World Health Organization
REGIONAL OFFICE FOR Europe

European Tobacco Control Status Report 2013

European tobacco control status report 2013

ABSTRACT

The greatest burden of disease in the WHO European Region is attributable to noncommunicable diseases. As one of the top modifiable behavioural risk factors, tobacco use is the most preventable cause of death and diseases that can be successfully tackled by comprehensive and evidence-based tobacco control policies. In the Region, 16% of all deaths are attributable to tobacco, the highest rate globally. This report, 10 years after the adoption of the WHO Framework Convention on Tobacco Control, looks back and takes stock of the situation in the Region in order to effectively target action towards a decrease in tobacco use and to further stimulate the discussion on the vision for achieving a tobacco-free Europe.

Keywords

HEALTH CAMPAIGNS
SMOKING
SMOKING AND HEALTH
TOBACCO
TOBACCO DEPENDENCE
TOBACCO INDUSTRY

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (http://www.euro.who.int/pubrequest).

© World Health Organization 2013
All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

Contents

Acknowledgements

Gauden Galea and Kristina Mauer-Stender conceptualized this publication. Yulnara Kadirova, Rula Khoury and Kristina Mauer-Stender further realized the publication and are grateful to all those who contributed.

Special thanks are due to David Ham and Joelle Khoury Auert who worked closely together on the first section of the report to take an in-depth look at the data that had been collected, analysed and validated by the countries for a series of the WHO reports on the global tobacco epidemic between 2007 and 2012, and provided their analysis of the regional status of tobacco control, also in relation to other WHO regions.

The Regional Office is also grateful to Vera Luiza da Costa e Silva who pushed the vision to explore the concept of a tobacco-free Europe and consider possible future scenarios of the status of tobacco.

Foreword

It is hard to imagine but not long ago, the use of tobacco was considered safe, smoking was permitted on airplanes and doctors and nurses were even promoting tobacco products. If we showed people living at that time the future of tobacco as it is now, and how far we have succeeded in tobacco control, it may have been hard for them to consider this "future" as feasible. So why not create our own "visionary future" that also goes beyond our current expectations? Why not consider a world where all public places are smoke free, a world where all tobacco products have large graphic warnings or even standardized packaging, a world where there is absolutely no advertising of tobacco products?

We have a powerful tool, the WHO Framework Convention on Tobacco Control (WHO FCTC), and we know it works, but we have to use it to its full potential. Ten years after the treaty was adopted, we see the number of people being protected by tobacco control measures growing at an increased pace. But to achieve the global voluntary noncommunicable target for a 30% relative reduction of tobacco use by 2025, do we need to accelerate our pace? This report shows that great progress has been made, but we have a long way to go to full implementation of the WHO FCTC. Only a few countries in the Region have taken a comprehensive approach to implementing the WHO FCTC. Preliminary projections into 2025 reveal that stronger action is needed to meet the global target.

We need to comprehend the magnitude of the number of people that still die from tobacco, but also see their faces behind this number. We need to feel the urgency of the lives affected by tobacco and particularly in these times of limited resources, the urgency behind the economic burden of tobacco on governments and on those addicted. We need to scale up our efforts.

Why not consider a tobacco-free region as our "visionary future"? In the WHO European Region, some countries are already paving the way, regionally and globally, to consider this vision in their tobacco control strategies. For these and for all others, full implementation of the WHO FCTC is the first step in the direction to a tobacco-free region.

We need to expect aggressive resistance from the tobacco industry every step of the way. We need to approach tobacco control in a well-orchestrated manner. Coordination among different sectors in a country is essential and in our globalized world, coordination between countries is paramount. This is an integral principle behind the regional health policy framework Health2020, and the WHO FCTC calls for such an approach. The WHO FCTC is based on evidence, and its impact is an inspiration that allows us to dream big to accomplish what is necessary. Tobacco control is Health2020 in action.

Zsuzsanna Jakab
WHO Regional Director for Europe

Introduction

Tobacco kills nearly 6 million people each year worldwide, more than HIV/AIDS, tuberculosis and malaria combined.

Unless strong action is taken, this number could rise to more than 8 million by 2030 *(1)*.

