow-up calls to potential tobacco quitters, can further improve the success rate (183).
- Mobile phone-based cessation interventions are also promising, with text-message interventions increasing the absolute quit rate by 4% (184).

Pharmacological interventions are safe and highly effective

- Nicotine Replacement Therapy (NRTs), which come in the form of patches and gums, can increase quit success by 6% - more than double the absolute quit rate.
- Other pharmacotherapy interventions such as Bupropion and Varenicline (which reduce the cravings and the pleasure effects of

smoking) can increase the chances of a successful quit attempt by up to 15%.

- Combining different types of NRTs, pharmacotherapies and behavioural interventions, under the guidance of a qualified health care professional, can further increase NRT effectiveness (182, 185).

Over one third of the world’s population are covered by comprehensive cessation services

Currently, 32 countries are covered by comprehensive cessation services (Fig. 25). Since 2007, 22 countries have adopted comprehensive cessation support services and 2.4 billion additional people are now protected by this measure, bringing the total to 2.8 billion people in 32 countries (Fig. 26).

Less than one third of high-income countries, 10% of middle-income countries and 7% of low-income countries offer comprehensive cessation support at best-practice level (Fig. 27). Globally, almost all high-income countries (88%) offer at least partial coverage of the cost of cessation services. Most middle-income countries (72%) do the same, while 21% of low-income countries offer some cost-coverage for services. There are 29 countries that provide no cessation support at all. Only three low-income countries (Democratic People's Republic of Korea, Ethiopia and Zambia) make cost-covered NRTs available to those who want to quit tobacco and only three have established national toll-free quit lines (Burkina Faso, Ethiopia and Zambia) (see Box 18 and Box 19 for examples of quit lines). These numbers show that while work has begun, there is still much more to be done (Fig. 27).

Cessation services must be ready to support increased numbers of potential quitters

Since 2020, six countries with a combined population of 262 million (Ethiopia, Iran (Islamic Republic of), Israel, Mauritius, Romania and Zambia) have started offering comprehensive cessation services, increasing the number of countries doing so from 26 to 32 and increasing the proportion of the world's population covered by comprehensive cessation services from 32% to 35% in the past 2 years (Fig. 26).

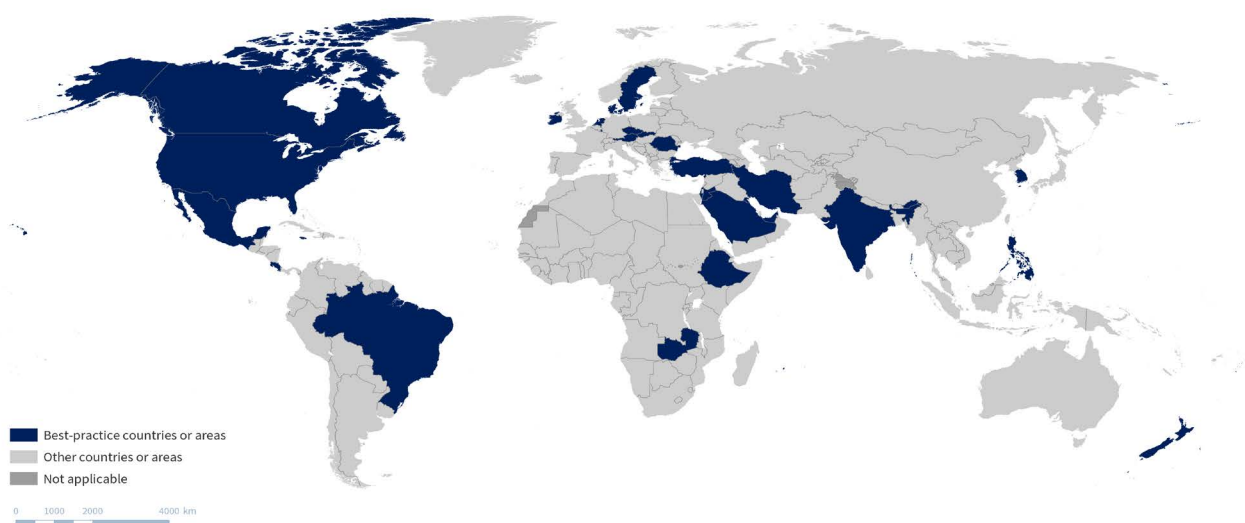
Three high-income countries, covering a population of 4.7 million, offer no support to help users quit, while 13 middle-income countries, with a total population of 89 million, and 13 low-income countries, with 244 million inhabitants, offer no support to tobacco users.

Sixty-two countries – home to 2 billion people – provide cessation support packages that are missing only one element to achieve best-practice

implementation: (i) a national toll-free quit line; (ii) cost-coverage of NRT; or (iii) cost-coverage of cessation services in clinical settings or in the community. Of these 62 countries, 23 need only to add a national toll-free quit line in order to bring comprehensive tobacco cessation support to an additional 710 million people; while 36 need to offer cost-covered NRTs to cover an additional 1.3 billion people; and three countries need to cost-cover one or more of its cessation services in clinical settings or the community so that an additional 52 million people will be covered.

Of the 546 million people (6.9% of the world's population) who live in one of the world's 100 largest cities, only 280 million (in 53 cities) are protected by a comprehensive cessation service (Table A4). Two of these cities are covered by city-level policies (China, Hong Kong SAR, and London). The remaining 48 are covered by national policies. Instead of waiting for a national policy to be put in place, the remaining 47 large cities not currently protected by a national best-practice policy could move ahead with a city, state or provincial-level policy to protect their large populations sooner.

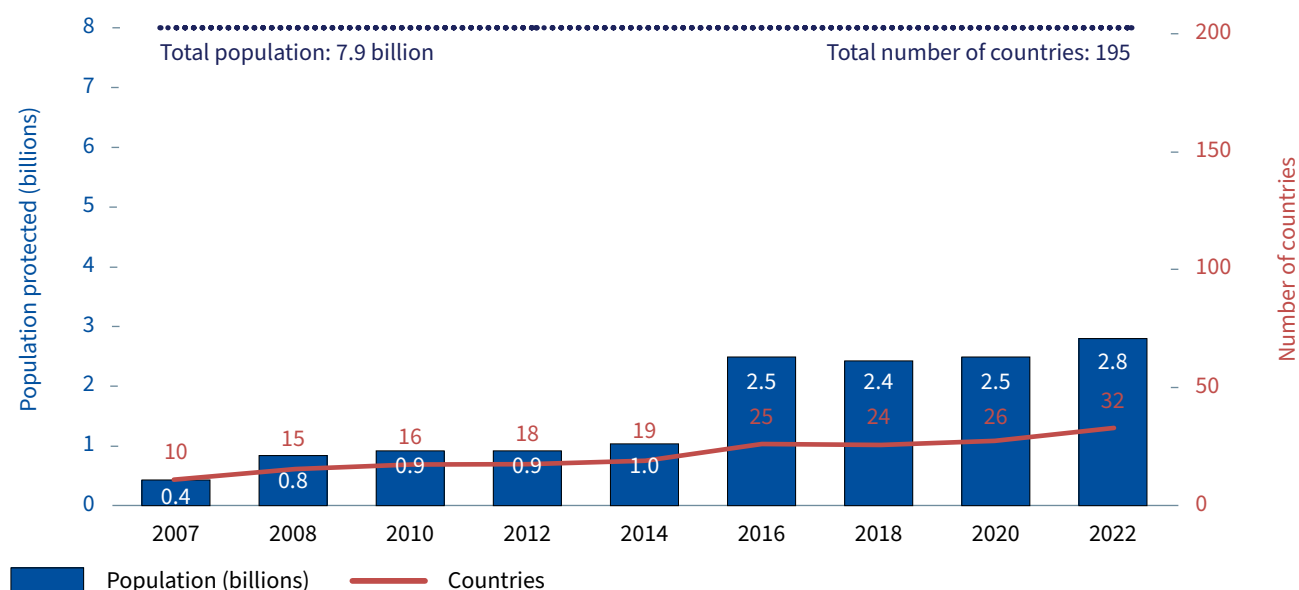
Fig. 25. Tobacco dependence treatment , highest achieving countries, 2022



Countries with the highest level of achievement: Austria, Brazil, Canada, Cook Islands, Costa Rica, Czechia, Denmark, Ethiopia^a, India, Iran (Islamic Republic of)^a, Ireland, Israel^a, Jamaica, Jordan, Kuwait, Luxembourg, Mauritius^a, Mexico, Netherlands (Kingdom of the), New Zealand, Philippines, Republic of Korea, Romania^a, Saudi Arabia, Singapore, Slovakia, Sweden, Tonga, Türkiye, United Arab Emirates, the United States, Zambia^a.

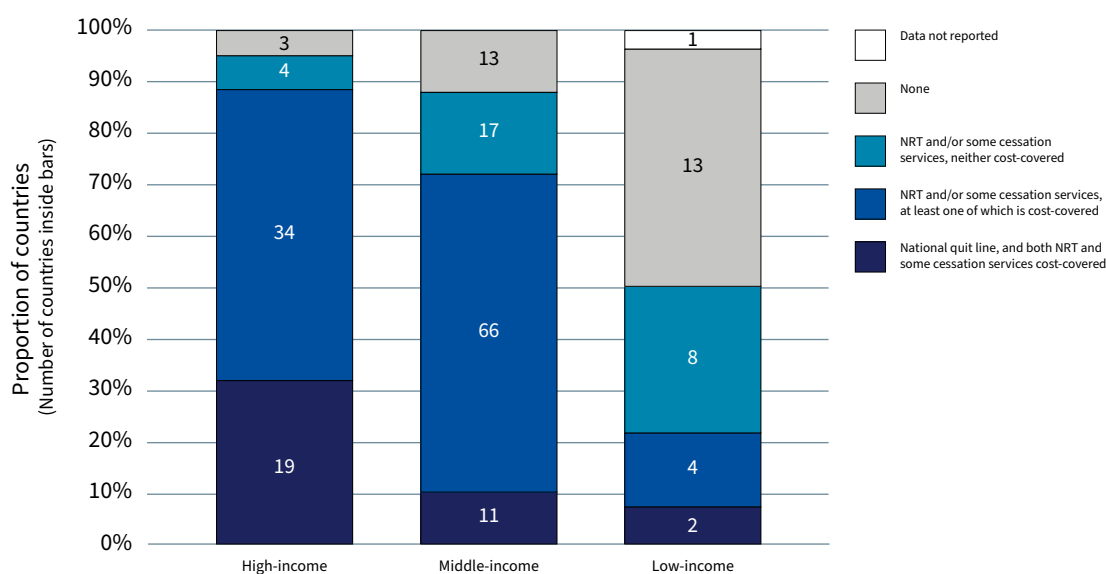
^aCountry newly at the highest level since 2020

Fig. 26. Progress in tobacco dependence treatment (2007–2022)



35% of the world’s population is covered by comprehensive cessation services – second only to graphic health warnings.

Fig. 27. Tobacco dependence treatment, by country-income group, 2022



Box 18. Tobacco cessation services go nationwide, Islamic Republic of Iran

In 2021, the Islamic Republic of Iran's Ministry of Health and Medical Education (MOHME) established a national tobacco cessation helpline and tobacco cessation service clinics nationwide (186).

The free tobacco cessation helpline is available 9am to 3pm, offers evidence-based support to people who want to quit tobacco, i.e., counseling and referrals to tobacco cessation service clinics for medication. The cessation clinics operate in 63 medical science universities (UMSs) – set up, supported and led by the Mental Health and Substance Abuse Prevention Department of MOHME. The tobacco cessation clinics (based in primary health care centres under supervision of the UMSs or specialist centres) can provide prescriptions from general practitioners for the NRT – which is fully covered by the insurance system, and affordable also for those who want to use it without a prescription.

By adding a national toll-free quit line and covering the cost of NRTs for tobacco users, Iran (Islamic Republic of) has progressed to meet the highest level of the “O” component of the MPOWER package for tobacco control. This key achievement was possible with WHO's technical assistance and the support of the WHO TFI Unit. The efforts led to establishing the Iranian comprehensive national cessation service including improving the management of tobacco cessation services, developing and operating a national toll-free quit line; capacity building for primary health care staff working in selected comprehensive health centres offering free tobacco cessation services; advocacy and social awareness-raising on tobacco cessation; and boosting the visibility of tobacco cessation services.



4030 Quit smoking helpline, Iran (Islamic Republic of)



Promotion message for quit smoking helpline, Iran (Islamic Republic of)

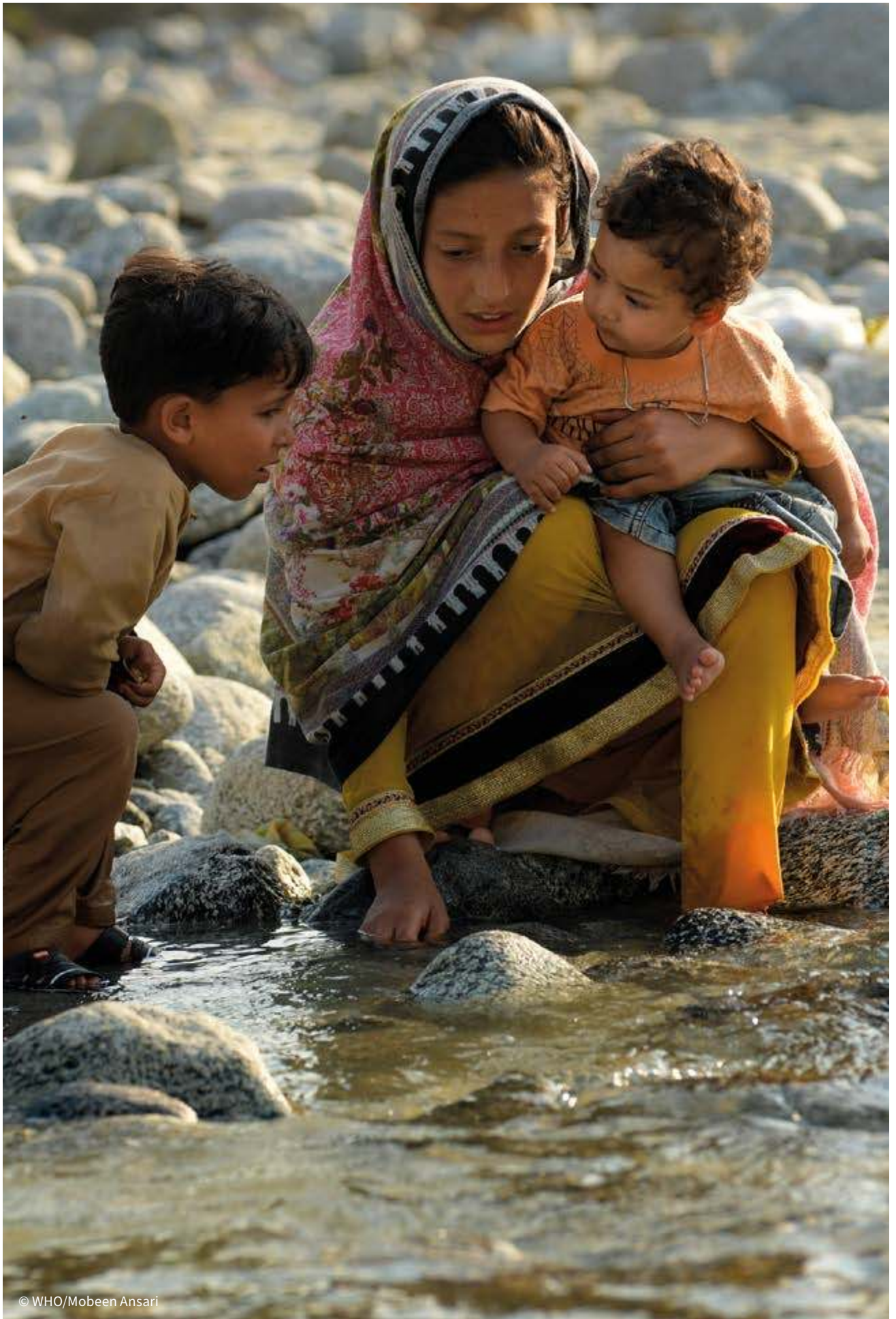
Box 19. Ethiopia and Zambia build upon existing resources to adopt cessation tobacco quitlines.

Lifeline/Childline Zambia (LLCZ) is a Zambian NGO founded in 2003 to respond to the HIV/AIDS pandemic. It runs two 24-hour toll-free lines – Lifeline 933 and 116 for Childline – providing support to vulnerable women and children facing abuse, mental health issues, and other challenges. Since 2022 the call centre has also received and responded to calls about tobacco addiction and offers assistance to those attempting to quit. The helpline provides one-on-one counselling, coping strategies, and referrals to resources and local cessation programmes.

Other services provided by LLCZ include WhatsApp, web-based assisted tobacco interventions, and text messaging, as well supporting family, friends, and health care professionals who want to help tobacco users to quit.

National Health information and counseling (952) is a toll-free health hotline run by Ethiopia's Ministry of Health that provides accurate information, counseling and referral services on different health topics. It was an important source of information during the COVID-19 pandemic. In March 2022, with the

support of WHO, the Ministry of Health trained 31 counsellors on tobacco cessation and quit line protocols. In the space of only 4 months the line received 112 calls from people seeking support on addictive substances and 61 of these were specific to tobacco use. Currently the toll-free health hotline is serving the community using more than five languages and is open 10 hours a day, 5 days a week.



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Warn about the dangers of tobacco

Article 11 of the WHO FCTC states:

Each Party shall ... adopt and implement ... effective measures to ensure that ... tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions". WHO FCTC Article 11 guidelines are intended to help Parties meet their obligations under Article 11 of the WHO FCTC, which provides a clear timeline for Parties to adopt appropriate measures (within 3 years after entry into force of the WHO FCTC for a given Party) (173).

Graphic health warning labels reliably reach users with critical information on dangers of tobacco

Many tobacco users are ill-informed about the dangers to which they expose themselves and others by consuming tobacco, and they have a right to be warned about the health impacts of the products they consume (187, 188).

Accurate, prominent and strong warnings on tobacco packaging reliably reach the users who purchase tobacco, increase knowledge about the harms of tobacco, prompt tobacco users to think about quitting, and can result in decreased tobacco use (189, 190).

Health warnings are most effective when they:

- are illustrated using pictures or graphics (191);
- use strong words to describe the harms caused by tobacco (192, 193);
- cover at least half of a package's surface (front and back) (194) (see Box 20);
- refer to specific health problems that arise from tobacco use;
- are rotated on a regular basis to maintain their impact (195).

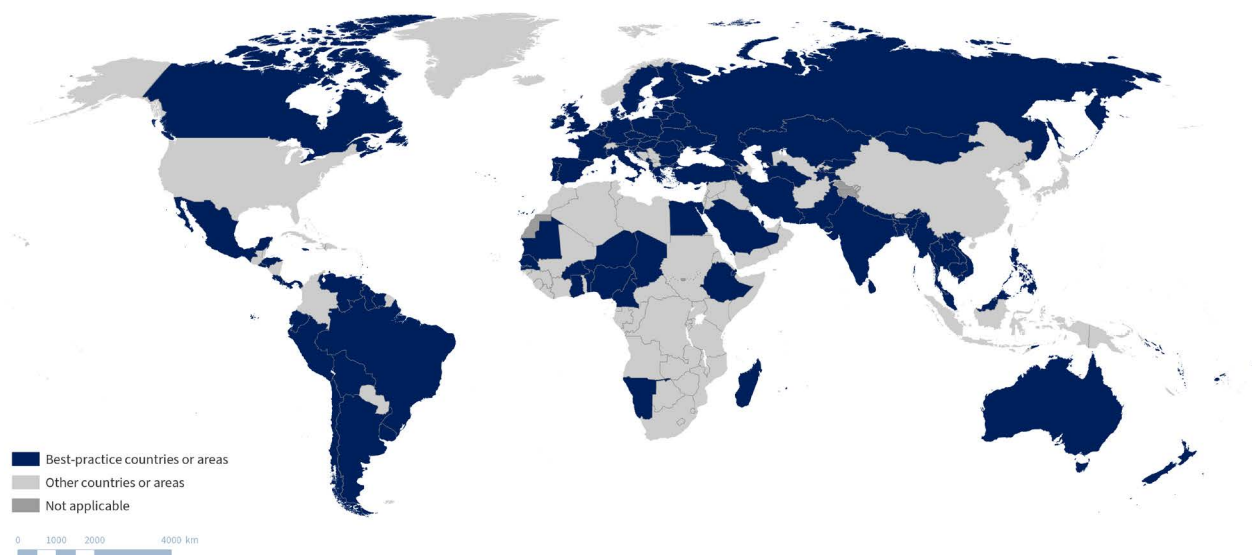
The tobacco industry also uses packaging to market their brands and include deceptive terms like "light" or "low tar". To address this, plain packaging is an increasingly adopted intervention that can reduce the impact of these marketing strategies and improve people's understanding (196).

More countries have adopted strong graphic health warnings than any other MPOWER measure

Since 2007, 94 countries have adopted strong graphic package warnings, thereby covering 4.2 billion additional people and bringing the total number of people protected by this measure to 4.5 billion across 103 countries. Of all MPOWER measures, large graphic pack warnings on cigarettes have seen most progress since 2007 – both in terms of countries deploying, and population covered by, a best-practice policy (Fig. 28 and Fig. 29).

Over the 15 years of MPOWER, the number of countries with large pictorial health warnings has increased from 9 to 103, a 10-fold increase.

Fig. 28. Health warning labels – highest achieving countries, 2022



Countries with the highest level of achievement: Albania, Argentina, Armenia, Australia, Austria, Bangladesh, Barbados, Belarus, Belgium, Benin^a, Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Cambodia, Cameroon, Canada, Chad, Chile, Costa Rica, Croatia, Cyprus, Czechia, Denmark, Djibouti, Ecuador, Egypt, El Salvador, Estonia, Ethiopia, Fiji, Finland, France, Gambia, Georgia, Germany, Ghana, Greece, Guyana, Honduras, Hungary, India, Iran (Islamic Republic of), Ireland, Italy, Jamaica, Kazakhstan, Kyrgyzstan, Lao People’s Democratic Republic, Latvia, Lithuania, Luxembourg, Madagascar, Malaysia, Malta, Mauritania, Mauritius, Mexico, Mongolia, Montenegro, Myanmar^a, Namibia, Nepal, Netherlands (Kingdom of the), New Zealand, Niger, Nigeria, Pakistan, Panama, Peru, Philippines, Poland, Portugal, Qatar, Republic of Moldova, Romania, Russian Federation, Saint Lucia, Samoa, Saudi Arabia, Senegal, Seychelles, Singapore, Slovakia, Slovenia, Solomon Islands, Spain, Sri Lanka, Suriname, Sweden, Tajikistan, Thailand, Timor-Leste, Trinidad and Tobago, Türkiye, Turkmenistan, Ukraine, the United Kingdom, Uruguay, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam

^aCountry newly at the highest level since 2020

Fig. 29. Progress in health warning labels (2007–2022)

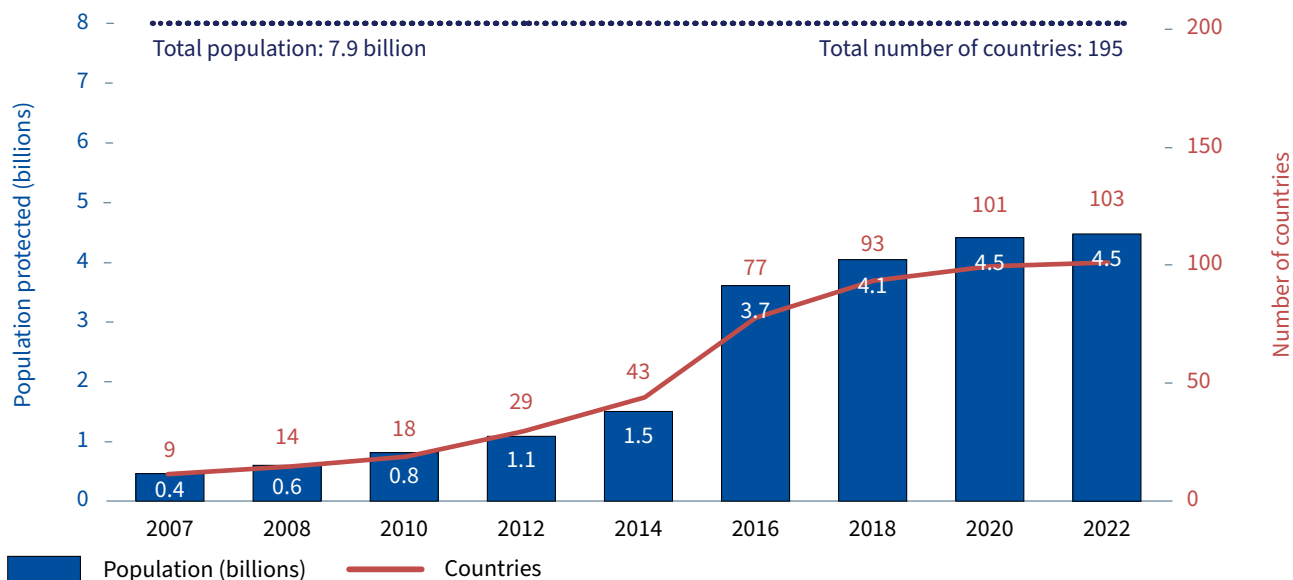
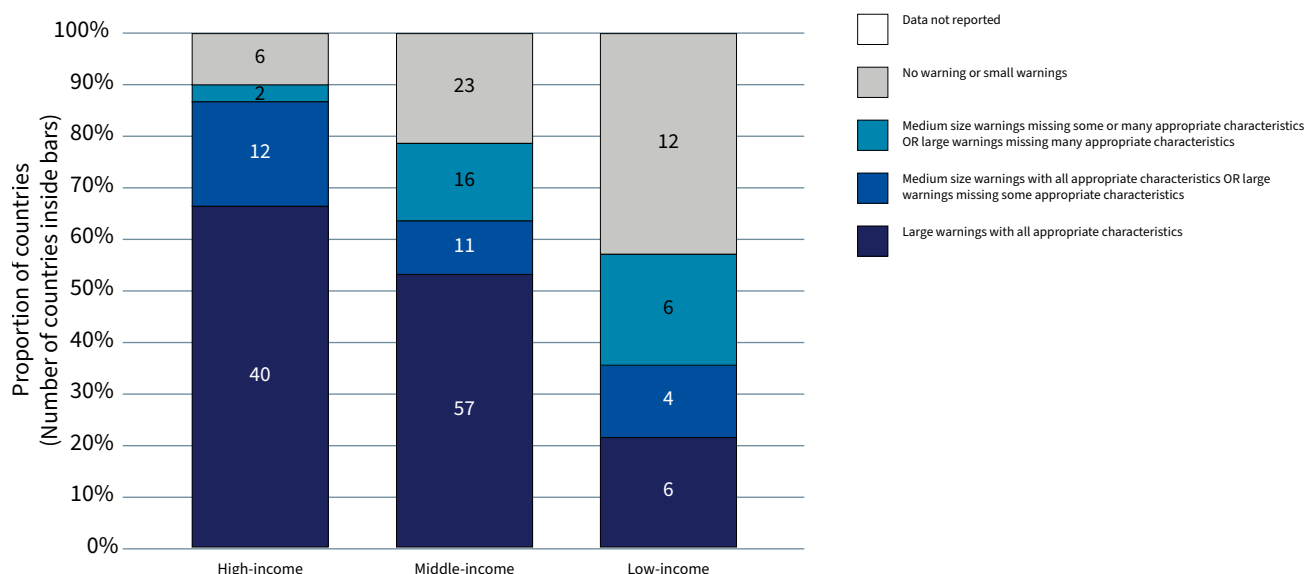


Fig. 30. Health warning labels, by country-income group, 2022



This means that strong health warnings now cover over half of the global population (57%) and over half of all countries: 67% of high-income countries, 53% of middle-income countries and 21% of low-income countries. Only 21 countries (four high-income, 11 middle-income and six low-income) have not adopted any warning labels, and 45 others have issued warnings that cover less than 50% of the principal package display areas (below the coverage required by the WHO FCTC) (Fig. 30).

In the past 2 years, two additional countries (Benin and Myanmar) (see Box 21), with a combined 1% of the world's population, have joined the 101 countries that required large graphic warning labels on tobacco products in 2020. Both countries are middle-income countries.

An increasing number of countries mandate plain packaging of tobacco products

Despite tobacco industry lobbying, several countries are moving forward with plain packaging. By the end of 2022, 22 countries had adopted legislation mandating plain packaging of tobacco products and had issued regulations with implementation dates (Australia, Belgium, Canada, Denmark, Finland, France, Georgia, Hungary, Ireland, Israel, Mauritius, Myanmar, Netherlands (Kingdom of the), New Zealand, Norway, Saudi Arabia, Singapore, Slovenia, Thailand, Türkiye, the United Kingdom, and Uruguay). One area of innovation is the application of health warnings on individual cigarettes. Canada will be the first country to use this intervention when the regulation comes into force in August 2023.

Strong graphic health warnings appear on cigarette packaging in over half of all countries

Eight countries, with 443 million people, need only raise the pack coverage by 20% or less to meet all best-practice criteria for large graphic pack warnings. An additional 14 countries have mandated large warnings (at least 50% of the pack) and need only add one criterion to achieve best-practice. Seven of these 14 countries, representing 153 million people, need only mandate that strong graphic health warnings appear on each package and any outside packaging used in the retail sale. Five countries, with a total 18 million people, need only add a graphic image to their current text-only warnings.

Of the 546 million people (6.9% of the world's population) who live in one of the world's 100 largest cities, only 397 million (in 68 cities) are informed about the dangers of tobacco use by the display of large graphic warning labels on their cigarette packs (Table A4). One of these cities is covered by city-level policies (China, Hong Kong SAR) and the remaining 67 are covered by national laws.

Box 20. Tunisia becomes first country in WHO Eastern Mediterranean Region to adopt 70% pictorial health warnings

Since 1999, tobacco packaging in Tunisia had featured only a single written health warning, but in 2022 the Tunisian Ministry of Health issued a new requirement for the placement of two annually rotating pictorial health warnings that occupy at least 70% of the principal display areas of tobacco packages (197). This decision has made Tunisia the country with the largest pictorial health warnings on tobacco packages in the WHO Eastern Mediterranean Region (198).

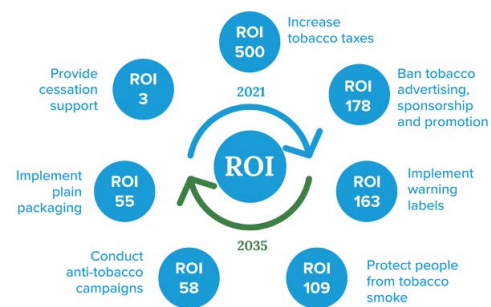
This key achievement was a result of the WHO FCTC 2030 project, in which WHO and the WHO FCTC

Secretariat supported Tunisia's tobacco control efforts through an anti-tobacco investment case study (199, 200). For every Tunisian dinar invested, pictorial health warning labels alerting people to the dangers of tobacco use generated 163 Tunisian dinars – making the labels one of the three highest return-on-investment strategies. Based on this evidence, WHO and WHO FCTC supported the Tunisian Ministry of Health to issue the order and to develop pictorial health warnings for display on tobacco products.

Warnings include written health messages in Arabic which describe the harmful effects of smoking. The warnings are approved by the Ministry of Health, printed in clear characters and images on a contrasting background, are apparent and understandable, and must not appear in a place where they risk being damaged when the package is opened, and not appear on the transparent sheet or on any other outer wrapping. The requirement to rotate health warnings is designed to minimize any “wear out” of the warnings' impact.



Graphic health warnings on cigarette packages, Tunisia



WHO FCTC Investment case: demonstrating the return-on-investment of tobacco control in Tunisia (200)

Box 21. Tobacco warnings go from strength to strength, Benin

When the newly adopted WHO FCTC was closed for signature on 29 June 2004, Benin was one of the 168 signatories. Signing the Treaty was a political act that indicated the agreement of a Member State to ratify it and its commitment to implement its provisions. One year later, on 3 November 2005, Benin ratified the Treaty, and became a Party to the WHO FCTC three months later.

Soon after this, on 7 August 2006, the national assembly adopted the Law No. 2006-12 Concerning Regulation of the Production, Commercialization and Consumption of Cigarettes and Other Tobacco Products. Under this law, for the first time in Benin, a textual warning was required to be displayed on at least 30% of the main areas of tobacco packages. This single textual warning was still displayed until recently.

Indeed, in 2017, Law No. 2017-27 of December 18, 2017 relating to the production, packaging, labelling, sale and use of tobacco and similar products was adopted, requiring

large pictorial health warnings to be displayed on tobacco packages for the first time in Benin. On 11 June 2021, the Minister of Health signed Decree No. 2021-0065 prescribing the graphic and written health warnings to be printed on the packaging of cigarettes and other tobacco products in 2022. Four new health warnings are required, each of them being accompanied with a descriptive picture. The four warnings will rotate every two years. The image covers 60% of front and rear surfaces of the packages, and the textual warning covers an additional 30% of these surfaces, which means 90% of front and rear of the tobacco packages are used for displaying mandatory health warnings and labelling requirements.

This was followed by Decree No. 2022-073 of February 9, 2022 setting the conditions and procedures for issuing approvals for the manufacture and import of tobacco, its derivatives and similar in the Republic of Benin, initiated by the Ministry in charge of trade pursuant to Article 8 of the Protocol

to Eliminate Illicit Trade in Tobacco Products that Benin ratified in 2018. The latter requires the validation of mock-ups of tobacco product packaging by the Ministry in charge of health before the issuance of approval to import and market tobacco products in Benin.



Graphic health warning, Benin

Anti-tobacco mass media campaigns

Article 12 of the WHO FCTC states:

“Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. ... each Party shall ... promote ... broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke; ... [Each party shall promote] public awareness about the risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles; ... [each party shall promote] public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption” (173).

Mass media campaigns are essential to all comprehensive tobacco control strategies or programmes

Anti-tobacco mass media campaigns are effective interventions that can quickly and efficiently reach large populations and help to reduce tobacco use, increase quit attempts, lower youth initiation rates and reduce second-hand smoke exposure in all countries (201–204). Mass media campaigns should:

- be well-designed through a collaborative approach involving health professionals, researchers, creative designers and the media (205);
- be hard-hitting, emotionally evocative and/or testimonial in nature (206);
- involve multiple communication channels (i.e. TV, radio and the Internet), which are more likely to have a longer-term impact on tobacco-use behaviour (207);
- be sustained over time (although campaigns with a duration of as little as 3 weeks can also have a positive impact) (208–210);

- include toll-free quit line numbers on campaign products, e.g. at the bottom of posters or at the end of TV advertisements.

Less than one quarter of the world’s population was exposed to a best-practice mass media campaign in 2022

Less than one quarter of the world’s population (1.5 billion people) live in a country that has aired at least one national best-practice anti-tobacco mass media campaign in the past 2 years (see Fig. 31). Another quarter of countries conducted mass media campaigns of at least 3 weeks’ duration, with some but not all best-practice criteria.

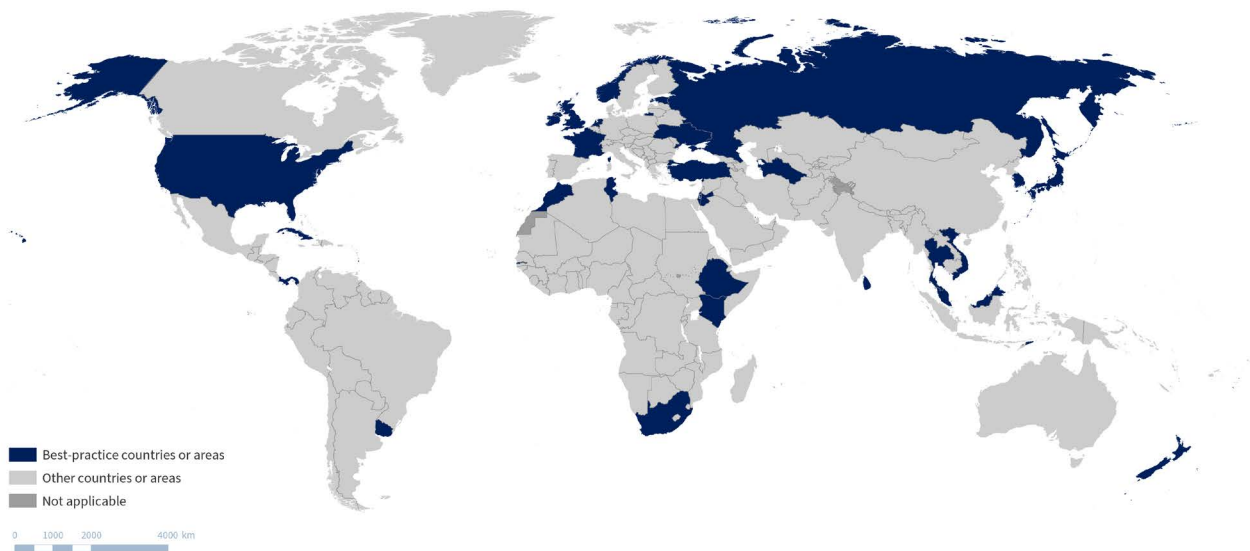
The first year for which mass media campaigns were monitored was 2010, and for the ensuing 4 years the proportion of the world’s population exposed to a best-practice mass media campaign rose, reaching 4.3 billion people in 39 countries in 2014. Regrettably, by 2022 this number had dropped by more than half, to 1.5 billion people in 36 countries (Fig. 32).

Of the 36 countries that ran an anti-tobacco mass media campaign since 2020, 16 were high-income countries (27% of high-income countries); 18 (17%) were middle-income countries; and two (7%) were low-income countries (see Box 22 and Box 23) (Fig. 33). More than half of the countries in the world (112 countries) have run no sustained campaign or have not reported data in the past 2 years, leaving about 24% of the world’s population not covered by this measure. This means that an estimated 217 million tobacco users have not been exposed recently to any anti-tobacco mass media campaign.

National anti-tobacco mass media reach continues to shrink

People in low-income countries are the least exposed to anti-tobacco mass media: over 80% of the population of low-income countries, living in 25 countries, have not been exposed to any kind of campaign in the past 2 years (Fig. 33).

Fig. 31. Anti-tobacco mass media campaigns, highest achieving countries and territory, 2022



Countries and territories with the highest level of achievement: Bahrain^a, Cuba, Estonia, Ethiopia, France, Gambia^a, Ireland, Israel^a, Japan, Jordan^a, Kenya^a, Malaysia, Monaco, Morocco, Nauru^a, Netherlands (Kingdom of the)^a, New Zealand, Norway, occupied Palestinian territory^a, Panama^a, Republic of Korea, Russian Federation, Saint Lucia, South Africa^a, Sri Lanka^a, Thailand, Timor-Leste, Tonga, Tunisia, Türkiye, Turkmenistan, Ukraine, the United Kingdom, the United States, Uruguay^a, Viet Nam

^aCountry newly at the highest level since 2020

6.4 billion people have not been warned about the dangers of tobacco by a best-practice mass media campaign in the last 2 years.

Fig. 32. Progress in anti-tobacco mass media campaigns, 2010–2022

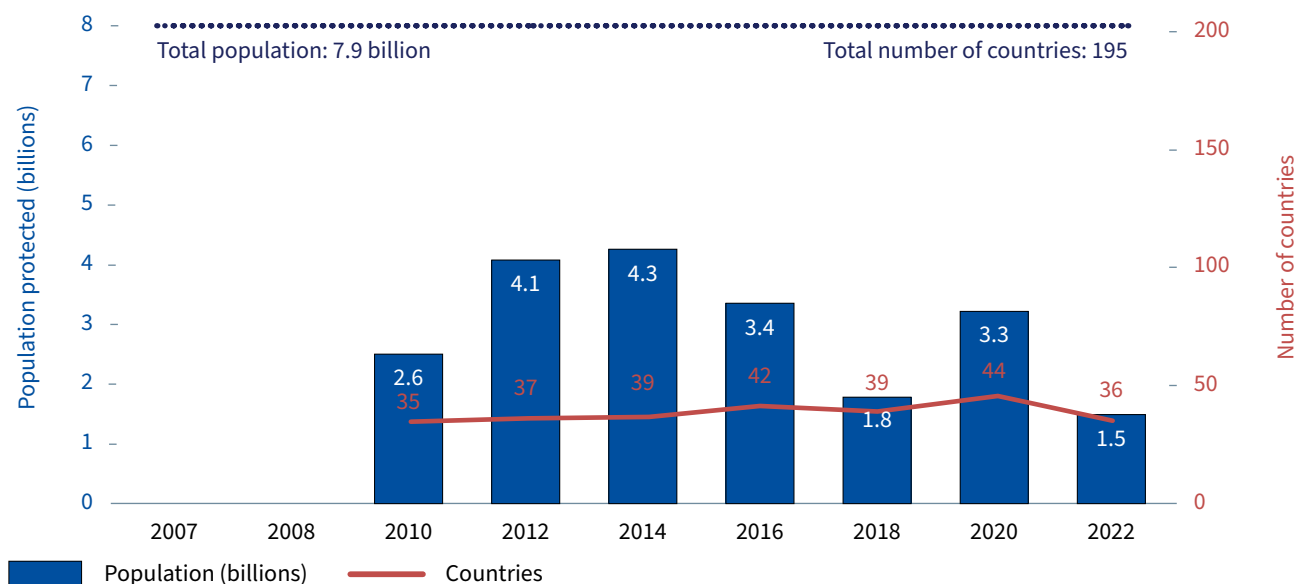
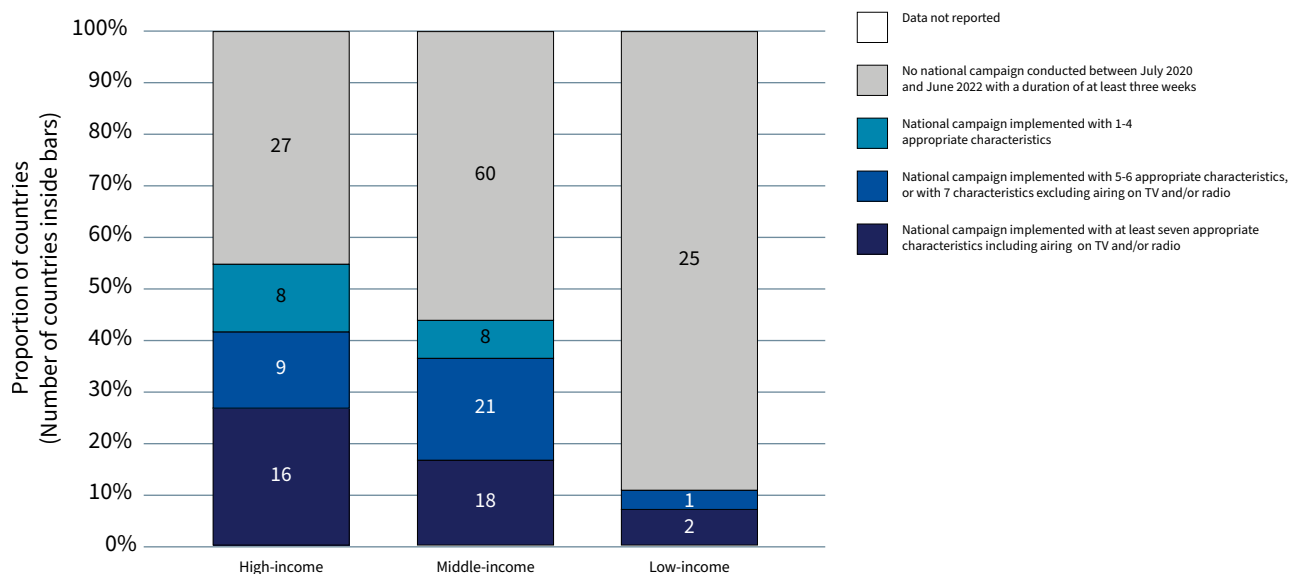


Fig. 33. Mass media campaigns by country-income level, 2022



Box 22. “United against tobacco and COVID-19” campaign success, occupied Palestinian territory

In the occupied Palestinian territory, the Palestinian Ministry of Health successfully aired its “United against tobacco and COVID-19” mass media campaign between June and September 2022, despite the ongoing emergency situation that deepened during the COVID-19 pandemic (211–214). The campaign was also conducted in Egypt, Iraq, Jordan, and Türkiye (213), and was funded by the Centers for Disease Control and implemented by Global Health Development Eastern Mediterranean Public Health Network (GHD|EMPHNET) with technical assistance from Vital Strategies (215).