Tobacco use or exposure to tobacco smoke negatively impacts health across the life course.

During fetal development, tobacco can increase rates of stillbirth and selected congenital malformations. In infancy, it can cause sudden infant death syndrome. In childhood and adolescence, tobacco can cause disability from respiratory diseases. In relatively young middle-aged adults, it can cause increased rates of cardiovascular disease and, later in life, higher rates of cancer (especially lung cancer), as well as death associated with diseases of the respiratory system *(2)*.

The fight against tobacco is a key action to help decrease noncommunicable diseases (NCDs).

Tobacco control measures greatly reduce NCDs – mainly cancers, cardiovascular diseases, diabetes and chronic respiratory diseases – that accounted for 63% of all deaths worldwide or 36 million people in 2008*(3)*.

NCDs are the leading cause of death, disease and disability and account for nearly 86% of deaths and 77% of the disease burden in the WHO European Region *(4)*.

Tobacco is the most preventable cause of death and diseases and can be successfully fought by means of a comprehensive set of tobacco control measures.

Effectiveness of tobacco control measures need to be ensured through targeted implementation and intersectoral actions.

The WHO Framework Convention on Tobacco Control (WHO FCTC) *(5)*, the cornerstone for tobacco control, was adopted unanimously by the World Health Assembly in 2003 and today counts 177 Parties. As of October 2013, 50 of the 53 Member States in the Region, as well as the European Union (EU), have become Parties to the Convention *(6)*.

© WHO

The WHO FCTC entered into force on 27 February 2005. The treaty outlines legally binding actions regarding price and tax measures (Article 6); non-price measures including protection from smoke exposure (Article 8); packaging and labelling measures (Article 11); education, communication, training and public awareness (Article 12); tobacco advertising, promotion and sponsorship bans (Article 13); and demand reduction measures concerning tobacco dependence and cessation (Article 14) *(5)*.

The fight against tobacco is also positively impacted by European directives, binding 28 of the 53 Member States in the Region *(7)*.

In the EU, some of the major directives related to tobacco are:

- Council Directive 2011/64/EU on the structure and rates of excise duty applied to manufactured tobacco (codification) *(8);*
- Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products *(9)*. A revision of the Directive has been undertaken to adapt to recent market, scientific and international changes *(10–12)*; and

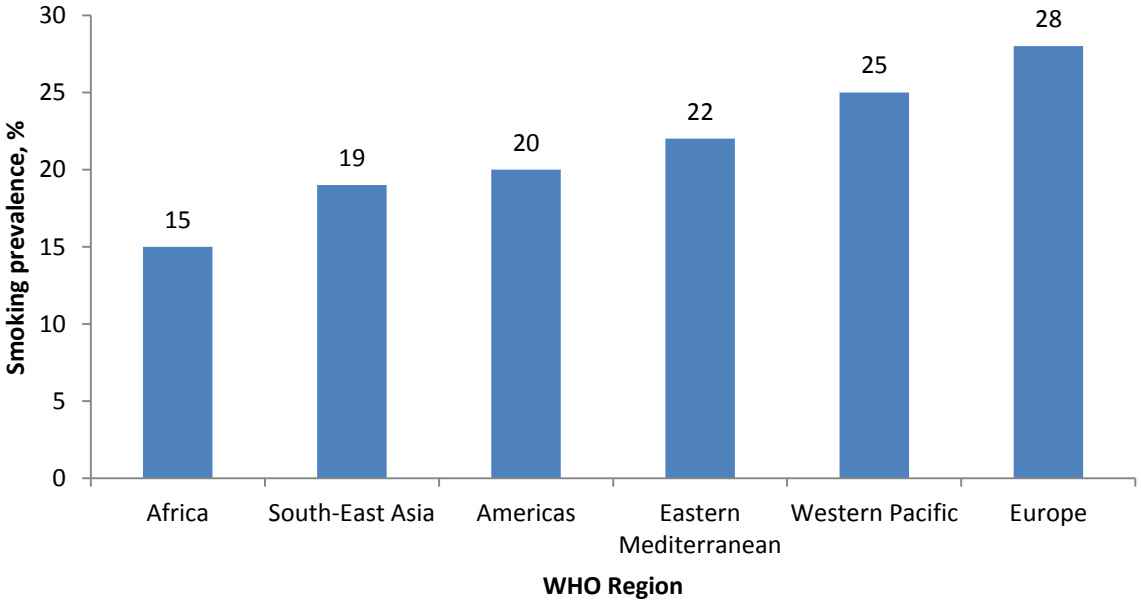
- Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products *(13).*

Despite tobacco control policies that are applicable globally (WHO FCTC), regionally (EU directives) and nationally, the tobacco epidemic persists.

© WHO

The European Region has the highest prevalence of tobacco smoking among the WHO regions at 28% (Fig. 1)

Fig. 1. Smoking prevalence in the WHO regions



Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

Tobacco use has a dramatic impact on mortality in Europe. The European and Americas regions have the highest mortality attributed to tobacco at 16% (Table 1).

Table 1. Proportion of all deaths attributed to tobacco in the WHO regions

WHO region	Deaths attributed to tobacco (%)
Europe	16
Americas	16
Western Pacific	13
South-East Asia	10
Eastern Mediterranean	7
Africa	3

Source: WHO global report: mortality attributable to tobacco *(15).*

Tobacco kills about 1.6 million people in the Region; more than 25% of global deaths are attributed to tobacco. Yet the Region accounts for only 14% of the world population *(16)*.

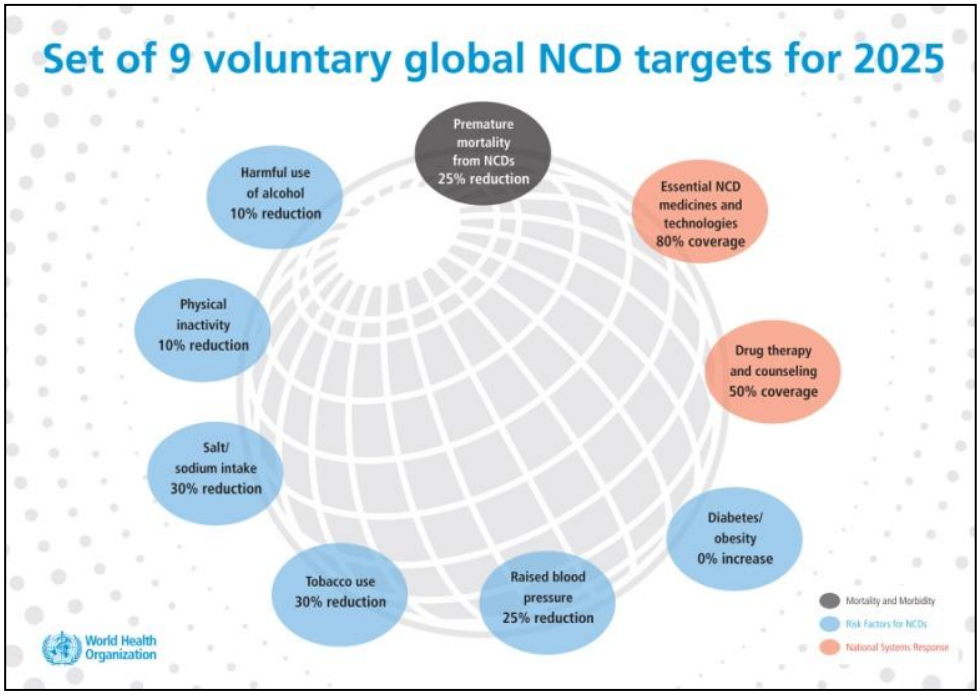
Insufficient implementation of tobacco control measures creates gaps and loopholes for the tobacco industry to exploit.

Fighting tobacco effectively calls for more political intersectoral support and courage; it takes strong leaders to issue strong policies.

Clear and specific targets have been defined to support and scale up efforts in fighting tobacco and NCDs.

The Sixty-sixth World Health Assembly adopted resolution WHA 66.10 in May 2013 on the global action plan for the prevention and control of NCDs 2013–2020, which included a 30% reduction in tobacco use by 2025 as one of its 9 voluntary global NCD targets (Fig. 2).