The campaign, covering villages, cities, and refugee camps, was run in parallel with other campaigns and highlighted the harms of tobacco and the benefits of tobacco cessation to smokers, their families and friends, and others (211–214). Built on five key activities, the campaign was aired on television and radio, and advertised via billboards, SMS messages, pre-paid Internet adverts, social media platforms, and posters on public transport. In addition, supporting activities were developed

throughout the campaign, including video interviews with children (held with their parents’ permission) in which they expressed their opinions about smoking (211–214).

Public surveys and focus group discussions were used to research the views of the target audience and inform and develop the campaign messages, and to pre-test the campaign materials before roll-out. The Ministry of Health monitored the campaign to ensure the campaign materials were used as planned, and worked with journalists to gain publicity.

The campaign achieved its predefined target by reaching more the 3 million Palestinian people, despite the challenges faced. The Palestinian Ministry of Health used the timing of the campaign to open smoking cessation clinics at all primary health care centres in 14 districts and used the campaign platform to start conversations with local communities to enact policies to decrease smoking prevalence. A post-implementation impact evaluation of the campaign was held.



United against tobacco and COVID-19 campaign- The risk of Argileh Smoking, occupied Palestinian territory

Box 23. Successful, sustained national tobacco control mass media campaigning, Viet Nam

Since 2015, the Viet Nam Tobacco Control Fund (VNTCF) at the Ministry of Health has conducted successful mass media communication campaigns to promote behaviour change and influence social norms among adults, youth and children. Campaigns also discouraged young people from starting and can mobilize non-smokers such as women to support policy and change norms.

The campaigns were carried out with technical support from partners including Vital Strategies (Vital), the Campaign for Tobacco Free Kids, the Viet Nam Public Health Association and the WHO Country Office in Viet Nam, and funded by a percentage of tobacco tax revenue earmarked for tobacco control activities. Campaign design, including audience selection, objectives, messages, materials and planning, was data-driven and evidence-based. Sources included the Global Adult Tobacco Survey of 2010 and 2015, and formative research from previous campaigns. Messages reached audiences through earned and paid media such as TV and billboards, as well as social media including the Vn0koithuoc (Smoke-free Vietnam) Facebook page. Support by VNTCF through the 63 provincial Centers for Disease Control and Prevention enabled messages to be disseminated through provincial cities, in hospital waiting rooms, buses, train stations, community

education settings, and provincial television.

Using insights into women's concerns about the harms of second-hand smoke, VNTCF and Vital provided strategic support to mass media campaigns run by the Viet Nam Women's Union, which has a network of around 20 million women. 'Quit Smoking to Protect Your Loved Ones' and 'Women create smoke-free homes' carried messages including the personal stories of women harmed by others' smoking into the homes of women across Viet Nam. Youth were another target audience. Partnering with the Youth Union, which has a membership of more than 7.3 million people aged 18–35 years, the team ran national competitions about the harms of tobacco and electronic cigarettes which achieved millions of views on the Union's social media platforms. This campaign mobilized the voices of youth to support tobacco control policies, and reject smoking and e-cigarettes.

To protect children, VNTCF and partners worked with the Ministry of Education and Training to raise awareness and support schools and students to say no to new tobacco and nicotine products.

Training curriculum and school-based communication products were developed with the engagement of teachers and parents' associations, raising the

voices of millions of secondary and high school students against new tobacco and nicotine products.

Annual evaluations of national mass media campaigns have consistently shown recall by more than half of the population aged 15 years and older, and support for tobacco control policies. Campaigns also increased smokers' and non-smokers' knowledge and concerns about the harms of smoking and exposure to second-hand smoke. Smokers said they were more likely to attempt to quit after seeing the campaigns. Non-smokers said they were more likely to complain about being exposed to smoke in public places.



A campaign poster illustrating a child affected by second-hand smoke in a café, Vietnam



Enforce bans on tobacco advertising, promotion and sponsorship

Article 13 of the WHO FCTC states:

“... [A] comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products. Each Party shall ... undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship. ... [W]ithin the period of 5 years after entry into force of this Convention for that Party, each Party shall undertake appropriate legislative, executive, administrative and/or other measures and report accordingly in conformity with Article 21”. WHO FCTC Article 13 guidelines are intended to assist Parties in meeting their obligations under Article 13 of the WHO-FCTC (173).

TAPS bans protect children from tobacco advertising and marketing tactics

Tobacco companies claim that the billions of dollars they spend annually on advertising serve only to increase their market share at the expense of competitors, but there is indisputable evidence that TAPS activities also increase or sustain tobacco use by effectively recruiting new tobacco users and discouraging current users from quitting (216–218). Tobacco companies use a mix of TAPS techniques, including:

- developing new products (e.g. ENDS) that circumvent regulations and attempt to maintain social acceptability of tobacco use (219);
- targeting young people and women, especially in low- and middle-income countries (220, 221) – such promotion increases the likelihood that adolescents will start to use tobacco which may lead to a higher prevalence of adult tobacco users in the future;
- activities that can influence the businesses that may benefit from the billions of dollars invested in TAPS themselves;
- attempts to avoid regulation by adopting weak voluntary advertising codes;

- discrediting the evidence base for restrictions;
- using lobbyists and litigation to avoid TAPS bans (222).

TAPS bans are an effective tobacco control measure to reduce tobacco use

TAPS bans effectively reduce tobacco sales and tobacco consumption in all parts of the world (223) and their impact may be strongest in low- and middle-income countries (224). Comprehensive bans on all TAPS activities are a key tobacco control strategy and policy measure (173) – one of only two WHO FCTC provisions with a mandatory timeframe for implementation.

Bans must cover all TAPS activities

TAPS bans must be comprehensive, as partial bans have little or no effect (225,226) and allow tobacco companies to exploit legal loopholes or shift their investments to forms of promotion that are not banned (227). Legislation to ban TAPS should use clear, uncomplicated language and unambiguous definitions, and avoid providing lists of prohibited activities that are, or could be understood to be, exhaustive (228).

Moreover, legislation must be coupled with strong enforcement and monitoring, with high financial penalties for violations (173). Bans must cover all TAPS activities, including:

- direct promotion (e.g. TV advertising, radio, print publications and billboards as well as advertising at points of sale);
- indirect promotion (e.g. brand stretching and brand sharing, free distribution, price discounts, product placement on TV/films and sponsorships including “corporate social responsibility” programmes) (229) (See Box 24 and Box 25);
- point of sale product displays that “normalize” tobacco products, prompt people to smoke, encourage impulse purchases, interfere with quitting, and increase the susceptibility of children and youth to see and try the products (230, 231);
- financial or in-kind contributions that tobacco companies may make to another entity for deserving or socially responsible causes – contributions that fall within the definition of tobacco sponsorship in article 1(g) of the WHO FCTC (232);
- corporate social responsibility activities that aim to convince governments to delay and refrain from implementing tobacco control programmes (233).

TAPS bans should protect children and adolescents from exposure through digital media

TAPS activities can appear via multiple social media platforms and children and adolescents are particularly exposed (234), not least through social media influencers, spokespeople, and brand-sponsored contests that are used to promote tobacco products (235, 236). Countries' existing TAPS ban legislation may not necessarily clearly or explicitly include a ban on advertisements on the Internet, so ensuring that bans cover Internet-based media is crucial. In some cases, enforcing TAPS bans on social media sites may require cross-border legislation, and for this reason, countries will need to cooperate and coordinate efforts (237) (see Box 26).

The number of countries covered by TAPS bans continues to steadily rise

Today 66 countries are covered by best-practice TAPS bans (Fig. 34). Since 2007, 58 countries have adopted comprehensive TAPS bans. 1.8 billion additional people are now protected by this measure, bringing the total to just under 2 billion people in 66 countries.

In 2007 there were only eight countries – 3% of the world's population – with best-practice TAPS bans in place (Fig. 35).

Almost half of low-income countries have complete TAPS bans

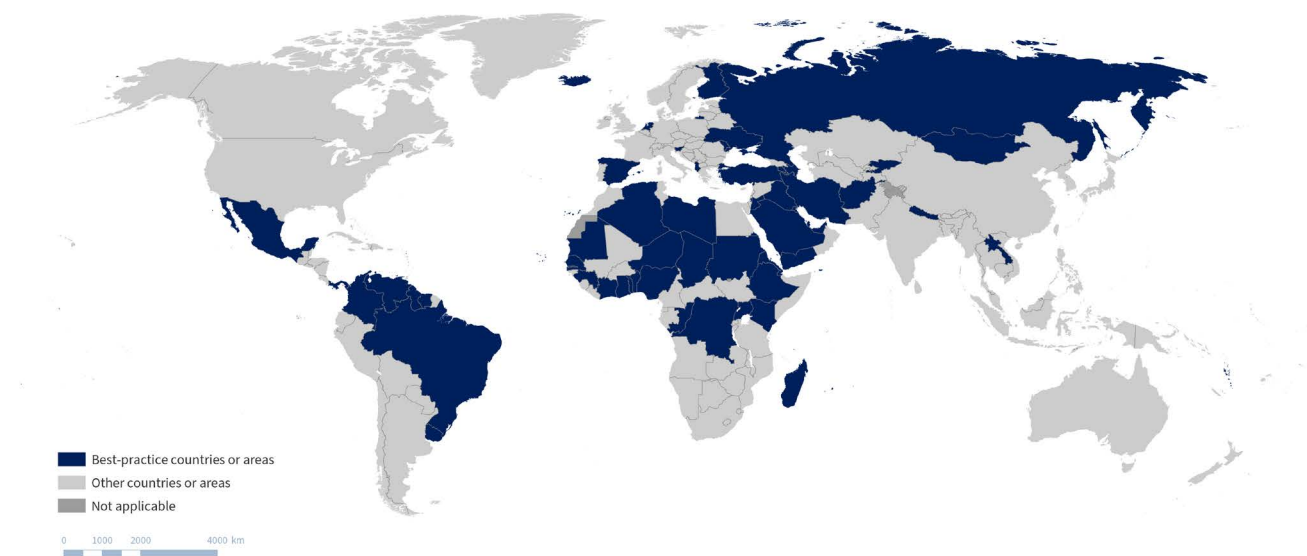
In 2022, of the 66 countries with comprehensive TAPS bans, 13 are low-income countries, 38 are middle-income countries and 15 are high-income countries. While almost half of all low-income countries have a best-practice TAPS ban in place, only one third of middle-income countries and one-quarter of high-income countries have achieved this (Fig. 36).

24 countries are close to a complete TAPS ban

A best-practice TAPS ban has 10 appropriate characteristics. In 2022, 24 countries covering 656 million people had mandated nine of these 10 characteristics and thus are only one provision away from achieving a best-practice ban. The most common missing provision is banning brand stretching (eight countries), followed by banning advertising at point of sale (six countries). The others are banning sponsorship (four countries), banning promotional discounts (three countries) and banning the appearance of tobacco products or brands in TV and/or films (one country). Thirty-nine countries, with 1.1 billion people, have a complete absence of TAPS bans, or very minimal restrictions.

Over one third of the 546 million people who live in the world's 100 largest cities are protected by TAPS bans. Thirty-six of the cities are covered by comprehensive national laws (Table A4). Instead of waiting for a national policy to be put in place, the remaining 64 of the world's largest cities not currently protected by a national best-practice policy could move ahead as appropriate with a city, state or provincial level policy to protect their large populations sooner.

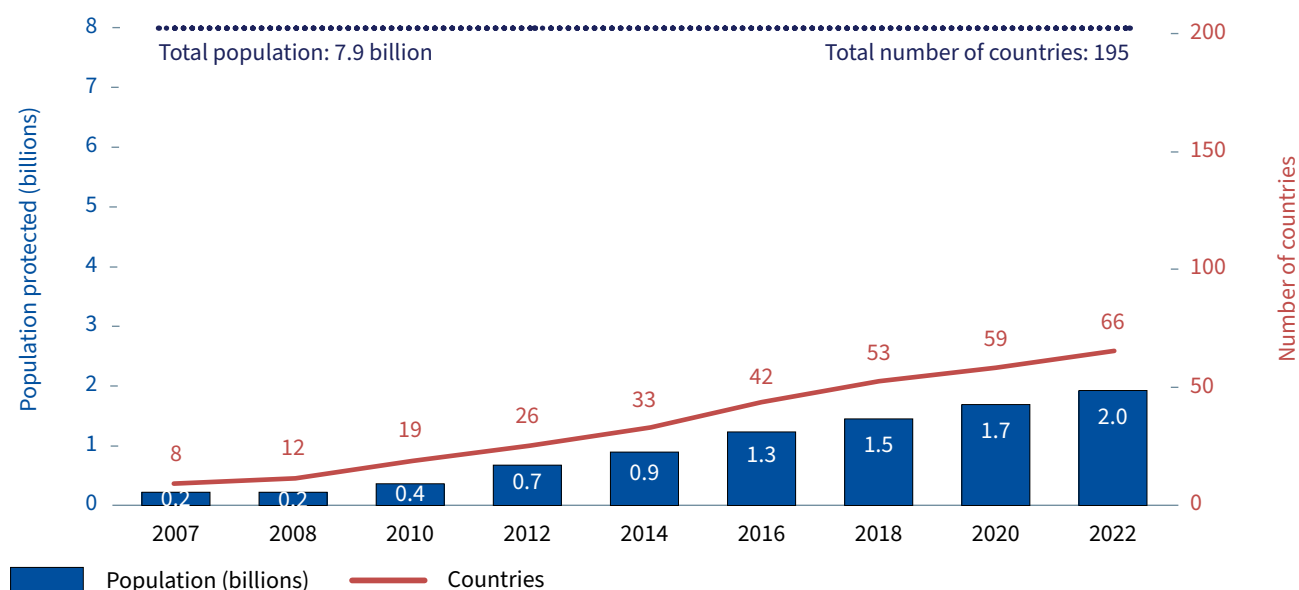
Fig. 34. Enforcement bans on advertising, promotion and sponsorship – highest achieving countries and territory, 2022



Countries and territories with the highest level of achievement: Afghanistan, Albania, Algeria, Antigua and Barbuda, Armenia, Azerbaijan, Bahrain, Benin, Brazil, Cabo Verde^a, Chad, Colombia, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Finland, Gambia, Ghana, Guinea, Guyana, Iceland, Iran (Islamic Republic of), Iraq, Jordan, Kenya, Kiribati, Kuwait, Kyrgyzstan^a, Lao People's Democratic Republic^a, Libya, Madagascar, Maldives, Mauritania, Mauritius, Mexico^a, Mongolia, Nepal, Netherlands (Kingdom of the)^a, Niger, Nigeria, Niue, occupied Palestinian territory, Panama, Qatar, Republic of Moldova, Russian Federation, Saudi Arabia, Senegal, Seychelles, Slovenia, Spain, Sudan^a, Suriname, Togo, Türkiye, Tuvalu, Uganda, Ukraine^a, United Arab Emirates, Uruguay, Vanuatu, Venezuela (Bolivarian Republic of), Yemen

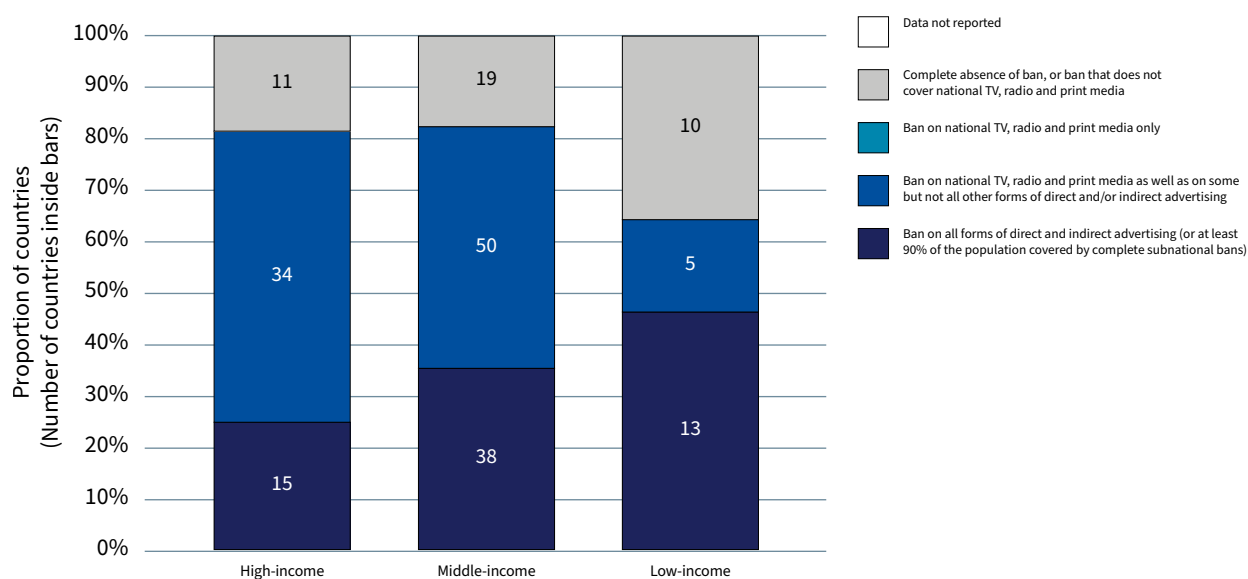
^aCountry newly at the highest level since 2020

Fig. 35. Progress in bans on tobacco advertising, promotion and sponsorship, 2007–2022



With seven new countries at best-practice level in 2022, one third of countries and 25% of the world population is covered by TAPS bans.

Fig. 36. Bans on advertising, promotion and sponsorship, by country-income level



Box 24. Cabo Verde strengthens legislative field regarding tobacco advertising

New legislation to ban tobacco advertising in Cabo Verde was approved by the country's parliament in 2022, stipulating that "all forms of direct or indirect, hidden, concealed and subliminal advertising and promotion of tobacco companies and their brands are prohibited", alongside all types of sponsorship or information campaigns.

The ban on direct tobacco advertising includes advertising in international magazines and newspapers, international television and radio, national television and radio, local magazines and newspapers, posters and outdoor advertising, point-of-sale advertising and Internet advertising.

The new tobacco legislation also prohibits smoking (including through the use of e-cigarettes) in places where sovereign bodies, public administration services and bodies, and State companies are located, as well as in hospitals, buildings serving people under the age of 18 years; and sports facilities, among others.

It also sets out the prohibition of the sale, supply and consumption of tobacco by people under the age of 18 years, and a "ban on the marketing of tobacco in establishments, particularly educational, health and sports establishments, thus limiting young people's access to tobacco products".

According to a STEPS non-communicable disease survey conducted in 2020, the prevalence of tobacco use in Cabo Verde is 12.5% and 15% of the population is exposed to second-hand smoke (238).



March for tobacco control – Santa Catarina, Cabo Verde

Box 25. Law tightens to include sponsorship ban and other key measures, Sudan

In 2005, Sudan adopted a national tobacco control law prohibiting tobacco advertising and promotion. However, tobacco sponsorship was not addressed by the 2005 law, leaving legislative gaps that the tobacco industry was exploiting (239).

In 2018, the Government of Sudan asked the WHO FCTC Secretariat to conduct a joint needs assessment mission for tobacco control in Sudan considering its obligations under the Convention, during which an international team interacted with Sudan's Federal Ministry of Health and various national stakeholders; the WHO regional and country offices; and the United Nations resident coordinator (240). Banning sponsorship was among the development areas identified during the mission in order for the tobacco control legislation to comply with Article 13 of the WHO FCTC.

Despite the emergency situation in Sudan, the Federal Ministry of Health successfully issued the relevant tobacco control regulations in 2021, which put in place a total ban on tobacco advertising, promotion, and sponsorship. Article 22 of the 2021 tobacco control regulations includes a ban on the tobacco industry's corporate social responsibility activities. Also, it prohibits the entities that produce or import tobacco and its products from funding or making contributions to social, academic, health, sports, and other activities. The legislation also covers further tobacco control measures, such as requiring graphic health warnings on 75% of all tobacco product packaging and preventing exposure to tobacco smoke in some indoor public places.

Interference from the tobacco industry has been a major challenge, as they used to support events and projects targeting young people and children. But this regulation will lessen tobacco companies' interference. This legislative accomplishment allowed Sudan to advance to the highest degree of MPOWER component E compliance.



Tobacco control workshop, Sudan

Box 26. Strengthening tobacco marketing regulations using continuous digital media monitoring

Digital media, particularly social networking sites, continue to increase in popularity as more of the world becomes connected to the Internet. Globally, there are now more than 5 billion Internet users and 4.7 billion social media users (241, 242). This growth is accompanied by a rise in tobacco marketing (243) using social networking sites to reach younger audiences with interactive content that often features social media influencers who have large followings (244).

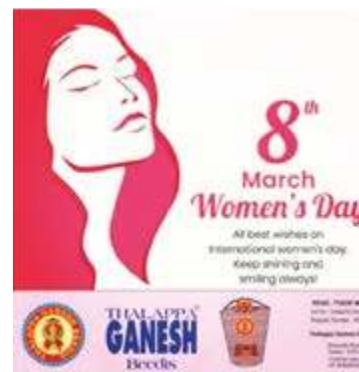
Currently, not all TAPS bans explicitly ban Internet advertisements (245). Even where they do, the expansive and user-controlled nature of social networking sites makes enforcement a challenge. Monitoring and reporting of tobacco marketing on social networking sites is crucial to identify ways to strengthen TAPS policies, as well as evolving industry marketing trends. The WHO FCTC acknowledges this, urging governments to work with civil society partners to closely monitor and improve tobacco marketing regulations and promote global collaboration.

The [Tobacco Enforcement and Reporting Movement \(TERM\)](#) is a continuous, real-time digital monitoring system that catches online tobacco marketing as it happens. It was launched by Vital Strategies with input from local governments and partners and is currently operational in India,

Indonesia and Mexico. TERM uses an artificial intelligence platform to scan for tobacco marketing on social networking sites using keyword-based searches. These findings are then thoroughly vetted by local experts to identify hidden forms of marketing, such as surrogate marketing and brand extensions, and to identify evolutions in tobacco marketing, including digital marketing trends such as gaming and advertising in the metaverse.

TERM analysis is summarized in clear reports that help governments in India, Indonesia and Mexico make the case for stronger tobacco marketing interventions. This includes elevating tobacco marketing issues in the media and guiding counter-marketing campaigns in all three countries, and energizing coalitions to advocate for stronger consumer protection and digital safety laws in Indonesia. The TERM approach can be adapted for use elsewhere, and the data it gathers is available to governments and tobacco control advocates. Further details are available at <https://termcommunity.com>

Digital media monitoring can play a critical role in supporting government action to strengthen tobacco control policies and counter industry interference. A partnership between governments and civil society organizations is important to the successful implementation of MPOWER policies.



A bidi company in India shares a greeting for International Women's Day.



A "metaverse party" promotes tobacco on social networking sites in Indonesia.



© WHO/Martha Tadesse

Article 6 of the WHO FCTC states:

“...[P]rice and tax measures are an effective and important means of reducing tobacco consumption... [Parties should adopt]...measures which may include:...tax policies and...price policies on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption” (173).

Raising taxes to increase the price of tobacco products is the most effective tobacco control measure

A report published in 2019 estimated that 27.2 million premature deaths could be averted globally within a 50 year period if countries raised the price of tobacco by 50% using tax increases (245). This is equivalent to eliminating all global cancer deaths for a span of 3 years (around 9 million deaths per year). On average, a 10% price increase will reduce consumption by 5–8% in low- and middle-income countries, and by about 4% in high-income countries (245). Tobacco taxation is rightly considered a highly cost-effective “best-buy” intervention, meaning that its returns and economic benefits are several times higher than its costs (13, 14, 246) – indeed, in low- and middle-income countries such tax increases can cost as little as US\$ 0.05 per capita each year to administer (247).

Tobacco tax revenues can help the government fund a sustainable tobacco programme

Tax increases generate government revenue (248, 249) that could be used for tobacco control programmes as well as other important health and social initiatives, which have now been successfully demonstrated in some countries (250, 251). In fact, the Addis Ababa Action Agenda 2015 recognizes

that tax measures on tobacco can be an effective means of reducing tobacco consumption and health care costs and that they represent a revenue stream for financing for development (252).

Taxes should be raised periodically to offset inflation and income growth

Governments must monitor tobacco tax rates and prices relative to real income and significantly raise tax rates at regular intervals to ensure that tobacco products do not become more affordable – a trend common in many countries where income and purchasing power are growing rapidly (248). Despite some of these countries raising tobacco tax rates, they have not offset inflation and income growth, causing an erosion of the tax’s value and effectiveness in reducing consumption (248). Nominal tax increases that do not make tobacco products less affordable are unlikely to reduce consumption or encourage cessation (see Box 27).

Amidst the persistently high core inflation faced by several countries, particularly emerging and developing economies, it becomes imperative for governments to safeguard the real value of tobacco taxes. Although inflationary pressures are anticipated to decrease in 2023, they are expected to remain at elevated levels for an extended period; hence, policy-makers should take proactive measures to ensure that tobacco products remain unaffordable in light of the ongoing inflationary challenges (253).

Tobacco tax policies need strong tax administration

Of the different types of tax levied on tobacco products, excise taxes are the most effective at raising prices and generating a significant health impact (248,254). Simple tax structures are easiest to administer – while complex structures and tiered excise taxes should be avoided to diminish incentives for companies to price tobacco products in ways that can undermine the health and revenue impact of tobacco taxes (248).

Key interventions to improve tax administration include:

- ensuring compliance (through licensing, detailed tax declaration requirements and advanced information technology);
- ensuring control and enforcement on the supply chain (through, for example, the use of risk-based approaches for enforcement targets, tax stamps, track and trace systems, implementing anti-forestalling methods);
- following clearly defined procedures after detecting illicit trade of tobacco (including high penalties) (248).

Experiences from numerous countries show that illicit trade of tobacco products can be successfully addressed even when taxes and prices are increased, hence the threat of tax evasion should not be used as a reason to forgo tax increases (248, 255).

Political will is critical to ensure adoption of tax reforms

Pre-empting the “SCARE” tactics (Smuggling and illicit trade, Court and legal challenges, Anti-poor rhetoric or regressivity, Revenue reduction, Employment impact) (248) deployed by the tobacco industry to block any major tobacco tax reforms can greatly help the smooth adoption of important tobacco tax reforms. Experience from countries around the world shows that these arguments are either unfounded or greatly exaggerated and that tax increases are in fact good for health, for equity, for revenues and for the economy overall, with very little risk of facing legal threats, especially when laws are carefully designed and enacted (248) (see Box 28).

The evidence on tobacco interventions indicates that the most effective and efficient way to reduce tobacco use is to raise the price of tobacco through tobacco taxes. However, tobacco tax is the least-adopted MPOWER measure. In 2022 only 12% of the world’s population living in 41 countries were protected by tax rates at 75% or more of the price of the most popular brand of cigarettes (Fig. 37).

The total number of countries that have raised tobacco taxes to a level at (or above) 75% of the price of the most sold brand of cigarettes between 2020 and 2022 remained constant, but because some countries were replaced with others the number of people protected by this level of tax decreased from 1.1 billion to 1 billion (Fig. 38).

Between 2020 and 2022, four countries (Australia, Lithuania, Nicaragua, and Vanuatu) increased their taxes to best-practice levels, while another four countries lost their position in this top group (Egypt, Georgia, Sri Lanka and Ukraine) (see Technical Note III). The most significant tax share increase in the four countries raising taxes was made by Nicaragua (from 56.8% in 2020 to 75.7% in 2022), and Vanuatu (from 58.3% in 2020 to 77.5% in 2022). No low-income countries have raised taxes to 75% or above since 2020, but eight countries, all in the African Region, increased taxes enough since 2020 to move one category closer to best-practice level (Table A1).

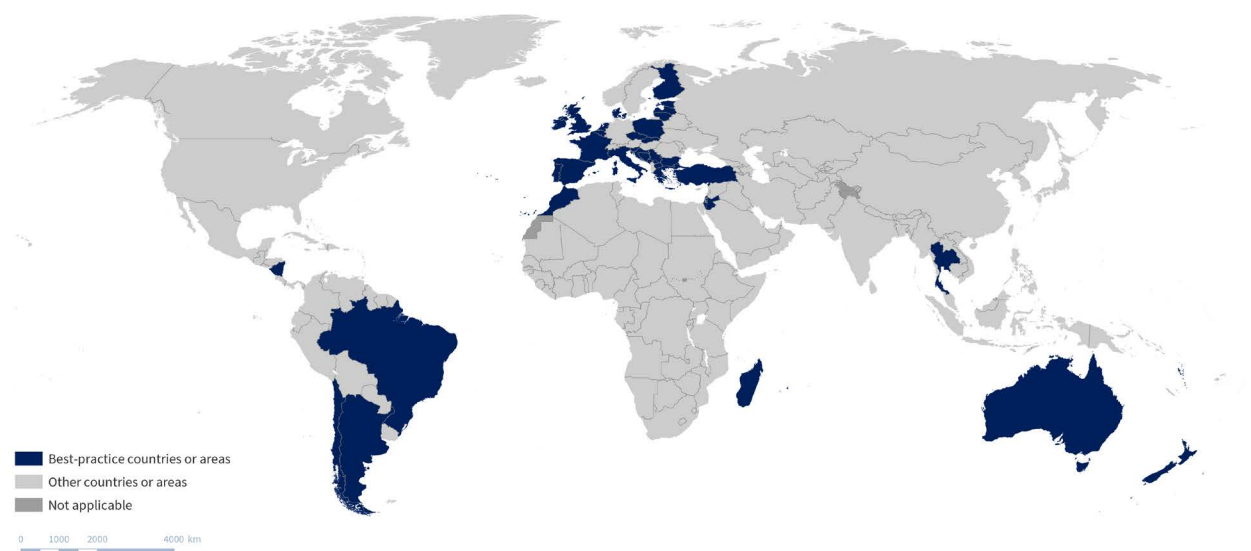
In 2008, globally, 23 countries had tax rates at 75% or more of the price of a pack of cigarettes, covering only half a billion people or 7% of the world’s population. Since then, an additional half a billion people in 24 more countries have become covered by best-practice taxation levels, while only six countries lost their position in this top group.

Of these 24 countries, 11 are high-income countries that have raised taxes sufficiently to reach the highest level of implementation (Andorra, Australia, Croatia, Denmark, Greece, Israel, Latvia, Lithuania, Netherlands (Kingdom of the), New Zealand, and Slovenia). Eleven middle-income countries and one territory have reached the highest level of taxation since 2008 (Argentina, Bosnia and Herzegovina, Brazil, Montenegro, Morocco, Nicaragua, North Macedonia, occupied Palestinian territory, Serbia, Thailand, Türkiye and Vanuatu). One low-income country began taxing at or above 75% in 2010 (Madagascar) and currently remains the only low-income country at the highest level of implementation (Fig. 39).

Today, middle-income countries constitute more than half of the population (52%) protected by this measure. Only 3% of protected people live in low-income countries.

Of the 546 million people who live in one of the world’s 100 largest cities, only 127 million (in 24 cities) are protected by tobacco taxation (Table A4). No city has yet, independently of national government, introduced taxes on tobacco products that have resulted in raising the share of total taxes to 75% or more of the retail price.

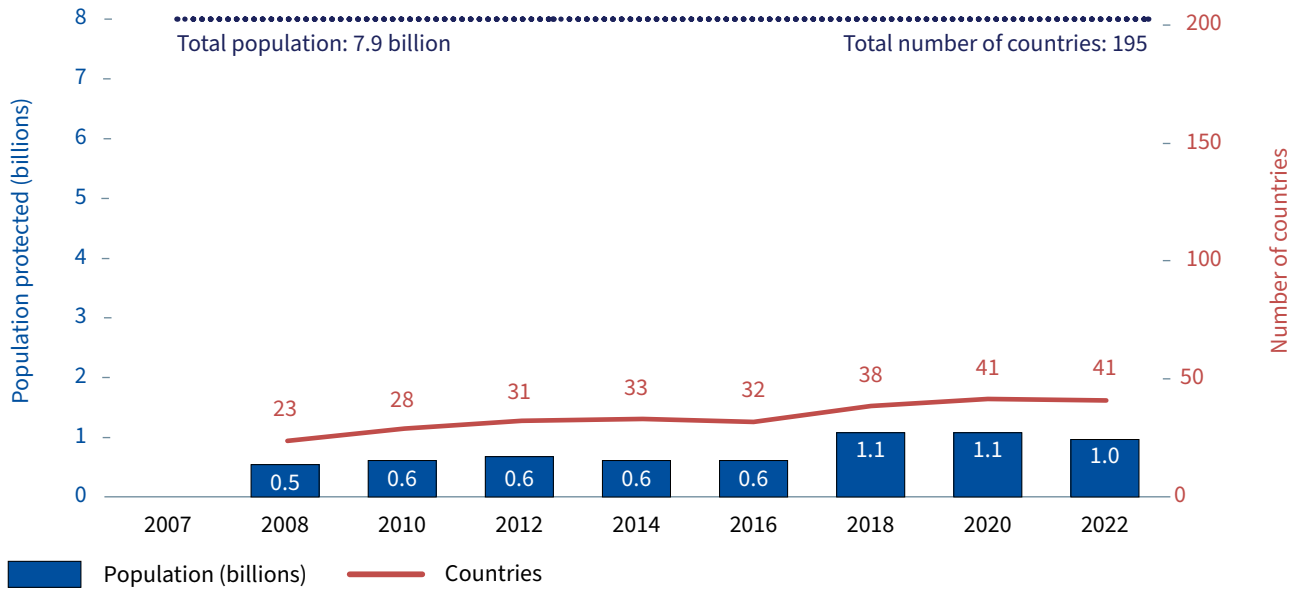
Fig. 37. Raising taxes on tobacco, best-practice countries and territory, 2022



Countries and territories with the highest level of achievement: Andorra, Argentina, Australia^a, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Chile, Croatia, Czechia, Denmark, Estonia, Finland, France, Greece, Ireland, Israel, Italy, Jordan, Latvia, Lithuania^a, Madagascar, Malta, Mauritius, Montenegro, Morocco, Netherlands (Kingdom of the), New Zealand, Nicaragua^a, North Macedonia, occupied Palestinian territory, Poland, Portugal, Serbia, Slovakia, Slovenia, Spain, Thailand, Türkiye, the United Kingdom, Vanuatu^a

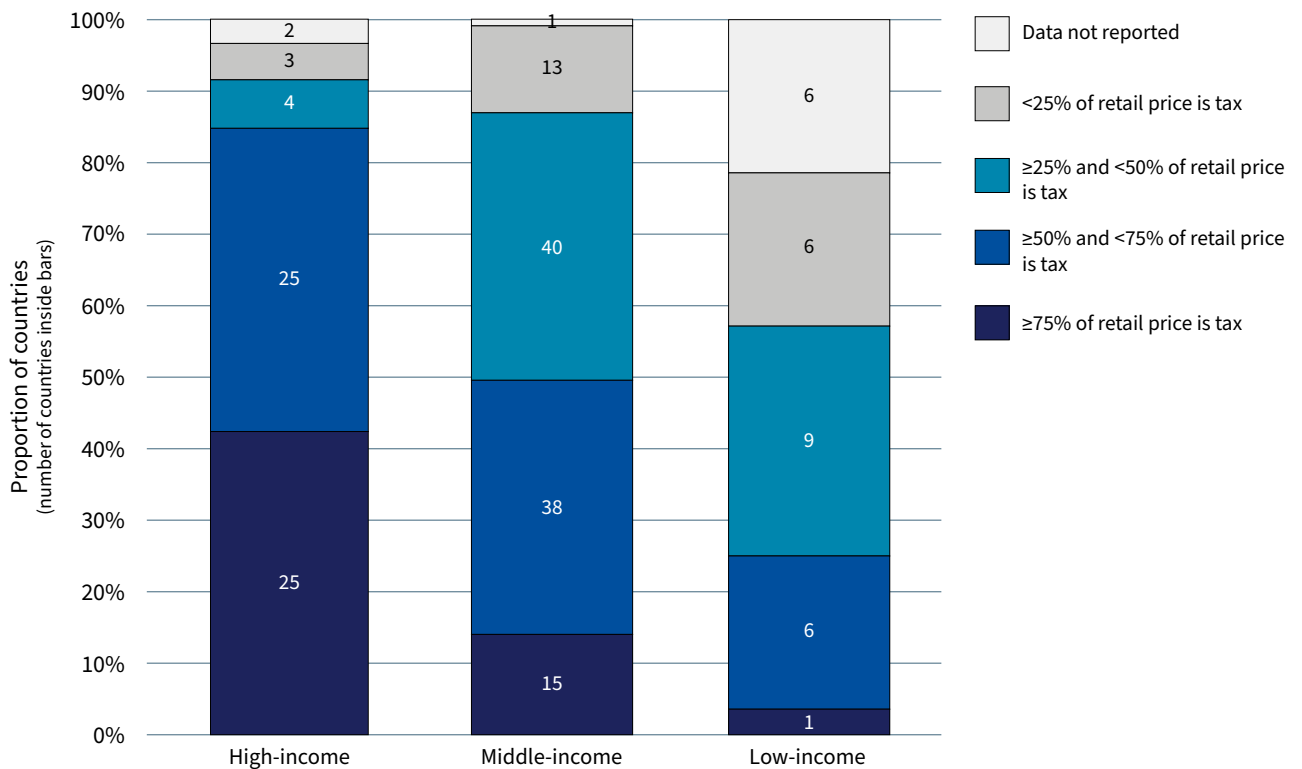
^aCountry newly at the highest level since 2020

Fig. 38. Progress in total tax on cigarettes $\geq 75\%$ of retail price, 2008–2022



One billion people are covered by high tobacco taxes.

Fig. 39. Total tax on cigarettes, by country-income level, 2022



Total tax on cigarettes

Today, 18 countries need raise taxes only an additional 5% or less of the retail price to reach best-practice level – protecting an additional 659 million people.

In 2022, 42% of high-income countries (25 countries), 14% of middle-income countries (15 countries) levied taxes at best-practice level. Only one low-income country – Madagascar – had taxes at the highest level. However, 18 countries (nine high-income, eight middle-income and one low-income) are just 5 percentage points away from the best-practice level and have tax rates between 70% and 75% of retail price. If these countries increased their tax rates to 75%, an additional 660 million people would be covered by the most effective measure to reduce tobacco use.

Furthermore, only 5% of high-income countries do not tax tobacco at a minimal level (i.e. under 25% of the retail price), 15% of low- and middle-income countries are missing the opportunity to save lives by raising taxes above the basic level (see Annex 1).

Low- and middle-income countries have much progress to make to raise taxes and prices

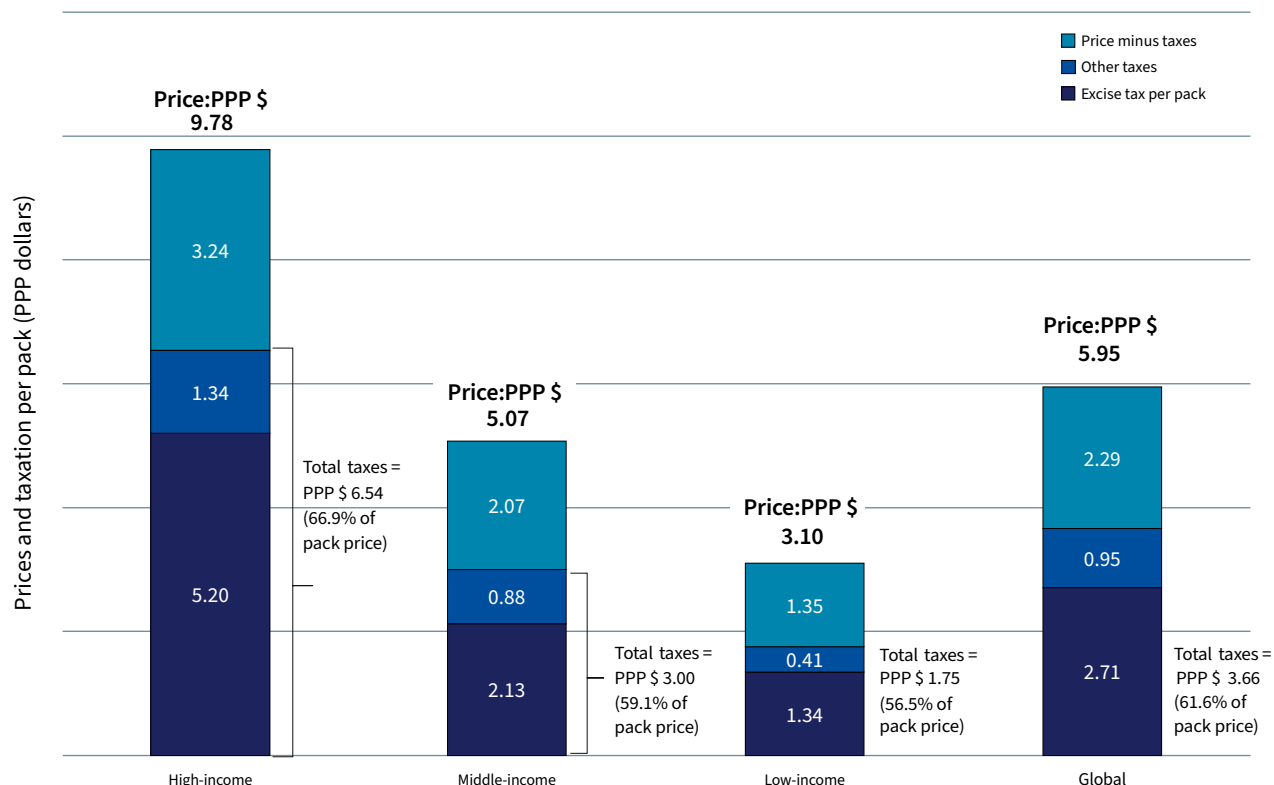
Price and tax levels are highest in high-income countries, even when adjusting for differences in purchasing power. Cigarette pack prices, total taxes and the tobacco excise component as a share of pack prices are all lower in low- and middle-income countries, with average total tax as a proportion of price amounting to 56.5% in low-income countries and 59.1% in middle-income countries. This proportion reaches 66.9% in high-income countries.

There is a strong case for all countries, particularly low- and middle-income countries, to increase their excise taxes further, which will have the effect of making cigarettes less affordable (Fig. 40).

Affordability should be continuously decreased through regular and ambitious tax increases

The affordability of cigarettes is measured by the per capita GDP required to purchase 2000 cigarettes of the most sold brand reported in a given year. The average change over the period 2012–2022 was calculated for this current report. Using this measure, cigarettes have become less affordable in 64 countries and did not significantly change in 88 countries, while they became more affordable in 25 countries. Of those 25 countries, 17 were low- and middle-income countries (see Annex 1).

Fig. 40. Weighted average retail price and taxation (excise and totals) of most sold brand of cigarettes, 2022



Note: Averages are weighted by WHO estimates of number of current cigarette smokers ages 15+ in each country in 2022. Prices are expressed in Purchasing Power Parity (PPP) adjusted dollars or international dollars to account for differences in the purchasing power across countries. Based on 55 high-income, 103 middle-income and 21 low-income countries with data on prices of most sold brand, excise and other taxes, and PPP conversion factors.