Fig. 2. NCD Global Monitoring Framework: set of 9 voluntary global NCD targets for 2025



Source: NCD Global Monitoring Framework *(17)*.

On a regional level, the Region has developed a health policy framework, Health 2020, laying down a strategic path and a set of priorities on the means to improve health *(18)*. One of the four priorities is to tackle Europe's major disease burden from NCDs, including tobacco.

Ten years after the adoption of the WHO FCTC, it is time to look back and take stock of the situation in the Region in order to effectively target action to decrease tobacco use and to further stimulate the increasing interest on endgame strategies.

Identifying existing gaps in tobacco control measures are crucial to target actions needed to decrease and stop the tobacco epidemic.

The first part of this report analyses the status of various WHO FCTC measures, including a review of the progress made and existing gaps in the Region and in relation to other WHO regions.

The analysis is based on data that have been collected and validated by the countries for the series of WHO reports on the global tobacco epidemic between 2007 and 2012 *(19–22)*.

The second part of this report explores the concept of the endgame and explores three future scenarios: tobacco as a legal product, as a drug and as a commodity.

Some countries in the Region are paving the way, regionally and globally, for others to consider the endgame in their tobacco control strategies, publicly announcing a target year to end tobacco use in their populations. Nevertheless, before considering future approaches, many countries in the Region still need to fully implement comprehensive tobacco control measures as the first step in the direction of a tobacco endgame. The immediate implementation of the WHO FCTC will already provide a better world for future generations.

Part I – WHO FCTC implementation status

The first part of this report provides an analysis for the European Region of the implementation status of some core demand reduction provisions in the WHO FCTC, including price and tax measures (Article 6); protection from exposure to tobacco smoke (Article 8); packaging and labelling of tobacco products (Article 11); education, communication, training and public awareness (Article 12); tobacco advertising, promotion and sponsorship (TAPS) (Article 13); and demand reduction measures concerning tobacco dependence and cessation (Article 14).

Progress and gaps in the implementation of the WHO FCTC measures are identified and reviewed from:
- a global perspective, providing a comparison of the European Region with other WHO regions;
- a regional perspective, highlighting main trends, strengths and policy gaps; and
- a subregional perspective, providing an intraregional comparison of the policy status among high income countries (HICs) and low- and middle-income countries (LMICs).[1]
- Unless otherwise specified, the data presented represent the period 2007–2012.

[1] High-income countries are: Andorra, Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Poland, Portugal, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

Middle-income countries are: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Latvia, Lithuania, Montenegro, Republic of Moldova, Romania, the Russian Federation, Serbia, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

Low-income countries are Kyrgyzstan and Tajikistan.

Since only two European countries fall into the category of low-income countries, the categories of LMICs were merged and compared with the category of HICs for the subregional analysis.

Article 6: Europe leading the way globally

Box 1. Key facts

- The WHO European region is doing better than all other WHO Regions regarding tax measures
- The proportion of WHO European countries where tax represents more than 75% of the retail price of the most popular brand of cigarettes has increased by 29% between 2008 and 2012
- In 47% of the WHO European countries more than 75% of the retail price of the most popular brand of cigarettes is tax.
- The WHO European region records a great disparity in cigarette retail prices

A summary of how European countries are implementing Article 6 of the WHO FCTC is in Box 1.

Price and tax measures are an important means of reducing tobacco consumption, especially among young people.

The WHO FCTC therefore encourages each Party to adopt, as part of its national health objectives for tobacco control, appropriate tax and price policies on tobacco products (Article 6).

In the Region, major achievements have been realized regarding tax measures.

Raising taxes on tobacco products is one of the most effective ways to decrease tobacco use *(23, 24)*.

The number of European countries where taxes represent more than 75% of the retail price of the most popular brand of cigarettes[2] has increased from 15 in 2008 to 25 in 2012.This corresponds to an increase from 28% to 47% of European countries.

EU legislation has contributed significantly to the success of tax measures.

The latest piece of legislation, Council Directive 2011/64/EU of 21 June 2011 on the structure and rates of excise duty applied to manufactured tobacco (codification), binds EU countries to:

- a minimum excise duty of 57% of the retail selling price of cigarettes
- a minimum excise duty of €64 per 1000 cigarettes regardless of the retail selling price *(8).*

HICs record excellent results within the Region.

In 2012, 61% of HICs had taxes representing more than 75% of the retail price, compared to 27% of LMICs for a regional average of 47%. Although they are still trailing behind, LMICs have nevertheless improved significantly; in four years, the figure rose from 5% in 2008 to 27% in 2012.

The Region has not only made important progress over the years but is also doing better than all other WHO regions.

In 2012, 47% of countries in the Region (25 countries) had tax shares representing more than 75% of the retail price of the most popular brand of cigarettes (Table 2).

[2]The series of WHO reports on the global tobacco epidemic provide four categories to group countries depending on their tax share; the category "more than 75% of the retail price is tax" is for countries providing the highest tax shares *(19–22)*.

Table 2. Countries with tax shares representing more than 75% of the retail price of the most popular brand of cigarettes in the WHO regions, 2012

WHO region[a]	Countries	
	No.	%
Europe	25	47
Eastern Mediterranean	3	13
Americas	2	6
Western Pacific	1	4
Africa	1	2
South-East Asia	0	0

[a]Following resolution WHA66.21 adopted during the Sixty-sixth World Health Assembly in 2013, South Sudan was reassigned from the Eastern Mediterranean Region to the African Region. Data and calculations used for this report cover the period 2007–2012 when South Sudan was in the Eastern Mediterranean Region.

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

However, a great disparity between cigarette retail prices (CRPs) persists in Europe.

Data collected for 2012 show that the retail price for the most sold cigarettes brand (pack of 20) ranges from Int$ 1.02 (Kazakhstan) to Int$ 10.56 (Ireland).

The great disparity in CRPs within the Region, shown in Table 3, raises the issue of cross-border purchasing and/or illicit trade.

Table 3. CRP of the most sold brand in the European Region, 2012

CRP (Int $)	Countries[a]	
	No.	%
< 3	13	25
3–5	15	28
5–8	19	36
< 8	3	6

[a]Data not available for Andorra, Monaco and San Marino.
Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

This is particularly true where great disparities in CRPs exist in neighbouring countries as it does, for example, in:

- Romania (Int$ 6.11) and Ukraine (Int$ 1.75) or the Republic of Moldova (Int$ 1.80)
- Turkmenistan (Int$ 4.96) and Uzbekistan (Int$ 1.80)
- Bulgaria (Int$ 6.13) and The former Yugoslav Republic of Macedonia (Int$ 2.57)
- Turkey (Int$ 4.89) and Georgia (Int$ 1.37).

The great disparity in CRPs does not necessarily result from different tax shares.

It is important to note that there is no systematic link between high tax share and high CRP. The final tax share (including all applicable taxes) can be similar in several countries having very different CRPs.

For example, in some countries where about 80% of the retail price is tax, the final retail price differs considerably: Int$ 2.18 for Montenegro, Int$ 4.56 for Slovenia, Int$ 4.89 for Turkey, Int$ 4.98 for Finland, Int$ 6.78 for France and Int$ 9.79 for the United Kingdom.

Combining all types of tax undermines the tobacco industry strategies.

Different types of tax may be used to tax tobacco products, including excise duty taxes and import duties (both applicable to selected goods, e.g. tobacco products), as well as value-added-taxes and sales taxes (both applicable to all goods).

Ad valorem excise taxes can significantly impact the retail price; the higher the rate, the greater the price increase.

However, ad valorem excise taxes can be undermined by the tobacco industry by setting low retail prices, which can mitigate the impact of a high tax rate.

On the contrary, amount-specific excise taxes are not calculated in reference to retail price but apply per stick, per pack, per 1000 sticks, or per kilogram (e.g. Int$ 1.75 per pack of 20 cigarettes);

thus the tobacco industry cannot influence excise taxes by lowering retail prices.

In this context, it is important to note that different types of taxes need to be combined to contribute effectively to an increase of the retail price thus leading to a decrease in tobacco consumption.

While price and tax measures are a cost-effective way to reduce tobacco consumption, they should be complemented by non-price measures, including protection from exposure to tobacco smoke; packaging and labelling of tobacco products; education, communication, training and public awareness; and TAPS.