Those are concerning changes when compared with the change in affordability calculated over the period of 2010–2020 in the previous report. The number of countries where cigarettes have become less affordable was 84 (compared now to 64), while the number of countries with no change in affordability was 68 (compared now to 88), and those with an increased affordability were 20 (compared now to 25). Countries need to implement more ambitious tax increases in order to reduce affordability in a significant way over time (Fig. 41).

More countries are adopting better tax structures over time

In 2008, 22 countries had no excise taxes on tobacco – a clear illustration of how taxation was under-used as a policy tool to influence tobacco consumption. However, by 2022 this number had halved, suggesting a positive trend towards implementing tobacco taxation as a public health measure.

Furthermore, the shift from ad valorem taxes to mixed excise or specific excise taxes is an encouraging development. In 2008, 54 countries relied on ad valorem taxes, which can be less effective in reducing tobacco use as they may increase price dispersion and encourage substitution to lower-priced alternatives. However, by 2022 the number of countries using ad valorem taxes had decreased to 34. During the same period, the use of mixed excise or specific excise taxes had increased to from 48 countries to 64, and from 56 to 70, respectively (Fig. 42).

It is noteworthy that in 2008, of the 48 countries using a mixed system, 56% relied more on the ad valorem component, indicating a need for better alignment of tax structures with best-practice. By 2022, the balance had shifted, with only 40% of the (now) 64 countries using a mixed system relying more on the ad valorem component and 60% relying more on the specific component. This shift

signifies progress towards maximizing the impact of tobacco taxes on public health by reducing price differentials and deterring consumers from switching to cheaper alternatives. Overall, the data suggest a positive trend in adopting best practices in tobacco tax policies. However, there is still room for improvement, particularly in countries that continue to rely heavily on ad valorem taxes and those that have not implemented any excise taxes.

Since 2020, 21 countries have made incremental progress in tobacco taxes and shifted to a higher MPOWER group.

Fig. 41. Change in affordability of cigarettes, 2012–2022

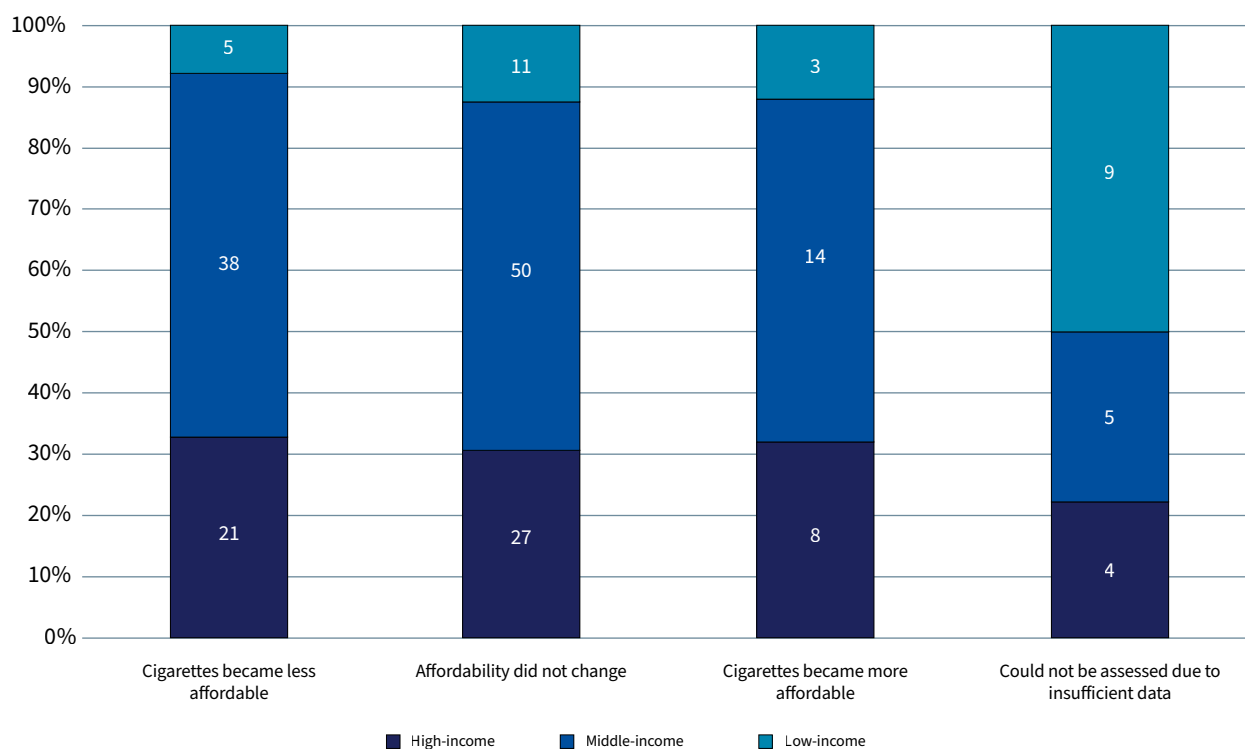
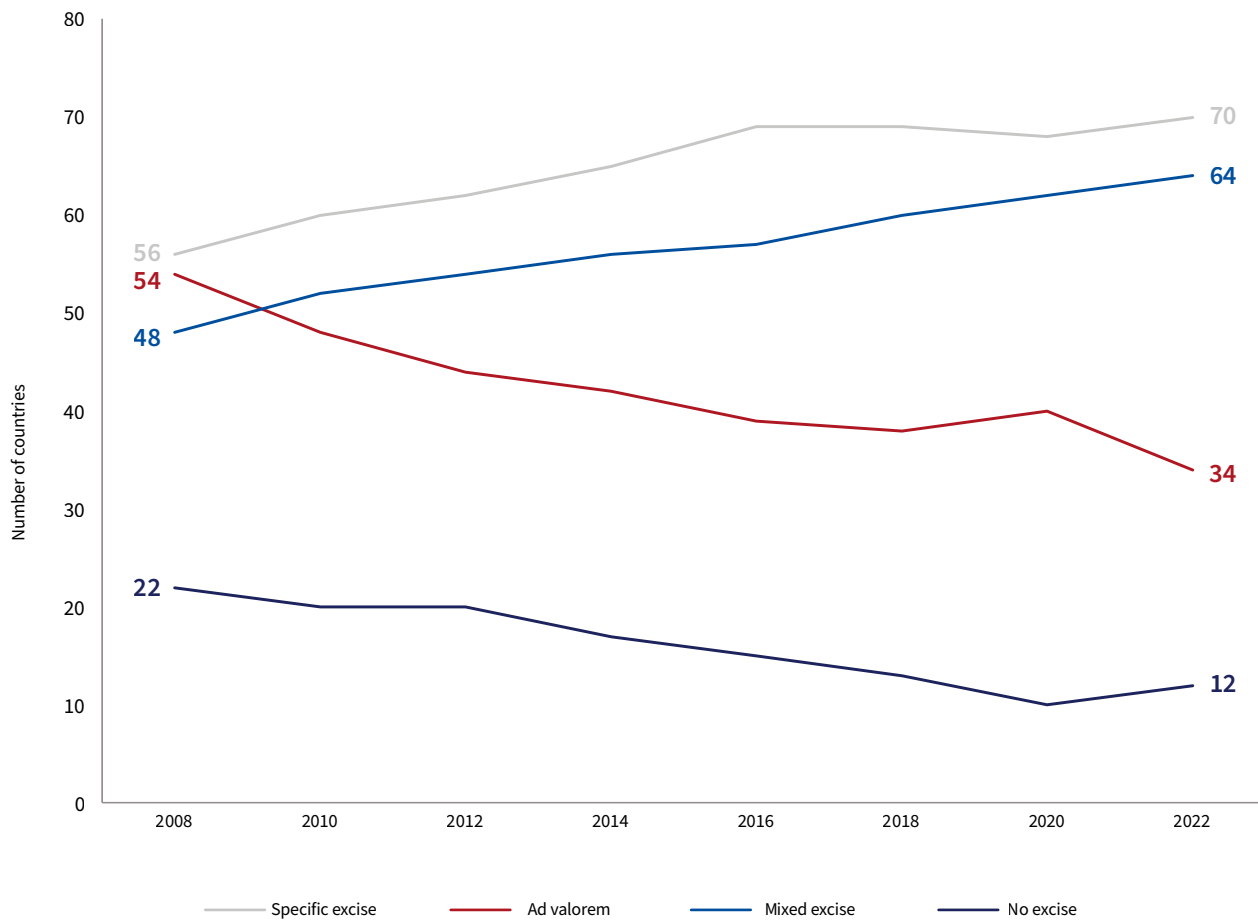


Fig. 42. Number of countries with different excise tax structures over time, 2008–2022



Box 27. Historic levels of tobacco taxation are reached, Peru

Peru is a regional and global leader in tobacco taxation, ranking among the top 10 countries implementing tobacco taxes by the Tobacconomics Cigarette Tax Scorecard – a tool that evaluates cigarette tax policies based on their structure, tax share, price, and affordability. The scorecard assigned Peru a score of 4.13/5 – the second-highest score among Latin American countries after Ecuador and significantly higher than regional and global averages

This achievement has been years in the making. Since the 1990s, Peru has applied an excise tax on cigarettes, but between 1999 and 2009, tobacco tax policy, from a health perspective, moved slowly. In 2010, the excise tax design was strengthened when a specific (quantity-based) component was introduced to replace the ad-valorem structure. Between 2010 and 2016, no further adjustments took place. Then, in 2016, the government increased the specific excise by more than 150% – the largest increase in tobacco excise

tax in Peru’s history. The total tax share (taxes as a percentage of the price of the most sold brand) jumped from 37.8% to 49.5%. This was a win for reducing the affordability of cigarettes (by nearly 2%) and for simultaneously increasing tax collection. As a result, in 2017, Peru’s Ministry of Economy and Finance was selected as one of WHO’s World No Tobacco Day Award recipients, an award that “recognizes institutions, organizations, and individuals who have made outstanding contributions in the fight against smoking in their country”.

This trend continued, and in 2018 another increase of the specific excise was implemented – along with adjustments for alcohol, sugar-sweetened beverages, and fuel taxes – marking the first time such a tax adjustment was introduced in the country with an explicit public health rationale. In a celebrated move, Peru then took a further step in 2020 to protect public health and implement a key WHO FCTC Article 6 guideline

by modifying the methodology to calculate its amount-specific excise tax on cigarettes so that it would automatically account for inflation, thus preserving the real value of the tax over time.

Peru currently boasts a 73.3% total tax share, the highest ever recorded by the country. Yet there is room for improvement – prices have been declining since the last adjustment. Challenges for the future include pushing affordability levels lower and the tax rate higher to achieve the WHO-recommended 75% total tax share thresholds.



News article informing of the Government’s actions to raise taxes on cigarette, sugary and alcoholic beverages, Peru

Box 28. Cigarette tax hikes pave the way for a healthier future, Timor-Leste

Timor-Leste is one of the newest countries in the world and its fast-growing population is one of the world’s youngest. In his speech for Universal Health Coverage (UHC) Day in December 2022, the country’s Finance Minister highlighted this, noting that in order to “reap the advantage of this demographic dividend, our people need to be healthy, educated and live with confidence”. This observation reflects the high levels of tobacco use and other causes of noncommunicable diseases to which the population is exposed.

The Minister’s UHC Day speech announced that Timor-Leste would significantly increase excise taxes on unhealthy products like tobacco, emphasizing that, “these taxes are considered win-win policies because not only do they save lives and prevent disease, but they promote health equity and they are a great source of financing the state budget”. Most notably, the excise tax on tobacco has increased dramatically – from US\$ 19/kg in December 2021 to US\$ 50/kg in January 2022, and US\$ 100/kg in January 2023.

Evidence collected for this report shows the immediate impact of these excise tax increases, with the retail price of cigarettes increasing by 75% – from US\$ 2 in 2020 to US\$ 2.25 in 2022 and US\$ 3.50 per pack in 2023. The share of tax in the retail price of cigarettes increased from 21.8% in 2020 to 47.2% in 2022 and to 59.8% in 2023. While it is still too early to assess the impact of these increases on tobacco use, there is little doubt that Timor-Leste has become a global leader for health taxes and, in turn, has promoted a healthier – more sustainable – future for generations to come.



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National tobacco control programmes

The WHO Framework Convention on Tobacco Control strongly suggests that countries set up a national tobacco control programme (NTCP) to lead their tobacco control efforts. To this end, WHO FCTC Article 5 states that: “Each Party shall develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes ... [and] establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control.” In addition, WHO FCTC Article 26.2 sets out that: “Each Party shall provide financial support in respect of its national activities intended to achieve the objective of the Convention” (173).

A national tobacco control programme can provide a strong foundation for tobacco control efforts.

The WHO FCTC strongly suggests that all countries set up a national tobacco control programme (NTCP, or similar coordination mechanism) to lead the development and maintenance of sustainable policies that can reverse the tobacco epidemic (256). While ministries of health – or equivalent government agencies – take the lead on strategic tobacco control planning and policy setting, other ministries or agencies can report to the NTCP (257). NTCPs should:

- be adequately financed and clearly focused;
- be integrated into countries’ broad health and development agendas (258);
- be decentralized subnationally where necessary (e.g. in large or federal countries) to allow flexibility in policy development and programme implementation;
- be resourced to build implementation capacity that can be sustained over time;
- enable policies and programmes to reach as wide a population as possible;

- ensure that population subgroups with disproportionately high rates of tobacco use are reached by policies and programmes tailored to their needs (259).

NTCPs should involve civil society and must exclude the tobacco industry

NTCPs require the involvement of appropriate nongovernmental organizations and other civil society groups to maintain progress on national as well as global tobacco control efforts. NTCPs must specifically exclude the tobacco industry and its allies, which cannot be legitimate stakeholders in tobacco control efforts (256).

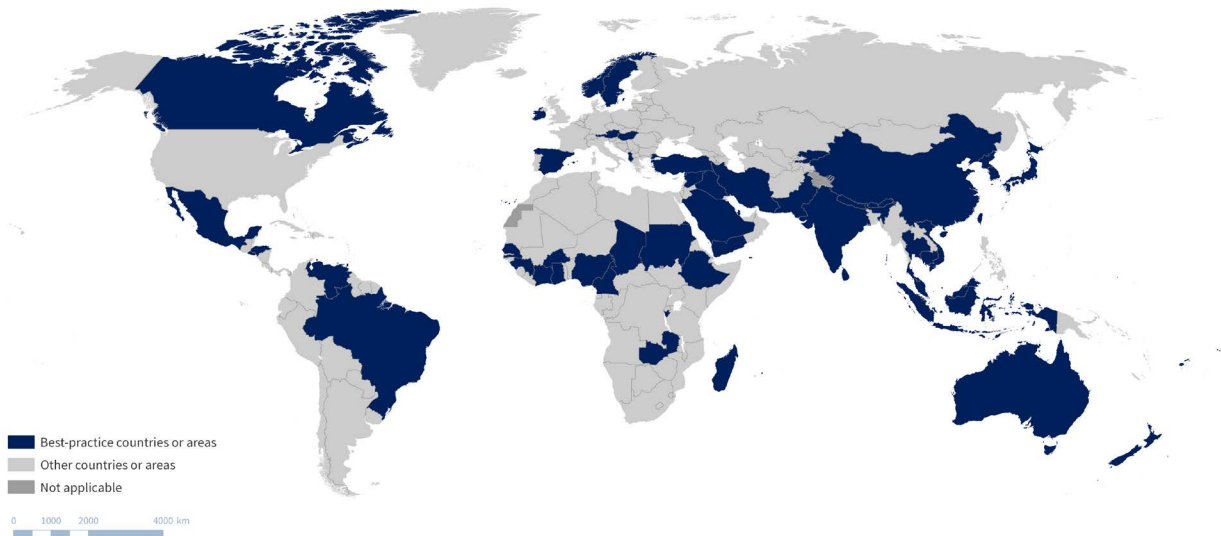
Fifty-eight countries have a national agency with responsibility for tobacco control objectives staffed by at least five full-time equivalent people, meaning that 67% of the world’s population are protected by such an agency (Fig. 43) (see Box 29). An additional 113 countries (home to another third of the world’s population) are working on tobacco control objectives with fewer staff (81 countries), or with an unknown number of staff (32 countries).

Over the 14 years since NTCP data were first collected (in 2008), progress has been achieved with a total of 16 countries, home to 748 million people, establishing a well-staffed national team working full time on tobacco control. It is worth noting that this measure may underestimate the true extent of NTCPs in countries because information on tobacco control programme staffing at national level is incomplete, and there is no formal mechanism for collecting this information (Fig. 44).

Twenty-one countries (with almost 300 million people) have no national agency for tobacco control, including 17 low- and middle-income countries (Fig. 45).

In the past 2 years, four countries (Austria, Japan, Palau, and Samoa) enhanced their national tobacco control programmes sufficiently to reach the highest level of adoption, adding 133 million people to the population covered. At the same time, five countries (Lebanon, Marshall Islands, Mongolia, Tuvalu, and Uruguay) dropped below best-practice level – leaving 12 million people less protected (Box 29).

Fig. 43. National tobacco control programmes, highest-achieving countries, 2022



Countries with the highest level of achievement: Albania, Australia, Austria^a, Bhutan, Brazil, Brunei Darussalam, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Chad, China, Côte d'Ivoire, Democratic People's Republic of Korea, El Salvador, Ethiopia, Fiji, Ghana, Guinea, Honduras, Hungary, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Japan^a, Kyrgyzstan, Madagascar, Malaysia, Mauritius, Mexico, Micronesia (Federated States of), Nepal, New Zealand, Nigeria, Norway, Pakistan, Palau^a, Qatar, Republic of Korea, Samoa^a, Saudi Arabia, Senegal, Singapore, Spain, Sri Lanka, Sudan, Sweden, Syrian Arab Republic, Thailand, Trinidad and Tobago, Türkiye, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia.

^aCountry newly at the highest level since 2020

Fig. 44. Progress in national tobacco control programmes, 2008–2022

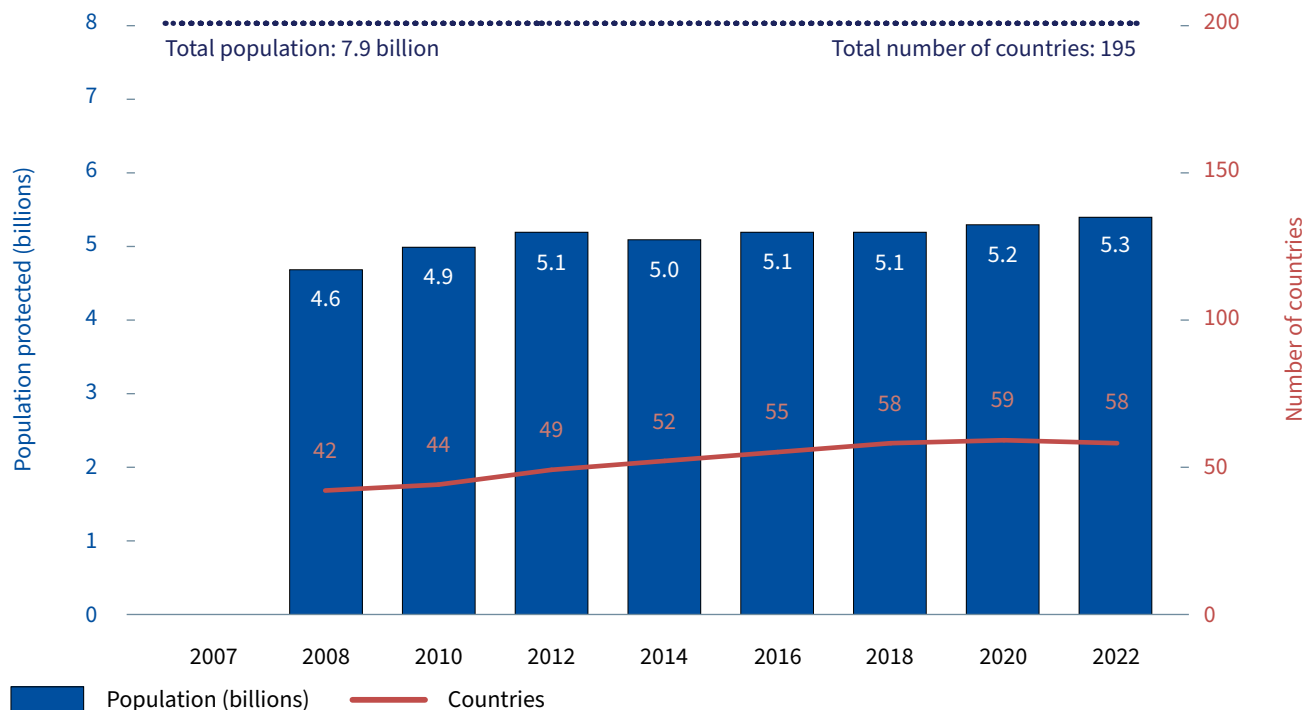
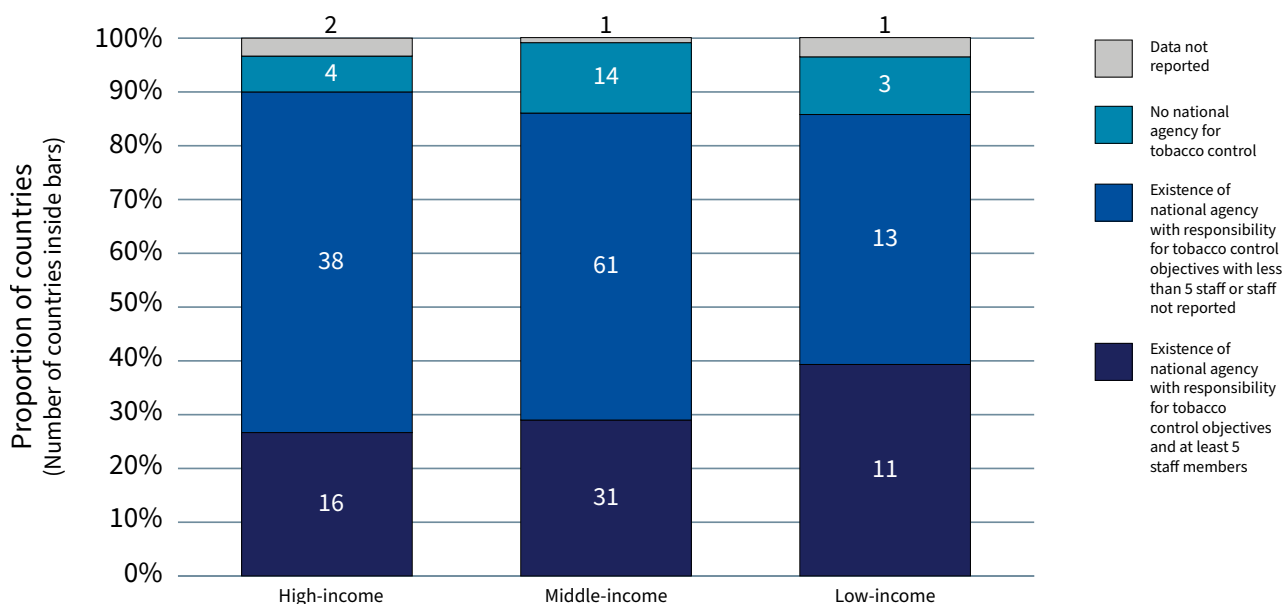


Fig. 45. National tobacco control programmes (2022)



Box 29. A decade of strong tobacco control, Suriname

Suriname’s National Tobacco Control Program (NTCP) has worked hard over the years to advance the country’s tobacco control agenda, and in particular on building multisectoral action through networking and consultations with policy-makers from different government sectors as well as non-state actors. The NTCP successfully mobilized resources and led a dialogue with diverse areas to build consensus towards keeping tobacco control as a priority within a National NCD strategic plan (2021–2028).

In 2013, Suriname made history as the first CARICOM country to implement a comprehensive Tobacco Control Act, aligning with WHO FCTC Articles 8, 11, and 13. This milestone achieved 100% smoke-free environments, graphic health warnings covering 50% of tobacco packaging, and a complete ban on tobacco advertising, promotion, and sponsorship.

Despite these advancements, challenges in enforcement persisted due to unfinished administrative procedures related to compliance and enforcement, insufficient intersectoral collaboration and the absence of a national strategic plan for tobacco control, among others.

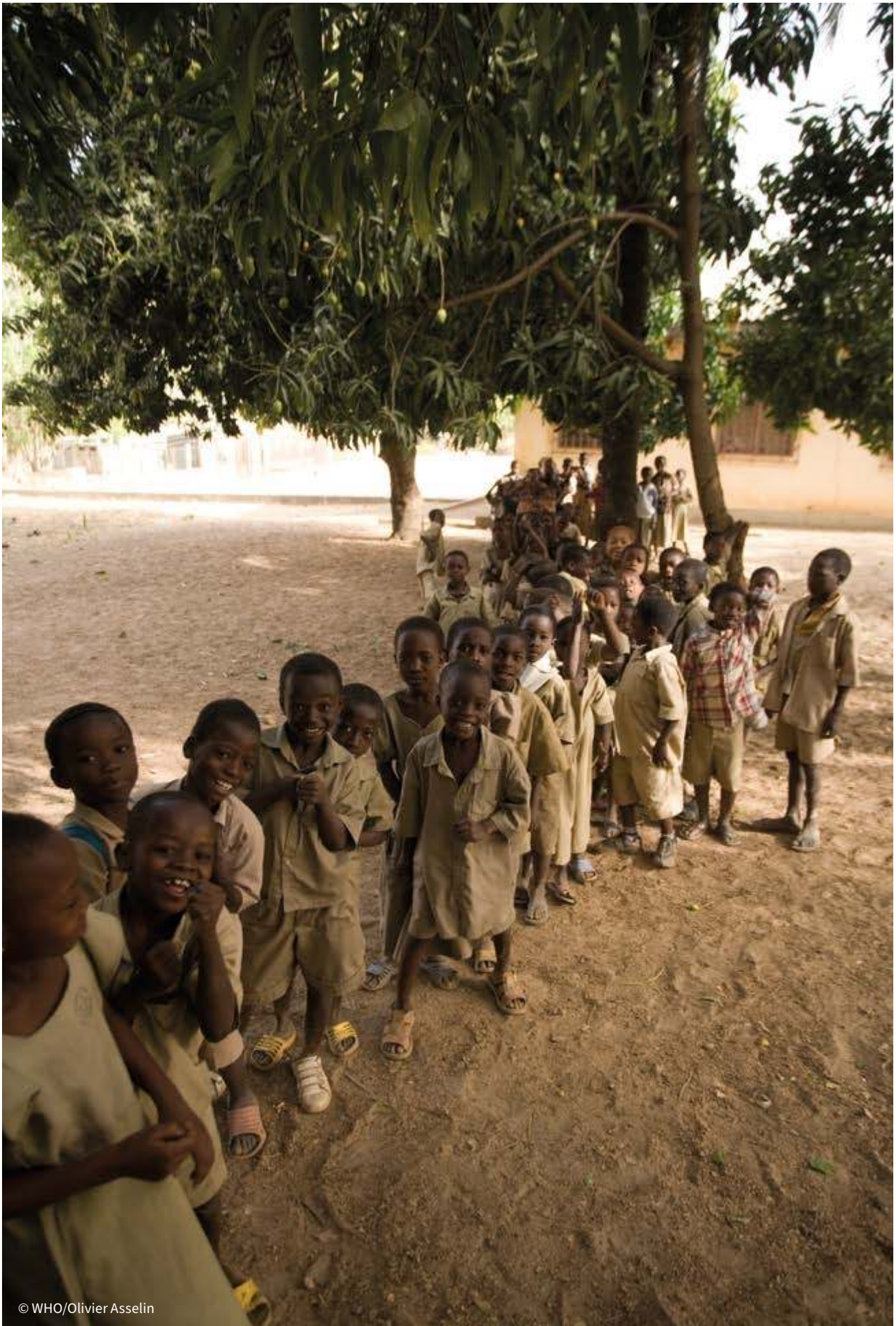
To address these challenges, the NTCP in Suriname actively sought support from the FCTC 2030 project. This project facilitated dialogue with key stakeholders and international experts, assessing the needs for investing in key tobacco control measures and developing a national Tobacco Control Strategy and Plan of Action. These efforts aimed to strengthen the Tobacco Control Act and enhance its enforcement. Notably, on the tenth anniversary of the Act, necessary legal measures were approved to fine violators of its provisions. The NTCP will plan the effective implementation by training enforcement officers from relevant

sectors such as the Environmental and Labor Inspectorate, and the Economic control unit.

Currently, the National Strategy and Plan of Action is in the final stages of drafting and expected to be approved in the coming months. Throughout these processes, the Suriname National Tobacco Control Program demonstrated commendable leadership and efforts emphasizing the crucial role of national programs in fostering consensus and prioritizing tobacco control as public health priority for Member States.



Taxation workshop for stakeholders in Suriname



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Electronic nicotine delivery systems

Decision FCTC/COP7(9) invites Parties to consider applying regulatory measures (such as those referred to in document FCTC/COP/7/11) to prohibit or restrict the manufacture, import, distribution, presentation, sale and use of ENDS, as appropriate to their national laws and public health objectives (11).

ENDS and ENDS heat a liquid to create aerosols that are inhaled by the user. These “e-liquids” contain nicotine (but not tobacco) and other additives, flavours and chemicals – some of which are toxic to people’s health. ENDS are essentially the same as ENDS but the e-liquid used is marketed as free of nicotine. MPOWER measures, as well as other policy measures (including age restrictions on sales, and flavour bans or restrictions) can be applied to ENDS.

ENDS are addictive and harmful, particularly for young people

ENDS contain nicotine – the highly addictive substance in tobacco. Using ENDS poses the risk of nicotine addiction, including among children and adolescents. Research findings show that non-smoking young people who use ENDS are more likely to become cigarette smokers, exposing them to the harmful effects of smoking, including addiction to tobacco (260).

ENDS are undoubtedly harmful (261). For example, nicotine can have deleterious impacts on brain development, leading to long-term consequences for children and adolescents in particular (262). ENDS use among children and adolescents under the age of 20 years is of concern in many countries, not only because of the detrimental effects of nicotine in this age group but also because most young ENDS users are non-tobacco users (263).

ENDS marketing is targeted at young people

ENDS are marketed and promoted by tobacco and related industries using many well-known, and some newer, covert tactics, including on social media to target their products at young people (264). ENDS are targeted specifically at children and young adults and marketed in thousands of flavours, the majority of which increase the palatability of the products and are appealing to younger people (265).

ENDS undermine tobacco control progress and threaten smoke-free environments

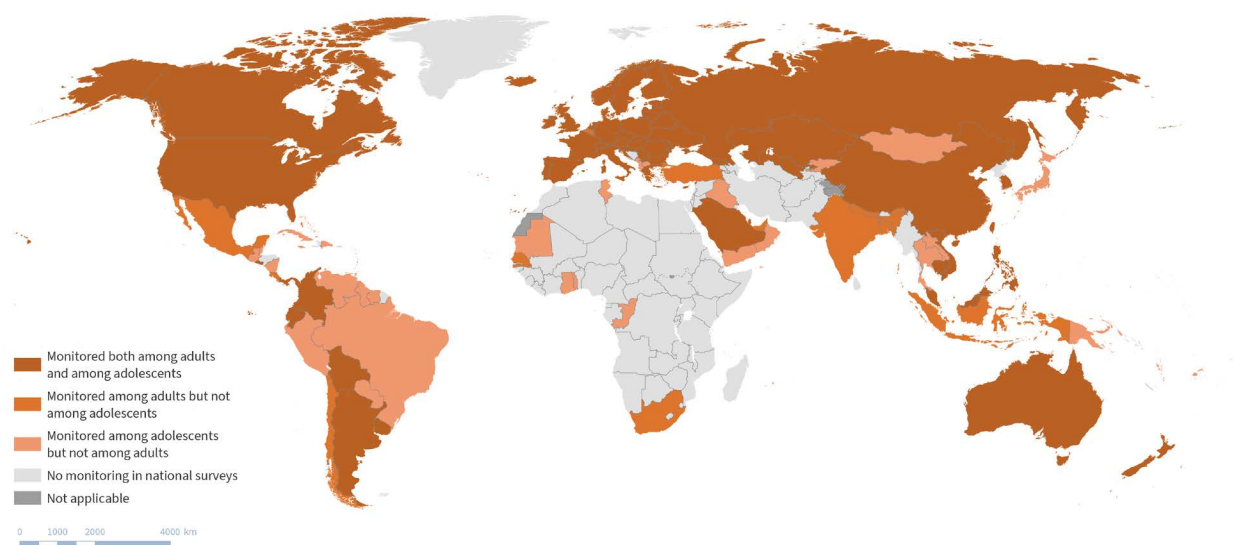
In many social contexts, thanks to the success of smoke-free environment policies, smoking tobacco has been “denormalized”, particularly in indoor public areas (266). The use of ENDS risks renormalizing smoking behaviour, particularly among younger populations (267–269). ENDS advocates and those in the tobacco and related industries have tried to undermine indoor smoking bans by lobbying for exceptions for the use of ENDS in indoor areas (270). ENDS products generate aerosols that look similar to tobacco smoke – an association further complicated by the difficulty in distinguishing these products from HTPs, which, contain tobacco. It is often difficult to tell if a person is smoking a tobacco product or using an ENDS.

E-cigarette use in the population should be incorporated into nationally representative surveys

More and more countries are asking people about their use of e-cigarettes in nationally representative population-based surveys among adults and school-based surveys among adolescents. By 2022, 73 countries were using national population-based surveys to monitor use of e-cigarettes among adults (generally among people aged 15 years and above, but different surveys use different age ranges). Many countries have concerns around uptake of ENDS among young people, and currently 103 countries are monitoring e-cigarette use among adolescents through national school-based surveys. Over 3 billion people live in the 59 countries which monitor e-cigarette use among both adults and adolescents. Still, 78 countries, with a combined population of 1.9 billion people, have not started monitoring e-cigarette use and have no data to guide local policy and regulatory decisions (Fig. 46).

Of the 59 countries that monitor e-cigarette use among both adults and adolescents, 21 are middle-income countries and 38 are high-income countries. While no low-income countries are among them, Togo and Yemen conduct surveys among adolescents that incorporate questions about e-cigarette use.

Fig. 46. E-cigarette use monitoring among adolescents and adults through nationally representative surveys



Countries that monitor e-cigarette use among both adults and adolescents: Argentina, Australia, Austria, Belarus, Bolivia (Plurinational State of), Brunei Darussalam, Bulgaria, Cambodia, Canada, China, Colombia, Croatia, Cyprus, Czechia, Denmark, Ecuador, El Salvador, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Malaysia, Malta, Marshall Islands, Netherlands (Kingdom of the), New Zealand, Norway, Panama, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Saint Lucia, Saudi Arabia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Ukraine, United Kingdom, the United States, Uruguay, Uzbekistan, and Viet Nam.

Too many countries do not regulate ENDS

Globally, 121 countries have adopted measures addressing ENDS (Fig. 47): 34 of these countries ban the sale of ENDS (e.g. see Box 30), while 87 countries (45% of all countries) covering 3.3 billion people allow the sale of ENDS and have adopted one or more measures either fully or partially to regulate them. These measures include bans on the use of ENDS in public indoor areas;

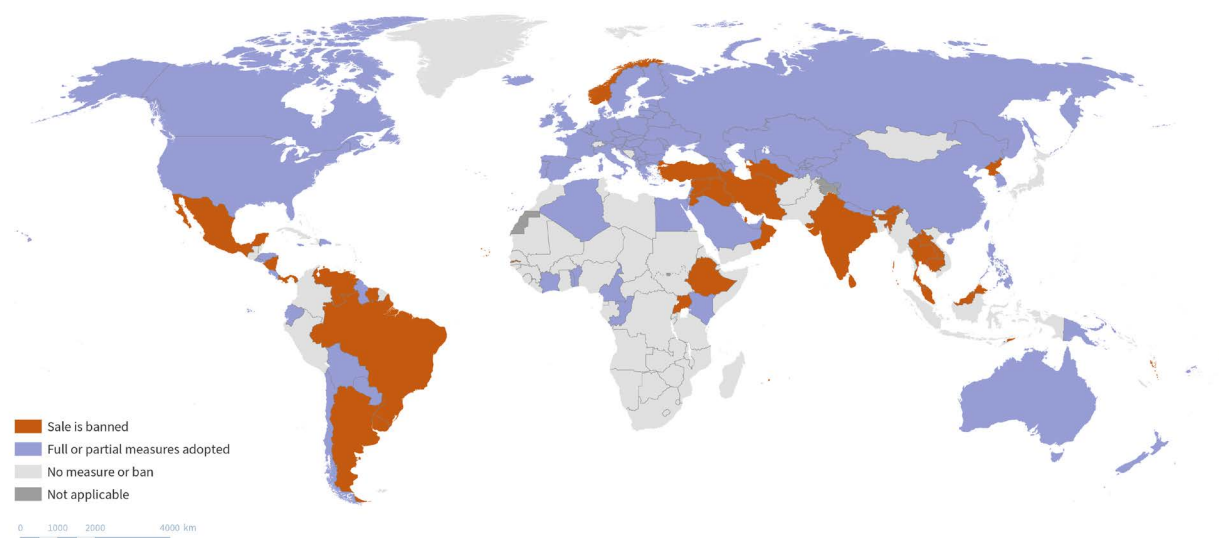
bans on advertising, promotion and sponsorship; the application of health warnings on packaging; age restrictions on the sale of ENDS; and flavour bans or restrictions (see Box 31). Countries that levy excises on ENDS are noted separately. The remaining 74 countries, home to almost one third of the world's population (over 2 billion people), have no regulations in place addressing ENDS (including no ban on use in public places, no labelling requirements, no bans on advertising and promotion). This is seven fewer countries than

in 2020, when 81 countries were not regulating ENDS in any way.

While 85% of high-income countries have either a regulation or a sales ban in effect, 40% of middle-income countries and 79% of low-income countries have taken no regulatory action concerning ENDS. Of the countries that have banned the sale of ENDS, 22 are middle-income countries, seven are high-income countries and five are low-income countries (Fig. 48).

Where not banned, ENDS must be strictly regulated.

Fig. 47. Measures to regulate ENDS – full, partial or no ban, 2022

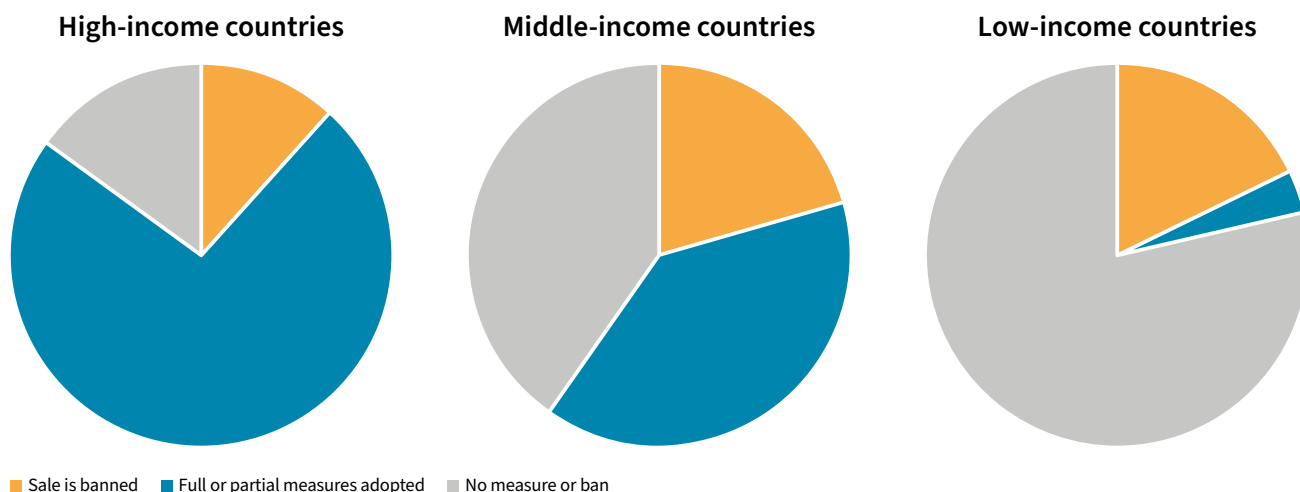


ENDS are regulated in: Albania, Algeria, Andorra, Armenia, Australia, Austria, Azerbaijan, Bahrain, Barbados, Belarus, Belgium, Benin, Bolivia (Plurinational State of), Bulgaria, Cameroon, Canada, Chile, China, Congo, Costa Rica, Côte d'Ivoire, Croatia, Cyprus, Czechia, Denmark, Dominican Republic, Ecuador, Egypt, El Salvador, Estonia, Fiji, Finland, France, Georgia, Germany, Greece, Guyana, Honduras, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Latvia, Lebanon, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Nepal, Netherlands (Kingdom of the), New Zealand, Niue, North Macedonia, Palau, Papua New Guinea, Paraguay, Philippines, Poland, Portugal, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Saint Lucia, Samoa, San Marino, Saudi Arabia, Serbia, Slovakia, Slovenia, Spain, Sweden, Tajikistan, Togo, Tuvalu, Ukraine, United Arab Emirates, United Kingdom, the United States, Uzbekistan

Sale of ENDS is banned in: Argentina, Brazil, Brunei Darussalam, Cabo Verde, Cambodia, Democratic People's Republic of Korea, Ethiopia, Gambia, India, Iran (Islamic Republic of), Iraq, Jordan, Lao People's Democratic Republic, Malaysia, Mauritius, Mexico, Nicaragua, Norway, occupied Palestinian territory, Oman, Panama, Qatar, Singapore, Sri Lanka, Suriname, Syrian Arab Republic, Thailand, Timor-Leste, Türkiye, Turkmenistan, Uganda, Uruguay, Vanuatu, and Venezuela (Bolivarian Republic of).

42 countries completely ban the use of ENDS in all indoor public places, workplaces and public transport – six more than in 2020.

Fig. 48. Status of measures to regulate ENDS, by country-income level



Measures include:

- Prohibiting the use of ENDS in indoor public places
- Health warnings applied to packaging
- Prohibiting the advertisement, promotion and sponsorship of ENDS
- Minimum age restrictions applied to sale of ENDS
- Ban of flavours

ENDS use in public indoor places, workplaces and public transport should be banned to protect public health

Using ENDS in public places where smoking is banned can re-normalize smoking in public. Only 42 countries completely ban the use of ENDS in all indoor public places, workplaces and public transport – though this is an improvement on the 36 countries with a complete ban in 2020.

An additional 45 countries ban e-cigarette use in some public places but not all. The remaining 108 countries have either no smoke-free places (37 countries), or ENDS are not explicitly covered by smoke-free measures where they exist for cigarettes (71 countries).

Health warning labels on packaging as well as advertising and promotion bans or restrictions should be applied to ENDS (devices and/or e-liquids)

ENDS users should be warned about the products they use. Of the 161 countries which allow the sale of ENDS, 97 do not require any health warnings labels on the packages of these products and 64 impose the display of health warnings (on either the packaging of ENDS devices, e-liquids or both).

In total, 105 countries do not ban or restrict the advertising and promotion of ENDS, including half (17) of the 34 countries where the sale of these products is banned.

Flavours should be banned to reduce the appeal of ENDS products to children and adolescents

Excluding countries that ban the sale of ENDS, only four countries have adopted a ban on the characterizing flavours in ENDS (Finland, Hungary, Lithuania, Montenegro). Nine other countries ban only selected flavours or permit specific flavours (China, Denmark, Egypt, Estonia, Germany, New Zealand, Philippines, Saudi Arabia, Ukraine).