Only an integrated approach can be fully effective.

Article 8: Europe trailing behind

A summary of how European countries are implementing Article 8 of the WHO FCTC is in Box 2.

Box 2. Key facts

- Only nine European countries ban smoking in all public places and compliance varies.
- The European Region lags behind most WHO regions regarding protection from smoke exposure.
- Protection from smoke exposure remains insufficient, particularly in government facilities, public transport, restaurants, pubs and bars, and indoor offices.
- The European Region is doing well, with 62% of countries legislating fines both on the establishment and the smoker.

"…scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability" (Article 8.1 WHO FCTC) *(5)*.

To protect people against the devastating effect of tobacco smoke on health, the WHO FCTC requires each Party to adopt and implement measures providing protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

Guidelines for implementation of Article 8 were developed to assist Parties in meeting their obligations and to identify the key elements of legislation necessary to effectively protect people from exposure to tobacco smoke *(25)*.

The guidelines strongly recommend the adoption of comprehensive smoke-free legislation within five years after entry into force of the WHO FCTC.

Some progress was made in implementing comprehensive smoking bans.

The number of European countries banning smoking in all public places has increased from 4 countries in 2007 to 9 (17% of European) countries in 2012, although compliance varies.[3]

Despite progress, the Region still provides less protection from smoke exposure than most WHO regions.

With just nine of its countries implementing smoking bans in all public places, the European Region ranks second to last among WHO regions, performing better than only the African Region (Table 4).

Table 4. Countries implementing smoking bans in all public places in the WHO regions, 2012

WHO region	Countries	
	No.	%
Americas	14	40
South-East Asia	3	27
Western Pacific	7	26
Eastern Mediterranean	5	22
Europe	9	17
Africa	5	11

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

Progress reducing smoke exposure over the last years has been uneven; not all public places were equally regulated.

Between 2007 and 2012, legislative improvements regarding the scope of smoking

[3] Albania, Ireland, Turkmenistan and the United Kingdom were classified as smoke-free countries in 2007. Turkey became smoke-free in 2008; Greece, Malta and Spain in 2010; and Bulgaria in 2012. *(19–22)*.

bans were made, but did not apply to the same extent to all categories of public places.

Improvements were particularly significant for schools, universities, government facilities, public transport, restaurants, pubs and bars. The proportion of European countries banning smoking in each of these places was about 20% higher in 2012 than in 2007.