The European Union Tobacco Products Directive revision of 2014 set out to ban ingredients that increase inhalation. This may be interpreted to include menthol flavours.

Age restrictions on the sale of ENDS have been adopted by only 73 countries

Of the 161 countries that permit the sale of ENDS, 73 countries limit their sale to a minimum age (18 years of age in 65 countries, 19 years of age in one country and 21 years of age in seven countries), while the other 88 countries do not. This means 45% of countries ban the sale of ENDS to minors, compared with 90% of countries that apply age restrictions to tobacco purchases.

There is no consistency in taxing ENDS or ENNDS products, and taxes are too low

Given the large heterogeneity of those products, data were collected for e-liquids used in open systems, closed systems that are rechargeable, and disposable systems. Open systems are products that allow the user to fill their device with the mixtures they want (with no nicotine, different nicotine concentrations and/or flavours and e-liquids). Closed systems are products that come with a pre-filled container (called a cartridge, pod or tank) and where own mixes are not possible. Some closed systems are rechargeable, others are disposable.

Of the 50 countries where data are available for open-system ENDS, 20 countries (40%) impose no excise tax on open-system e-liquids. And of the 48 countries where data are available for rechargeable closed systems, 21 countries (43.8%) impose no excise tax on closed-system e-liquids (commonly sold as pods). Finally, of the 48 countries where data are available for disposable products, 23 countries (47.9%) impose no excise tax on the product.

In countries where an excise tax is imposed on ENDS e-liquids, the tax is generally quite low, with the majority of countries having a total tax share below 25% of the retail price (21 out of 50 countries with estimates for open systems, 36 out of 48 countries with estimates for rechargeable closed systems and 40 out of 48 countries with estimates for disposable closed systems).

The tobacco control community must anticipate that nicotine products and tobacco products will evolve rapidly, and plan for their regulation

In recent years, newer nicotine and tobacco products have been introduced to several markets. These are rapidly evolving and may have implications for regulation. Therefore, the availability, characteristics, and use of these and other emerging products should be closely monitored and regulations should be future-proofed as much as possible to cover these products. This report did not collect data on nicotine pouches or other novel nicotine products.

Measures applied to ENNDS are often not consistent with those applied to ENDS

Data collected on ENNDS indicate that although 29 countries that ban the sale of ENDS also ban the sale of ENNDS, and 58 countries that regulate ENDS also regulate ENNDS, yet others have differing approaches for these products, including banning the sale of one when allowing the sale of the other. Only 31 countries completely ban the use of ENNDS in all indoor public places, workplaces and public transport, and another 29 ban their use in some public places. Twenty-seven countries who fully or partially ban use of ENDS in public places have no explicit ban on the use of ENNDS in those same places. A total of 105 countries with over 3 billion people are not covered by any measures that specifically address ENNDS.

Only 45% of countries ban the sale of ENDS to minors.



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Box 30. Implementing a ban on ENDS, Lao People's Democratic Republic

In November 2021, the Lao People's Democratic Republic took significant action to protect its population from the detrimental health, social, environmental and economic consequences of tobacco by adopting amendments to strengthen its National Tobacco Control Law. Following evidence-based awareness-raising by the Ministry of Health, international NGOs and other stakeholders to garner support for stronger national tobacco control laws, the country's National Assembly unanimously passed a strengthened law. One rapidly growing market targeted by the strengthened law was that of ENDS products – a market presenting a threat to the hard-won progress in tobacco control achieved by the country to date, including its comprehensive smoke-free law, large pictorial health warnings, and age restrictions on the purchase of

tobacco products. Data from the country's Global Youth Tobacco Survey 2016 had shown that 4.3% of students were using electronic cigarettes (5% of boys and 3.7% of girls).

To address this threat, the 2021 amended law clearly articulates regulations applied to new and emerging products. Despite tobacco industry attempts to interfere with the legislative process, amendments to the law included banning the production, import, export, distribution, trade, sale and use of electronic cigarettes (ENDS, ENNDS), HTPs, and baraku (shisha).

This noteworthy step will help protect the population from the harms of these products – including the children and adolescents who, as a potential new user group, are particularly exposed to aggressive marketing by the

tobacco industry. Cross-sectoral coordination and collaboration at all levels of governance is key for the implementation of the law.



Dr Snong Thongsana, Honourable Vice Minister for Health of Lao People's Democratic Republic, and Ministry of Health staff actively raise awareness about the ENDS ban on World No Tobacco Day 2023.

Box 31. Netherlands (Kingdom of the) protects young people by addressing point of sale advertising of ENDS

In order to protect youth, Netherlands (Kingdom of the) has introduced measures to make tobacco products and related products like ENDS less visible, applying restrictions on the advertising and display of these products at points of sale. Since July 2020, supermarkets in Netherlands (Kingdom of the) are prohibited from displaying tobacco products, e-cigarettes, and e-liquids. Since January 2021, the points of sale display ban also applies to other retail outlets, including fuel stations and online shops. Since July 2021 the ban also applies to specialty shops.

Enforcement of the display ban consisted of monthly compliance monitoring inspections followed

by more targeted inspections, and inspections based on complaints. Most inspections were conducted in response to complaints from members of the public recorded through the website and based on results of compliance monitoring inspections. The sanctions consist of formal warnings and fines. Arrangements were made with online national marketplaces to proactively remove advertisements in which tobacco products, e-cigarettes or e-liquids were displayed.

After intensive monitoring and inspections of the advertising ban, compliance by online shops is considered fair to good (65% of the online shops indicate the products for sale only by means of a neutral

and sober description and without a picture). However, compliance lags behind in small shops, such as night shops and mini markets, that are not affiliated with a trade association.

The main challenges and lessons learned are: where possible, inform and educate the different trade associations to promote compliance, inform the general public as well, and provide a transition period. Exceptions to the display ban for certain shops can complicate enforcement because the requirements for specialty shops have to be checked and assessed.



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6. Conclusion

MPOWER was introduced 15 years ago. At the time 1.1 billion people were protected by at least one MPOWER measure at best-practice level. Now more than 1.5 billion are covered by at least three of these measures and 5.6 billion people are protected by at least one.

The MPOWER technical package has achieved some huge successes. Fifteen years of dedicated collaboration have seen the global prevalence of smoking reduce from 22.8% in 2007 to 17.0% in 2021. If this prevalence had not declined, there would be 300 million additional smokers today. This reduction in the prevalence of smoking has come about through the collective and coordinated efforts of a global community dedicated to tobacco control and remaining steadfast against the interference from the tobacco and related industries. But with more than 8 million people dying from tobacco-related diseases every

year, new and emerging threats such as those posed by ENDS and the ongoing presence of an ever-shifting industry, we still have so much work to do.

This year we are very pleased to congratulate two countries, Mauritius and Netherlands (Kingdom of the), which join Brazil and Türkiye as countries that have accomplished the landmark achievement of putting in place the full MPOWER package at best-practice level. And with only one measure left to adopt, a further eight countries can soon join their ranks. Establishing all MPOWER measures at best-practice level means that the combined impact of these measures will be greater than their parts, and is the best way to protect a country's population and give them the best chance to reduce tobacco use and improve the health of generations to come.

While 71% of the world's population is afforded protection from MPOWER policies in place, 2.3 billion people, in 44 countries, are not covered by any evidence-based demand-reduction tobacco control measures, leaving them at most risk of health and economic harms of tobacco use. And although the prevalence of smoking has declined in most countries, as the total population grows, the total number of people smoking decreases at a slower pace. The gaps in MPOWER adoption need to be filled much faster.

This report, which focuses on measures aimed at protecting people from tobacco smoke, brings our attention to the need to accelerate the adoption of smoke-free environments and strengthen implementation to ensure compliance with such laws. Smoke-free indoor public places protect non-smokers and encourage smokers to quit so that smoking is viewed



increasingly as socially unacceptable by generations to come. In spite of the strong opposition from the tobacco and related industries, almost half of the world's countries have managed to extend 100% smoke-free laws to the venues most vigorously defended by industry lobbyists: restaurants, cafés, pubs and bars, including not allowing designated smoking areas or rooms or other exceptions under the law. And studies have demonstrated both the health and economic benefits reaped as a result. This illustrates what can be achieved.

Health care and educational facilities have progressed further than venues associated with hospitality, and now 75% of countries have comprehensive legislation protecting people in these spaces. In some countries, measures to protect children, an especially vulnerable population, from second-

hand smoke have extended to outdoor and private places. Sixty countries have adopted smoke-free playgrounds and 25 require cars transporting children below the age of 18 to be smoke-free.

To effectively protect people from the dangers of second-hand tobacco smoke, enforcement of smoke-free legislation is essential to ensuring compliance with the law. Currently, 111 countries use fines to penalize both the patron and the establishment for violations of smoking bans, an additional 7 countries fine only the establishment where the violation occurred and 52 countries fine only the customer who smoked, amounting to a total of 170 countries that fine smoking in a smoke-free place. Establishments can also be fined for failing to display no-smoking signs in 117 countries, and for allowing ashtrays in smoke-free areas in 29 countries. Only 61 countries

have dedicated funds for enforcement written into their legislation and 91 are required by law to have an established complaint mechanism system.

This year we not only celebrate the fifteenth year of MPOWER but also the twentieth anniversary of the WHO FCTC, reminding us that every government has an obligation to protect the health of its people, and that is why all Parties to the WHO FCTC have made a commitment to implement strong tobacco control policies as an important means of doing so. There is still more work to do but with these established and powerful global health tools we are in an excellent position to accelerate progress and make bold strides to a healthier future.





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TECHNICAL NOTES

TECHNICAL NOTE I Evaluation of existing policies and compliance

TECHNICAL NOTE II Smoking prevalence in WHO Member States

TECHNICAL NOTE III Tobacco taxes in WHO Member States

ANNEXES

ANNEX 1. Regional summary of MPOWER measures

ANNEX 2. Regional summary of smoke-free measures

ANNEX 3. Year of highest level of achievement in selected tobacco control measures

ANNEX 4. Highest level of achievement in selected tobacco control measures in the 100 biggest cities in the world

ANNEX 5. Status of the WHO Framework Convention on Tobacco Control and of the Protocol to Eliminate Illicit Trade in Tobacco Products

Evaluation of existing policies and compliance

This report provides summary indicators of country achievements for each of the MPOWER measures, and the methodology used to calculate each indicator is described in this Technical Note. To ensure consistency and comparability, the data collection and analysis methodology used in this report are based on previous editions of the report. Some details of the methodology employed in earlier reports, however, have been revised and strengthened for the present report. Where revisions have been made, data from previous reports have been re-analysed so that results are comparable across years.

Data sources

Data were collected using the following sources:

- For all measures: official reports from WHO FCTC Parties to the Conference of the Parties (COP) and their accompanying documentation.¹
- For M (monitoring): tobacco prevalence surveys not reported through the COP reporting mechanism were collected mainly through WHO Regional and WHO Country Offices. Technical Note II provides further details.
- For P (protect people from tobacco smoke), W (warn about the dangers of tobacco) and E (enforce bans on tobacco advertising, promotion and sponsorship): original tobacco control legislation (including regulations) adopted in all Member States that relate to smoke-free environments, packaging and labelling measures and tobacco advertising, promotion and sponsorship. Tobacco control laws and regulations as well as product regulations are also the sources of data for ENDS and ENNDS. In cases where a law had been adopted by 31 December 2022 but had not yet entered into force, the respective law was assessed, and data were reported with an asterisk denoting “Provision adopted but not implemented by 31 December 2022”. In cases where a law had been adopted but not yet the implementing regulations, the note “Regulations are pending” is added.
- For W (mass media): data on anti-tobacco mass media campaigns were obtained from Member States. In order to avoid unnecessary data collection, WHO conducted a screening for anti-tobacco mass media campaigns in all WHO Country Offices. In countries where potentially eligible mass media campaigns were identified, focal points in each country were contacted for further information on these campaigns, and data on eligible campaigns were gathered and systematically recorded.
- For O (offer help to quit tobacco use): data not reported under the COP reporting mechanism were collected mainly through WHO Regional and WHO Country Offices.
- For R (raise taxes on tobacco): the prices of the most sold brand of cigarettes, the cheapest brand and a premium brand were collected from ministries of health or finance and, in fewer cases, from online stores through regional data collectors. Information on the taxation of cigarettes (and when possible, most commonly used other smoked, smokeless tobacco products, heated tobacco products and cheapest brands of e-liquids of Electronic Nicotine and Non-Nicotine Delivery Systems), tax structure, use of stamps or fiscal marks and revenues from tobacco taxation was collected from ministries of finance. Technical Note III provides the detailed methodology used.

Based on these sources of information, WHO assessed each indicator as at 31 December 2022. Exceptions to this cut-off date were tobacco product prices and taxes (cut-off date 31 July 2022) and anti-tobacco mass media campaigns (cut-off date 30 June 2022).

Data validation

For each country, every data point for which legislation was the source was assessed by two expert staff from two different WHO offices, generally one from WHO headquarters and the other from the respective WHO Regional Office. Any inconsistencies were reviewed by the two WHO expert staff involved and, if needed, by one third expert staff member not yet involved in the appraisal of the legislation.

Disagreements in the interpretation of the legislation were resolved by: (i) checking the original texts of the legislation; (ii) trying to obtain consensus from the two expert staff involved in the data collection; (iii) trying to obtain clarification from the national tobacco control focal point in the Ministry of Health, or if needed from judges or lawyers in the concerned country; and (iv) the decision of the third expert in cases where differences remained. Data were also checked for completeness and logical consistency across variables in the MPOWER database.

Data sign-off

Final, validated data for each country were sent to the respective governments for review and sign-off. To facilitate review by governments, a summary sheet was generated for each country and was sent for review prior to the close of the report database. In cases where national authorities requested data changes, the requests were assessed by WHO expert staff according to both the legislation/materials and the clarification shared by the national authorities, and data were updated or left unchanged. In cases where national authorities explicitly did not agree with the data, this is specifically noted in the annex tables. Further details about the data processing procedure are available from WHO.

Data analysis

It is important to note that data about laws reflect the status of legislation adopted by 31 December 2022 that has a stated date of effect and is not undergoing a legal challenge that could impact the date of implementation. Data from laws not in effect by 31 December 2022 have a footnote stating this. The summary measures developed for this report are the same as those used for the 2021 report.

The report provides analysis of progress made between 2020 and 2022, and between 2007 and 2022 using the latest assessment of the status of measures in each year so that the results are comparable across years. For R, the earliest comparable data are 2008 and for mass media, data are available only from 2010. To calculate the change in the percentage of the population covered by each policy or measure over time, population estimates for the year 2022² were used. Using a static year eliminates the effect of population growth when measuring change over time. Indicators from previous years have been recalculated, according to legislation/materials received after the assessment period of the respective report or according to changes in the indicator methodology. All income groups used for this report derive from the World Bank income-group classification published on 1 July 2022 by the World Bank.³ Upper-middle and lower-middle income groups are combined into one group for this report.

When country or population totals for MPOWER measures are referred to collectively in the analysis section of this report, only the implementation of tobacco control measures (smoke-free legislation, cessation services, warning labels, advertising, promotion and sponsorship bans, and tobacco taxes) is included in these totals.

Monitoring of tobacco use and anti-tobacco mass media campaigns are reported separately.

Correction to previously published data

The 2020 data published in the last report were reviewed, and about 3% of data points were corrected. The full set of MPOWER data revised for all years back to 2007 is available in the WHO Global Health Observatory at <https://www.who.int/data/gho/data/themes/theme-details/GHO/tobacco-control>.

Monitoring of tobacco use and prevention policies

The strength of a national tobacco surveillance system is assessed by the frequency and periodicity of nationally representative surveys among the adult and adolescent population in countries. Countries are grouped in the top Monitoring category when all criteria listed below are met for both adolescent and adult surveys:

- whether a survey was carried out recently (in the past 5 years);
- whether the survey was representative of the country's population;
- whether a similar survey was repeated within 5 years of a previous survey (periodic); and
- whether the adolescent and adult populations were surveyed through school-based and household population-based surveys respectively.

Surveys were considered recent if conducted in the past 5 years. For this report, this means 2017 or later. Surveys were considered representative only if a scientific random sampling method was used to ensure nationally representative results. (Although they provide useful

information, subnational surveys or national surveys of specific population groups provide insufficient information to enable tobacco control action for the total population.) Surveys were considered periodic if the same survey or a survey using the same or similar questions was run at least once during the 5 years prior to the most recent survey. Due to COVID-19, it is assumed that planned surveys may have been delayed up to 2 years, therefore this 5-year period is exceptionally extended to 7 years in this report. Countries who were at the highest level of achievement in the previous report have not been downgraded in this report.

The following definitions apply to adolescent and adult surveys:

Adolescent surveys:

School-based surveys of students aged 13–15 years or other age range encountered during secondary-level school. The questions asked in the surveys should provide indicators that are consistent with those specified in the Global Youth Tobacco Survey questionnaires and manuals.

Adult surveys:

Population-based surveys that provide indicators for adults aged 15 years and over (or another age range starting around 15 and including people older than 15), consistent with those specified in the Global Adult Tobacco Survey questionnaires and manuals.

The groupings for the Monitoring indicator are listed below.

| | |
|--|---|
| | No known data or no recent* data or data that are not both recent* and representative** |
| | Recent* and representative** data for either adults or adolescents |
| | Recent* and representative** data for both adults and adolescents |
| | Recent*, representative** and periodic*** data for both adults and adolescents |
| * Data from 2017 or later. ** Survey sample representative of the national population. *** Collected at least every 5 years. | |

Smoke-free legislation

There is a wide range of places and institutions that can be made smoke-free by law. Smoke-free legislation can be in place at the national or subnational level. The report includes data based on national legislation, and legislation in subnational jurisdictions where available and where smoke-free national laws are incomplete. The assessment of subnational smoke-free legislation includes first-level administrative subdivisions of a country, as listed in ISO3166. Subnational data only reflect the content of the subnational laws. Provisions covered by national legislation are indicated by an informative note next to the subnational data. In cases where the status of smoke-free legislation is not reported for some or all subnational jurisdictions, we assume the existing national law applies. Legislation was assessed to determine whether smoke-free laws provided for a complete⁴ indoor smoke-free environment at all times, in all the facilities of each of the following eight places:

- health care facilities;
- educational facilities other than universities;
- universities;
- governmental facilities;
- indoor offices and workplaces not considered in any other category;
- restaurants or facilities that serve mostly food;
- cafés, pubs and bars or facilities that serve mostly beverages;
- public transport.

Groupings for the smoke-free legislation indicator are based on the number of the above eight places where indoor smoking is completely prohibited. Countries with no complete smoking ban at national level but where at least 90% of the population is covered by complete subnational smoke-free laws are grouped in the top category.

The groupings for the smoke-free legislation indicator are listed below.

| | |
|--|--|
| | Not reported |
| | Complete absence of bans, or up to two public places completely smoke-free |
| | Three to five public places completely smoke-free |
| | Six to seven public places completely smoke-free |
| | All public places completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation) |

In addition to the data used for the above groupings of the smoke-free legislation indicator, other related data were collected for this round of the report, and are reported in Annex 2. This includes the additional questions on outdoor places mentioned above as well as new questions about specific indoor places (airports, indoor waiting areas of public transport, hotels, cultural facilities, shops, private cars with the presence of a child under 18 years old) as well as new questions on fines and on the requirement of displaying non-smoking signs where smoking is banned.

A number of countries include exceptions to their smoke-free law that allow for the provision of smoking areas or designated smoking rooms (DSRs) in certain public places and workplaces. This is reported as a “No”. For the small number of countries where DSRs are allowed under “very strict technical requirements”,⁵ this is reported in the Annex tables as a “No” with an asterisk instead of a “Yes”. If DSRs are allowed but the very strict requirements are missing or not mentioned in the legislation, this is reported as a “No”. The groupings for smoke-free laws treat an asterisk the same as a “No”, because a law that allows DSRs in any form does not provide complete protection.

For the first time the smoke-free status of outdoor areas of these eight places was also assessed. A clear and explicit mention of the outdoor place was required. When the outdoor smoking ban was complete, a “yes” was reported; when the outdoor smoking ban was incomplete (some outdoor places smoke-free, but smoking areas were allowed) it was reported “partial”. When there was no clear mention of the outdoor area, or no smoking ban, a “no” was reported. The sum of “yes” and/or “partial” in the eight places assessed is reported in Annex 2.

Tobacco dependence treatment

The indicator of achievement in treatment for tobacco dependence is based on whether the country has available:

- nicotine replacement therapy (NRT);
- tobacco cessation support;
- reimbursement for any of the above; and
- a national toll-free quit line.

Despite the low cost of quit lines, few low- and middle-income countries have implemented such programmes. Thus, national toll-free quit lines are included as a qualification only for the highest category. Reimbursement for tobacco dependence treatment is considered only for the top two categories to take restricted national budgets of many lower-income countries into consideration.

The top three categories reflect varying levels of government commitment to the provision of nicotine replacement therapy and cessation support.

The groupings for the tobacco dependence treatment indicator are listed below.

| | |
|--|--|
| | Not reported |
| | None |
| | NRT* and/or some cessation services** (neither cost-covered) |
| | NRT* and/or some cessation services** (at least one of which is cost-covered) |
| | National toll-free quit line, and both NRT* and some cessation services** (cost-covered) |

* Nicotine replacement therapy.

** Tobacco cessation support available in any of the following places: health clinics or other primary care facilities, hospitals, office of a health professional, the community or other settings

In addition to data used for the grouping of the tobacco dependence treatment indicator, other related data such as information on countries’ essential medicines lists, etc. were collected.

Warning labels on tobacco packaging

The section of the report that assesses each country's legislation on health warnings includes the following information about cigarette package warnings:

- whether specific health warnings are mandated;
- the mandated size of the warnings, as a percentage of the front and back of the cigarette package;
- whether the warnings appear on individual packages as well as on any outside packaging and labelling used in retail sale;
- whether the warnings describe specific harmful effects of tobacco use on health;
- whether the warnings are large, clear, visible and legible (e.g. specific colours and font styles and sizes are mandated);
- whether the warnings rotate;
- whether the warnings are written in (all) the principal language(s) of the country;
- whether the warnings include pictures or pictograms.

The size of the warnings on both the front and back of the cigarette pack were averaged to calculate the percentage of the total pack surface area covered by warnings. This information was combined with the warning characteristics to construct the groupings for the health warnings indicator.

The groupings for the health warnings indicator are listed below.

| | |
|---|---|
| | Data not reported |
| | No warnings or small warnings ¹ |
| | Medium size warnings ² missing some ³ or many ⁴ appropriate characteristics ⁵ OR large warnings ⁶ missing many ⁴ appropriate characteristics ⁵ |
| | Medium size warnings ² with all appropriate characteristics ⁵ OR large warnings ⁶ missing some ³ appropriate characteristics ⁵ |
| | Large warnings ⁶ with all appropriate characteristics ⁵ |
| 1 | Average of front and back of package is less than 30%. |
| 2 | Average of front and back of package is between 30 and 49%. |
| 3 | One to three. |
| 4 | Four or more. |
| 5 | Appropriate characteristics: <ul style="list-style-type: none"> ■ specific health warnings mandated; ■ appearing on individual packages as well as on any outside packaging and labelling used in retail sale; ■ describing specific harmful effects of tobacco use on health; ■ are large, clear, visible and legible (e.g. specific colours and font style and sizes are mandated); ■ rotate; ■ include pictures or pictograms; ■ written in (all) the principal language(s) of the country. |
| 6 | Average of front and back of the package is at least 50%. |

In addition to the data about cigarettes used for the grouping of the health warnings indicator, data about other smoked tobacco products and smokeless tobacco products, as well as other related data such as the appearance of the quit line number, the requirement for plain packaging, etc. were collected.

Plain packaging (also called standardized packaging) is defined by WHO FCTC Article 11 guidelines as a measure “to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style”.

In order for a country to appear in this report as having introduced plain packaging, the following criteria (established by WHO FCTC Article 13 guidelines) are requested by a law and the implementing rules:

- black and white or two other contrasting colours, as prescribed by national authorities;
- nothing other than a brand name, a product name and/or manufacturer's name, contact details and the quantity of product in the packaging, without any logos or other features apart from health warnings, tax stamps and other government-mandated information or markings;
- prescribed font style and size for the above elements;
- standardized shape, size and materials;
- there should be no advertising or promotion inside or attached to the package or on individual cigarettes or other tobacco products.

Countries with a law requiring plain packaging but with no implementing rules or regulations yet adopted, will not be reported as having introduced plain packaging but will have the footnote “Legislation enabling plain packaging but regulations pending” added in the report. This is also the case for countries that have required health warnings by law without having yet issued the proper texts and/or images by decree, rule, regulation, etc.

Anti-tobacco mass media campaigns

Countries undertake communication activities for many reasons, including improving public relations, creating attention for an issue, building support for public policies, and prompting behaviour change. Anti-tobacco communication campaigns, which are a core tobacco control intervention, must have specified features in order to be minimally effective: they must be of sufficient duration and must be designed to effectively support tobacco control priorities, including increasing knowledge, changing social norms, promoting cessation, preventing tobacco uptake, and increasing support for good tobacco control policies.

With this in mind, and consistent with the definition of “anti-tobacco mass media campaigns” in the last report, only mass media campaigns that were:

- (i) designed to support tobacco control;
- (ii) at least 3 weeks in duration; and
- (iii) implemented between 1 July 2020 and 30 June 2022 were considered eligible for analysis. For the sake of logistical feasibility and cross-country comparability, only national-level campaigns were considered eligible.

Consistent with the last report and to enable greater accuracy, materials from campaigns had to be submitted and verified based on the eligibility criteria for all countries.

Eligible campaigns were assessed according to the following characteristics, which signify the use of a comprehensive communication approach:

1. The campaign was part of a comprehensive tobacco control programme.
2. Before the campaign, research was undertaken or reviewed to gain a thorough understanding of the target audience.
3. Campaign communication materials were pre-tested with the target audience and refined in line with campaign objectives.
4. Air time (radio, television) and/or placement (billboards, print advertising, etc.) were obtained by purchasing or securing it using either the organization’s own internal resources or an external media planner or agency (this information indicates whether the campaign adopted a thorough media planning and buying process to effectively and efficiently reach its target audience).
5. The implementing agency worked with journalists to gain publicity or news coverage for the campaign.
6. Process evaluation was undertaken to assess how effectively the campaign had been implemented.

7. An outcome evaluation process was implemented to assess campaign impact.
8. The campaign was aired on television and/or radio.

The groupings for the mass media campaigns indicator are listed below.

| | |
|--|---|
| | Data not reported |
| | No national campaign conducted between July 2020 and June 2022 with a duration of at least 3 weeks |
| | National campaign conducted with one to four appropriate characteristics |
| | National campaign conducted with five to six appropriate characteristics, or with seven characteristics excluding airing on television and/or radio |
| | National campaign conducted with at least seven appropriate characteristics including airing on television and/or radio |

- point of sale (indoor);
- free distribution of tobacco products in the mail or through other means;
- promotional discounts;
- non-tobacco products identified with tobacco brand names (brand stretching);⁶
- brand names of non-tobacco products used for tobacco products (brand sharing);⁷
- appearance of tobacco brands (product placement) or tobacco products in television and/or films;
- sponsorship (contributions and/or publicity of contributions).

The first four types of advertising listed are termed “direct” advertising, and the remaining six are termed “indirect” advertising. Complete bans on tobacco advertising, promotion and sponsorship usually start with bans on direct advertising in national media and progress to bans on indirect advertising as well as promotion and sponsorship.

Bans on advertising, promotion and sponsorship

The report includes data on legislation in national as well as subnational jurisdictions. The assessment of subnational legislation on advertising, promotion and sponsorship bans includes first-level administrative subdivisions as listed in ISO3166.

Subnational data only reflect the content of subnational laws. Provisions covered by national legislation are indicated by an informative note next to the subnational data. In cases where the status of advertising, promotion and sponsorship legislation is not reported for some or all subnational jurisdictions, we assume the existing national law applies.

Country-level achievements in banning tobacco advertising, promotion and sponsorship were assessed based on whether the bans covered the following types of advertising:

- national television and radio;
- local magazines and newspapers;
- billboards and outdoor advertising;

The basic distinction for the two lowest groups is whether bans cover national television, radio and print media or not, and the remaining groups were constructed based on how comprehensively the law covers bans of the other forms of direct and indirect advertising included in the analysis. In cases where the law did not explicitly address cross-border advertising, it was interpreted that advertising at both domestic and international levels was covered by the ban only if advertising was totally banned at national level.

The groupings for the bans on advertising, promotion and sponsorship indicator are listed below. Countries where at least 90% of the population were covered by subnational legislation completely banning tobacco advertising, promotion and sponsorship are grouped in the top category.

| | |
|--|---|
| | Data not reported |
| | Complete absence of ban, or ban that does not cover national television (TV), radio and print media |
| | Ban on national TV, radio and print media only |
| | Ban on national TV, radio and print media as well as on some (but not all) other forms of direct* and/or indirect** advertising |
| | Ban on all forms of direct* and indirect** advertising (or at least 90% of the population covered by subnational legislation completely banning tobacco advertising, promotion and sponsorship) |
| | <p>* Direct advertising bans:</p> <ul style="list-style-type: none"> ■ national television and radio; ■ local magazines and newspapers; ■ billboards and outdoor advertising; ■ point of sale (indoor). <p>** Indirect advertising bans:</p> <ul style="list-style-type: none"> ■ free distribution of tobacco products in the mail or through other means; ■ promotional discounts; ■ non-tobacco goods or services identified with tobacco brand names (brand stretching); ■ brand names of non-tobacco products used for tobacco products (brand sharing); ■ appearance of tobacco brands (product placement) or tobacco products in television and/or films; ■ sponsorship (contributions and/or publicity of contributions). |

In addition to the data used for the grouping of the bans on advertising, promotion and sponsorship indicator, other related data, such as bans on Internet sales or on display of tobacco products at points of sale were collected.

Tobacco taxes

Countries are grouped according to the percentage contribution of all tobacco taxes to the retail price of a pack of 20 of the most popular brand of cigarettes. Taxes assessed include excise tax, value added tax (or sales taxes), import duty (when the cigarettes were imported) and any other taxes levied. In the case of countries where different levels of taxes applied to cigarettes are based on length, quantity produced, or price level, only the rate that applied to the most popular brand is used in the calculation.

Given the lack of information on country and brand-specific profit margins of retailers and wholesalers, their profits were assumed to be zero (unless provided by the national data collector).

The groupings for the tobacco tax indicator are listed below. Please refer to Technical Note III for more details.

| | |
|--|--|
| | Data not reported |
| | < 25% of retail price is tax |
| | ≥ 25% and < 50% of retail price is tax |
| | ≥ 50% and < 75% of retail price is tax |
| | ≥ 75% of retail price is tax |

Trend in affordability of the most sold brand of cigarettes

The affordability of cigarettes was computed as the percentage of per capita GDP required to purchase 2000 cigarettes of the most popular brand in each year of this report from 2012 to 2022. GDP per capita data in local currency units were sourced from IMF's World Economic Outlook (WEO) database. The least-squares annual growth rate of affordability was computed by fitting a linear regression trend line to the logarithmic values of the affordability measure.

The groupings for the affordability indicator are listed below. Please refer to Technical Note III for more details.

| | |
|-----|---|
| YES | Cigarettes less affordable – per capita GDP needed to buy 2000 cigarettes of the most sold brand increased on average between 2012 and 2022 |
| NO | Cigarettes more affordable – per capita GDP needed to buy 2000 cigarettes of the most sold brand declined on average between 2012 and 2022 |
| ↔ | No trend change in affordability of cigarettes between 2012 and 2022 |
| ... | Insufficient data to conduct a trend analysis |

National tobacco control programmes

Classification of countries' national tobacco control programmes is based on the existence of a national agency with responsibility for tobacco control objectives. Countries with at least five full-time equivalent staff members working at the national agency with responsibility for tobacco control meet the criteria for the highest group.

The groupings for the national tobacco control programme indicator are listed below.

| | |
|--|---|
| | Data not reported |
| | No national agency for tobacco control |
| | Existence of national agency with responsibility for tobacco control objectives with no or fewer than five full-time equivalent staff members |
| | Existence of national agency with responsibility for tobacco control objectives and at least five full-time equivalent staff members |

MPOWER summaries

The MPOWER groups, coded by colour as described above, are summarised in Annex 1.

Data collected and reported for ENDS and ENNDS in relation to the P, W and E measures

This report includes some data collected about ENDS and ENNDS (Annex 2). For P, W and E related data, the methodology used to collect and validate the data as well as the criteria used, were identical to those described earlier in this Technical Note. However, no subnational legislation was assessed for these products (only national legislation).

Specifications on data about ENDS and ENNDS

In terms of product regulation, ENDS and ENNDS were categorized based on provisions in national legislation or regulations. For countries where the sale of ENDS and ENNDS is banned, we have nonetheless reported on regulations relating to their use, advertising, promotion, and sponsorship. For W and E, a distinction was made between the regulation applicable to the electronic devices and the one applicable to the e-liquids.

The questions used for the groupings of the P, W and E measures described earlier were all assessed, and other related data such as minimum sale age, or regulation of flavours, were also collected.

Compliance assessment

Compliance with national and comprehensive subnational smoke-free legislation as well as with advertising, promotion and sponsorship bans was assessed by up to five national experts, who scored the compliance in these two areas as “minimal”, “moderate” or “high”. These five experts were selected according to the following criteria:

- person in charge of tobacco prevention in the country’s ministry of health, or the most senior government official in charge of tobacco control or tobacco-related conditions;
- the head of a prominent nongovernmental organization dedicated to tobacco control;
- a health professional (e.g. physician, nurse, pharmacist or dentist) specializing in tobacco-related conditions;
- a staff member of a public health university department;
- the tobacco control focal point of the WHO Country Office.

The experts performed their assessments independently. Average scores were calculated by WHO from the five individual assessments by assigning two points for highly enforced policies, one point for moderately enforced

policies and no points for minimally enforced policies, with a potential minimum of 0 and maximum of 10 points in total from these five experts.

The compliance assessment was obtained for legislation implemented by 1 April 2022. For countries with more recent implementation, compliance data are reported as “not applicable”.

The compliance assessments are listed in Annex 2. Annex 1 summarizes this information. Compliance scores are represented separately from the grouping (i.e. compliance is not included in the calculation of the grouping categories).

Background chapters

All background chapters were developed as brief summaries of the topic areas covered and are not intended to be comprehensive reviews of the existing literature.

All recommendations presented are based upon pre-existing Member State agreements or published technical guidance.

-
- 1 Parties report on the implementation of the WHO Framework Convention on Tobacco Control according to Article 21. The objective of reporting is to enable Parties to learn from each other’s experience in implementing the WHO FCTC. Parties’ reports are also the basis for review by the COP of the implementation of the WHO FCTC. Since 2012, all Parties submit their reports at the same time once every 2 years. For more information please refer to <https://www.who.int/fctc/reporting/en/>.
 - 2 United Nations Department of Economic and Social Affairs, Population Division in World population prospects 2022 (median fertility projection for the year 2022). For more information please refer to <https://population.un.org/wpp/Download/Standard/Population/>.
 - 3 The World Bank: World development indicators published July 1, 2022. For more information please refer to <https://datahelpdesk.worldbank.org/knowledgebase>.
 - 4 “Complete” is used in this report to mean that smoking is not permitted, with no exemptions allowed, except in residences and indoor places that serve as equivalents to long-term residential facilities, such as prisons and long-term health and social care facilities such as psychiatric units and nursing homes. Ventilation and any form of designated smoking rooms and/or areas do not protect from the harms of second-hand tobacco smoke, and the only laws that provide protection are those that result in the complete absence of smoking in all public places.
 - 5 Designated smoking room exceptions in the legislation that include at least three out of the six following characteristics, and include at least criteria 5 or 6, are denoted in the annex tables with an asterisk. The designated smoking room must:
 - be a closed indoor environment;
 - be furnished with automatic doors, generally kept closed;
 - be non-transit premises for non-smokers;
 - be furnished with appropriate forced-ventilation mechanical devices;
 - have appropriate installations and functional openings installed, and air must be expelled from the premises;
 - be maintained, with reference to surrounding areas, in a depression not lower than 5 Pascals.
 - 6 When legislation did not explicitly ban the identification of non-tobacco products with tobacco brand names (brand stretching) and did not provide a definition of tobacco advertising and promotion, it was interpreted that brand stretching was covered by the existing ban of all forms of advertising and promotion when the country was a Party to the WHO FCTC, assuming that the WHO FCTC definitions apply.
 - 7 When legislation did not explicitly ban the use of brand names of non-tobacco products for tobacco products (brand sharing) and did not provide a definition of tobacco advertising and promotion, it was interpreted that brand sharing was covered by the existing ban of all forms of advertising and promotion when the country was a Party to the WHO FCTC, assuming that the WHO FCTC definitions apply.



Tobacco use prevalence in WHO Member States

Monitoring the prevalence of tobacco use is central to efforts to control the global tobacco epidemic. Reliable prevalence data on the magnitude of the tobacco epidemic and its influencing factors provide the information needed to plan, adopt and evaluate the impact of tobacco control interventions. This report contains information on the prevalence of tobacco use sourced from the most recent surveys run by each Member State among the general population and among adolescents. WHO-modelled, age-standardized prevalence estimates for daily smoking among people aged 15 years and over are presented in Annex 1. This technical note provides information on the method used to generate the WHO prevalence estimates.

Sources of information

For modelling of WHO estimates of tobacco use prevalence, the following sources of information were explored (where official survey reports explaining the sampling, methodology and detailed results were not publicly available, Member States were asked to provide them):

- information on surveys provided by Parties to the WHO FCTC Secretariat in Party reports;
- information collected through WHO tobacco-focused surveys conducted under the aegis of the Global Tobacco Surveillance System – in particular, the Global Adult Tobacco Survey (GATS);
- tobacco information collected through other WHO-supported surveys including WHO STEPwise surveys and World Health Surveys;
- other systems-based surveys undertaken by cross-national organizations, including surveys such as the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Survey (MICS); and
- an extensive search through WHO regional offices and WHO country offices to identify country-specific surveys not part of international surveillance systems – such as the National Survey of Risk Factors in Argentina, or the Mauritius Non-Communicable Diseases Survey.

For the analysis, information from surveys conducted since 1990 was used if it:

- was officially recognized by the national health authority;
- included randomly selected participants who were representative of the general population (school-based surveys were specifically excluded);
- provided data for one or more of six tobacco use definitions: daily tobacco user, current tobacco user, daily tobacco smoker, current tobacco smoker, daily cigarette smoker or current cigarette smoker; and
- was disaggregated prevalence values by age and sex.

The above indicators provide for the most complete representation of tobacco use across countries and at the same time help minimize attrition of countries from further analysis because of lack of adequate data. Although differences exist in the types of tobacco products used in different countries and grown or manufactured in different regions of the world, data on at least one of these six indicators are available in most countries, thereby permitting robust statistical analyses.²

The information identified above is stored in the WHO Tobacco Control Global DataBank and, along with the source code used for generating the WHO smoking prevalence estimates, is published alongside this report at <https://www.who.int/health-topics/tobacco/>.

Analysis and presentation of tobacco use prevalence indicators

Estimation method

A statistical model based on a Bayesian negative binomial meta-regression was used to model crude adjusted and age-standardized estimates for countries for each indicator (current and daily tobacco use, current and daily tobacco smoking, and current and daily cigarette smoking) separately for men and women. A full description of the method is available as a peer-reviewed article in the *Lancet*, volume 385, No. 9972, p966–976 (2015).

Once the prevalence rates from national surveys were compiled into a dataset, the model was fit to calculate trend estimates for the six indicators specified above.

The model has two main components:

(a) adjusting for missing indicators and age groups, and (b) running a regression to generate an estimate of trends over time as well as the credible interval around the estimate.

Depending on the completeness of survey data from a particular country, the model at times makes use of data from other countries to fill gaps. Countries with data gaps “borrow information” from “priors” calculated from their data pooled with data from countries in the same UN subregion.³

Differences in age groups covered by each survey

Prevalence rates for any one country were sometimes reported for a variety of different age groups, according to the age range of each survey. Where rates were not collected for any age group in the range of 15 years and above, the model uses data from other surveys in the country's dataset to estimate the age pattern of tobacco use. For ages that the country has never surveyed, the average age pattern seen in countries in the same UN subregion is applied to the country's data.

Differences in the indicators of tobacco use measured

Countries may report different indicators across surveys (e.g. current smoking in one survey and daily smoking in another, or tobacco smoking in one and cigarette smoking in another). Where data are missing for any indicator, the model uses data from other surveys in the country's dataset to estimate the missing information. For indicators on which the country has never reported, the average relationships seen in countries in the same UN subregion are applied to the country's data.

Modelled results

The model was run for all countries with surveys that met the inclusion criteria. Results for countries with insufficient survey data (e.g. no surveys with a detailed age breakdown of prevalence for both sexes) were not reported.

The output of the model is a set of trend lines for each country that summarize its prevalence history from 2000 to the year of the most recent survey. If the most recent survey was earlier than 2021, the trend is projected to 2021. The projection assumes that the pace and level of adoption of new policies during the period covered by the countries' national surveys continued unchanged to 2021.

To allow global comparability, the trend calculation is the same for all countries. Countries with few surveys will have more borrowed information blended into their trend line than countries with many surveys. No allowances are made for inflection points in the specific years when tobacco control policies were introduced or improved. Therefore, WHO estimates and projections may differ from countries' own estimates and projections.

For this report, country-level trends have been summarized into average trends for high-income countries, middle-income countries, low-income countries and a global average. The estimated rates for the years 2007 and 2021 are presented.

In this report, comparable estimates of current tobacco use among people aged 15 years and over are presented at country-level for the year 2021. The rates are comparable because the model has standardized the survey results as described above, and then age-standardized as described below.

When calculating global and World Bank income group average prevalence rates, countries without estimates were included in the averages by assuming their prevalence rates are the same as the average rates seen in the UN subregion to which they belong.³

Age-standardized prevalence rates

Comparison of crude rates between two or more countries at one point in time, or of one country at different points in time, can be misleading if the two populations being compared have significantly different age distributions or differences in tobacco use by sex. Age-standardization is a method commonly used to overcome this problem and to allow for meaningful comparison of prevalence between countries, once all other comparison issues described above have been addressed. The method involves

applying the age-specific rates by sex in each population to one standard population (this report uses the WHO Standard Population, a fictitious population whose age distribution is largely reflective of the population age structure of low- and middle-income countries). The resulting age-standardized rates refer to the number of smokers per 100 WHO Standard Population. As a result, the rates generated using this process are only hypothetical numbers with no inherent meaning. They are meaningful only when comparing rates across countries or over wide time frames.

Comparison with smoking estimates in earlier editions of this report

The estimates in this report are consistent with each other but not with estimates produced for earlier editions of this report. While the method of estimation is the same, the updated data set for the period 1990–2022 is much more complete.

For example, since the *WHO report on the global tobacco epidemic, 2021*, 243 national surveys from 100 countries have been added to the data set, and 40 existing surveys have been updated with additional data points. Each round of WHO estimates is calculated using all available survey data back to 1990. The more data points available, the more robust the trend estimates are. Each estimation round therefore improves upon earlier published estimates, and only the latest round should be used.

While country-level estimates in this report pertain only to 2021, the trend from 2000 to 2025 is published in the biennial *WHO global report on trends in tobacco smoking 2000–2025*.

- 1 Tobacco smoking includes cigarette, cigar, pipe, hookah, shisha, water-pipe, heated tobacco products and any other form of smoked tobacco.
- 2 For countries where prevalence of smokeless tobacco use is reported, we have published these data.
- 3 For a complete list of countries by UN subregion, please refer to pages ix to xiii of World population prospects: the 2019 revision, published by the UN Department of Economic and Social Affairs at <https://population.un.org/wpp/Download/Standard/Population/> (accessed December 17, 2020). Please note that, for the purposes of tobacco use analysis, the following adjustments were made: (i) Eastern Africa subregion was divided into two regions: Eastern African Islands and Remainder of Eastern Africa; (ii) Armenia, Azerbaijan, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Tajikistan, Uzbekistan and Turkmenistan were classified with Eastern Europe; (iii) Cyprus, Israel and Türkiye were classified with Southern Europe; (iv) Central Africa and Southern Africa were combined into one subregion; (v) Melanesia, Micronesia and Polynesia subregions were combined into one subregion; and (vi) Ireland and the United Kingdom were combined with Northern America.

TECHNICAL NOTE III

Tobacco taxes in WHO Member States

This report includes appendices containing information on the share of total and excise taxes in the price of the most widely sold brand of cigarettes, based on tax policy information collected from each country. This note contains information on the methodology used by WHO to estimate the share of total and tobacco excise taxes in the price of a pack of 20 cigarettes using country-reported data. It also provides information on other data collected for this report in relation to tobacco taxation. There is also price and tax data on heated tobacco products or nicotine and non-nicotine delivery systems.

1. Data collection

All data were collected between June 2022 and February 2023 by WHO regional data collectors. The two main inputs into calculating the share of total and excise taxes were (1) prices and (2) tax rates and structure. Prices were collected for the most widely sold brand of cigarettes, the least-expensive brand and a premium brand for July 2022.

Data on tax structure were collected through contacts with ministries of finance. The validity of this information was checked against other sources. For many countries, this was done through the wealth of work and knowledge

accumulated by WHO working directly with ministries of finance on tobacco taxation since 2009. Other sources, including tax law documents, decrees and official schedules of tax rates and structures and trade information, when available, were either provided by data collectors or were downloaded from ministerial websites.

The tax data collected focus on indirect taxes levied on tobacco products (e.g. excise taxes of various types, import duties, value added taxes), which usually have the most significant impact on the price of tobacco products. Within indirect taxes, excise taxes are the most important because they are applied exclusively to tobacco and contribute

the most to increasing the price of tobacco products and subsequently reducing consumption. Thus, rates, amounts and point of application of excise taxes are central components of the data collected.

Certain other taxes, in particular direct taxes such as corporate taxes, can potentially impact tobacco prices to the extent that producers pass them on to final consumers. However, because of the practical difficulty of obtaining information on these taxes and the complexity in estimating their potential impact on price in a consistent manner across countries, they are not considered.



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The table below describes the types of tax information collected.

| | |
|--|---|
| <p>1. Specific excise taxes</p> | <p>A specific excise tax is a tax on a selected good produced for sale within a country or imported and sold in that country. In general, the tax is collected from the manufacturer or at the point of entry into the country by the importer, in addition to import duties. These taxes come in the form of an amount per stick, pack, per 1000 sticks, or per kilogram. Example: US\$ 1.50 per pack of 20 cigarettes.</p> |
| <p>2. Ad valorem excise taxes</p> | <p>An ad valorem excise tax is a tax on a selected good produced for sale within a country or imported and sold in that country. In general, the tax is collected from the manufacturer or at the point of entry into the country by the importer, in addition to import duties. These taxes come in the form of a percentage of the value of a transaction between two independent entities at some point of the production/distribution chain; ad valorem taxes are generally applied to the value of the transactions between the manufacturer and the retailer/wholesaler. Example: 60% of the manufacturer’s price.</p> |
| <p>3. Import duties</p> | <p>An import duty is a tax on a selected good imported into a country to be consumed in that country (i.e. the goods are not in transit to another country). In general, import duties are collected from the importer at the point of entry into the country. These taxes can be either specific or ad valorem. Specific import duties are applied in the same way as specific excise taxes (e.g. an amount per 1000 sticks). Ad valorem import duties are generally applied to the CIF (cost, insurance, freight) value, i.e. the value of the unloaded consignment that includes the cost of the product itself, insurance and transport and unloading. Example: 50% import duty levied on CIF.</p> |
| <p>4. Value added taxes and sales taxes</p> | <p>The value-added tax (VAT) is a “multi-stage” tax on all consumer goods and services applied proportionally to the price taxes the consumer pays for a product. Although manufacturers and wholesalers also participate in the administration and payment of the tax all along the manufacturing/distribution chain, they are all reimbursed through a tax credit system, so that the only entity who pays in the end is the final consumer. Most countries that impose a VAT do so on a base that includes any excise tax and customs duty. Example: VAT representing 10% of the retail price.</p> <p>Some countries, however, impose sales taxes instead. Unlike VAT, sales taxes are generally levied at the point of retail on the total value of goods and services purchased. For the purposes of the report, care was taken to ensure the VAT and/or sales tax shares were computed in accordance with country-specific rules.</p> |
| <p>5. Other taxes</p> | <p>Information was also collected on any other tax that is not called an excise tax, import duty, VAT or sales tax, but that applies to either the quantity of tobacco or to the value of a transaction of a tobacco product, with as much detail as possible regarding what is taxed and how the base is defined.</p> |

2. Data analysis

The price of the most sold brand of cigarettes was considered in the calculation of the tax as a share of the retail price. In the case of countries where different levels of taxes are applied on cigarettes based on length of cigarette, quantity produced, or type (e.g. filter vs. non-filter), only the relevant rate that applied to the most sold brand was used in the calculation.

In the case of Canada and the United States, national average estimates calculated for prices and taxes reflect the fact that different rates are applied by state/province over and above the applicable federal tax. In the case of Brazil, where state VATs vary, the highest rate, which is applied in most States, was applied. In the Federated States of Micronesia, which also has varying VAT rates across states, the VAT rate applicable to the state where price data was collected (Pohnpei) was used. A weighted average of retail price and tax was calculated for China given the very large array of brands sold in the market: the most sold brand changing almost every year and representing a very small share of the market was not representative.

The import duty was only used in the calculation of tax shares if the most sold brand of cigarettes was imported into the country. Import duty was not applied in total tax calculation for countries reporting that the most sold brand, even if an international brand, was produced locally. In cases where the imported cigarettes originated from a country with which a bilateral or multilateral trade agreement waived

the duty, care was taken to ensure that the import duty was not taken into account in calculating taxes levied.

“Other taxes” are all other indirect taxes not reported as excise taxes, import duties or VAT. An example of such tax is the environmental levy.

The next step of the exercise was to convert all taxes to the same base – in our case, the tax-inclusive retail sale price (hereafter referred to as P). Standardizing bases is important in calculating tax share correctly, as the example in the table below shows. Country B apparently applies the same ad valorem tax rate (20%) as Country A, but in fact ends up with a higher tax rate and a higher final price because the tax is applied later in the distribution chain. Comparing reported statutory ad valorem tax rates without taking into account the stage at which the tax is applied could therefore lead to biased results.

A similar methodology was used to calculate the price and tax share of the most common type of smoked (other than cigarettes) and smokeless tobacco products, as reported by each country. The calculation was made for the price of a product for 20 grams of any smoked or smokeless tobacco product, 20 sticks of cigarettes, bidis and heated tobacco products (HTPs) and one stick of cigars and cigarillos. For the e-liquid of closed electronic rechargeable and disposable nicotine or non-nicotine delivery systems (ENDS/ENNDS) the price and tax was calculated for 1 ml while for open systems, it was calculated for 10 ml. Price and tax for smoked tobacco products (including bidis, cigarillos, cigars, pipe tobacco, roll-your-own or

waterpipe tobacco) was calculated for 48 countries, while the calculation for smokeless tobacco products (chewing tobacco, dry snuff, moist snuff or nose tobacco) was made for 16 countries. Price and tax was also calculated for HTPs for 53 countries, for the e-liquid of a closed rechargeable electronic nicotine or non-nicotine delivery systems for 48 countries, for the e-liquid of closed disposable ENDS/ENNDS for 48 countries and for the e-liquid of an open electronic nicotine or non-nicotine delivery systems for 51 countries.

3. Calculation

As an example of the calculations performed, denote S_{ts} as the share of taxes in the price of a widely consumed brand of cigarettes (20-cigarette pack or equivalent). Then,

$$S_{ts} = S_{as} + S_{av} + S_{id} + S_{VAT} \quad \textcircled{1}$$

Where:

S_{ts} = Total share of taxes in the price of a pack of cigarettes;

S_{as} = Share of amount-specific excise taxes in the price of a pack of cigarettes;

S_{av} = Share of ad valorem excise taxes in the price of a pack of cigarettes;

S_{id} = Share of import duties in the price of a pack of cigarettes (if the most popular brand is imported);

S_{VAT} = Share of the value added tax in the price of a pack of cigarettes.

| | Country A (US\$) | Country B (US\$) |
|---|--------------------------|------------------------|
| [A] Manufacturer's price (same in both countries) | 2.00 | 2.00 |
| [B] Country A: ad valorem tax on manufacturer's price (20%) = 20% x [A] | 0.40 | - |
| [C] Retailer's and wholesaler's profit margin (same in both countries) | 0.20 | 0.20 |
| [D] Country B: ad valorem tax on retailer's price (20%) = 20% x [E] | - | 0.55 |
| [E] Final price = P = [A]+[B]+[C] or [A]+[C]+[D] | 2.60 | 2.75 |
| Total tax share (as % of P) | 0.40/2.60 = 15.4% | 0.55/2.75 = 20% |

Calculating S_{os} is straightforward and involves dividing the specific tax amount for a 20-cigarette pack by the retail sales price. Unlike S_{os} , the share of ad valorem taxes, S_{av} , depending on the base it is applied on, can be much more difficult to calculate and would involve making some assumptions described below. Import duties are sometimes amount-specific, sometimes value-based. S_{id} is therefore calculated the same way as S_{os} if it is amount-specific and the same way as S_{av} if it is value-based. VAT rates reported for countries are usually applied on the VAT-exclusive retail sale price but are also sometimes reported on VAT-inclusive prices. S_{VAT} is calculated to consistently reflect the share of the VAT in VAT-inclusive retail sale price.

The price of a pack of cigarettes can be expressed as the following (in the case of a country applying a specific excise and ad valorem excise applicable on the manufacturer's price or CIF value + import duty):

$$P = [(M + M \times ID) + (M + M \times ID) \times T_{av}\% + T_{os} + \pi] \times (1 + VAT\%), \text{ or}$$

$$P = [M \times (1 + ID) \times (1 + T_{av}\%) + T_{os} + \pi] \times (1 + VAT\%) \quad (2)$$

Where:

P = Price per pack of 20 cigarettes of the most popular brand consumed locally;

M = Manufacturer's/distributor's price, or import price if the brand is imported;

ID = Import duty rate (where applicable) on a pack of 20 cigarettes;¹

T_{av} = Statutory rate of ad valorem tax;

T_{os} = Amount-specific excise tax on a pack of 20 cigarettes;

π = Retailer's, wholesaler's and importer's profit per pack of 20 cigarettes (sometimes expressed as a mark-up);

VAT = Statutory rate of value added tax on VAT-exclusive price.

Changes to this formula were made based on country-specific considerations such as the base for the ad valorem tax and excise tax, the

existence – or not – of ad valorem and specific excise taxes, and whether the most popular brand was locally produced or imported. In many cases (particularly in low- and middle-income countries) the base for ad valorem excise tax was the manufacturer's price or CIF value. But in fact, the base of the ad valorem varies a lot around the world and can include other bases, such as retail price, retail price net of some taxes (and/or some predefined margins), retail price net of all taxes, etc.

Given knowledge of price (P) and amount-specific excise tax (T_{os}), the share S_{os} is easy to recover ($=T_{os}/P$). The case of ad valorem taxes (and, where applicable, S_{id}) is fairly straightforward when, by law, the base is retail price. The calculation is more complicated when the base is the manufacturer's price (M) and needs to be recovered to calculate the amount of ad valorem tax. In most of the cases, M was not known (unless specifically reported by the country), and therefore had to be estimated.

Using equation (2), it is possible to recover M :

$$M = \frac{P}{(1 + VAT\%) \times (1 + ID)} - \frac{\pi + T_{os}}{(1 + ID)} \quad (3)$$

π , or wholesalers' and retailers' profit margins, are rarely publicly disclosed and will vary from country to country. For domestically produced most popular brands, we considered π to be nil (i.e. =0) in the calculation of M because the retailer's and wholesaler's margins are assumed to be small. Setting the margin to 0, however, would result in an overestimation of M and therefore of the base for the ad valorem tax. This will in turn result in an overestimation of the amount of ad valorem tax. Since the goal of this exercise is to measure how high the share of tobacco taxes is in the price of a typical pack of cigarettes, assuming that the retailer's/wholesaler's profit (π) is nil, therefore, does not penalize countries by underestimating their ad valorem taxes. Considering this, it was decided that unless country-specific information was made available to

WHO, the retailer's or wholesaler's margin would be assumed to be nil for domestically produced brands.

For countries where the most popular brand is imported, the import duty is applied on CIF values, and the consequent excise taxes are typically applied on a base that includes the CIF value and the import duty, but not the importer's profit. For domestically produced cigarettes, the producer's price includes its own profit, so it is automatically included in M . However, the importer's profit can be relatively significant and setting it to zero (as in the case of domestically manufactured cigarettes) would substantially overestimate M , and thereby substantially overestimate the share of ad valorem tax in final price. For this reason, M had to be estimated differently for imported products: M^* (or the CIF value) was calculated either based on information reported by countries or using secondary sources (data from the United Nations Comtrade database²). M^* was normally calculated as the import price of cigarettes in a country (value of cigarette imports divided by the quantity of cigarette imports for the importing country).³ However, in a small number of cases where no such data were available (Bhutan, Cook Islands, Equatorial Guinea, Kiribati, Liberia, Marshall Islands, Tuvalu and Vanuatu), the export price was considered instead. The ad valorem and other taxes were then calculated in the same way as for local cigarettes, using M^* rather than M as the base, where applicable.

In the case of VAT, in most of the cases the base was P excluding the VAT (or, similarly, the manufacturer's/distributor's price plus all excise taxes). In other words:

$$S_{VAT} = VAT\% \times (1 - S_{VAT}), \text{ equivalent to } S_{VAT} = VAT\% \div (1 + VAT\%) \quad (4)$$

In some cases, however, we were informed that the VAT was not effectively collected at all levels of the supply chain and was mainly levied at the importing or manufacturing gate. In this case, the VAT was calculated on the basis of M (or M^*) and the different taxes collected at this stage, mainly import

1 Import duties may vary depending on the country of origin in cases of preferential trade agreements. WHO tried to determine the origin of the pack and relevance of using such rates where possible.

2 <https://comtradeplus.un.org/>

3 When quantity was reported in weight (kg) rather than number of sticks, the conversion was made assuming one stick contained one gram of tobacco.

duties and excise taxes (Angola, Benin, Cabo Verde, Cook Islands, Equatorial Guinea, Ghana, Guinea-Bissau, Kiribati, Malaysia, Mali, Mauritania, Sudan, Suriname, Tonga, Uganda Tuvalu and Vanuatu).

In sum, tax rates are calculated using the formula:

$$S_{ts} = S_{id} + S_{as} + S_{av} + S_{vat} \quad (5)$$

$$S_{as} = T_{as} \div P$$

$$S_{av} = (T_{av} \% \times M) \div P \text{ or } (T_{av} \% \times M^* \times (1 + S_{id})) \div P^4 \text{ if the most popular brand was imported}$$

$$S_{id} = (T_{id} \% \times M^*) \div P \text{ (if the import duty is value-based) or } ID \div P \text{ (if import duty is a specific amount per pack)}$$

$$S_{vat} = VAT\% \div (1 + VAT\%)$$

4. Prices

Primary collection of price data in this and previous reports involved surveying retail outlets. Price data was collected from two different types of outlets.

Questionnaires sent to data collectors were pre-populated with the names of the highest selling brand in each country. The popular brand was identified using data collected from the 2020 questionnaires, through reports from data collectors in 2022 and through WHO's close collaboration with ministries of finance. When possible, the identified most sold brand was cross-checked with estimates of brand market share of Euromonitor. For the countries where such data were not available, data collectors were asked to indicate the names of the popular brands and provide their prices. And in a small number of countries (around seven), prices of specific products including HTPs and ENDS/ENNDS e-liquids were collected from online shops.

The two types of retail outlets were defined as follows:

1. Supermarket/hypermarket: chain or independent retail outlets with a selling space of over 2500 square metres and a primary focus on selling food/beverages/tobacco and other groceries. Hypermarkets also sell a range of non-grocery merchandise.

2. Kiosk/newsagent/tobacconist/independent food store: small convenience stores, retail outlets selling predominantly food, beverages and tobacco or a combination of these (e.g. kiosk, newsagent or tobacconist) or a wide range of predominantly grocery products (independent food stores or independent small grocers).

Most sold brands have been used consistently over time to gain a better reflection of the change in prices. However, in some cases where the market share of the brand initially used was considered to have changed substantially, a change was made to the new, more prevalent brand. In 2022, changes in the brand were made for Democratic Republic of the Congo, Iraq, Mali, Niger, Micronesia (Federated States of, Morocco (different brand but same price category), Antigua and Barbuda, Kiribati (cheaper brand category), Bahamas, Dominica, Ghana, Panama, Senegal, Turkmenistan and Ukraine (more expensive brand category).

In 8 other countries (Albania, Bosnia and Herzegovina, Estonia, Latvia, Lithuania, Maldives, Japan and Marshall Islands) the brand reported in 2022 was a variant of the brand reported in 2020, with similar price levels and these were treated as identical in both years for purposes of price comparisons.

As in 2012, 2014, 2016, 2018 and 2020, the price used for each of the 27 countries of the European Union (EU) was the most sold brand collected by WHO. Prior to 2012, price and tax information were taken entirely from the EU's Taxation and Customs Union website. The price used by the EU in the past to calculate tax rates was the most popular price category (MPPC), which was assumed to be close to the most sold brand price category collected in this report. However, since 2011, the EU calculates and reports tax rates based on the Weighted Average Price (WAP) and therefore information on the MPPC is no longer readily available for EU countries. Consequently, in order to be consistent with past years' estimates and to ensure comparability with other countries, WHO decided in 2012 to collect first hand prices of the most sold brand to calculate tax rates.⁵ The most sold brand is determined based

on brand market shares reported from secondary sources, which is validated by countries. It is also worth noting that the EU tables use a WAP calculated from cigarette market data derived from the previous year (due to availability of data), which means that it would not reflect a price change that may have occurred following a tax increase in the next year. It also means that the tax share may not be representative of the actual tax share since the WAP and the tax rates are from different years. Excise and VAT rates are still collected from the EU published tables. This means, however, that tax shares as computed and reported in this report will not necessarily be similar to the rates published by the EU. This is mainly due to the calculation of the specific excise tax rates as a percentage of the retail price, which will vary depending on the price used.

5. Considerations in interpreting tax share changes

Changes in tax as a share of price are not only dependent on tax changes but also on price changes. Therefore, despite an increase in tax, the tax share could remain the same or go down; similarly, sometimes a tax share can increase even if there is no change/increase in the tax.

In the current database, there are cases where taxes increased between 2020 and 2022 but the share of tax as a percentage of the price went down. This is mainly due to the fact that, in absolute terms, the price increase was larger than the tax increase (particularly in the case of specific excise tax increases). For example, in Colombia, the specific excise tax increased from 2 430 Colombian pesos per 20 cigarettes in 2020 to 2 800 Colombian pesos per 20 cigarettes in 2022 (a 15.2% increase), while the price of the most sold brand increased from 5 571 to 7 138 Colombian pesos per pack (an 28.1% increase). In terms of tax share the excise represented 43.6% of the price in 2020 and it went down to 39.2% of the price in 2022. This is because price rose more than taxes.

4 Or $S_{av} = (T_{av} \% \times M^*) \div P$, if the ad valorem tax was applied only on the CIF value, not the CIF value + the import duty.

5 Due to a lack of capacity, the price is collected for cigarettes only while calculations for other smoked or smokeless tobacco products are made using the EU tables when available, including the WAP and tax rates.

In the same way, there are cases where increases (decreases) in tax as a share of price were mitigated by factors not directly related to tax rates. In the current database, this was attributable to one or more of the following reasons:

- In some instances, the price increased without a tax change, leading to a decrease in the tax share for a specific or mixed excise structure (e.g. Andorra, Belize, Brazil, China, Ecuador, Egypt, El Salvador, Ethiopia, Georgia, Guyana, Jamaica, Mongolia, Mozambique, Republic of Korea, Saint Lucia, Samoa, Sao Tome and Principe, Singapore, Spain, Sri Lanka, Switzerland and Uganda).
- In other cases, prices increased above tax increases, leading to a decrease in tax share for a specific or mixed excise structure (e.g. Austria, Bolivia (Plurinational State of), Colombia, Czechia, Gambia, Honduras, Hungary, Ireland, Israel, Japan, Kazakhstan, Kenya, Kyrgyzstan, Malawi, Mauritius, Montenegro, Myanmar, Netherlands (Kingdom of the), North Macedonia, Norway, Pakistan, Philippines, Portugal, Romania, Serbia, Sweden, Tunisia, Türkiye, Turkmenistan, the United Kingdom, the United States and Uruguay).
- In the case of imported products, the CIF value is an external variable that also influences the calculation of tax share. This has implications in countries where ad valorem is based on the CIF value, when import duties are applicable on the CIF value or when the VAT is calculated on the base of CIF value + excise rather than VAT exclusive retail price. For example, if the CIF value increases, the base for the application of the tax is higher, leading to a higher tax percentage if nothing else changes. Countries which have seen changes in their tax share mainly due to changes in CIF value include Angola, Cameroon, Ghana, Lao People's Democratic Republic, Mali, Marshall Islands and Niger.

- Care should also be taken in relation to countries where the most sold brand changed between 2020 and 2022. This also had an impact on the tax proportion of the affected countries which had a specific or mixed excise structure. In some cases, because the new brand reported was more expensive and despite tax increases, the total tax share decreased (Turkmenistan and Ukraine). In a different vein, Liberia saw its tax share go down despite no change in the statutory tax rate, this was due to the fact that the tax rate is set in US\$ and the exchange rate used went down between 2020 and 2022 reducing the effective value of the tax.

Finally, when new, improved information was provided in terms of taxation and prices for some countries, corrections were made in the calculations of tax rates for 2008, 2010, 2012, 2014, 2016, 2018 and 2020 estimates, as needed.

6. Taxation of novel and emerging nicotine and tobacco products

- Heated tobacco products (HTPs)

Similar to cigarettes, the price of the most sold brand of sticks (not the devices) has been collected and where applicable, taxes applied. The same methodology used for calculating the tax of cigarettes was followed for HTPs. Only two notable differences were applied: when specific excise tax was applied on the weight of tobacco contained in the sticks, the assumption was made that each stick contained 0.3 grams of tobacco (or 6 grams per pack of 20), unless indicated otherwise by a specific country. The assumption was made based on an average estimate published by the e-cigarettes market data provider ECigIntelligence.⁶

The second assumption was made on the value of the CIF for countries that applied an import duty based on the CIF value. Given the lack available data on the import value of HTPs, an extrapolation was made assuming the CIF value of HTPs would be higher than the CIF value of cigarettes. This was based on the assumption that the cost of HTP production was higher than cigarettes production. Estimates of the median CIF value as a proportion of retail price of the most sold brand of cigarette in 2020 and 2022 ranged around 13-16%. As a consequence, a standard CIF upward value of 20% of the retail price of the most sold brand of HTPs was applied for countries where a CIF value was needed to calculate the tax burden of HTPs.

- Electronic nicotine and non-nicotine delivery systems (ENDS/ENNDS)

Given the heterogeneity of the ENDS/ENNDS market and the difficulty in identifying a most sold brand that is representative enough of the market in a given country, data was collected on the price of the cheapest brand available for a nicotine or non-nicotine containing e-liquid (whichever was the cheapest available). Data was also collected for three types of e-liquids, those used for open systems and those for closed systems that are rechargeable and disposable ones.⁷ The tax was calculated in the same manner as for cigarettes with the only difference being the base quantity. For e-liquid, the base reported is the volume, per ml. Because of differences in prices and packaging, the price was standardised per 10 ml for open systems e-liquids and per 1 ml for closed systems e-liquids (rechargeable and disposable). Similar to the case of HTPs and where a CIF value was needed to calculate the tax burden on ENDS/ENNDS e-liquids, given the lack of data, assumptions were made regarding the CIF value as a proportion of the retail price of the cheapest brand reported. Assuming the CIF value was a proxy for the cost of production and, based on information from ECigIntelligence that mark-ups at the wholesale and retail levels could represent up to 100% of the cost at each level, it was assumed that the CIF value would be around 20% of the final retail price. A base of 20% of the

6 ECigIntelligence.com (restricted access).

7 Open systems are devices that allow the user to buy e-liquids and fill their device with the mixtures they want (with no nicotine, different nicotine concentrations and/or flavours). Closed systems are products that come with a prefilled container (called a cartridge, pod or tank). More specifically, disposable cigarettes are used only once and once consumed they are thrown away.

retail price was assigned for countries where the ad valorem excise or import duty was calculated on CIF value (except for Peru where a CIF value was reported by national authorities).

7. Supplementary tax information

An important consideration highlighted in this report is that many aspects of tobacco taxation need to be taken into account in order to assess if a tax policy is well designed. Tax as a proportion of price does not tell the whole story about the effectiveness of a tax policy. To explore other dimensions of tax policy, the report has been collecting since 2015 additional information in relation to tobacco taxation and compiles it into data that can inform researchers and policy-makers further on tax policy in different countries.

The information is compiled and classified in this report according to two main themes: tax structure/level and tax administration. Information was also collected in relation to countries that earmark tobacco taxes to fund health programmes and/or tobacco control activities. The different sets of data/indicators reported under each of the themes were developed and are justified based on evidence provided in past reports.

I. Tax structure/level

- a. Excise tax proportion of price: higher tax rates and greater reliance on excise is better.
- b. Type of excise applied: if excise tax is specific, ad valorem, a mix of the two, or if no excise is applied.
- c. Uniform vs. tiered excise tax system: a uniform excise is easier to administer than a tiered system where variable rates apply based on selected criteria within one tobacco product (not applicable in countries where no excise tax is implemented).

- d. Whether a country applies a specific excise or a mixed system **relying more on the specific tax component** (>50% of total excise is specific): specific excises typically lead to higher prices and a smaller price gap between different brands, which is better (not applicable in countries where only ad valorem excise is applicable or where no excise tax is implemented).
- e. If the excise applied is ad valorem or if it is mixed, and whether there is a minimum specific tax. A minimum tax provides protection against products being undervalued. It also forces prices up since the price will not be lower than the tax paid (this category does not apply to countries where only specific excise tax is applicable or where no excise tax is implemented).
- f. Base of the ad valorem tax in countries that apply an ad valorem or a mixed excise system. Ad valorem taxes applied to the retail price or the retail price excluding VAT are administratively simpler. The retail price is easier to determine than producer price or CIF value, and therefore there is less risk of undervaluation (not applicable in countries where only specific excise is applicable, or where no excise tax is implemented).
- g. If the excise tax applied is specific or if it is mixed, and whether the specific tax component is automatically adjusted for inflation (or other). If the specific tax is not adjusted for inflation (or another indicator such as income) over time, its impact will be eroded. It is good to have it adjusted automatically (this category does not apply to countries where only ad valorem excise tax is applicable or where no excise tax is implemented).
- h. Minimum price policy: while this is not reported as a best practice, it was considered important to report the countries that did impose minimum prices as part of their excise tax policy.

- i. **Price dispersion:** share of cheapest brand price in premium brand price (cheapest brand price ÷ premium brand price × 100). The higher the proportion, the smaller the gap and the fewer are the opportunities for substitution to cheaper brands.

II. Tax administration

- a. Requirement of tax stamps (or fiscal marks) on tobacco products: tax stamps help administrators ensure that producers and importers comply with tax payment requirements, help detect illicit tobacco products, and facilitate the prosecution of tax fraud cases. In addition to identifying if tax stamps are implemented in a country, data was collected to determine if those stamps contained different types of security features (overt and/or covert). Data was also collected to identify which countries required the presence of unique identifiers on cigarette packs and whether these identifiers were used for tracking and tracing purposes.
- b. Sales of duty free cigarettes: In most countries tobacco products are found to be sold without excise (and other indirect taxes such as VAT and import duties) in duty-free shops in airports, on international transport vehicles and/or other tax-free shops. Duty-free tobacco products are usually made available to travellers going out of the country, but they are now also made available for travellers entering a country. Banning the sale of duty-free cigarettes for personal consumption reduces the chance that these products end up in the illicit market. Additionally, there is no justification for selling a deadly product duty-free; those foregone taxes are a revenue loss for the government. Some countries have already acted and have banned the sale of duty-free tobacco products. Those products may still be found in airport and other tax-free shops, but they are sold with (excise) taxes included.

III. Earmarking

(Portion of taxes or revenues from taxes dedicated to health and/or tobacco control)

Taxes can generate substantial revenues. Earmarking all or a part of tobacco tax revenues can be a useful tool for improving the political economy of tobacco tax increases. Setting aside portions of tax revenue to fund tobacco control efforts or relevant health programmes can help convince the public, politicians and officials of the value of significant tobacco tax increases, which ultimate goal is to reduce tobacco use.

8. Estimates of the affordability of cigarettes (see Annex 1)

The affordability of cigarettes for each of the years 2012, 2014, 2016, 2018, 2020, and 2022 was measured by the per capita GDP required to purchase 2000 cigarettes of the most sold brand reported in that year. Analysis of affordability in this report informs the following:

- Affordability index (% of GDP per capita to buy 2000 cigarettes): across countries, a higher value indicates cigarettes are relatively more expensive in relation to income.
- Whether cigarettes have become relatively more affordable between 2012 and 2022 (change in the affordability index as measured above, between 2012 and 2022): as affordability decreases, consumption is discouraged.

Estimates of GDP per capita in local currency units were sourced from the IMF's World Economic Outlook (WEO) database which provides a complete series of estimates for most of the 195 countries reported on. Where GDP per capita data were not available in the WEO database, the World Bank's GDP per capita data series was used.

Countries for which no relevant data was available in the IMF WEO database or World Bank's GDP per capita series were dropped from the affordability analysis: Cook Islands, Democratic People's Republic of Korea, Niue, Syrian Arab Republic and Venezuela (Bolivarian Republic of). For each country-year pair, the currency reported for the most sold brand was tallied with the corresponding currency for the GDP series, and exchange rate conversions and adjustments were performed as needed (Belarus, Latvia, Liberia, Lithuania, Mauritania, Sao Tome and Principe, Somalia, Zambia and Zimbabwe).

To assess whether affordability changed on average since 2012, the average annual percentage change in affordability was calculated as the least squares growth rate for all countries with 4 or more years of data. This criterion automatically excluded Bhutan, Brunei Darussalam, Central African Republic, Djibouti, Guinea, Haiti, Monaco, and South Sudan, as less than 4 years of price data were available for analysis. Additionally, countries that did not report price data for the most sold brand in 2022 were excluded (Afghanistan, Brunei Darussalam, Djibouti, Eritrea, Guinea, Haiti, Sierra Leone, Somalia, Syrian Arab Republic, and Niue).

The affordability of cigarettes was judged to have been unchanged if the least squares trend in the per capita GDP required to purchase 2000 cigarettes (that is, 100 packs of 20 cigarettes) was not significant at the 5% level. Cigarettes were judged to have become less (more) affordable on average if the least squares trend in the per capita GDP required to purchase 2000 cigarettes was positive (negative) and significantly different from zero at the 5% level.

9. Estimates of inflation-adjusted prices

Inflation raises price levels for goods and services and affects people's purchasing power over time. Looking at prices from any two periods needs to account for inflation, especially in the current environment of soaring prices in almost all countries around the world. Consequently, for a better overview of the change in the price of the most sold brand of cigarettes between 2008 and 2022, a new table has been added to this report with inflation-adjusted prices. The price of the most sold brand of cigarettes was adjusted for inflation using annual percentage change in the average consumer prices – year-on-year changes in a country's local currency – from the IMF's World Economic Outlook. The adjustment was made from 2008 to 2022 using 2022 as the base year. Prices in international dollars (PPP) were also inflation-adjusted from 2008 to 2022 using annual percentages of average consumer prices for the United States and 2022 as the base year. The inflation-adjusted prices are not provided for Afghanistan, Argentina, Cook Islands, Cuba, Democratic People's Republic of Korea, Lebanon, Monaco, Niue, Somalia, South Sudan, and Syrian Arab Republic due to lack of information on inflation rates in those countries, and for Venezuela (Bolivarian Republic of) and Zimbabwe due to inconsistencies in the currencies reported to WHO.



Annex 1

Regional summary of MPOWER measures

Annex 1 provides an overview of selected tobacco control policies in countries. For each WHO region an overview table is presented that includes information on monitoring and prevalence, smoke-free environments, treatment of tobacco dependence, health warnings and packaging, anti-tobacco mass media campaigns, advertising, promotion and sponsorship bans, taxation levels, and affordability of cigarettes, based on the methodology outlined in Technical Notes I, II and III.

Country-level data were generally but not always provided with supporting documents such as laws, regulations, policy documents, etc. Available documents were assessed by WHO and this Annex provides summary measures or indicators of country achievements for each of the MPOWER measures. Detailed information, including detailed footnotes on each of the indicators,

is available in Annex 2 for smoke-free environments. It is important to note that data about laws reflect the status of legislation adopted by 31 December 2022 which has a stated date of effect and is not undergoing a legal challenge that could impact the date of implementation.

The summary measures reported for the *WHO report on the global tobacco epidemic, 2023* are the same as those in the 2021 report. The methodology used to calculate each indicator is described in Technical Note I. This review, however, does not constitute a thorough and complete legal analysis of each country's legislation. Except for smoke-free environments and bans on tobacco advertising, promotion and sponsorship, data were collected at the national/ federal level only and therefore provide incomplete information about Member States

where subnational governments play an active role in tobacco control. Daily smoking prevalence for the population aged 15 years and over in 2021 is an indicator modelled by WHO from tobacco use surveys published by Member States. Tobacco smoking is one of the most widely reported indicators in country surveys. The calculation of WHO estimates to allow international comparison is described in Technical Note II.

2022 Indicator and compliance

Table A1.1
African Region
 Summary of MPOWER measures

| Country | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans Lines represent level of compliance | O Cessation programmes | W | | E Advertising bans Lines represent level of compliance | R | |
|----------------------------------|---------------------------------------|-----------------|--|---------------------------|-----------------|------------|--|----------|---------------------------------------|
| | | | | | Health warnings | Mass media | | Taxation | Cigarettes less affordable since 2012 |
| Algeria | 14% | | III | | | | | 44.2% | Yes |
| Angola | ... | | III | | | | ... | 18.0% | Yes |
| Benin | 4% | | | | | | | 13.2% | No |
| Botswana | 11% | | — | | | | I | 55.2% | ↔ |
| Burkina Faso | 9% | | III | | | | | 43.5% | ↔ |
| Burundi | 6% | | I | | | | III | 37.3% | ↔ |
| Cabo Verde | 6% | | ... | | | | ... | 30.2% | ↔ |
| Cameroon | 4% | | ... | | | | ... | 38.4% | ↔ |
| Central African Republic | ... | | — | | | | — | 36.3% | ... |
| Chad | 6% | | | | | | | 54.9% | ↔ |
| Comoros | 10% | | | | | | | 73.5% | ↔ |
| Congo | 11% | | II | | | | | 24.9% | Yes |
| Côte d'Ivoire | 7% | | — | | | | | 39.5% | No |
| Democratic Republic of the Congo | 7% | | I | | | | | 52.1% | No |
| Equatorial Guinea | ... | | — | | | | — | 33.2% | Yes |
| Eritrea | ... | | — | | | | ... | ... | ... |
| Eswatini | 6% | | — | | | | ... | 54.3% | ↔ |
| Ethiopia | 3% | | | | | | | 48.5% | ↔ |
| Gabon | ... | | | | | | | 38.7% | ↔ |
| Gambia | 8% | | I | | | | | 47.2% | Yes |
| Ghana | 2% | | — | | | | | 22.5% | ↔ |
| Guinea | ... | | ... | | | | ... | ... | ... |
| Guinea-Bissau | 6% | | — | | | | — | 5.7% | ↔ |
| Kenya | 7% | | — | | | | ... | 32.9% | Yes |
| Lesotho | 15% | | ... | | | | — | 52.7% | ↔ |
| Liberia | 5% | | — | | | | — | 35.0% | Yes |
| Madagascar | 14% | | | | | | | 87.7% | ↔ |
| Malawi | 6% | | — | | | | — | 47.9% | No |
| Mali | 5% | | — | | | | | 20.5% | No |
| Mauritania | 7% | | III | | | | | 17.8% | No |
| Mauritius | 16% | | | | ☆ | | | 78.2% | Yes |
| Mozambique | ... | | | | | | | 23.9% | Yes |
| Namibia | 9% | | ... | | | | ... | 50.6% | ↔ |
| Niger | 4% | | | | | | | 36.0% | ↔ |
| Nigeria | 2% | | I | | | | | 44.0% | ↔ |
| Rwanda | 8% | | — | | | | ... | 64.3% | ↔ |
| Sao Tome and Principe | 4% | | — | | | | ... | 29.9% | ↔ |
| Senegal | 5% | | | | | | | 48.6% | Yes |
| Seychelles | 16% | | | | | | | 69.5% | ↔ |
| Somalia | ... | | — | | | | — | ... | ... |
| South Africa | 17% | | — | | | | | 60.1% | ↔ |
| South Sudan | ... | | — | | | | — | 63.2% | ... |
| Togo | 4% | | | | | | | 24.9% | ↔ |
| Uganda | 5% | | III | | | | | 29.8% | Yes |
| United Republic of Tanzania | 6% | | — | | | | ... | 30.0% | No |
| Zambia | 9% | | ... | | | | — | 22.7% | ↔ |
| Zimbabwe | 7% | | ... | | | | — | 34.5% | ↔ |

2022 Indicator and compliance

Table A1.2

Region of
the AmericasSummary of
MPOWER measures

| Country | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans | O Cessation programmes | W | | E Advertising bans | R | |
|------------------------------------|---------------------------------------|-----------------|-------------------------------------|---------------------------|-------------------------------------|-------------------------------------|-------------------------------------|----------|---------------------------------------|
| | | | | | Health warnings | Mass media | | Taxation | Cigarettes less affordable since 2012 |
| | | | Lines represent level of compliance | | Lines represent level of compliance | Lines represent level of compliance | Lines represent level of compliance | | |
| Antigua and Barbuda | ... | | | | | | | 14.9% | ↔ |
| Argentina | 17% | | | | | | | 76.5% | ↔ |
| Bahamas | 8% | | — | | | | ... | 53.6% | Yes |
| Barbados | 5% | | | | | | — | 43.0% | ↔ |
| Belize | 5% | | — | | | | — | 33.6% | ↔ |
| Bolivia (Plurinational State of) | ... | | | | | | | 31.5% | ... |
| Brazil | 10% | | | | | | | 80.2% | No |
| Canada | 9% | | | | ☆ | | | 63.3% | Yes |
| Chile | 18% | | | | | | | 80.3% | Yes |
| Colombia | 5% | | | | | | | 65.2% | Yes |
| Costa Rica | 5% | | | | | | | 55.1% | ↔ |
| Cuba | 12% | | | | | | — | 10.0% | ↔ |
| Dominica | ... | | — | | | | — | 26.1% | Yes |
| Dominican Republic | 8% | | | | | | — | 44.7% | ↔ |
| Ecuador | 4% | | | | | | | 64.0% | Yes |
| El Salvador | 5% | | | | | | | 45.7% | Yes |
| Grenada | ... | | — | | | | — | 44.0% | No |
| Guatemala | 5% | | | | | | ... | 49.0% | ↔ |
| Guyana | 8% | | | | | | | 24.9% | ↔ |
| Haiti | 5% | | — | | | | — | 27.1% | ... |
| Honduras | 6% | | | | | | ... | 38.3% | Yes |
| Jamaica | 7% | | | | | | ... | 38.8% | ↔ |
| Mexico | 8% | | | | | | | 67.6% | ↔ |
| Nicaragua | ... | | | | | | ... | 75.7% | Yes |
| Panama | 2% | | | | | | | 56.5% | ↔ |
| Paraguay | 7% | | | | | | | 19.2% | ↔ |
| Peru | 5% | | | | | | ... | 73.3% | ↔ |
| Saint Kitts and Nevis | ... | | — | | | | — | 19.8% | ↔ |
| Saint Lucia | 9% | | | | | | — | 43.1% | ↔ |
| Saint Vincent and the Grenadines | ... | | — | | | | — | 23.2% | ↔ |
| Suriname | ... | | | | | | | 49.3% | Yes |
| Trinidad and Tobago | ... | | | | | | | 27.5% | Yes |
| United States | 14% | | ... | | | | ... | 37.4% | ↔ |
| Uruguay | 17% | | | | ☆ | | | 65.5% | ↔ |
| Venezuela (Bolivarian Republic of) | ... | | | | | | | 73.4% | ... |

2022 Indicator and compliance

Table A1.3

South-East Asia Region

Summary of MPOWER measures

| Country | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans | O Cessation programmes | W | | E Advertising bans | R | |
|---------------------------------------|---------------------------------------|-----------------|-------------------------------------|---------------------------|-----------------|-------------------------------------|-----------------------|----------|---------------------------------------|
| | | | | | Health warnings | Mass media | | Taxation | Cigarettes less affordable since 2012 |
| | | | Lines represent level of compliance | | | Lines represent level of compliance | | | |
| Bangladesh | 16% | | | | | | | 58.4% | Yes |
| Bhutan | 4% | | — | | | | | 12.5% | — |
| Democratic People's Republic of Korea | 14% | | | | | | — | 0.0% | ... |
| India | 6% | | | | | | | 57.6% | ↔ |
| Indonesia | 31% | | | | | | ... | 72.9% | ↔ |
| Maldives | 18% | | I | | | | | 29.9% | Yes |
| Myanmar | 15% | | | | ☆ | | | 36.0% | ↔ |
| Nepal | 12% | | | | | | | 31.4% | Yes |
| Sri Lanka | 7% | | | | | | | 66.9% | Yes |
| Thailand | 16% | | | | ☆ | | | 81.3% | ↔ |
| Timor-Leste | 24% | | | | | | | 47.2% | ↔ |

2022 Indicator and compliance

Table A1.4

European
RegionSummary of
MPOWER measures

| Country | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans | O Cessation programmes | W | | E Advertising bans | R | |
|------------------------------|---------------------------------------|-----------------|-------------------------------------|---------------------------|-----------------|------------|-------------------------------------|----------|---------------------------------------|
| | | | | | Health warnings | Mass media | | Taxation | Cigarettes less affordable since 2012 |
| | | | Lines represent level of compliance | | | | Lines represent level of compliance | | |
| Albania | 18% | | | | | | | 66.7% | ↔ |
| Andorra | 31% | | | | | | — | 78.3% | ↔ |
| Armenia | 24% | | | | | | | 48.5% | No |
| Austria | 20% | | | | | | | 74.0% | ↔ |
| Azerbaijan | 17% | | | | | | | 50.3% | ↔ |
| Belarus | 23% | | | | | | | 56.6% | ↔ |
| Belgium | 21% | | | | ☆ | | | 79.9% | Yes |
| Bosnia and Herzegovina | 30% | | — | | | | — | 84.0% | ↔ |
| Bulgaria | 32% | | | | | | | 85.3% | No |
| Croatia | 31% | | | | | | | 86.0% | ↔ |
| Cyprus | 29% | | | | | | | 74.4% | ↔ |
| Czechia | 23% | | | | | | | 75.6% | Yes |
| Denmark | 14% | | | | ☆ | | | 81.5% | ↔ |
| Estonia | 20% | | | | | | | 88.2% | No |
| Finland | 14% | | | | ☆ | | | 89.4% | Yes |
| France | 28% | | | | ☆ | | | 83.8% | Yes |
| Georgia | 27% | | | | ☆ | | | 74.5% | Yes |
| Germany | 17% | | — | | | | | 64.4% | Yes |
| Greece | 26% | | ... | | | | ... | 81.2% | ↔ |
| Hungary | 28% | | ... | | ☆ | | ... | 72.0% | ↔ |
| Iceland | 7% | | | | | | | 63.6% | ↔ |
| Ireland | 16% | | | | ☆ | | | 76.1% | No |
| Israel | 17% | | | | ☆ | | | 76.6% | ↔ |
| Italy | 21% | | — | | | | | 76.7% | ↔ |
| Kazakhstan | 16% | | | | | | | 50.4% | Yes |
| Kyrgyzstan | 21% | | ... | | | | ... | 51.3% | Yes |
| Latvia | 26% | | | | | | | 81.4% | No |
| Lithuania | 23% | | ... | | | | ... | 76.1% | ↔ |
| Luxembourg | 18% | | | | | | | 68.5% | ↔ |
| Malta | 20% | | ... | | | | ... | 77.6% | No |
| Monaco | ... | | | | | | — | ... | ... |
| Montenegro | 25% | | ... | | | | ... | 75.9% | Yes |
| Netherlands (Kingdom of the) | 17% | | | | ☆ | | | 76.9% | ↔ |
| North Macedonia | ... | | ... | | | | ... | 77.0% | Yes |
| Norway | 10% | | | | ☆ | | | 59.6% | ↔ |
| Poland | 21% | | | | | | | 78.4% | No |
| Portugal | 19% | | | | | | | 78.0% | No |
| Republic of Moldova | 25% | | | | | | | 65.4% | ↔ |
| Romania | 26% | | | | | | | 69.1% | No |
| Russian Federation | 28% | | | | | | | 61.0% | Yes |
| San Marino | ... | | ... | | | | ... | 74.2% | Yes |
| Serbia | 33% | | ... | | | | ... | 75.1% | Yes |
| Slovakia | 24% | | | | | | | 76.7% | Yes |
| Slovenia | 18% | | | | ☆ | | | 79.0% | ↔ |
| Spain | 26% | | | | | | | 77.6% | ↔ |
| Sweden | 8% | | — | | | | ... | 67.9% | ↔ |
| Switzerland | 21% | | — | | | | ... | 59.0% | ↔ |
| Tajikistan | ... | | ... | | | | ... | 59.0% | Yes |
| Türkiye | 26% | | ... | | ☆ | | ... | 80.8% | ↔ |
| Turkmenistan | 4% | | | | | | | 31.3% | Yes |
| Ukraine | 23% | | — | | | | — | 70.7% | Yes |
| United Kingdom | 12% | | | | ☆ | | | 83.7% | Yes |
| Uzbekistan | 8% | | | | | | | 56.4% | Yes |

2022 Indicator and compliance

Table A1.5

Eastern Mediterranean Region

Summary of MPOWER measures

< “occupied Palestinian territory” should be understood to refer to the “occupied Palestinian territory, including East Jerusalem”.

| Country or territory | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans | O Cessation programmes | W | | E Advertising bans | R | |
|----------------------------------|---------------------------------------|-----------------|-------------------------------------|---------------------------|-----------------|------------|-------------------------------------|----------|---------------------------------------|
| | | | Lines represent level of compliance | | Health warnings | Mass media | Lines represent level of compliance | Taxation | Cigarettes less affordable since 2012 |
| | | | | | | | | | |
| Afghanistan | 7% | | ... | | | | ... | ... | ... |
| Bahrain | 12% | | — | | | | | 73.4% | Yes |
| Djibouti | ... | | ... | | | | ... | ... | ... |
| Egypt | 22% | | | | | | | 74.9% | ↔ |
| Iran (Islamic Republic of) | 8% | | | | | | | 25.7% | Yes |
| Iraq | 17% | | | | | | | 16.9% | ↔ |
| Jordan | 30% | | | | | | | 78.0% | Yes |
| Kuwait | 16% | | ... | | | | ... | 24.0% | ↔ |
| Lebanon | 22% | | | | | | | 9.9% | ↔ |
| Libya | ... | | | | | | | 32.0% | ↔ |
| Morocco | 11% | | | | | | | 76.1% | ↔ |
| occupied Palestinian territory < | 26% | | | | | | | 84.6% | Yes |
| Oman | 6% | | — | | | | ... | 66.0% | Yes |
| Pakistan | 8% | | ... | | | | ... | 51.8% | ↔ |
| Qatar | 9% | | ... | | | | ... | 68.2% | Yes |
| Saudi Arabia | 10% | | ... | | ☆ | | ... | 73.8% | Yes |
| Somalia | ... | | — | | | | — | ... | ... |
| Sudan | ... | | — | | | | | 73.3% | ↔ |
| Syrian Arab Republic | ... | | ... | | | | ... | ... | ... |
| Tunisia | 18% | | — | | | | ... | 69.4% | ↔ |
| United Arab Emirates | 8% | | | | | | | 71.7% | Yes |
| Yemen | 13% | | | | | | | 57.0% | Yes |

Change since 2020

| P Smoking bans | O Cessation programmes | W Health warnings | E Advertising bans | R Taxation |
|---|---------------------------|----------------------|-----------------------|---------------|
| Change in POWER indicator group, up or down, since 2020 | | | | |
| | | | | |
| | | | | |
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ADULT DAILY SMOKING PREVALENCE*: AGE-STANDARDIZED PREVALENCE RATES FOR ADULT DAILY SMOKERS OF TOBACCO (BOTH SEXES COMBINED), 2021

| | |
|-----|-------------------------|
| ... | Estimates not available |
| | 30% or more |
| | From 20% to 29.9% |
| | From 15% to 19.9% |
| | Less than 15% |

* The figures should be used strictly for the purpose of drawing comparisons across countries and must not be used to estimate absolute number of daily tobacco smokers in a country.

MONITORING: PREVALENCE DATA

| | |
|--|---|
| | No known data or no recent data or data that are not both recent and representative |
| | Recent and representative data for either adults or youth |
| | Recent and representative data for both adults and youth |
| | Recent, representative and periodic data for both adults and youth |

SMOKE-FREE ENVIRONMENTS: SMOKING BANS

| | |
|-----|--|
| ... | Data not reported |
| | Complete absence of ban, or up to two public places completely smoke-free |
| | Three to five public places completely smoke-free |
| | Six to seven public places completely smoke-free |
| | All public places completely smoke-free (or at least 90% of the population covered by complete subnational smoke-free legislation) |

CESSATION PROGRAMMES: TREATMENT OF TOBACCO DEPENDENCE

| | |
|-----|--|
| ... | Data not reported |
| | None |
| | NRT and/or some cessation services (neither cost-covered) |
| | NRT and/or some cessation services (at least one of which is cost-covered) |
| | National quit line, and both NRT and some cessation services cost-covered |

HEALTH WARNINGS: HEALTH WARNINGS ON CIGARETTE PACKAGES

| | |
|-----|--|
| ... | Data not reported |
| | No warnings or small warnings |
| | Medium size warnings missing some appropriate characteristics OR large warnings missing many appropriate characteristics |
| | Medium size warnings with all appropriate characteristics OR large warnings missing some appropriate characteristics |
| | Large warnings with all appropriate characteristics |

MASS MEDIA: ANTI-TOBACCO CAMPAIGNS

| | |
|-----|---|
| ... | Data not reported |
| | No national campaign conducted between July 2020 and June 2022 with a duration of at least three weeks |
| | National campaign conducted with one to four appropriate characteristics |
| | National campaign conducted with five to six appropriate characteristics |
| | National campaign conducted with at least seven appropriate characteristics including airing on television and/or radio |

ADVERTISING BANS: BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP

| | |
|-----|--|
| ... | Data not reported |
| | Complete absence of ban, or ban that does not cover national television, radio and print media |
| | Ban on national television, radio and print media only |
| | Ban on national television, radio and print media as well as on some but not all other forms of direct and/or indirect advertising |
| | Ban on all forms of direct and indirect advertising (or at least 90% of the population covered by subnational legislation completely banning tobacco advertising, promotion and sponsorship) |

TAXATION: SHARE OF TOTAL TAXES IN THE RETAIL PRICE OF THE MOST WIDELY SOLD BRAND OF CIGARETTES

| | |
|-----|--------------------------------------|
| ... | Data not reported |
| | <25% of retail price is tax |
| | ≥25% and <50% of retail price is tax |
| | ≥50% and <75% of retail price is tax |
| | ≥75% of retail price is tax |

COMPLIANCE: COMPLIANCE WITH BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP, AND ADHERENCE TO SMOKE-FREE LAWS

| | |
|--|-------------------------------------|
| | Complete compliance (8/10 to 10/10) |
| | Moderate compliance (3/10 to 7/10) |
| | |
| | |
| | |
| | Minimal compliance (0/10 to 2/10) |

AFFORDABILITY OF CIGARETTES

| | |
|-----|--|
| YES | Cigarettes less affordable - per capita GDP needed to buy 2000 cigarettes of the most sold brand increased on average between 2012 and 2022. |
| NO | Cigarettes more affordable - per capita GDP needed to buy 2000 cigarettes of the most sold brand declined on average between 2012 and 2022. |
| ↔ | No trend change in affordability of cigarettes between 2012 and 2022. |
| ... | Insufficient data to conduct a trend analysis. |

SYMBOLS LEGEND

| | |
|-----|--|
| ☆ | Plain packaging is mandated. |
| ∇ | Law adopted but not implemented by 31 December 2022. |
| ▼▲ | Change in POWER indicator group, up or down, between 2020 and 2022. Some 2020 data were revised in 2022. 2022 grouping rules were applied to both years. |
| ... | Data not reported/not available |
| - | Data not required/not applicable |

PLEASE REFER TO TECHNICAL NOTE I FOR DEFINITIONS OF CATEGORIES

2022 Indicator and compliance

Table A1.6

Western Pacific Region

Summary of MPOWER measures

| Country | Adult daily smoking prevalence (2021) | M Monitoring | P Smoking bans Lines represent level of compliance | O Cessation programmes | W | | E Advertising bans Lines represent level of compliance | R | |
|----------------------------------|---------------------------------------|-----------------|--|---------------------------|-----------------|------------|--|----------|---------------------------------------|
| | | | | | Health warnings | Mass media | | Taxation | Cigarettes less affordable since 2012 |
| Australia | 12% | | ... | | ☆ | | | 77.0% | Yes |
| Brunei Darussalam | 12% | | ... | | | | ... | — | — |
| Cambodia | 14% | | | | | | ... | 26.4% | No |
| China | 21% | | | | | | | 52.2% | No |
| Cook Islands | 18% | | ... | | | | ... | 72.8% | ... |
| Fiji | 16% | | | | | | | 38.7% | Yes |
| Japan | 17% | | | | | | — | 59.9% | Yes |
| Kiribati | 36% | | | | | | | 50.9% | ↔ |
| Lao People's Democratic Republic | 22% | | | | | | | 15.4% | No |
| Malaysia | 17% | | — | | | | | 51.6% | ↔ |
| Marshall Islands | 19% | | ... | | | | ... | 51.1% | No |
| Micronesia (Federated States of) | ... | | ... | | | | ... | 45.0% | Yes |
| Mongolia | 23% | | | | | | | 42.1% | ↔ |
| Nauru | 37% | | | | | | | 42.2% | Yes |
| New Zealand | 11% | | | | ☆ | | | 82.8% | Yes |
| Niue | ... | | ... | | | | ... | ... | ... |
| Palau | 14% | | | | | | | 74.1% | Yes |
| Papua New Guinea | 34% | | ... | | | | ... | 65.2% | No |
| Philippines | 16% | | | | | | | 50.6% | Yes |
| Republic of Korea | 19% | | | | | | | 73.8% | ↔ |
| Samoa | 19% | | | | | | | 47.2% | Yes |
| Singapore | 13% | | | | ☆ | | | 66.3% | No |
| Solomon Islands | 29% | | ... | | | | ... | 43.3% | ↔ |
| Tonga | 26% | | | | | | | 67.4% | Yes |
| Tuvalu | 27% | | ... | | | | ... | 35.5% | ↔ |
| Vanuatu | ... | | — | | | | ... | 77.5% | ↔ |
| Viet Nam | 19% | | | | | | | 34.3% | No |



Annex 2

Regional summary of smoke-free measures

Annex 2 provides detailed information on smoke-free environments in WHO Member States for each WHO region.

The following data are reported in this Annex:

- smoking bans in general indoor public places;
- smoking bans in selected additional indoor and outdoor public places;
- additional characteristics of smoking bans (enforcement, signage, penalties, etc).

Table A2.1.1

African Region

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

... Data not available.

– Data not required/not applicable.

1 Implementation decree pending.

2 Legislation enabling a complete smoking ban but regulations pending.

3 Regulations are pending.

4 Smoking is banned and the law does not allow designated smoking rooms, except if the health authority allows them by administrative act. Until now, no such administrative act has been taken.

5 However the Minister may allow a person to smoke in a non-smoking area.

| Country | Health care facilities | | Educational facilities except universities | | Universities | |
|----------------------------------|------------------------|-------------------------|--|-------------------------|------------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Algeria | Yes | 5 | Yes | 5 | Yes | 3 |
| Angola | Yes | 9 | Yes | 5 | Yes | 4 |
| Benin | Yes | 10 | Yes | 8 | Yes | 4 |
| Botswana | No | — | No | — | No | — |
| Burkina Faso | Yes | 4 | Yes | 5 | Yes | 3 |
| Burundi | Yes | 7 | Yes | 5 | Yes | 3 |
| Cabo Verde | Yes | ... | Yes | ... | Yes | ... |
| Cameroon | Yes | ... | Yes | ... | Yes | ... |
| Central African Republic | No | — | No | — | No | — |
| Chad | Yes | 10 | Yes | 5 | Yes | 5 |
| Comoros | Yes | 10 | Yes | 9 | Yes | 5 |
| Congo | Yes | 10 | Yes | 4 | Yes | 10 |
| Côte d'Ivoire | No ² | — | No ² | — | No ² | — |
| Democratic Republic of the Congo | Yes | 8 | Yes | 10 | Yes | 3 |
| Equatorial Guinea | No | — | No | — | No | — |
| Eritrea | No | — | No | — | No | — |
| Ethiopia | Yes | 9 | Yes | 5 | Yes | 4 |
| Eswatini | No | — | No | — | No | — |
| Gabon | Yes | 10 | Yes | 4 | Yes | 8 |
| Gambia | Yes | 5 | Yes | 5 | Yes | 5 |
| Ghana | No☆ | — | No☆ | — | No☆ | — |
| Guinea | Yes | ... | Yes | ... | Yes | ... |
| Guinea-Bissau | No | — | No | — | No | — |
| Kenya | No | — | No | — | No | — |
| Lesotho | Yes | ... | No | — | No | — |
| Liberia | No | — | No | — | No | — |
| Madagascar | Yes | 7 | Yes | 7 | Yes | 4 |
| Malawi | No | — | No | — | No | — |
| Mali | No | — | No | — | No | — |
| Mauritania | Yes | 5 | No ³ | — | No ³ | — |
| Mauritius | Yes | 7 | Yes | 6 | Yes | 5 |
| Mozambique | No | — | No | — | No | — |
| Namibia | Yes | ... | Yes | ... | Yes | ... |
| Niger | Yes | 5 | Yes | 0 | Yes | 0 |
| Nigeria | Yes | 10 | Yes | 3 | No☆ | — |
| Rwanda | No | — | No | — | No | — |
| Sao Tome and Principe | No | — | No | — | No | — |
| Senegal | Yes | 8 | Yes | 4 | Yes | 2 |
| Seychelles | Yes | 10 | Yes | 10 | Yes | 10 |
| Sierra Leone | No | — | No | — | No | — |
| South Africa | No ⁴ | — | No ⁴ | — | No ⁴ | — |
| South Sudan | No | — | No | — | No | — |
| Togo | Yes | 10 | Yes | 10 | Yes | 10 |
| Uganda | Yes | 6 | Yes | 8 | Yes | 4 |
| United Republic of Tanzania | No | — | No | — | No☆ | — |
| Zambia | Yes | ... | Yes | ... | Yes | ... |
| Zimbabwe | Yes ⁵ | ... | Yes ⁵ | ... | Yes ⁵ | ... |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number of outdoor places where smoking is banned either fully or partially | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|-------------------------|-------------------------------|-------------------------|-----------------|-------------------------|-----------------|-------------------------|------------------|-------------------------|--|-------------------------|--|--|
| Ban | Compliance [^] | Ban | Compliance [^] | Ban Notes | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Places | Compliance [^] | Places | Ban |
| No | — | No | — | No | — | No | — | No | — | 3 | 3 | 1 | No |
| Yes | 9 | No | — | No | — | No | — | Yes | 9 | 5 | 3 | 1 | No |
| Yes | 7 | Yes | 9 | Yes | 4 | Yes | 2 | Yes | 9 | 8 | 6 | 1 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 6 | Yes | 10 | Yes | 4 | Yes | 3 | Yes | 7 | 8 | 3 | 2 | — |
| Yes | 3 | Yes | 5 | Yes | 3 | Yes | 3 | Yes | 5 | 8 | 2 | 8 | — |
| Yes | ... | No | — | No ¹ | — | No ¹ | — | Yes | ... | 5 | ... | 7 | No |
| No | — | No | — | No | — | No | — | No | — | 3 | ... | 3 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 5 | Yes | 5 | Yes | 10 | Yes | 0 | Yes | 5 | 8 | 5 | 0 | — |
| Yes | 8 | No | — | No | — | No | — | Yes | 5 | 5 | 8 | 1 | No |
| Yes | 5 | Yes | 2 | Yes | 0 | Yes | 0 | Yes | 10 | 8 | 2 | 8 | — |
| No ² | — | No ² | — | No ² | — | No ² | — | No ² | — | 0 | — | 0 | No |
| No ³ | — | No ³ | — | No ³ | — | No ³ | — | Yes | 7 | 4 | 1 | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 5 | Yes | 6 | Yes | 4 | Yes | 4 | Yes | 9 | 8 | 6 | 8 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | — |
| Yes | 7 | Yes | 8 | No | — | No | — | No | — | 5 | 4 | 2 | No |
| Yes | 2 | Yes | 5 | Yes | 0 | Yes | 0 | Yes | 5 | 8 | 1 | 0 | — |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 0 | — | 0 | No |
| Yes | ... | No | — | No | — | No | — | Yes | ... | 5 | ... | 1 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 1 | ... | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 4 | Yes | 6 | Yes | 6 | Yes | 0 | Yes | 8 | 8 | 5 | 8 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No ³ | — | No ³ | — | No ³ | — | No ³ | — | Yes | 10 | 2 | 3 | 0 | No |
| Yes | 8 | Yes | 10 | Yes | 9 | Yes | 6 | Yes | 10 | 8 | 5 | 7 | — |
| Yes | 8 | No | — | No | — | No | — | No | — | 1 | 4 | 0 | No |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 8 | — |
| No | — | No | — | No | — | No | — | Yes | 5 | 4 | 0 | 2 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No | — | 2 | 1 | 8 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 10 | Yes | 8 | No☆ | — | Yes | 3 | Yes | 10 | 7 | 4 | 0 | No |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | 8 | 10 | 3 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No ⁴ | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 10 | No | — | No☆ | — | No☆ | — | No☆ | — | 4 | 7 | 6 | No |
| Yes | 5 | Yes | 6 | Yes | 4 | Yes | 0 | Yes | 2 | 8 | 3 | 8 | — |
| No | — | No | — | No☆ | — | No☆ | — | No | — | 0 | — | 0 | Yes |
| Yes | ... | No | — | Yes | ... | Yes | ... | Yes | ... | 7 | ... | 0 | No |
| No | — | No | — | No | — | No | — | Yes ⁵ | ... | 4 | ... | 0 | No |

Table A2.1.2

Region of the Americas

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

... Data not available.

– Data not required/not applicable.

¹ Ban/measure is in effect in all subnational jurisdictions.

² Ban/measure is in effect in most subnational jurisdictions.

| Country | Health care facilities | | Educational facilities except universities | | Universities | |
|------------------------------------|------------------------|-------------------------|--|-------------------------|------------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Antigua and Barbuda | Yes | 10 | Yes | 10 | Yes | 8 |
| Argentina | Yes | 8 | Yes | 10 | Yes | 5 |
| Bahamas | No | — | No | — | No | — |
| Barbados | Yes | 10 | Yes | 10 | Yes | 10 |
| Belize | No | — | No | — | No | — |
| Bolivia (Plurinational State of) | Yes | 10 | Yes | 5 | Yes | 3 |
| Brazil | Yes | 9 | Yes | 8 | Yes | 5 |
| Canada | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 9 |
| Chile | Yes | 10 | Yes | 10 | Yes | 8 |
| Colombia | Yes | 10 | Yes | 10 | Yes | 7 |
| Costa Rica | Yes | 8 | Yes | 7 | Yes | 5 |
| Cuba | Yes | 5 | Yes | 5 | Yes | 5 |
| Dominica | No | — | No | — | No | — |
| Dominican Republic | Yes | 5 | Yes | 4 | Yes | 0 |
| Ecuador | Yes | 10 | Yes | 8 | Yes | 3 |
| El Salvador | Yes | 10 | Yes | 10 | Yes | 10 |
| Grenada | No | — | No | — | No | — |
| Guatemala | Yes | 10 | Yes | 8 | Yes | 5 |
| Guyana | Yes | 8 | Yes | 8 | Yes | 7 |
| Haiti | No | — | No | — | No | — |
| Honduras | Yes | 10 | Yes | 10 | Yes | 8 |
| Jamaica | Yes | 10 | Yes | 10 | Yes | 3 |
| Mexico | Yes | 9 | Yes | 9 | Yes | 3 |
| Nicaragua | Yes | 10 | Yes | 10 | Yes | 7 |
| Panama | Yes | 10 | Yes | 10 | Yes | 8 |
| Paraguay | Yes | 10 | Yes | ... | Yes | 5 |
| Peru | Yes | 10 | Yes | 10 | Yes | 3 |
| Saint Kitts and Nevis | No | — | No | — | No | — |
| Saint Lucia | Yes | 10 | Yes | 10 | Yes | 8 |
| Saint Vincent and the Grenadines | No | — | No | — | No | — |
| Suriname | Yes | 8 | Yes | 8 | Yes | 8 |
| Trinidad and Tobago | Yes | 8 | Yes | 10 | Yes | 5 |
| United States | No | — | No | — | No | — |
| Uruguay | Yes | 10 | Yes | 10 | Yes | 10 |
| Venezuela (Bolivarian Republic of) | Yes | 10 | Yes | 8 | Yes | 5 |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number of outdoor places where smoking is banned either fully or partially | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|--------------|-------------------------------|--------------|------------------|--------------|------------------|--------------|------------------|--------------|--|--------------|--|--|
| Ban Notes | Compliance ^ | Ban Notes | Compliance ^ | Ban Notes | Compliance ^ | Ban Notes | Compliance ^ | Ban | Compliance ^ | Places | Compliance ^ | Places | Ban |
| Yes | 8 | Yes | 10 | Yes | 7 | Yes | 8 | Yes | 10 | 8 | 7 | 6 | — |
| Yes | 8 | Yes | 7 | Yes | 10 | Yes | 5 | Yes | 10 | 8 | 8 | 2 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 8 | Yes | 8 | 8 | 10 | 0 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 7 | Yes | 5 | Yes | 5 | Yes | 0 | Yes | 0 | 8 | 0 | 6 | — |
| Yes | 10 | Yes | 8 | Yes | 9 | Yes | 6 | Yes | 10 | 8 | 8 | 0 | — |
| Yes ¹ | 10 | No ² | — | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 9 | 7 | 10 | 0 | Yes |
| Yes | 8 | Yes | 8 | Yes | 10 | Yes | 10 | Yes | 10 | 8 | 8 | 3 | — |
| Yes | 8 | Yes | 10 | Yes | 10 | Yes | 7 | Yes | 10 | 8 | 8 | 0 | — |
| Yes | 7 | Yes | 8 | Yes | 10 | Yes | 8 | Yes | 10 | 8 | 8 | 8 | — |
| No | — | No | — | No | — | No | — | Yes | 7 | 4 | 5 | 0 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 3 | 4 | 3 | No |
| Yes | 10 | Yes | 10 | Yes | 8 | Yes | 5 | Yes | 8 | 8 | 5 | 3 | — |
| Yes | 10 | Yes | 8 | Yes | 3 | Yes | 2 | Yes | 8 | 8 | 5 | 7 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 8 | Yes | 8 | Yes | 8 | Yes | 2 | Yes | 7 | 8 | 5 | 0 | — |
| Yes | 5 | Yes | 7 | Yes | 3 | Yes | 0 | Yes | 3 | 8 | 3 | 8 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 8 | Yes | 10 | Yes | 5 | Yes | 7 | Yes | 8 | 8 | 7 | 0 | — |
| Yes | 8 | Yes | 10 | Yes | 3 | Yes | 0 | Yes | 7 | 8 | 5 | 8 | — |
| Yes | 8 | Yes | 10 | Yes | 6 | Yes | 3 | Yes | 9 | 8 | 8 | 8 | — |
| Yes | 7 | Yes | 3 | No | — | No | — | Yes | 3 | 6 | 7 | 6 | No |
| Yes | 10 | Yes | 10 | Yes | 8 | Yes | 8 | Yes | 10 | 8 | 10 | 1 | — |
| Yes | 4 | Yes | 8 | Yes | 8 | Yes | 4 | Yes | 8 | 8 | 8 | 2 | — |
| Yes | 8 | Yes | 10 | Yes | 8 | Yes | 5 | Yes | 8 | 8 | 8 | 3 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 10 | Yes | 10 | Yes | 8 | Yes | 2 | Yes | 10 | 8 | 7 | 8 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | 5 | Yes | 10 | Yes | 7 | Yes | 5 | Yes | 3 | 8 | 3 | 3 | — |
| Yes | 5 | Yes | 10 | Yes | 7 | Yes | 2 | Yes | 10 | 8 | 5 | 0 | — |
| Yes | ... | No | — | No | — | No | — | No | — | 1 | ... | 0 | Yes |
| Yes | 10 | Yes | 8 | Yes | 10 | Yes | 8 | Yes | 8 | 8 | 10 | 3 | — |
| Yes | 8 | Yes | 8 | Yes | 8 | Yes | 5 | Yes | 10 | 8 | 8 | 0 | — |

Table A2.1.3

South-East Asia Region

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

– Data not required/not applicable.

¹ Smoking is banned, except if the health authority allows designated smoking rooms by administrative act. Until now, no such administrative act has been made.

| Country | Health care facilities | | Educational facilities except universities | | Universities | |
|---------------------------------------|------------------------|-------------------------|--|-------------------------|------------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Bangladesh | Yes | 8 | Yes | 8 | Yes | 3 |
| Bhutan | No | — | No | — | No | — |
| Democratic People's Republic of Korea | Yes | 10 | Yes | 10 | Yes | 10 |
| India | Yes | 8 | Yes | 6 | Yes | 5 |
| Indonesia | Yes | 9 | Yes | 9 | Yes | 4 |
| Maldives | Yes | 9 | Yes | 5 | Yes | 6 |
| Myanmar | Yes | 8 | Yes | 8 | Yes | 5 |
| Nepal | Yes | 10 | Yes | 8 | Yes | 8 |
| Sri Lanka | Yes | 10 | Yes | 10 | Yes | 10 |
| Thailand | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 6 |
| Timor-Leste | Yes | 10 | Yes | 10 | Yes | 4 |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number Of Outdoor Places Where Smoking Is Banned Either Fully Or Partially | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|-------------------------|-------------------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|--|-------------------------|--|--|
| Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Places | Compliance [^] | Places | Places |
| No | — | No | — | No | — | No | — | No | — | 3 | 5 | 1 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 1 | No |
| No | — | Yes | 10 | Yes | 8 | Yes | 8 | Yes | 10 | 7 | 10 | 0 | No |
| Yes | 5 | Yes | 8 | No [☆] | — | No [☆] | — | Yes | 9 | 6 | 4 | 1 | Yes |
| No | — | No | — | No | — | No | — | Yes | 3 | 4 | 4 | 0 | Yes |
| Yes | 6 | No | — | No | — | No | — | Yes | 7 | 5 | 1 | 5 | No |
| Yes | 5 | No | — | Yes | 2 | No | — | No | — | 5 | 5 | 3 | No |
| Yes | 10 | Yes | 9 | Yes | 4 | Yes | 0 | Yes | 9 | 8 | 6 | 2 | — |
| Yes | 10 | Yes | 10 | No | — | No | — | Yes | 9 | 6 | 6 | 1 | No |
| Yes ¹ | 5 | Yes ¹ | 10 | Yes ¹ | 4 | Yes ¹ | 3 | Yes ¹ | 5 | 8 | 6 | 8 | — |
| No | — | No | — | Yes | 3 | Yes | 3 | Yes | 3 | 6 | 8 | 0 | No |

Table A2.1.4

European Region

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

... Data not available.

– Data not required/not applicable.

1 Ban/measure is in effect in all subnational jurisdictions.

2 The three jurisdictions in the country (Federation of Bosnia and Herzegovina, Republika Srpska and Brcko District of Bosnia and Herzegovina) adopted separate tobacco control legislation with several differences. There is no tobacco control legislation at level of Bosnia and Herzegovina.

3 Smoking is banned but the ban does not apply to waterpipes.

4 Smoking is banned except in cigar bars allowed under very strict licensing conditions.

5 Smoking is banned except in cigar or pipe clubs specially set out for this purpose.

6 These places are not reported as completely smoke-free because the law provides for the possibility of creating designated smoking rooms under specific conditions. However in practice many of them are completely smoke-free.

7 Provision adopted but not implemented by 31 December 2022.

| Country | Health care facilities | | Educational facilities except universities | | Universities | |
|------------------------------|------------------------|-------------------------|--|-------------------------|------------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Albania | Yes | 10 | Yes | 10 | Yes | 10 |
| Andorra | Yes | 10 | Yes | 10 | Yes | 10 |
| Armenia | Yes | 10 | Yes | 10 | Yes | 10 |
| Austria | No | — | Yes | 10 | No | — |
| Azerbaijan | Yes | 7 | Yes | 8 | Yes | 7 |
| Belarus | No | — | Yes | 10 | Yes | 8 |
| Belgium | No☆ | — | Yes ¹ | ... | No☆ | — |
| Bosnia and Herzegovina | No ² | — | No ² | — | No ² | — |
| Bulgaria | Yes | 4 | Yes | 5 | Yes | 5 |
| Croatia | Yes | 7 | Yes | 5 | Yes | 5 |
| Cyprus | Yes | 10 | Yes | 10 | Yes | 10 |
| Czechia | Yes | 10 | Yes | 10 | Yes | 10 |
| Denmark | No | — | Yes | 8 | No | — |
| Estonia | No | — | Yes | 7 | No | — |
| Finland | No☆ | — | Yes | 10 | No☆ | — |
| France | Yes | 10 | Yes | 8 | Yes | 7 |
| Georgia | Yes | 8 | Yes | 10 | Yes | 9 |
| Germany | No | — | No | — | No | — |
| Greece | Yes | ... | Yes | ... | Yes | ... |
| Hungary | Yes | ... | Yes | ... | Yes | ... |
| Iceland | No | — | Yes | 10 | No | — |
| Ireland | Yes | 8 | Yes | 9 | Yes | 8 |
| Israel | Yes | 7 | Yes | 8 | No | — |
| Italy | No☆ | — | No☆ | — | No☆ | — |
| Kazakhstan | Yes | 8 | Yes | 8 | Yes | 8 |
| Kyrgyzstan | Yes | ... | Yes | ... | Yes | ... |
| Latvia | Yes | 8 | Yes | 10 | Yes | 10 |
| Lithuania | Yes | ... | Yes | ... | Yes | ... |
| Luxembourg | No☆ | — | Yes | 7 | Yes | 8 |
| Malta | Yes | ... | Yes | ... | Yes | ... |
| Monaco | No☆ | — | Yes | 10 | Yes | 10 |
| Montenegro | Yes | ... | Yes | ... | Yes | ... |
| Netherlands (Kingdom of the) | Yes | 8 | Yes | 10 | Yes | 10 |
| Norway | Yes | 10 | Yes | 10 | Yes | 10 |
| North Macedonia | Yes | ... | Yes | ... | Yes | ... |
| Poland | Yes | 9 | Yes | 8 | No | — |
| Portugal | Yes | 8 | Yes | 8 | Yes | 5 |
| Republic of Moldova | Yes | 10 | Yes | 10 | Yes | 10 |
| Romania | Yes | 10 | Yes | 8 | Yes | 8 |
| Russian Federation | Yes | 9 | Yes | 7 | Yes | 7 |
| San Marino | Yes | ... | Yes | ... | Yes | ... |
| Serbia | Yes | ... | Yes | ... | Yes | ... |
| Slovakia | Yes | 10 | Yes | 8 | Yes | 8 |
| Slovenia | Yes | 10 | Yes | 10 | Yes | 10 |
| Spain | Yes | 8 | Yes | 9 | Yes | 8 |
| Sweden | No | — | No | — | No | — |
| Switzerland | No ⁶ | — | No ⁶ | — | No ⁶ | — |
| Tajikistan | Yes | ... | Yes | ... | Yes | ... |
| Türkiye | Yes | ... | Yes | ... | Yes | ... |
| Turkmenistan | Yes | 10 | Yes | 10 | Yes | 10 |
| Ukraine | Yes | ... | Yes | ... | Yes | ... |
| United Kingdom | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 9 |
| Uzbekistan | No | — | No | — | No | — |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number of outdoor places where smoking is banned either fully or partially | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|-------------------------|-------------------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|--|-------------------------|--|--|
| Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Places | Compliance ^Λ | Places | Places |
| Yes | 10 | Yes | 10 | Yes | 8 | Yes | 7 | Yes | 8 | 8 | 10 | 0 | — |
| Yes | 10 | No☆ | — | No☆ | — | No☆ | — | Yes | 10 | 5 | 10 | 1 | — |
| Yes | 8 | Yes | 7 | Yes | 7 | Yes | 5 | No | — | 7 | 7 | 6 | No |
| No | — | No | — | Yes | 10 | Yes | 7 | Yes | 10 | 4 | 10 | 1 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 3 | 5 | 4 | No |
| No | — | No | — | No | — | No | — | No | — | 2 | 8 | 5 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | Yes | 10 | 2 | 8 | 2 | No |
| No ² | — | No ² | — | No ² | — | No ² | — | No ² | — | 0 ² | — | 0 | No |
| Yes | 4 | Yes | 4 | Yes | 3 | Yes | 1 | Yes | 10 | 8 | 4 | 1 | — |
| Yes | 7 | Yes | 7 | No☆ | — | No | — | Yes | 10 | 6 | 5 | 3 | No |
| Yes | 10 | Yes | 7 | Yes | 5 | Yes | 3 | No | — | 7 | 7 | 2 | No |
| No | — | No | — | No ³ | — | No ³ | — | Yes | 10 | 4 | 8 | 1 | No |
| No | — | No | — | No | — | No | — | No | — | 1 | 10 | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 1 | 7 | 1 | No |
| No☆ | — | No☆ | — | No | — | No☆ | — | No | — | 1 | 10 | 1 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 3 | 7 | 2 | No |
| Yes | 4 | Yes | 8 | Yes | 10 | No ⁴ | — | Yes | 8 | 7 | 10 | 3 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 2 | — |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | No | — | 7 | ... | 7 | No |
| No | — | No | — | No | — | No | — | No | — | 1 | 10 | 2 | No |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | 8 | 9 | 0 | — |
| Yes | 8 | No | — | No | — | No | — | No | — | 3 | 5 | 3 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 0 | — | 3 | No |
| Yes | 8 | Yes | 8 | No | — | No | — | Yes | 8 | 6 | 5 | 0 | No |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 3 | — |
| Yes | 8 | No | — | Yes | 10 | Yes | 8 | No | — | 6 | 8 | 4 | No |
| No | — | No | — | Yes | ... | No ⁵ | — | No | — | 4 | ... | 5 | No |
| No | — | No | — | No☆ | — | No☆ | — | Yes | 10 | 3 | 10 | 3 | — |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 1 | — |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 2 | 10 | 1 | — |
| Yes | ... | No | — | No | — | No | — | No | — | 4 | ... | 0 | No |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 7 | Yes | 10 | 8 | 8 | 1 | — |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | 8 | 10 | 2 | — |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 0 | — |
| No | — | No | — | No | — | No | — | Yes | 10 | 3 | 6 | 1 | No |
| Yes | 8 | Yes | 8 | No☆ | — | No☆ | — | Yes | 10 | 6 | 7 | 1 | No |
| Yes | 10 | Yes | 8 | Yes | 8 | Yes | 7 | Yes | 8 | 8 | 10 | 8 | — |
| Yes | 7 | Yes | 10 | Yes | 8 | Yes | 7 | Yes | 10 | 8 | 8 | 0 | — |
| Yes | 6 | Yes | 9 | Yes | 10 | Yes | 9 | Yes | 10 | 8 | 10 | 4 | — |
| Yes | ... | No☆ | — | No☆ | — | No☆ | — | Yes | ... | 5 | ... | 0 | — |
| Yes | ... | No | — | No | — | No | — | Yes | ... | 5 | ... | 3 | No |
| No | — | Yes | 6 | No | — | No | — | No | — | 4 | 6 | 2 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | No☆ | — | 3 | 8 | 2 | No |
| Yes | 8 | Yes | 10 | Yes | 9 | Yes | 8 | Yes | 9 | 8 | 9 | 3 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 1 | No |
| No ⁶ | — | No ⁶ | — | No ⁶ | — | No ⁶ | — | No ⁶ | — | 0 | — | 0 | No |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 4 | — |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 4 | — |
| Yes | 10 | Yes | 10 | Yes | 9 | Yes | 9 | Yes | 10 | 8 | 10 | 4 | — |
| Yes | ... | Yes ⁷ | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 4 | — |
| Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 10 | Yes ¹ | 10 | 8 | 10 | 0 | — |
| No | — | No | — | No | — | No | — | Yes | 6 | 1 | 4 | 0 | No |

Table A2.1.5

Eastern Mediterranean Region

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

... Data not available.

– Data not required/not applicable.

< “occupied Palestinian territory” should be understood to refer to the “occupied Palestinian territory, including east Jerusalem”.

¹ Data not approved by national authorities.

| Country or territory | Health care facilities | | Educational facilities except universities | | Universities | |
|----------------------------------|------------------------|-------------------------|--|-------------------------|-----------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Afghanistan | Yes | ... | Yes | ... | Yes | ... |
| Bahrain | No ¹ | — | No ¹ | — | No ¹ | — |
| Djibouti | Yes | ... | Yes | ... | Yes | ... |
| Egypt | Yes | 4 | Yes | 5 | Yes | 1 |
| Iran (Islamic Republic of) | Yes | 10 | Yes | 10 | Yes | 6 |
| Iraq | Yes | 8 | Yes | 5 | Yes | 4 |
| Jordan | Yes | 4 | Yes | 5 | Yes | 3 |
| Kuwait | Yes | ... | Yes | ... | Yes | ... |
| Lebanon | Yes | 10 | Yes | 8 | Yes | 8 |
| Libya | Yes | 3 | Yes | 3 | Yes | 0 |
| Morocco | Yes | 10 | Yes | 10 | Yes | 5 |
| occupied Palestinian territory < | Yes | 5 | Yes | 3 | Yes | 0 |
| Oman | No | — | No | — | No | — |
| Pakistan | Yes | ... | Yes | ... | Yes | ... |
| Qatar | Yes | ... | Yes | ... | Yes | ... |
| Saudi Arabia | Yes | ... | Yes | ... | Yes | ... |
| Somalia | No | — | No | — | No | — |
| Sudan | No | — | No | — | No | — |
| Syrian Arab Republic | Yes | ... | Yes | ... | Yes | ... |
| Tunisia | No | — | No | — | No | — |
| United Arab Emirates | Yes | 10 | Yes | 10 | Yes | 5 |
| Yemen | No | — | Yes | 3 | Yes | 0 |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number of outdoor places where smoking is banned either fully or partially | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|-------------------------|-------------------------------|-------------------------|-------------|-------------------------|---------------|-------------------------|------------------|-------------------------|--|-------------------------|--|--|
| Ban | Compliance [^] | Ban Notes | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] | Places | Compliance [^] | Places | Places |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 0 | — |
| No ¹ | — | No ¹ | — | No☆ | — | No☆ | — | No ¹ | — | 0 | — | 0 | No |
| Yes | ... | Yes | ... | No | — | No | — | Yes | ... | 6 | ... | 4 | No |
| Yes | 1 | Yes | 1 | Yes | 1 | Yes | 0 | Yes | 5 | 8 | 3 | 0 | — |
| Yes | 10 | Yes | 9 | Yes | 8 | Yes | 5 | Yes | 10 | 8 | 10 | 0 | — |
| Yes | 4 | Yes | 5 | Yes | 0 | Yes | 0 | Yes | 4 | 8 | 4 | 7 | — |
| Yes | 0 | Yes | 3 | Yes | 0 | Yes | 0 | Yes | 5 | 8 | 0 | 0 | — |
| No | — | No | — | No | — | No | — | Yes | ... | 4 | ... | 4 | No |
| Yes | 3 | Yes | 5 | Yes | 3 | Yes | 1 | Yes | 3 | 8 | 3 | 3 | — |
| Yes | 0 | Yes | 0 | Yes | 3 | Yes | 3 | Yes | 5 | 8 | 2 | 0 | — |
| Yes | 3 | Yes | 8 | No | — | No | — | No | — | 5 | 5 | 0 | No |
| Yes | 0 | Yes | 0 | Yes | 0 | Yes | 0 | Yes | 0 | 8 | 0 | 1 | — |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 0 | — |
| No☆ | — | No | — | No☆ | — | No☆ | — | No☆ | — | 3 | ... | 0 | No |
| Yes | ... | Yes | ... | No☆ | — | No☆ | — | Yes | ... | 6 | ... | 8 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No | — | No | — | Yes | ... | Yes | ... | Yes | ... | 6 | ... | 2 | No |
| No | — | No | — | No | — | No | — | No | — | 0 | — | 0 | No |
| No☆ | — | No☆ | — | No☆ | — | No☆ | — | Yes | 10 | 4 | 10 | 4 | No |
| Yes | 0 | Yes | 0 | No | — | No | — | Yes | 0 | 5 | 0 | 0 | No |

Table A2.1.6

Western Pacific Region

Public places with complete smoking bans

[^] Based on a score of 0-10, where 0 is low compliance. Refer to Technical Note I for more information.

... Data not available.

– Data not required/not applicable.

¹ Ban/measure is in effect in all subnational jurisdictions.

² Ban/measure is in effect in most subnational jurisdictions.

³ Smoking is banned and the law does not allow designated smoking rooms, except if the health authority allows them by administrative act. Until now, no such administrative act has been taken.

⁴ Smoking is banned by law, with an exemption for indoor or enclosed workplace accessible by one person only, where smoking by that person is allowed. However, this exemption has never been applied in any workplaces as of today in Vanuatu.

| Country | Health care facilities | | Educational facilities except universities | | Universities | |
|----------------------------------|------------------------|-------------------------|--|-------------------------|------------------|-------------------------|
| | Ban | Compliance [^] | Ban | Compliance [^] | Ban | Compliance [^] |
| Australia | Yes ¹ | ... | No ² | — | No ² | — |
| Brunei Darussalam | Yes | ... | Yes | ... | Yes | ... |
| Cambodia | Yes | 8 | Yes | 10 | Yes | 10 |
| China | No | — | Yes | 10 | No | — |
| Cook Islands | Yes | ... | Yes | ... | Yes | ... |
| Fiji | Yes | 10 | No | — | No | — |
| Japan | Yes | 10 | Yes | 10 | Yes | 10 |
| Kiribati | Yes | 8 | No | — | No | — |
| Lao People's Democratic Republic | Yes | 8 | Yes | 8 | Yes | 7 |
| Malaysia | No ³ | — | No ³ | — | No ³ | — |
| Marshall Islands | Yes | ... | Yes | ... | Yes | ... |
| Micronesia (Federated States of) | Yes ¹ | ... | Yes ¹ | ... | Yes ¹ | ... |
| Mongolia | Yes | 8 | Yes | 9 | Yes | 5 |
| Nauru | Yes | 8 | Yes | 10 | Yes | 10 |
| New Zealand | Yes | 10 | Yes | 10 | Yes | 8 |
| Niue | Yes | ... | Yes | ... | Yes | ... |
| Palau | Yes | 10 | Yes | 10 | Yes | 8 |
| Papua New Guinea | Yes | ... | Yes | ... | Yes | ... |
| Philippines | Yes | 8 | Yes | 10 | Yes | 8 |
| Republic of Korea | Yes | 10 | Yes | 8 | No | — |
| Samoa | Yes | 7 | Yes | 5 | Yes | 5 |
| Singapore | Yes | 10 | Yes | 8 | Yes | 8 |
| Solomon Islands | Yes | ... | Yes | ... | No | — |
| Tonga | Yes | 7 | Yes | 7 | No | — |
| Tuvalu | No | — | No | — | No | — |
| Vanuatu | No ⁴ | — | No ⁴ | — | No ⁴ | — |
| Viet Nam | Yes | 8 | Yes | 8 | Yes | 5 |

| Government facilities | | Indoor offices and workplaces | | Restaurants | | Pubs and bars | | Public transport | | Number of indoor places with a complete smoking ban and overall compliance score | | Number of outdoor places where smoking is banned either fully or partially | | Smoking is comprehensively banned in one or more jurisdictions |
|-----------------------|-------------------------|-------------------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|------------------|-------------------------|--|-------------------------|--|--------|--|
| Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Ban | Compliance ^Λ | Places | Compliance ^Λ | Places | Places | |
| Yes ¹ | ... | Yes ¹ | ... | Yes ¹ | ... | Yes ¹ | ... | Yes ¹ | ... | 6 | ... | 2 | Yes | |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 8 | — | |
| Yes | 5 | Yes | 10 | Yes | 5 | Yes | 0 | Yes | 10 | 8 | 5 | 7 | — | |
| No | — | No | — | No | — | No | — | Yes | 10 | 2 | 6 | 1 | Yes | |
| Yes | ... | No | — | Yes | ... | Yes | ... | Yes | ... | 7 | ... | 0 | No | |
| No | — | No | — | Yes | 5 | No | — | Yes | 7 | 3 | 3 | 0 | No | |
| Yes | 10 | No | — | No | — | No | — | No | — | 4 | 10 | 0 | No | |
| Yes | 8 | Yes | 10 | Yes | 6 | Yes | 3 | Yes | 6 | 6 | 5 | 0 | No | |
| Yes | 7 | Yes | 8 | Yes | 7 | Yes | 3 | Yes | 5 | 8 | 7 | 8 | — | |
| No | — | No | — | No ³ | — | No | — | No ³ | — | 0 | — | 7 | No | |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 0 | — | |
| Yes | ... | Yes ¹ | ... | No | — | No | — | No | — | 5 | ... | 1 | Yes | |
| Yes | 8 | No | — | No | — | No | — | Yes | 6 | 5 | 5 | 3 | No | |
| Yes | 7 | Yes | 10 | Yes | 8 | Yes | 8 | Yes | 10 | 8 | 5 | 0 | — | |
| Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | Yes | 10 | 8 | 10 | 1 | — | |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 2 | — | |
| Yes | 10 | Yes | 10 | No | — | No | — | Yes | 10 | 6 | 10 | 3 | No | |
| Yes | ... | Yes | ... | Yes | ... | Yes | ... | Yes | ... | 8 | ... | 0 | — | |
| Yes | 7 | No | — | No | — | No | — | Yes | 5 | 5 | 7 | 7 | No | |
| No | — | No | — | No | — | No | — | No | — | 2 | 9 | 4 | No | |
| Yes | 5 | Yes | 5 | No | — | No | — | Yes | 5 | 6 | 7 | 0 | No | |
| No | — | No | — | Yes | 8 | No☆ | — | Yes | 10 | 5 | 8 | 4 | — | |
| No | — | No | — | No | — | No | — | Yes | ... | 3 | ... | 7 | No | |
| Yes | 7 | Yes | 10 | Yes | 8 | Yes | 7 | Yes | 8 | 7 | 5 | 1 | No | |
| Yes | ... | No | — | Yes | ... | Yes | ... | Yes | ... | 4 | ... | 0 | No | |
| No ⁴ | — | No ⁴ | — | No ⁴ | — | No ⁴ | — | No ⁴ | — | 0 | — | 0 | No | |
| Yes | 5 | Yes | 7 | Yes | 3 | No | — | No | — | 6 | 5 | 2 | No | |

Table A2.2.1

African Region

Additional public places with complete smoking bans

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

... Data not available.

– Data not required/not applicable.

1 Regulations are pending.

2 Smoking is banned and the law does not allow designated smoking rooms, except if the health authority allows them by administrative act. Until now, no such administrative act has been taken.

3 However the Minister may allow a person to smoke in a non-smoking area.

| Country | Public transport | | |
|----------------------------------|--|-----------------------|---------------------------------------|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Algeria | Yes | Yes | No |
| Angola | Yes | Yes | Yes |
| Benin | Yes | Yes | Yes |
| Botswana | No | No | No |
| Burkina Faso | Yes | Yes | Yes |
| Burundi | Yes | Yes | Yes |
| Cabo Verde | Yes | Yes | Yes |
| Cameroon | No | No | No |
| Central African Republic | No | No | No |
| Chad | Yes | Yes | Yes |
| Comoros | Yes | Yes | Yes |
| Congo | Yes | Yes | Yes |
| Côte d'Ivoire | No | No | No |
| Democratic Republic of the Congo | Yes | Yes | Yes |
| Equatorial Guinea | No | No | No |
| Eritrea | No | No | No |
| Ethiopia | Yes | Yes | Yes |
| Eswatini | No | No | No |
| Gabon | No | Yes | No |
| Gambia | Yes | Yes | Yes |
| Ghana | No☆ | No☆ | No☆ |
| Guinea | Yes | Yes | Yes |
| Guinea-Bissau | No | No | No |
| Kenya | No | No | No |
| Lesotho | No | No | No |
| Liberia | No | No | No |
| Madagascar | Yes | Yes | Yes |
| Malawi | No | No | No |
| Mali | No | No | No |
| Mauritania | Yes | Yes | Yes |
| Mauritius | Yes | Yes | Yes |
| Mozambique | No | Yes | No |
| Namibia | Yes | Yes | Yes |
| Niger | Yes | Yes | Yes |
| Nigeria | No | No | No |
| Rwanda | No | No | No |
| Sao Tome and Principe | No | No | No |
| Senegal | Yes | Yes | Yes |
| Seychelles | Yes | Yes | Yes |
| Sierra Leone | No | No | No |
| South Africa | No | Yes | No |
| South Sudan | No | No | No |
| Togo | Yes | Yes | No☆ |
| Uganda | Yes | Yes | Yes |
| United Republic of Tanzania | No | No | No |
| Zambia | Yes | Yes | Yes |
| Zimbabwe | Yes | Yes | Yes |

| Indoor waiting areas of public transport (train station, metro station, etc.) | Airports | Hotels | | Prisons | Shops (supermarket, shop, shopping mall) | Cultural facilities (museum, cinema, theatre, arena) | Private vehicles with children aged < 18 years | Outdoor children playgrounds/ parks |
|---|-----------------|-----------------|-----------------|-----------------|--|--|--|-------------------------------------|
| | | Main areas | Bedrooms | | | | | |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | No | No | No | No | No | No | Yes | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Yes | Yes | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| No | No | No | No | No | No | No | No | No |
| No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| No | No | No | No | No | No | No | No | Yes |
| No | No | No | No | No | No | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | Yes | No |
| No | No | No | No | No | No | Yes | No | Yes |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | Yes | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | Yes | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | Yes | Yes |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | No☆ | No☆ | No | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| No ² | No ² | No ² | No | No | No ² | No ² | No | No |
| No | No | No | No | No | No | No | No | No |
| No☆ | No☆ | No☆ | No☆ | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No☆ | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | Yes ³ | No | No |

Table A2.2.2

Region of the Americas

Additional public places with complete smoking bans

... Data not available.

– Data not required/not applicable.

1 Ban/measure is in effect in all subnational jurisdictions.

| Country | Public transport | | |
|------------------------------------|--|--------------------------|---|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Antigua and Barbuda | Yes | Yes | Yes |
| Argentina | Yes | Yes | Yes |
| Bahamas | No | No | No |
| Barbados | Yes | Yes | Yes |
| Belize | No | No | No |
| Bolivia (Plurinational State of) | Yes | Yes | Yes |
| Brazil | Yes | Yes | Yes |
| Canada | Yes | Yes | Yes |
| Chile | Yes | Yes | Yes |
| Colombia | Yes | Yes | Yes |
| Costa Rica | Yes | Yes | Yes |
| Cuba | Yes | Yes | Yes |
| Dominica | No | No | No |
| Dominican Republic | No | No | No |
| Ecuador | Yes | Yes | Yes |
| El Salvador | Yes | Yes | Yes |
| Grenada | No | No | No |
| Guatemala | Yes | Yes | Yes |
| Guyana | Yes | Yes | Yes |
| Haiti | No | No | No |
| Honduras | Yes | Yes | Yes |
| Jamaica | Yes | Yes | Yes |
| Mexico | Yes | Yes | Yes |
| Nicaragua | Yes | Yes | Yes |
| Panama | Yes | Yes | Yes |
| Paraguay | Yes | Yes | Yes |
| Peru | Yes | Yes | Yes |
| Saint Kitts and Nevis | No | No | No |
| Saint Lucia | Yes | Yes | Yes |
| Saint Vincent and the Grenadines | No | No | No |
| Suriname | Yes | Yes | Yes |
| Trinidad and Tobago | Yes | Yes | Yes |
| United States | No | No | No |
| Uruguay | Yes | Yes | Yes |
| Venezuela (Bolivarian Republic of) | Yes | Yes | Yes |

Table A2.2.3

South-East Asia Region

Additional public places with complete smoking bans

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

... Data not available.

– Data not required/not applicable.

| Country | Public transport | | |
|---------------------------------------|--|--------------------------|---|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Bangladesh | No | Yes | No |
| Bhutan | No | No | No |
| Democratic People's Republic of Korea | Yes | Yes | Yes |
| India | Yes | Yes | Yes |
| Indonesia | Yes | Yes | Yes |
| Maldives | Yes | Yes | Yes |
| Myanmar | No | Yes | No |
| Nepal | Yes | Yes | Yes |
| Sri Lanka | Yes | Yes | Yes |
| Thailand | Yes | Yes | Yes |
| Timor-Leste | Yes | Yes | Yes |

| Indoor waiting areas of public transport (train station, metro station, etc.) | Airports | Hotels | | Prisons | Shops (supermarket, shop, shopping mall) | Cultural facilities (museum, cinema, theatre, arena) | Private vehicles with children aged < 18 years | Outdoor children playgrounds/parks |
|---|----------|------------|----------|---------|--|--|--|------------------------------------|
| | | Main areas | Bedrooms | | | | | |
| No | No | No | No | No | No | Yes | No | Yes |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | No | No | Yes | Yes | No | No |
| Yes | No☆ | No☆ | No☆ | Yes | Yes | Yes | No | No |
| Yes | Yes | No | No | No | No | No | No | No |
| Yes | No | No | No | No | Yes | Yes | No | Yes |
| No | No | No | No | Yes | Yes | Yes | No | Yes |
| Yes | No | No | Yes | No | Yes | Yes | No | Yes |
| Yes | No | No | No | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | Yes | Yes | No | No | Yes | No | No |

Table A2.2.4

European Region

Additional public places with complete smoking bans

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

1 The three jurisdictions in the country (Federation of Bosnia and Herzegovina, Republika Srpska and Brcko District of Bosnia and Herzegovina) adopted separate tobacco control legislation with several differences. There is no tobacco control legislation at level of Bosnia and Herzegovina.

2 Ban/measure is in effect in all subnational jurisdictions.

| Country | Public transport | | |
|------------------------------|--|-----------------------|---------------------------------------|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Albania | Yes | Yes | Yes |
| Andorra | Yes | Yes | Yes |
| Armenia | No | Yes | No |
| Austria | Yes | Yes | Yes |
| Azerbaijan | No☆ | Yes | No☆ |
| Belarus | Yes | Yes | No |
| Belgium | Yes | Yes | Yes |
| Bosnia and Herzegovina | No ¹ | No ¹ | No ¹ |
| Bulgaria | Yes | Yes | Yes |
| Croatia | Yes | Yes | Yes |
| Cyprus | Yes | No | No |
| Czechia | Yes | Yes | Yes |
| Denmark | Yes | Yes | No |
| Estonia | No | Yes | No |
| Finland | No | No | No |
| France | No☆ | No☆ | No☆ |
| Georgia | Yes | Yes | Yes |
| Germany | No | No | No |
| Greece | Yes | Yes | Yes |
| Hungary | No | Yes | Yes |
| Iceland | Yes | Yes | No |
| Ireland | Yes | Yes | Yes |
| Israel | Yes | No | No |
| Italy | No☆ | Yes | Yes |
| Kazakhstan | Yes | Yes | Yes |
| Kyrgyzstan | Yes | Yes | Yes |
| Latvia | No | Yes | No |
| Lithuania | No | No | Yes |
| Luxembourg | Yes | Yes | Yes |
| Malta | Yes | Yes | Yes |
| Monaco | No☆ | No☆ | No☆ |
| Montenegro | No | No | No |
| Netherlands (Kingdom of the) | Yes | Yes | Yes |
| Norway | Yes | Yes | Yes |
| North Macedonia | Yes | Yes | Yes |
| Poland | Yes | Yes | Yes |
| Portugal | Yes | Yes | Yes |
| Republic of Moldova | Yes | Yes | Yes |
| Romania | Yes | Yes | Yes |
| Russian Federation | Yes | Yes | Yes |
| San Marino | Yes | Yes | Yes |
| Serbia | Yes | Yes | Yes |
| Slovakia | Yes | No | No |
| Slovenia | No☆ | No☆ | No☆ |
| Spain | Yes | Yes | Yes |
| Sweden | No | No | No |
| Switzerland | No | No | No |
| Tajikistan | Yes | Yes | Yes |
| Türkiye | Yes | Yes | Yes |
| Turkmenistan | Yes | Yes | Yes |
| Ukraine | Yes | Yes | Yes |
| United Kingdom | Yes | Yes | Yes |
| Uzbekistan | Yes | Yes | Yes |

| Indoor waiting areas of public transport (train station, metro station, etc.) | Airports | Hotels | | Prisons | Shops (supermarket, shop, shopping mall) | Cultural facilities (museum, cinema, theatre, arena) | Private vehicles with children aged < 18 years | Outdoor children playgrounds/parks |
|---|------------------|------------------|-----------------|------------------|--|--|--|------------------------------------|
| | | Main areas | Bedrooms | | | | | |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | NA | Yes | No | No☆ | Yes | Yes | No | Yes |
| Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| No | No | No | Yes | No | No | No | Yes | No |
| No☆ | No☆ | Yes | Yes | No☆ | No☆ | Yes | No | Yes |
| No | No | No | No | No | No | No | No | Yes |
| No☆ | No☆ | No☆ | No | No | No☆ | No☆ | Yes | No |
| No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | No☆ | No | No | Yes | Yes | No | No |
| No | No | No | No | No | Yes | Yes | Yes | Yes |
| Yes | No | No | No | No | No | Yes | No | Yes |
| No | No | No | No | Yes | No | No | No | No |
| Yes | Yes | No | No | No | Yes | No | No | No |
| No☆ | No☆ | No☆ | No | No☆ | No☆ | No☆ | No | Yes |
| No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | Yes | Yes |
| Yes | No | Yes | Yes | No | Yes | Yes | Yes | No |
| No | No | No | No | No | No | No | No | No |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | Yes | No | No | Yes | Yes | No | Yes |
| Yes | Yes | Yes | No | No | Yes | Yes | No | No |
| Yes | Yes | Yes | No | No | Yes | Yes | Yes | No |
| No | No | No | No | No | No | No | No | No |
| Yes | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | Yes | No |
| No | No | No | No | No | No | Yes | Yes | Yes |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | No | Yes | No | No | Yes | Yes | Yes | Yes |
| No | No | No | No | No | No | No | Yes | No |
| No | No | No☆ | No | No | Yes | Yes | No | Yes |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | Yes |
| No☆ | No☆ | No☆ | No | No | No☆ | No☆ | No | No |
| No | No | No | No | No | Yes | Yes | No | Yes |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | No | No | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | Yes | Yes | No | Yes |
| No☆ | No☆ | No☆ | No | No | No☆ | No☆ | No | Yes |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Yes | No | Yes | Yes | No | Yes | Yes | No | No |
| Yes | No | Yes | Yes | No | Yes | Yes | No | Yes |
| No☆ | No☆ | No☆ | No | No | No☆ | No☆ | No | No |
| Yes | Yes | No | No | No | No | Yes | No | No |
| Yes | Yes | No | No | No | Yes | Yes | No | No |
| No☆ | No☆ | No☆ | No | No | No☆ | No☆ | Yes | No |
| Yes | Yes | Yes | No | No | Yes | Yes | No | Yes |
| No | No | No | No | No | No | No | No | Yes |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes |
| Yes | Yes | Yes | No | No | Yes | Yes | No | Yes |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes ² | Yes ² | Yes ² | No | Yes ² | Yes ² | Yes ² | Yes ² | No |
| No | No | No | No | No | No | No | No | No |

Table A2.2.5

Eastern Mediterranean Region

Additional public places with complete smoking bans

☆ Separate, completely enclosed smoking rooms are allowed under very strict conditions (refer to Technical Note I for more details).

< “occupied Palestinian territory” should be understood to refer to the “occupied Palestinian territory, including east Jerusalem”.

1 Data not approved by national authorities.

| Country or territory | Public transport | | |
|----------------------------------|--|-----------------------|---------------------------------------|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Afghanistan | Yes | Yes | Yes |
| Bahrain | No ¹ | No ¹ | No ¹ |
| Djibouti | Yes | Yes | Yes |
| Egypt | Yes | Yes | Yes |
| Iran (Islamic Republic of) | Yes | Yes | Yes |
| Iraq | Yes | Yes | Yes |
| Jordan | Yes | Yes | Yes |
| Kuwait | Yes | Yes | Yes |
| Lebanon | Yes | Yes | Yes |
| Libya | Yes | Yes | Yes |
| Morocco | No | No | No |
| occupied Palestinian territory < | Yes | Yes | Yes |
| Oman | No | No | No |
| Pakistan | Yes | Yes | Yes |
| Qatar | No☆ | No☆ | No☆ |
| Saudi Arabia | Yes | Yes | Yes |
| Somalia | No | No | No |
| Sudan | No | No | No |
| Syrian Arab Republic | Yes | Yes | Yes |
| Tunisia | No | No | No |
| United Arab Emirates | Yes | Yes | Yes |
| Yemen | Yes | Yes | Yes |

| Indoor waiting areas of public transport (train station, metro station, etc.) | Airports | Hotels | | Prisons | Shops (supermarket, shop, shopping mall) | Cultural facilities (museum, cinema, theatre, arena) | Private vehicles with children aged < 18 years | Outdoor children playgrounds/parks |
|---|-----------------|-----------------|-----------------|-----------------|--|--|--|------------------------------------|
| | | Main areas | Bedrooms | | | | | |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | No |
| No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | No ¹ | Yes | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | No | No | No | No | No | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | No |
| No | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | Yes | No |
| Yes | Yes | No☆ | No☆ | No☆ | Yes | No☆ | No | Yes |
| No | No | No | No | No | No | No | No | No |
| No | No | No | No | No | No | No | No | Yes |
| No | No | No | No | No | No | Yes | No | No |
| No | No | No | No | No | No | Yes | No | No |
| No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | No☆ | No | No |
| Yes | No | No | No | Yes | No | No | No | No |

Table A2.2.6

Western Pacific Region

Additional public places with complete smoking bans

- 1 Ban/measure is in effect in all subnational jurisdictions.
- 2 Smoking is banned and the law does not allow designated smoking rooms, except if the health authority allows them by administrative act. Until now, no such administrative act has been taken.
- 3 Ban/measure is in effect in all subnational jurisdictions but exception for government owned boats/ships where designated smoking areas are allowed.
- 4 Smoking is banned by law, with an exemption for indoor or enclosed workplace accessible by one person only, where smoking by that person is allowed. However, this exemption has never been applied in any workplaces as of today in Vanuatu.

| Country | Public transport | | |
|----------------------------------|--|-----------------------|---------------------------------------|
| | Land transport (train, taxi, bus, metro, tram) | Air transport (plane) | Water transport (boat, vessel, ferry) |
| Australia | Yes | Yes | Yes |
| Brunei Darussalam | Yes | Yes | Yes |
| Cambodia | Yes | Yes | Yes |
| China | Yes | Yes | Yes |
| Cook Islands | Yes | Yes | Yes |
| Fiji | Yes | Yes | Yes |
| Japan | No | Yes | No |
| Kiribati | Yes | Yes | Yes |
| Lao People's Democratic Republic | Yes | Yes | Yes |
| Malaysia | No ² | No ² | No ² |
| Marshall Islands | Yes | Yes | Yes |
| Micronesia (Federated States of) | Yes ¹ | Yes ¹ | No ³ |
| Mongolia | Yes | Yes | Yes |
| Nauru | Yes | Yes | Yes |
| New Zealand | Yes | Yes | Yes |
| Niue | Yes | Yes | Yes |
| Palau | Yes | Yes | Yes |
| Papua New Guinea | Yes | Yes | Yes |
| Philippines | Yes | Yes | Yes |
| Republic of Korea | Yes | Yes | No |
| Samoa | Yes | Yes | Yes |
| Singapore | Yes | Yes | Yes |
| Solomon Islands | Yes | Yes | Yes |
| Tonga | Yes | Yes | Yes |
| Tuvalu | Yes | Yes | Yes |
| Vanuatu | No ⁴ | No ⁴ | No ⁴ |
| Viet Nam | No | Yes | No |

| Indoor waiting areas of public transport (train station, metro station, etc.) | Airports | Hotels | | Prisons | Shops (supermarket, shop, shopping mall) | Cultural facilities (museum, cinema, theatre, arena) | Private vehicles with children aged < 18 years | Outdoor children playgrounds/parks |
|---|------------------|------------------|-----------------|------------------|--|--|--|------------------------------------|
| | | Main areas | Bedrooms | | | | | |
| Yes ¹ | Yes ¹ | Yes ¹ | No | Yes ¹ | Yes ¹ | Yes ¹ | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | Yes |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Yes | Yes | No | No | No | No | No | No | Yes |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | Yes | No | No | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| No ² | No ² | No ² | No ² | No ² | No ² | No ² | No | Yes |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | No |
| Yes | No | Yes | No | No | No | No | No | Yes |
| Yes | No | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | No | Yes | Yes | Yes | No | No |
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No | No | No | No | No | No | No | No | Yes |
| Yes | No | No | No | No | No | No | No | Yes |
| Yes | Yes | No | No | Yes | Yes | Yes | No | No |
| Yes | No | Yes | No | No | Yes | Yes | No | Yes |
| Yes | Yes | No | No | No | No | No | No | No |
| No | Yes | Yes | Yes | No | Yes | Yes | No | No |
| No | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| No ⁴ | No ⁴ | No ⁴ | No ⁴ | No ⁴ | No ⁴ | No ⁴ | No | No |
| No | No | No | No | Yes | Yes | Yes | No | No |

Table A2.3.1

African Region

Additional characteristics of smoking bans

– Data not required/not applicable.

§ Ban applies to ENDS only.

1 Regulations are pending.

| Country | Signage | | Fines on the establishment | | |
|----------------------------------|--|--|---|---------------------------|----------------------------------|
| | Requirement to display no-smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Algeria | Yes | No | No | No | No |
| Angola | Yes | No | Yes | No | Yes |
| Benin | Yes | No | Yes | No | Yes |
| Botswana | Yes | No | Yes | No | Yes |
| Burkina Faso | Yes | No | No | No | — |
| Burundi | Yes | No | No | No | Yes |
| Cabo Verde | Yes | No | No | No | Yes |
| Cameroon | No | — | No | No | — |
| Central African Republic | No | — | No | No | — |
| Chad | Yes | No | Yes | Yes | Yes |
| Comoros | Yes | No | No | No | Yes |
| Congo | Yes | No | Yes | Yes | Yes |
| Côte d'Ivoire | Yes | No | Yes | No | No |
| Democratic Republic of the Congo | No | — | No | No | — |
| Equatorial Guinea | No | — | No | No | — |
| Eritrea | Yes | No | Yes | No | Yes |
| Ethiopia | Yes | No | Yes | Yes | Yes |
| Eswatini | Yes | No | No | No | No |
| Gabon | Yes | No | Yes | No | Yes |
| Gambia | Yes | No | Yes | Yes | Yes |
| Ghana | Yes | No | Yes | Yes | Yes |
| Guinea | Yes | No | No | No | Yes |
| Guinea-Bissau | No | — | No | No | — |
| Kenya | Yes | No | Yes | Yes | Yes |
| Lesotho | Yes | No | No | No | No |
| Liberia | Yes | No | No | No | Yes |
| Madagascar | Yes | No | No | No | No |
| Malawi | No | — | No | No | — |
| Mali | No | — | No | No | — |
| Mauritania | Yes | No | No | No | Yes |
| Mauritius | Yes | No | Yes | Yes | Yes |
| Mozambique | Yes | No | No | No | Yes |
| Namibia | Yes | Yes | Yes | No | Yes |
| Niger | No | — | Yes | No | — |
| Nigeria | Yes | No | Yes | Yes | Yes |
| Rwanda | Yes | No | No | No | No |
| Sao Tome and Principe | Yes | No | No | No | Yes |
| Senegal | Yes | No | Yes | Yes | Yes |
| Seychelles | Yes | No | Yes | No | Yes |
| Sierra Leone | No | — | No | No | — |
| South Africa | Yes | No | Yes | No | Yes |
| South Sudan | No | — | No | No | — |
| Togo | Yes | No | Yes | Yes | Yes |
| Uganda | Yes | No | Yes | Yes | Yes |
| United Republic of Tanzania | Yes | No | Yes | No | Yes |
| Zambia | Yes | No | No | No | Yes |
| Zimbabwe | Yes | No | No | No | Yes |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ENDS/ENNDS in public places | |
|---------------------------------|---------------------------------|--|-------------------------------------|--|----|
| Yes | No | No | No explicit ban on use | Use is banned in some public places ¹ | \$ |
| Yes | No | No | Use is banned in some public places | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | Use is banned in all public places | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |

Table A2.3.2

Region of the Americas

Additional characteristics of smoking bans

– Data not required/not applicable.

§ Ban applies to ENDS only.

| Country | Signage | | Fines on the establishment | | |
|------------------------------------|---|--|---|---------------------------|----------------------------------|
| | Requirement to display non smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Antigua and Barbuda | Yes | No | No | No | No |
| Argentina | Yes | Yes | Yes | No | Yes |
| Bahamas | No | — | No | No | — |
| Barbados | Yes | No | Yes | No | Yes |
| Belize | No | — | No | No | — |
| Bolivia (Plurinational State of) | Yes | No | No | No | No |
| Brazil | No | — | No | No | — |
| Canada | No | — | Yes | No | — |
| Chile | Yes | No | Yes | No | Yes |
| Colombia | Yes | No | Yes | No | Yes |
| Costa Rica | Yes | No | Yes | No | Yes |
| Cuba | Yes | No | No | No | No |
| Dominica | No | — | No | No | — |
| Dominican Republic | Yes | No | Yes | No | Yes |
| Ecuador | Yes | Yes | Yes | Yes | Yes |
| El Salvador | Yes | Yes | Yes | No | No |
| Grenada | No | — | No | No | — |
| Guatemala | Yes | No | Yes | No | Yes |
| Guyana | Yes | No | Yes | Yes | Yes |
| Haiti | No | — | No | No | — |
| Honduras | Yes | No | Yes | No | Yes |
| Jamaica | Yes | No | No | No | Yes |
| Mexico | Yes | Yes | Yes | No | No |
| Nicaragua | Yes | No | Yes | No | Yes |
| Panama | Yes | Yes | Yes | No | Yes |
| Paraguay | Yes | No | Yes | No | Yes |
| Peru | Yes | No | Yes | No | Yes |
| Saint Kitts and Nevis | No | — | No | No | — |
| Saint Lucia | Yes | No | No | No | Yes |
| Saint Vincent and the Grenadines | No | — | No | No | — |
| Suriname | Yes | No | Yes | Yes | Yes |
| Trinidad and Tobago | No | — | Yes | No | — |
| United States | No | — | No | No | — |
| Uruguay | Yes | No | Yes | Yes | Yes |
| Venezuela (Bolivarian Republic of) | Yes | No | Yes | No | Yes |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ENDS/ENNDS in public places | |
|---------------------------------|---------------------------------|--|-------------------------------------|---|----|
| No | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | Use is banned in all public places | \$ |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| No | Yes | No | Use is banned in all public places | Use is banned in all public places | \$ |
| No | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in some public places | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places | \$ |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places | \$ |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places | |
| Yes | No | No | Use is banned in all public places | Use is banned in all public places | \$ |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | \$ |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places | |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | Use is banned in all public places | Use is banned in all public places | \$ |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | No explicit ban on use | |
| No | No | No | Use is banned in some public places | No explicit ban on use | |
| No | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |

Table A2.3.3

South-East Asia Region

Additional characteristics of smoking bans

– Data not required/not applicable.

| Country | Signage | | Fines on the establishment | | |
|---------------------------------------|---|--|---|---------------------------|----------------------------------|
| | Requirement to display non smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Bangladesh | Yes | No | Yes | Yes | Yes |
| Bhutan | Yes | No | Yes | No | Yes |
| Democratic People's Republic of Korea | No | — | No | No | — |
| India | Yes | No | Yes | No | No |
| Indonesia | No | — | No | No | — |
| Maldives | Yes | Yes | Yes | No | Yes |
| Myanmar | Yes | No | Yes | No | Yes |
| Nepal | Yes | No | Yes | No | Yes |
| Sri Lanka | No | — | Yes | No | — |
| Thailand | Yes | No | Yes | Yes | Yes |
| Timor-Leste | Yes | No | No | No | No |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ENDS/ENNDS in public places |
|---------------------------------|---------------------------------|--|-------------------------------------|---|
| Yes | No | No | No explicit ban on use | No explicit ban on use |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use |
| No | No | No | No explicit ban on use | No explicit ban on use |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use |
| Yes | No | No | No explicit ban on use | No explicit ban on use |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in all public places |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places |

Table A2.3.4

European Region

Additional characteristics of smoking bans

– Data not required/not applicable.

§ Ban applies to ENDS only.

1 The three jurisdictions in the country (Federation of Bosnia and Herzegovina, Republika Srpska and Brcko District of Bosnia and Herzegovina) adopted separate tobacco control legislation with several differences. There is no tobacco control legislation at level of Bosnia and Herzegovina.

2 Ban/measure is in effect in all subnational jurisdictions.

| Country | Signage | | Fines on the establishment | | |
|------------------------------|---|--|---|---------------------------|----------------------------------|
| | Requirement to display non smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Albania | Yes | No | Yes | Yes | Yes |
| Andorra | Yes | No | Yes | No | Yes |
| Armenia | Yes | No | No | No | Yes |
| Austria | Yes | No | Yes | No | Yes |
| Azerbaijan | Yes | No | Yes | No | Yes |
| Belarus | Yes | No | No | No | No |
| Belgium | Yes | No | Yes | Yes | Yes |
| Bosnia and Herzegovina | No ¹ | — ¹ | No ¹ | No ¹ | — ¹ |
| Bulgaria | No | — | Yes | No | — |
| Croatia | No | — | Yes | No | — |
| Cyprus | Yes | No | Yes | No | Yes |
| Czechia | Yes | No | Yes | No | Yes |
| Denmark | No | — | Yes | No | — |
| Estonia | No | — | Yes | No | — |
| Finland | Yes | No | Yes | No | No |
| France | Yes | No | Yes | Yes | Yes |
| Georgia | Yes | Yes | Yes | Yes | Yes |
| Germany | No | — | No | No | — |
| Greece | Yes | No | Yes | Yes | Yes |
| Hungary | Yes | Yes | Yes | No | Yes |
| Iceland | No | — | No | No | — |
| Ireland | Yes | Yes | Yes | No | Yes |
| Israel | Yes | No | Yes | Yes | Yes |
| Italy | Yes | No | No | No | Yes |
| Kazakhstan | Yes | No | Yes | No | Yes |
| Kyrgyzstan | Yes | No | No | No | No |
| Latvia | Yes | No | No | No | Yes |
| Lithuania | Yes | No | No | No | No |
| Luxembourg | No | — | Yes | No | — |
| Malta | Yes | No | Yes | No | Yes |
| Monaco | No | — | Yes | No | — |
| Montenegro | Yes | No | Yes | No | Yes |
| Netherlands (Kingdom of the) | No | — | Yes | No | — |
| Norway | Yes | No | Yes | No | Yes |
| North Macedonia | No | — | No | No | — |
| Poland | Yes | No | No | No | Yes |
| Portugal | Yes | No | Yes | No | Yes |
| Republic of Moldova | Yes | No | Yes | No | Yes |
| Romania | Yes | No | No | No | No |
| Russian Federation | Yes | No | Yes | No | Yes |
| San Marino | Yes | No | Yes | No | Yes |
| Serbia | Yes | Yes | Yes | No | Yes |
| Slovakia | Yes | Yes | Yes | No | Yes |
| Slovenia | No | — | Yes | No | — |
| Spain | Yes | No | Yes | No | Yes |
| Sweden | Yes | No | No | No | No |
| Switzerland | No | — | No | No | — |
| Tajikistan | Yes | No | Yes | No | Yes |
| Türkiye | Yes | Yes | Yes | Yes | Yes |
| Turkmenistan | No | — | No | No | — |
| Ukraine | Yes | No | No | Yes | Yes |
| United Kingdom | Yes ² | No | Yes ² | No | Yes ² |
| Uzbekistan | No | — | No | No | — |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ENDS/ENNDs in public places | |
|---------------------------------|---------------------------------|--|-------------------------------------|---|----|
| Yes | No | Yes | No explicit ban on use | Use is banned in all public places | |
| Yes | No | Yes | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes ¹ | No ¹ | No ¹ | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | Use is banned in all public places | No explicit ban on use | |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| No | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in all public places | No explicit ban on use | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | Yes | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | No explicit ban on use | Use is banned in some public places | |
| No | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | Yes | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | \$ |
| Yes | No | Yes | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | Use is banned in some public places | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in some public places | \$ |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | \$ |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | Use is banned in all public places | |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes ² | No | Yes ² | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | Use is banned in some public places | |

Table A2.3.5

Eastern Mediterranean Region

Additional characteristics of smoking bans

- Data not required/not applicable.
- < “occupied Palestinian territory” should be understood to refer to the “occupied Palestinian territory, including east Jerusalem”.
- \$ Ban applies to ENDS only.

| Country or territory | Signage | | Fines on the establishment | | |
|----------------------------------|---|--|---|---------------------------|----------------------------------|
| | Requirement to display non smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Afghanistan | Yes | No | No | No | No |
| Bahrain | Yes | No | Yes | No | Yes |
| Djibouti | Yes | No | No | No | Yes |
| Egypt | Yes | No | Yes | No | Yes |
| Iran (Islamic Republic of) | Yes | No | No | No | No |
| Iraq | Yes | No | No | No | No |
| Jordan | Yes | No | Yes | No | Yes |
| Kuwait | Yes | No | Yes | No | No |
| Lebanon | Yes | No | Yes | No | Yes |
| Libya | Yes | No | No | No | No |
| Morocco | Yes | No | No | No | No |
| occupied Palestinian territory < | Yes | No | No | No | No |
| Oman | No | — | No | No | — |
| Pakistan | Yes | No | No | No | Yes |
| Qatar | Yes | No | Yes | No | No |
| Saudi Arabia | Yes | No | No | No | Yes |
| Somalia | No | — | No | No | — |
| Sudan | No | — | Yes | No | — |
| Syrian Arab Republic | Yes | No | No | No | Yes |
| Tunisia | Yes | No | No | No | No |
| United Arab Emirates | Yes | No | No | No | Yes |
| Yemen | Yes | No | No | No | No |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ends/ennds in public places | |
|---------------------------------|---------------------------------|--|-------------------------------------|---|----|
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | Yes | No explicit ban on use | Use is banned in some public places | |
| Yes | No | Yes | No explicit ban on use | Use is banned in all public places | \$ |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | Use is banned in all public places | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | Use is banned in some public places | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |

Table A2.3.6

Western Pacific Region

Additional characteristics of smoking bans

– Data not required/not applicable.

§ Ban applies to ENDS only.

1 Ban/measure is in effect in all subnational jurisdictions.

| Country | Signage | | Fines on the establishment | | |
|----------------------------------|---|--|---|---------------------------|----------------------------------|
| | Requirement to display non smoking signs in smoke-free places | Required signs identify a telephone number or other mechanisms for the public to report violations | For not asking a patron to stop smoking | For not removing ashtrays | For not posting no-smoking signs |
| Australia | No | — | Yes ¹ | No | — |
| Brunei Darussalam | Yes | Yes | Yes | No | Yes |
| Cambodia | Yes | Yes | Yes | Yes | Yes |
| China | No | — | Yes | No | — |
| Cook Islands | Yes | No | Yes | No | Yes |
| Fiji | Yes | No | Yes | No | Yes |
| Japan | No | — | Yes | No | — |
| Kiribati | Yes | No | Yes | No | Yes |
| Lao People's Democratic Republic | Yes | No | No | No | No |
| Malaysia | Yes | No | Yes | No | Yes |
| Marshall Islands | Yes | No | Yes | No | Yes |
| Micronesia (Federated States of) | Yes ¹ | No | No | No | No |
| Mongolia | Yes | Yes | No | No | Yes |
| Nauru | Yes | No | Yes | No | Yes |
| New Zealand | No | — | Yes | No | — |
| Niue | Yes | No | Yes | No | Yes |
| Palau | Yes | No | Yes | No | Yes |
| Papua New Guinea | Yes | No | Yes | No | Yes |
| Philippines | Yes | Yes | Yes | Yes | Yes |
| Republic of Korea | Yes | No | Yes | No | Yes |
| Samoa | Yes | No | Yes | Yes | Yes |
| Singapore | Yes | No | Yes | No | Yes |
| Solomon Islands | Yes | No | Yes | Yes | Yes |
| Tonga | Yes | No | Yes | No | Yes |
| Tuvalu | Yes | No | Yes | No | Yes |
| Vanuatu | Yes | No | Yes | No | Yes |
| Viet Nam | Yes | No | Yes | No | Yes |

| Fines on the patron for smoking | Dedicated funds for enforcement | Citizen complaints and investigations system | Ban on use of HTPs in public places | Ban on use of ends/ennds in public places | |
|---------------------------------|---------------------------------|--|-------------------------------------|---|----|
| Yes ¹ | No | Yes ¹ | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | Yes | No explicit ban on use | Use is banned in all public places | |
| Yes | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | Use is banned in some public places | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | No | No | Use is banned in some public places | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| No | Yes | No | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| No | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| No | No | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | No | No | No explicit ban on use | Use is banned in all public places | |
| Yes | Yes | No | No explicit ban on use | Use is banned in some public places | \$ |
| Yes | No | No | No explicit ban on use | Use is banned in all public places | \$ |
| Yes | Yes | No | Use is banned in some public places | Use is banned in some public places | |
| Yes | Yes | Yes | Use is banned in some public places | Use is banned in some public places | \$ |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | Use is banned in all public places | Use is banned in all public places | |
| Yes | Yes | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | No | No | No explicit ban on use | Use is banned in some public places | |
| Yes | No | No | No explicit ban on use | No explicit ban on use | |
| Yes | Yes | Yes | No explicit ban on use | No explicit ban on use | |



Annex 3

Year of highest level of achievement in selected tobacco control measures

Annex 3 provides information on the year in which respective countries attained the highest level of achievement for five of the MPOWER measures. Data are shown separately for each WHO region.

For Monitoring tobacco use the earliest year assessed is 2007. However, it is possible that while 2007 is reported as the year of highest achievement for some countries, they actually may have reached this level earlier.

Years of highest level achievement of the MPOWER measure Raise taxes on tobacco are not included in this Annex. The share of taxes in product price depends both on tax policy and on demand and supply factors that affect manufacturing and retail prices. Countries with tax increases might have seen the share of tax remain unchanged or even decline if the non-tax share of price rose at the same, or a higher rate, complicating the interpretation of the year of highest level of achievement.

See Technical Note III for details on the calculation of tax shares.

Table A3.1

African Region

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

| Country |
|----------------------------------|
| Algeria |
| Angola |
| Benin |
| Botswana |
| Burkina Faso |
| Burundi |
| Cabo Verde |
| Cameroon |
| Central African Republic |
| Chad |
| Comoros |
| Congo |
| Côte d'Ivoire |
| Democratic Republic of the Congo |
| Equatorial Guinea |
| Eritrea |
| Eswatini |
| Ethiopia |
| Gabon |
| Gambia |
| Ghana |
| Guinea |
| Guinea-Bissau |
| Kenya |
| Lesotho |
| Liberia |
| Madagascar |
| Malawi |
| Mali |
| Mauritania |
| Mauritius |
| Mozambique |
| Namibia |
| Niger |
| Nigeria |
| Rwanda |
| Sao Tome and Principe |
| Senegal |
| Seychelles |
| Somalia |
| South Africa |
| South Sudan |
| Togo |
| Uganda |
| United Republic of Tanzania |
| Zambia |
| Zimbabwe |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| | | | | 2018 |
| | 2017 | | 2021 | 2017 |
| | 2010 | | 2015 | |
| | 2018 | | | 2022 |
| | | | 2018 | |
| | 2010 | | 2015 | 2010 |
| | 2012 | | | 2018 |
| | | | | 2019 |
| | | | | 2018 |
| | | | | 2004 |
| | 2019 | 2022 | 2019 | 2019 |
| | 2016 | | 2019 | 2016 |
| | | | 2018 | 2012 |
| | | | | 2012 |
| | | | | 2007 |
| | 2013 | | 2012 | 2003 |
| | | | 2020 | 2018 |
| 2022 | 2022 | 2022 | 2008 | 2008 |
| | 2010 | | 2013 | |
| | | | 2019 | 2006 |
| | | | 2019 | 2015 |
| | | | 2016 | 2016 |
| | 2009 | | 2012 | 2009 |
| | | | | 2012 |
| | 2015 | | | 2015 |
| | | 2022 | | |

Table A3.2

Region of the Americas

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* or earlier year.

| Country |
|------------------------------------|
| Antigua and Barbuda |
| Argentina |
| Bahamas |
| Barbados |
| Belize |
| Bolivia (Plurinational State of) |
| Brazil |
| Canada |
| Chile |
| Colombia |
| Costa Rica |
| Cuba |
| Dominica |
| Dominican Republic |
| Ecuador |
| El Salvador |
| Grenada |
| Guatemala |
| Guyana |
| Haiti |
| Honduras |
| Jamaica |
| Mexico |
| Nicaragua |
| Panama |
| Paraguay |
| Peru |
| Saint Kitts and Nevis |
| Saint Lucia |
| Saint Vincent and the Grenadines |
| Suriname |
| Trinidad and Tobago |
| United States |
| Uruguay |
| Venezuela (Bolivarian Republic of) |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| | 2018 | | | 2018 |
| | 2011 | | 2012 | |
| | 2010 | | 2017 | |
| | 2020 | | 2009 | |
| 2015 | 2011 | 2002 | 2003 | 2011 |
| 2007* | 2007 | 2008 | 2011 | |
| 2007* | 2013 | | 2006 | |
| | 2008 | | | 2009 |
| 2008 | 2012 | 2018 | 2013 | |
| | | | | |
| | | | | |
| 2014 | 2011 | | 2012 | |
| 2022 | 2015 | | 2011 | |
| | 2008 | | | |
| | 2017 | | 2018 | 2017 |
| | 2010 | | 2017 | |
| | 2013 | 2016 | 2013 | |
| | 2021 | 2014 | 2009 | 2021 |
| | 2008 | | 2005 | 2008 |
| | 2020 | | | |
| 2008 | 2010 | | 2010 | |
| | 2020 | | 2017 | |
| | 2013 | | 2016 | 2013 |
| | 2009 | | 2013 | |
| 2007* | | 2008 | | |
| 2007* | 2005 | | 2005 | 2014 |
| | 2011 | | 2004 | 2019 |

Table A3.3

South-East Asia Region

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

▾ Policy adopted but not implemented by 31 December 2022.

* or earlier year.

| Country |
|---------------------------------------|
| Bangladesh |
| Bhutan |
| Democratic People's Republic of Korea |
| India |
| Indonesia |
| Maldives |
| Myanmar |
| Nepal |
| Sri Lanka |
| Thailand |
| Timor-Leste |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| | | | 2015 | |
| 2014 | | | | |
| | | 2016 | 2016 | |
| 2015 | | | | 2010 |
| | | | 2021 | |
| | 2011 | | 2011 | 2014 |
| 2018 | | | 2012 | |
| 2007* | 2010 | | 2005 | |
| | | | 2018 | |

Table A3.4

European Region

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

▾ Policy adopted but not implemented by 31 December 2022.

* or earlier year.

| Country |
|------------------------------|
| Albania |
| Andorra |
| Armenia |
| Austria |
| Azerbaijan |
| Belarus |
| Belgium |
| Bosnia and Herzegovina |
| Bulgaria |
| Croatia |
| Cyprus |
| Czechia |
| Denmark |
| Estonia |
| Finland |
| France |
| Georgia |
| Germany |
| Greece |
| Hungary |
| Iceland |
| Ireland |
| Israel |
| Italy |
| Kazakhstan |
| Kyrgyzstan |
| Latvia |
| Lithuania |
| Luxembourg |
| Malta |
| Monaco |
| Montenegro |
| Netherlands (Kingdom of the) |
| North Macedonia |
| Norway |
| Poland |
| Portugal |
| Republic of Moldova |
| Romania |
| Russian Federation |
| San Marino |
| Serbia |
| Slovakia |
| Slovenia |
| Spain |
| Sweden |
| Switzerland |
| Tajikistan |
| Türkiye |
| Turkmenistan |
| Ukraine |
| United Kingdom |
| Uzbekistan |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| | 2006 | | 2020 | 2006 |
| 2007* | | | 2016 | 2020 |
| 2007* | | 2020 | 2016 | |
| 2014 | | | | 2017 |
| 2021 | | | 2016 | |
| 2007* | | | 2016 | |
| 2007* | 2012 | | 2016 | |
| 2010 | | | 2017 | |
| 2014 | | | 2017 | |
| 2012 | | 2018 | 2016 | |
| 2007* | | 2011 | 2016 | |
| 2008 | | | 2016 | |
| 2012 | | | 2016 | 2016 |
| 2007* | | | 2016 | |
| 2012 | | | 2018 | |
| 2007* | | | 2016 | |
| 2007* | 2010 | | 2016 | |
| 2010 | | | 2016 | |
| 2007* | | | | 2006 |
| 2007* | 2004 | 2003 | 2016 | |
| | | 2022 | | |
| 2007* | | | 2016 | |
| 2008 | | | 2014 | |
| | 2021 | | 2014 | 2021 |
| 2007* | | | 2016 | |
| 2008 | | | 2016 | |
| 2010 | | 2016 | 2017 | |
| 2007* | 2010 | | 2016 | |
| 2014 | | | 2018 | |
| 2007* | 2021 | 2014 | 2016 | 2021 |
| | 2008 | | | |
| 2012 | 2013 | | | |
| 2007* | | | 2016 | |
| 2007* | | | 2015 | |
| 2013 | 2015 | | 2015 | 2015 |
| 2008 | 2015 | 2022 | 2016 | |
| 2007* | 2013 | | 2014 | 2013 |
| 2010 | | | | |
| 2007* | | 2018 | 2016 | |
| 2007* | | | 2017 | 2017 |
| 2007* | 2010 | | 2017 | 2010 |
| 2007* | | 2018 | 2016 | |
| 2007* | | | | |
| 2018 | 2018 | | 2018 | |
| 2007* | 2008 | 2010 | 2012 | 2012 |
| | 2000 | | 2014 | |
| 2007* | 2021 | | 2009 | 2021 |
| 2007* | 2006 | | 2016 | |

Table A3.5

Eastern Mediterranean Region

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* or earlier year.

< "occupied Palestinian territory" should be understood to refer to "occupied Palestinian territory, including East Jerusalem".

| Country or territory |
|----------------------------------|
| Afghanistan |
| Bahrain |
| Djibouti |
| Egypt |
| Iran (Islamic Republic of) |
| Iraq |
| Jordan |
| Kuwait |
| Lebanon |
| Libya |
| Morocco |
| occupied Palestinian territory < |
| Oman |
| Pakistan |
| Qatar |
| Saudi Arabia |
| Somalia |
| Sudan |
| Syrian Arab Republic |
| Tunisia |
| United Arab Emirates |
| Yemen |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| | 2015 | | | 2015 |
| | | | | 2011 |
| | | | 2008 | 2007 |
| | 2010 | | 2008 | |
| 2007* | 2007 | 2022 | 2008 | 2007 |
| | 2014 | | | 2020 |
| | 2020 | 2020 | | 2020 |
| | | 2012 | | 2016 |
| 2013 | 2011 | | | |
| | 2009 | | | 2009 |
| | 2011 | | | 2011 |
| | 2009 | | 2017 | |
| | | | 2019 | 2016 |
| | | 2018 | 2017 | 2017 |
| | | | | 2021 |
| | | | | |
| | | 2008 | | 2013 |
| | | | | 2013 |

Table A3.6

Western Pacific Region

Year of highest level of achievement in selected tobacco control measures

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* or earlier year.

| Country |
|----------------------------------|
| Australia |
| Brunei Darussalam |
| Cambodia |
| China |
| Cook Islands |
| Fiji |
| Japan |
| Kiribati |
| Lao People's Democratic Republic |
| Malaysia |
| Marshall Islands |
| Micronesia (Federated States of) |
| Mongolia |
| Nauru |
| New Zealand |
| Niue |
| Palau |
| Papua New Guinea |
| Philippines |
| Republic of Korea |
| Samoa |
| Singapore |
| Solomon Islands |
| Tonga |
| Tuvalu |
| Vanuatu |
| Viet Nam |

| Year the highest level of achievement was attained | | | | |
|--|-----------------------------------|--------------------------------|-----------------------------------|--|
| Monitor tobacco use | Protect people from tobacco smoke | Offer help to quit tobacco use | Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship |
| 2007* | 2005 | | 2004 | |
| 2014 | 2012 | | 2007 | |
| 2012 | 2016 | | 2016 | |
| 2019 | | | | |
| 2007* | | 2020 | | |
| | | | 2013 | |
| 2007* | | | | |
| | | | | 2013 |
| 2015 | 2016 | | 2016 | 2021 |
| 2010 | | | 2008 | |
| | 2006 | | | |
| | | | | |
| 2009 | | | 2012 | 2012 |
| | 2009 | | | |
| 2007* | 2003 | 2000 | 2007 | |
| | 2018 | | | 2018 |
| 2010 | | | | |
| | 2012 | | | |
| 2007* | | 2020 | 2014 | |
| 2007* | | 2006 | | |
| | | | 2013 | |
| 2008 | | 1999 | 2012 | |
| | | | 2013 | |
| | | 2020 | | |
| | | | | 2008 |
| | | | 2013 | 2008 |
| 2012 | | | 2013 | |



Annex 4

Highest level of achievement in selected tobacco control measures in the 100 biggest cities in the world

Annex 4 provides information on whether the populations of the world's 100 biggest cities are covered by selected tobacco control measures at the highest level of achievement.

Cities are listed alphabetically. There are many ways to define geographically and measure the size of "a city". For the purposes of this report, we focused on the jurisdictional boundaries of cities, since subnational laws will apply to populations within jurisdictions.

Where a large "city" includes several jurisdictions or parts of jurisdictions, it is possible that not everyone in the entire "city" is covered by the same laws. We therefore use the list of cities and their populations published in the United Nations Statistics Division Demographic Yearbook, since these are defined jurisdictionally. Please refer to https://unstats.un.org/unsd/demographic-social/products/dyb/dyb_2021/ for the source data.

Refer to Technical Note I for definitions of highest level of achievement.

Table A4
Highest level of achievement in selected tobacco control measures in the 100 biggest cities* in the world

* Only cities which appear among the top 100 cities globally, sorted by population size, according to the United Nations Statistics Division Demographic Yearbook 2021 (available at: https://unstats.un.org/unsd/demographic-social/products/dyb/dyb_2021/).

▾ Policy adopted but not implemented by 31 December 2022.

| | |
|----------|--|
| N | City's population is covered by national legislation or policy at the highest level of achievement. |
| S | City's population is covered by state-level legislation or policy at the highest level of achievement. |
| C | City's population is covered by city-level legislation or policy at the highest level of achievement. |

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

| City | Population | Coverage at the highest level of achievement | |
|-----------------------------|------------|--|--------------------------------|
| | | Protect people from tobacco smoke | Offer help to quit tobacco use |
| Abidjan | 5 467 296 | | |
| Adana | 2 258 718 | N | N |
| Addis Ababa | 3 774 000 | N | N |
| Ahmadabad | 5 633 927 | | N |
| Aleppo | 4 450 000 | | |
| Alexandria | 5 163 750 | N | |
| Algiers | 2 712 944 | | |
| Amman | 3 999 008 | N | N |
| Ankara | 5 663 322 | N | N |
| Antalya | 2 548 308 | N | N |
| Baku | 2 285 273 | | |
| Bandung | 2 444 160 | C | |
| Bangkok | 8 392 556 | N | |
| Beijing | 18 796 000 | C | |
| Belo Horizonte | 2 530 701 | N | N |
| Bengaluru | 8 495 492 | | N |
| Berlin | 3 644 826 | | |
| Bogotá | 7 834 167 | N | |
| Brasília | 3 094 325 | N | N |
| Brisbane | 2 560 720 | S | |
| Buenos Aires | 15 567 820 | N | |
| Bursa | 3 101 833 | N | N |
| Busan | 3 343 528 | | N |
| Cairo | 9 539 673 | N | |
| Cali | 2 264 748 | N | |
| Casablanca (Dar-el-Beida) | 3 566 020 | | |
| Chennai | 4 646 732 | | N |
| Chicago | 2 696 555 | | N |
| Chittagong | 2 591 681 | | |
| Daegu | 2 419 246 | | N |
| Damasus Rural (Rif Dimashq) | 2 529 000 | | |
| Dar es Salaam | 5 147 070 | | |
| Delhi | 11 034 555 | | N |
| Dhaka | 8 906 035 | | |
| Douala | 3 322 170 | | |
| Faisalabad | 3 203 846 | N | |
| Fortaleza | 2 703 391 | N | N |
| Guadalajara | 5 268 642 | N | N |
| Guayaquil | 2 652 684 | N | |
| Hanoi | 8 246 540 | | |
| Ho Chi Minh City | 9 227 598 | | |
| Hong Kong SAR | 7 413 100 | C | C |
| Houston | 2 288 250 | | N |
| Hyderabad | 6 993 262 | S | N |
| Incheon | 2 951 030 | | N |
| Istanbul | 15 462 452 | N | N |
| Izmir | 4 394 694 | N | N |
| Jaipur | 3 046 163 | | N |
| Jakarta | 10 562 088 | C | |
| Jiddah | 3 430 697 | | N |
| Kabul | 4 775 074 | N | |
| Kanpur | 2 768 057 | | N |
| Karachi | 14 910 352 | N | |

| Coverage at the highest level of achievement | | | Country |
|--|--|------------------------|-----------------------------|
| Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship | Raise taxes on tobacco | |
| | N | | Côte d'Ivoire |
| N | N | N | Türkiye |
| N | N | | Ethiopia |
| N | | | India |
| | | | Syrian Arab Republic |
| N | | | Egypt |
| | N | | Algeria |
| | N | N | Jordan |
| N | N | N | Türkiye |
| N | N | N | Türkiye |
| | N | | Azerbaijan |
| | | | Indonesia |
| N | | N | Thailand |
| | | | China |
| N | N | N | Brazil |
| N | | | India |
| N | | | Germany |
| | N | | Colombia |
| N | N | N | Brazil |
| N | | N | Australia |
| N | | N | Argentina |
| N | N | N | Türkiye |
| | | | Republic of Korea |
| N | | | Egypt |
| | N | | Colombia |
| | | N | Morocco |
| N | | | India |
| | | | United States |
| N | | | Bangladesh |
| | | | Republic of Korea |
| | | | Syrian Arab Republic |
| | | | United Republic of Tanzania |
| N | | | India |
| N | | | Bangladesh |
| N | | | Cameroon |
| N | | | Pakistan |
| N | N | N | Brazil |
| N | N | | Mexico |
| N | | | Ecuador |
| N | | | Viet Nam |
| N | | | Viet Nam |
| C | | | China, Hong Kong SAR |
| | | | United States |
| N | | | India |
| | | | Republic of Korea |
| N | N | N | Türkiye |
| N | N | N | Türkiye |
| N | | | India |
| | | | Indonesia |
| N | N | | Saudi Arabia |
| | N | | Afghanistan |
| N | | | India |
| N | | | Pakistan |

Table A4 (continued)
Highest level of achievement in selected tobacco control measures in the 100 biggest cities* in the world

* Only cities which appear among the top 100 cities globally, sorted by population size, according to the United Nations Statistics Division Demographic Yearbook 2021 (available at: https://unstats.un.org/unsd/demographic-social/products/dyb/dyb_2021/).

▾ Policy adopted but not implemented by 31 December 2022.

| | |
|----------|--|
| N | City's population is covered by national legislation or policy at the highest level of achievement. |
| S | City's population is covered by state-level legislation or policy at the highest level of achievement. |
| C | City's population is covered by city-level legislation or policy at the highest level of achievement. |

Note: an empty cell indicates that the population is not covered by the measure at the highest level of achievement.

| City | Population | Coverage at the highest level of achievement | |
|-------------------|------------|--|--------------------------------|
| | | Protect people from tobacco smoke | Offer help to quit tobacco use |
| Kolkata | 4 496 694 | | N |
| Kyiv | 2 893 215 | N | |
| Lahore | 11 126 285 | N | |
| Lima | 10 922 735 | N | |
| London | 8 135 667 | S | C |
| Los Angeles | 3 849 297 | S | N |
| Lucknow | 2 817 105 | | N |
| Madrid | 3 320 069 | N | |
| Manaus | 2 255 903 | N | N |
| Mashhad | 3 001 184 | N | N |
| Medan | 2 435 252 | C | |
| Medellín | 2 573 220 | N | |
| Melbourne | 5 159 211 | S | |
| Mexico City | 21 804 515 | N | N |
| Monterrey | 5 341 177 | N | N |
| Moscow | 11 918 057 | N | |
| Mumbai | 12 442 373 | | N |
| Nagoya | 2 332 176 | | |
| Nagpur | 2 405 665 | | N |
| Nairobi | 4 395 749 | | |
| Nakhon Ratchasima | 2 477 991 | N | |
| New York | 8 467 513 | | N |
| Osaka | 2 752 412 | | |
| Ouagadougou | 2 415 266 | N | |
| Puebla-Tlaxcala | 3 199 530 | N | N |
| Pune | 3 124 458 | | N |
| Pyongyang | 2 581 076 | | |
| Quezon City | 2 960 048 | | N |
| Rio De Janeiro | 6 775 561 | N | N |
| Riyadh | 5 188 286 | | N |
| Rome | 2 789 260 | | |
| Saint Petersburg | 4 990 602 | N | |
| Salvador | 2 900 319 | N | N |
| São Paulo | 12 396 372 | N | N |
| Seoul | 9 601 693 | | N |
| Singapore | 5 453 566 | | N |
| Surabaya | 2 874 314 | | |
| Surat | 4 501 610 | | N |
| Sydney | 5 367 206 | S | |
| Tashkent | 2 694 378 | | |
| Tehran | 8 693 706 | N | N |
| Tokyo | 9 733 276 | | |
| Toluca | 2 353 924 | N | N |
| Toronto | 2 974 293 | S | N |
| Yangon | 5 211 431 | | |
| Yaounde | 3 255 651 | | |
| Yokohama | 3 777 491 | | |

| Coverage at the highest level of achievement | | | Country |
|--|--|------------------------|---------------------------------------|
| Warn about the dangers of tobacco | Enforce bans on tobacco advertising, promotion and sponsorship | Raise taxes on tobacco | |
| N | | | India |
| N | N | | Ukraine |
| N | | | Pakistan |
| N | | | Peru |
| N | | N | United Kingdom |
| | | | United States |
| N | | | India |
| N | N | N | Spain |
| N | N | N | Brazil |
| N | N | | Iran (Islamic Republic of) |
| | | | Indonesia |
| | N | | Colombia |
| N | | N | Australia |
| N | N | | Mexico |
| N | N | | Mexico |
| N | N | | Russian Federation |
| N | | | India |
| | | | Japan |
| N | | | India |
| | N | | Kenya |
| N | | N | Thailand |
| | | | United States |
| | | | Japan |
| N | | | Burkina Faso |
| N | N | | Mexico |
| N | | | India |
| | | | Democratic People's Republic of Korea |
| N | | | Philippines |
| N | N | N | Brazil |
| N | N | | Saudi Arabia |
| N | | N | Italy |
| N | N | | Russian Federation |
| N | N | N | Brazil |
| N | N | N | Brazil |
| | | | Republic of Korea |
| N | | | Singapore |
| | | | Indonesia |
| N | | | India |
| N | | N | Australia |
| | | | Uzbekistan |
| N | N | | Iran (Islamic Republic of) |
| | | | Japan |
| N | N | | Mexico |
| N | | | Canada |
| N | | | Myanmar |
| N | | | Cameroon |
| | | | Japan |



Annex 5

Status of the WHO Framework Convention on Tobacco Control and of the Protocol to Eliminate Illicit Trade in Tobacco Products

Annex 5 shows the status of the **WHO Framework Convention on Tobacco Control (WHO FCTC)** and of the **Protocol to Eliminate Illicit Trade in Tobacco Products**.

Ratification is the international act by which countries that have already signed a convention formally state their consent to be bound by it. Accession is the international act by which countries that have not signed a treaty/convention formally state their consent to be bound by it. Acceptance and approval are the legal equivalent to ratification.

Signature of a convention indicates that a country is not legally bound by the treaty but is committed not to undermine its provisions.

The WHO FCTC entered into force on 27 February 2005. The treaty remains open for ratification, acceptance, approval, formal confirmation and accession indefinitely for States and eligible regional economic integration organizations wishing to become Parties to it.

The Protocol to Eliminate Illicit Trade in Tobacco Products entered into force on 25 September 2018. It is subject to ratification, acceptance, approval or accession by States and to formal confirmation or accession by regional economic integration organizations that are Party to the WHO Framework Convention on Tobacco Control.

Table A5

Status of WHO Member States with regard to the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products as at 1 June 2023

- * Ratification is the international act by which countries that have already signed a treaty or convention formally state their consent to be bound by it.
- a Accession is the international act by which countries that have not signed a treaty/ convention formally state their consent to be bound by it.
- A Acceptance is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- AA Approval is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- c Formal confirmation is the international act corresponding to ratification by a State, whereby an international organization (in the case of the WHO FCTC, competent regional economic integration organizations) formally state their consent to be bound by a treaty/convention.
- d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered.

| Country |
|---------------------------------------|
| Afghanistan |
| Albania |
| Algeria |
| Andorra |
| Angola |
| Antigua and Barbuda |
| Argentina |
| Armenia |
| Australia |
| Austria |
| Azerbaijan |
| Bahamas |
| Bahrain |
| Bangladesh |
| Barbados |
| Belarus |
| Belgium |
| Belize |
| Benin |
| Bhutan |
| Bolivia (Plurinational State of) |
| Bosnia and Herzegovina |
| Botswana |
| Brazil |
| Brunei Darussalam |
| Bulgaria |
| Burkina Faso |
| Burundi |
| Cabo Verde |
| Cambodia |
| Cameroon |
| Canada |
| Central African Republic |
| Chad |
| Chile |
| China |
| Colombia |
| Comoros |
| Congo |
| Cook Islands |
| Costa Rica |
| Côte d'Ivoire |
| Croatia |
| Cuba |
| Cyprus |
| Czechia |
| Democratic People's Republic of Korea |
| Democratic Republic of the Congo |
| Denmark |
| Djibouti |
| Dominica |
| Dominican Republic |
| Ecuador |
| Egypt |

| WHO Framework Convention on Tobacco Control | | Protocol to Eliminate Illicit Trade in Tobacco Products | |
|---|--|---|--|
| Date of signature | Date of ratification* (or legal equivalent) | Date of signature | Date of ratification* (or legal equivalent) |
| 29 Jun 2004 | 13 Aug 2010 | | |
| 29 Jun 2004 | 26 Apr 2006 | | |
| 20 Jun 2003 | 30 Jun 2006 | | |
| | 11 May 2020 a | | |
| 29 Jun 2004 | 20 Sept 2007 | | |
| 28 Jun 2004 | 5 Jun 2006 | | |
| 25 Sept 2003 | | | |
| | 29 Nov 2004 a | | |
| 5 Dec 2003 | 27 Oct 2004 | | |
| 28 Aug 2003 | 15 Sept 2005 | 9 Jan 2014 | 28 Oct 2014 |
| | 1 Nov 2005 a | | |
| 29 Jun 2004 | 3 Nov 2009 | | |
| | 20 Mar 2007 a | | |
| 16 Jun 2003 | 14 Jun 2004 | | |
| 28 Jun 2004 | 3 Nov 2005 | | |
| 17 Jun 2004 | 8 Sept 2005 | | |
| 22 Jan 2004 | 1 Nov 2005 | 17 May 2013 | 22 Feb 2019 |
| 26 Sept 2003 | 15 Dec 2005 | | |
| 18 Jun 2004 | 3 Nov 2005 | 24 Sept 2013 | 6 Jul 2018 |
| 9 Dec 2003 | 23 Aug 2004 | | |
| 27 Feb 2004 | 15 Sept 2005 | | |
| | 10 Jul 2009 a | | |
| 16 Jun 2003 | 31 Jan 2005 | 1 Oct 2013 | |
| 16 Jun 2003 | 3 Nov 2005 | | 14 Jun 2018 a |
| 3 Jun 2004 | 3 Jun 2004 | | |
| 22 Dec 2003 | 7 Nov 2005 | | |
| 22 Dec 2003 | 31 Jul 2006 | 8 Mar 2013 | 30 Mar 2016 |
| 16 Jun 2003 | 22 Nov 2005 | | |
| 17 Feb 2004 | 4 Oct 2005 | | 16 Oct 2019 a |
| 25 May 2004 | 15 Nov 2005 | | |
| 13 May 2004 | 3 Feb 2006 | | |
| 15 Jul 2003 | 26 Nov 2004 | | |
| 29 Dec 2003 | 7 Nov 2005 | | |
| 22 Jun 2004 | 30 Jan 2006 | | 13 Jun 2018 a |
| 25 Sept 2003 | 13 Jun 2005 | | |
| 10 Nov 2003 | 11 Oct 2005 | 10 Jan 2013 | |
| | 10 Apr 2008 a | 21 Feb 2013 | |
| 27 Feb 2004 | 24 Jan 2006 | | 14 Oct 2016 a |
| 23 Mar 2004 | 6 Feb 2007 | | 14 May 2015 a |
| 14 May 2004 | 14 May 2004 | | |
| 3 Jul 2003 | 21 Aug 2008 | 21 Mar 2013 | 7 Mar 2017 |
| 24 Jul 2003 | 13 Aug 2010 | 24 Sept 2013 | 25 May 2016 |
| 2 Jun 2004 | 14 Jul 2008 | | 10 Jun 2019 a |
| 29 Jun 2004 | | | |
| 24 May 2004 | 26 Oct 2005 | 23 Oct 2013 | 29 Aug 2017 |
| 16 Jun 2003 | 1 Jun 2012 | | 12 Jul 2019 a |
| 17 Jun 2003 | 27 Apr 2005 | | |
| 28 Jun 2004 | 28 Oct 2005 | 9 Dec 2013 | |
| 16 Jun 2003 | 16 Dec 2004 | 7 Jan 2014 | |
| 13 May 2004 | 31 Jul 2005 | | |
| 29 Jun 2004 | 24 Jul 2006 | | |
| | | | |
| 22 Mar 2004 | 25 Jul 2006 | 25 Sept 2013 | 15 Oct 2015 |
| 17 Jun 2003 | 25 Feb 2005 | | 10 Sept 2020 a |

Table A5 (continued)
Status of WHO Member States with regard to the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products as at 1 June 2023

- * Ratification is the international act by which countries that have already signed a treaty or convention formally state their consent to be bound by it.
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- A Acceptance is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- AA Approval is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- c Formal confirmation is the international act corresponding to ratification by a State, whereby an international organization (in the case of the WHO FCTC, competent regional economic integration organizations) formally state their consent to be bound by a treaty/convention.
- d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered.

| Country |
|----------------------------------|
| El Salvador |
| Equatorial Guinea |
| Eritrea |
| Estonia |
| Eswatini |
| Ethiopia |
| Fiji |
| Finland |
| France |
| Gabon |
| Gambia |
| Georgia |
| Germany |
| Ghana |
| Greece |
| Grenada |
| Guatemala |
| Guinea |
| Guinea-Bissau |
| Guyana |
| Haiti |
| Honduras |
| Hungary |
| Iceland |
| India |
| Indonesia |
| Iran (Islamic Republic of) |
| Iraq |
| Ireland |
| Israel |
| Italy |
| Jamaica |
| Japan |
| Jordan |
| Kazakhstan |
| Kenya |
| Kiribati |
| Kuwait |
| Kyrgyzstan |
| Lao People's Democratic Republic |
| Latvia |
| Lebanon |
| Lesotho |
| Liberia |
| Libya |
| Lithuania |
| Luxembourg |
| Madagascar |
| Malawi |
| Malaysia |
| Maldives |
| Mali |
| Malta |
| Marshall Islands |

| WHO Framework Convention on Tobacco Control | | Protocol to Eliminate Illicit Trade in Tobacco Products | |
|---|--|---|--|
| Date of signature | Date of ratification* (or legal equivalent) | Date of signature | Date of ratification* (or legal equivalent) |
| 18 Mar 2004 | 21 Jul 2014 | | |
| | 17 Sept 2005 a | | |
| 8 Jun 2004 | 27 Jul 2005 | | |
| 29 Jun 2004 | 13 Jan 2006 | | 21 Sept 2016 a |
| 25 Feb 2004 | 25 Mar 2014 | | |
| 3 Oct 2003 | 3 Oct 2003 | 11 Jul 2013 | 24 Apr 2019 |
| 16 Jun 2003 | 24 Jan 2005 | 25 Sept 2013 | |
| 16 Jun 2003 | 19 Oct 2004 AA | 10 Jan 2013 | 30 Nov 2015 |
| 22 Aug 2003 | 20 Feb 2009 | 10 Jan 2013 | 1 Oct 2014 A |
| 16 Jun 2003 | 18 Sept 2007 | | 26 Sept 2016 a |
| 20 Feb 2004 | 14 Feb 2006 | | |
| 24 Oct 2003 | 16 Dec 2004 | 1 Oct 2013 | 31 Oct 2017 |
| 20 Jun 2003 | 29 Nov 2004 | 24 Sept 2013 | 22 Oct 2021 |
| 16 Jun 2003 | 27 Jan 2006 | 9 Jul 2013 | 24 May 2021 |
| 29 Jun 2004 | 14 Aug 2007 | | |
| 25 Sept 2003 | 16 Nov 2005 | | |
| 1 Apr 2004 | 7 Nov 2007 | | 9 May 2017 a |
| | 7 Nov 2008 a | 24 Sept 2013 | |
| | 15 Sept 2005 a | | |
| 23 Jul 2003 | | | |
| 18 Jun 2004 | 16 Feb 2005 | | |
| 16 Jun 2003 | 7 Apr 2004 | | 23 Jun 2020 a |
| 16 Jun 2003 | 14 Jun 2004 | | |
| 10 Sept 2003 | 5 Feb 2004 | | 5 Jun 2018 a |
| | | | |
| 16 Jun 2003 | 6 Nov 2005 | 7 Jan 2014 | 27 Aug 2018 |
| 29 Jun 2004 | 17 Mar 2008 | | 2 Dec 2015 a |
| 16 Sept 2003 | 7 Nov 2005 | 20 Dec 2013 | |
| 20 Jun 2003 | 24 Aug 2005 | 23 Dec 2013 | |
| 16 Jun 2003 | 2 Jul 2008 | | |
| 24 Sept 2003 | 7 Jul 2005 | | |
| 9 Mar 2004 | 8 Jun 2004 A | | |
| 28 May 2004 | 19 Aug 2004 | | |
| 21 Jun 2004 | 22 Jan 2007 | | |
| 25 Jun 2004 | 25 Jun 2004 | 29 May 2013 | 4 May 2020 |
| 27 Apr 2004 | 15 Sept 2005 | | |
| 16 Jun 2003 | 12 May 2006 | 11 Nov 2013 | 21 Feb 2019 |
| 18 Feb 2004 | 25 May 2006 | | |
| 29 Jun 2004 | 6 Sept 2006 | | |
| 10 May 2004 | 10 Feb 2005 | | 4 Feb 2016 a |
| 4 Mar 2004 | 7 Dec 2005 | | |
| 23 Jun 2004 | 14 Jan 2005 | | |
| 25 Jun 2004 | 15 Sept 2009 | | |
| 18 Jun 2004 | 7 Jun 2005 | 10 Jan 2013 | |
| 22 Sept 2003 | 16 Dec 2004 | 6 Sept 2013 | 14 Dec 2016 |
| 16 Jun 2003 | 30 Jun 2005 | | 25 Jul 2019 a |
| 24 Sept 2003 | 22 Sept 2004 | 25 Sept 2013 | 21 Sept 2017 |
| | | | |
| 23 Sept 2003 | 16 Sept 2005 | | |
| 17 May 2004 | 20 May 2004 | | |
| 23 Sept 2003 | 19 Oct 2005 | 8 Jan 2014 | 17 Jun 2016 |
| 16 Jun 2003 | 24 Sept 2003 | | 2 Aug 2018 a |
| 16 Jun 2003 | 8 Dec 2004 | | |

Table A5 (continued)
Status of WHO Member States with regard to the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products as at 1 June 2023

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- d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered.

| Country |
|----------------------------------|
| Mauritania |
| Mauritius |
| Mexico |
| Micronesia (Federated States of) |
| Monaco |
| Mongolia |
| Montenegro |
| Morocco |
| Mozambique |
| Myanmar |
| Namibia |
| Nauru |
| Nepal |
| Netherlands (Kingdom of the) |
| New Zealand |
| Nicaragua |
| Niger |
| Nigeria |
| Niue |
| North Macedonia |
| Norway |
| Oman |
| Pakistan |
| Palau |
| Panama |
| Papua New Guinea |
| Paraguay |
| Peru |
| Philippines |
| Poland |
| Portugal |
| Qatar |
| Republic of Korea |
| Republic of Moldova |
| Romania |
| Russian Federation |
| Rwanda |
| Saint Kitts and Nevis |
| Saint Lucia |
| Saint Vincent and the Grenadines |
| Samoa |
| San Marino |
| Sao Tome and Principe |
| Saudi Arabia |
| Senegal |
| Serbia |
| Seychelles |
| Sierra Leone |
| Singapore |
| Slovakia |
| Slovenia |
| Solomon Islands |
| Somalia |
| South Africa |

| WHO Framework Convention on Tobacco Control | | Protocol to Eliminate Illicit Trade in Tobacco Products | |
|---|--|---|--|
| Date of signature | Date of ratification* (or legal equivalent) | Date of signature | Date of ratification* (or legal equivalent) |
| 24 Jun 2004 | 28 Oct 2005 | | |
| 17 Jun 2003 | 17 May 2004 | | 26 Jun 2018 a |
| 12 Aug 2003 | 28 May 2004 | | |
| 28 Jun 2004 | 18 Mar 2005 | | |
| | | | |
| 16 Jun 2003 | 27 Jan 2004 | 1 Nov 2013 | 8 Oct 2014 |
| | 23 Oct 2006 d | 1 Jul 2013 | 11 Oct 2017 |
| 16 Apr 2004 | | | |
| 18 Jun 2003 | 14 Jul 2017 | | |
| 23 Oct 2003 | 21 Apr 2004 | 10 Jan 2013 | |
| 29 Jan 2004 | 7 Nov 2005 | | |
| | 29 Jun 2004 a | | |
| 3 Dec 2003 | 7 Nov 2006 | | |
| 16 Jun 2003 | 27 Jan 2005 A | 6 Jan 2014 | 3 Jul 2020 A |
| 16 Jun 2003 | 27 Jan 2004 | | |
| 7 Jun 2004 | 9 Apr 2008 | 10 Jan 2013 | 20 Dec 2013 |
| 28 Jun 2004 | 25 Aug 2005 | | 12 Jul 2017 a |
| 28 Jun 2004 | 20 Oct 2005 | | 8 Mar 2019 a |
| 18 Jun 2004 | 3 Jun 2005 | | |
| | 30 Jun 2006 a | 8 Jan 2014 | |
| 16 Jun 2003 | 16 Jun 2003 AA | 16 Oct 2013 | 29 Jun 2018 |
| | 9 Mar 2005 a | | |
| 18 May 2004 | 3 Nov 2004 | | 29 Jun 2018 a |
| 16 Jun 2003 | 12 Feb 2004 | | |
| 26 Sept 2003 | 16 Aug 2004 | 10 Jan 2013 | 23 Sept 2016 |
| 22 Jun 2004 | 25 May 2006 | | |
| 16 Jun 2003 | 26 Sept 2006 | | 27 Sept 2022 a |
| 21 Apr 2004 | 30 Nov 2004 | | |
| 23 Sept 2003 | 6 Jun 2005 | | |
| 14 Jun 2004 | 15 Sept 2006 | | |
| 9 Jan 2004 | 8 Nov 2005 AA | 8 Jan 2014 | 22 Jul 2015 |
| 17 Jun 2003 | 23 Jul 2004 | 18 Jun 2013 | 2 Jul 2018 |
| 21 Jul 2003 | 16 May 2005 | 10 Jan 2013 | |
| 29 Jun 2004 | 3 Feb 2009 | | 10 May 2022 a |
| 25 Jun 2004 | 27 Jan 2006 | | |
| | 3 Jun 2008 a | | |
| 2 Jun 2004 | 19 Oct 2005 | | 19 May 2023 a |
| 29 Jun 2004 | 21 Jun 2011 | | |
| 29 Jun 2004 | 7 Nov 2005 | | |
| 14 Jun 2004 | 29 Oct 2010 | | |
| 25 Sept 2003 | 3 Nov 2005 | | 29 Jun 2018 a |
| 26 Sept 2003 | 7 Jul 2004 | | |
| 18 Jun 2004 | 12 Apr 2006 | | |
| 24 Jun 2004 | 9 May 2005 | | 9 Oct 2015 a |
| 19 Jun 2003 | 27 Jan 2005 | | 31 Aug 2016 a |
| 28 Jun 2004 | 8 Feb 2006 | | 30 Jun 2017 a |
| 11 Sept 2003 | 12 Nov 2003 | | 7 Jan 2020 a |
| | 22 May 2009 a | | |
| 29 Dec 2003 | 14 May 2004 | | |
| 19 Dec 2003 | 4 May 2004 | | 25 Sept 2017 a |
| 25 Sept 2003 | 15 Mar 2005 | 6 Jan 2014 | |
| 18 Jun 2004 | 10 Aug 2004 | | |
| | | | |
| 16 Jun 2003 | 19 Apr 2005 | 10 Jan 2013 | |

Table A5 (continued)
Status of WHO Member States with regard to the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products as at 1 June 2023

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- d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered.


| Country |
|------------------------------------|
| South Sudan |
| Spain |
| Sri Lanka |
| Sudan |
| Suriname |
| Sweden |
| Switzerland |
| Syrian Arab Republic |
| Tajikistan |
| Thailand |
| Timor-Leste |
| Togo |
| Tonga |
| Trinidad and Tobago |
| Tunisia |
| Türkiye |
| Turkmenistan |
| Tuvalu |
| Uganda |
| Ukraine |
| United Arab Emirates |
| United Kingdom |
| United Republic of Tanzania |
| United States |
| Uruguay |
| Uzbekistan |
| Vanuatu |
| Venezuela (Bolivarian Republic of) |
| Viet Nam |
| Yemen |
| Zambia |
| Zimbabwe |

| WHO Framework Convention on Tobacco Control | | Protocol to Eliminate Illicit Trade in Tobacco Products | |
|---|--|---|--|
| Date of signature | Date of ratification* (or legal equivalent) | Date of signature | Date of ratification* (or legal equivalent) |
| 16 Jun 2003 | 11 Jan 2005 | | 23 Dec 2014 a |
| 23 Sept 2003 | 11 Nov 2003 | | 8 Feb 2016 a |
| 10 Jun 2004 | 31 Oct 2005 | 30 Sept 2013 | |
| 24 Jun 2004 | 16 Dec 2008 | | |
| 16 Jun 2003 | 7 Jul 2005 | 6 Jan 2014 | 9 Jul 2019 |
| 25 Jun 2004 | | | |
| 11 Jul 2003 | 22 Nov 2004 | 10 Jan 2013 | |
| | 21 Jun 2013 a | | |
| 20 Jun 2003 | 8 Nov 2004 | | |
| 25 May 2004 | 22 Dec 2004 | | |
| 12 May 2004 | 15 Nov 2005 | 9 Jan 2014 | 31 Jan 2018 |
| 25 Sept 2003 | 8 Apr 2005 | | |
| 27 Aug 2003 | 19 Aug 2004 | | |
| 22 Aug 2003 | 7 Jun 2010 | 11 Jan 2013 | |
| 28 Apr 2004 | 31 Dec 2004 | 10 Jan 2013 | 26 Apr 2018 |
| | 13 May 2011 a | | 30 Mar 2015 a |
| 10 Jun 2004 | 26 Sept 2005 | | |
| 5 Mar 2004 | 20 Jun 2007 | | |
| 25 Jun 2004 | 6 Jun 2006 | | |
| 24 Jun 2004 | 7 Nov 2005 | | |
| 16 Jun 2003 | 16 Dec 2004 | 17 Dec 2013 | 27 Jun 2018 |
| 27 Jan 2004 | 30 Apr 2007 | 24 Sept 2013 | |
| 10 May 2004 | | | |
| 19 Jun 2003 | 9 Sept 2004 | 10 Jan 2013 | 24 Sept 2014 |
| | 15 May 2012 a | | |
| 22 Apr 2004 | 16 Sept 2005 | | |
| 22 Sept 2003 | 27 Jun 2006 | | |
| 3 Sept 2003 | 17 Dec 2004 | | |
| 20 Jun 2003 | 22 Feb 2007 | 7 Jan 2014 | |
| | 23 May 2008 a | | |
| | 4 Dec 2014 a | | |

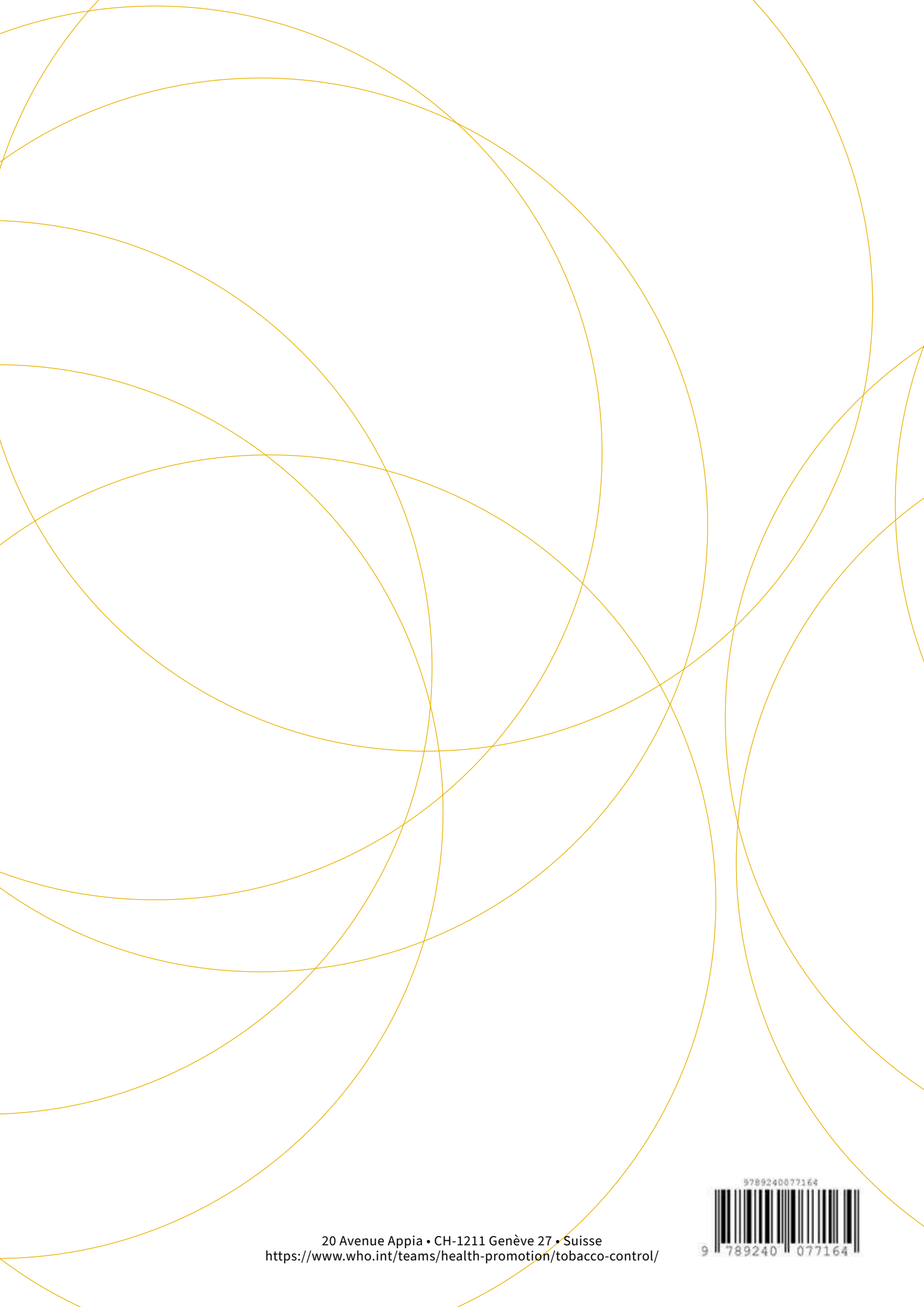
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| 80 | © WHO/Martha Tadesse |
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| 92 | © WHO/Olivier Asselin |
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<https://www.who.int/teams/health-promotion/tobacco-control/>