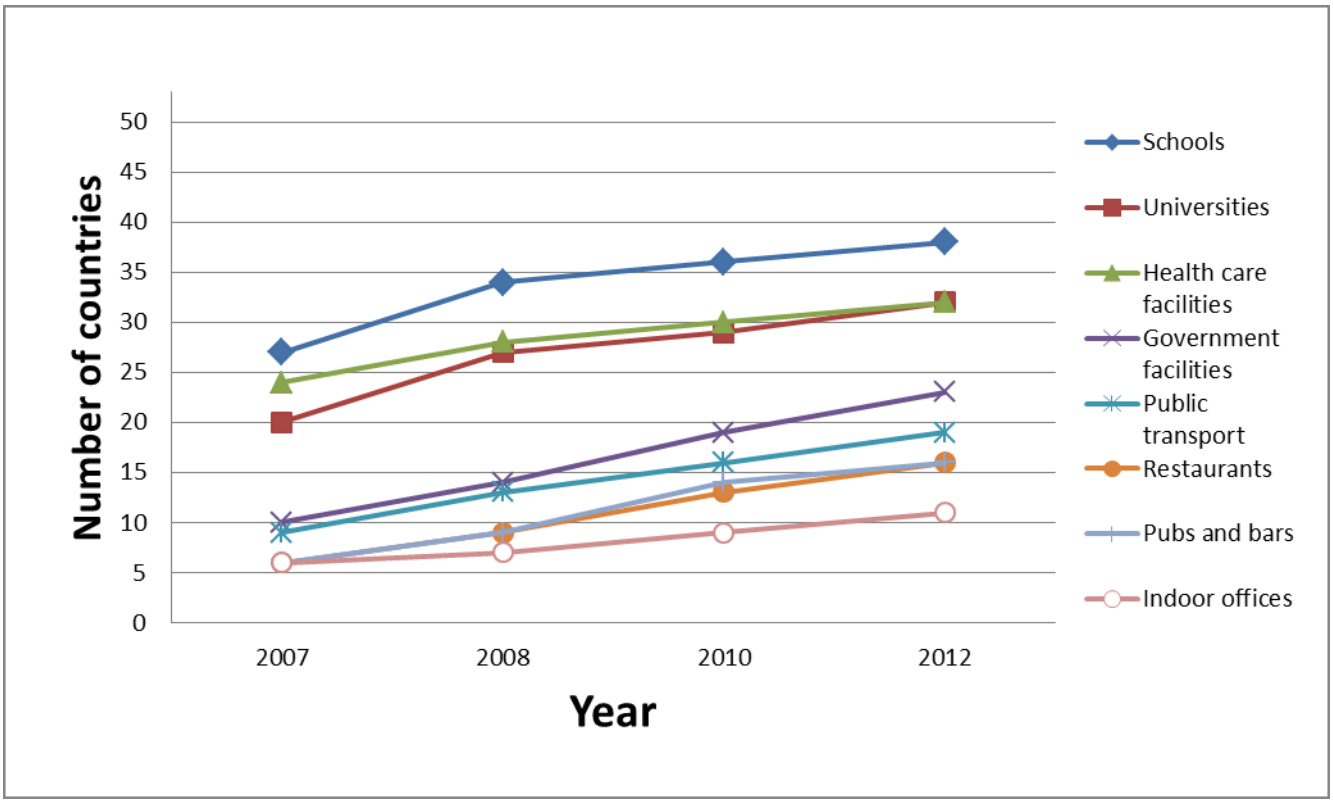
In contrast, progress for health care facilities and indoor offices was more limited for the same period (2007–2012); the proportion of European countries that banned smoking in health care facilities rose by only 15% and those that banned smoking in indoor offices by just 10%.

Protection from exposure to tobacco smoke varies greatly depending on the type of public places (Fig. 3).

In 2012, 32 European countries banned smoking in health care facilities, 32 banned smoking in universities and 38 banned smoking in schools.

In contrast, other public places such as government facilities, public transport, pubs and bars, restaurants and indoor offices have less coverage. In 2012, 23 European countries banned smoking in government facilities, 19 banned smoking in public transport, 16 banned smoking in restaurants, 16 in pubs and bars, and only 11 banned smoking in indoor offices.

Fig. 3. Smoking bans in public places in the European Region, 2007–2012



Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14).*

LMICs generally provide more protection from exposure to tobacco smoke in most public places.

LMICs lead the way banning smoking in health care facilities and universities (73%); government facilities (50%); and pubs, bars and restaurants (36%); the corresponding figures for HICs are 52%, 39% and 26%, respectively and the regional averages are 60%, 43% and 20%, respectively.

Most countries in the Region have legislation that penalizes smoking.

Penalties are one of the measures to ensure high compliance with existing policies.

The number of countries in the Region that have legislation penalizing smoking rose from 35 in 2007 to 49 in 2012, which represents about 92% of European countries.

The most noticeable progress was made in the category of countries imposing fines for violation of smoking bans on both the establishment and the smoker as recommended by WHO in Article 8 of the WHO FCTC *(25)*. The number of countries in this category has increased from 22 (42%) to 33 countries (62%) in the Region. In all other WHO regions, the corresponding figures range from 28% in the African Region to 52% in the Eastern Mediterranean Region.

HICs are doing particularly well imposing extensive fines.

HICs are doing very well imposing fines on both the establishment and the smoker (77% of HICs compared to 41% of LMICs).

In contrast, LMICs appear to focus only on the smoker. Of the LMICs, 41% impose fines only on the smoker compared to 13% of HICs.

Article 11: more to be done despite progress

A summary of how countries in the Region are implementing Article 11 of the WHO FCTC is in Box 3.

Box 3. Key facts

- Fewer European countries have no warnings or small warnings; the proportion of countries decreased from 21% in 2007 to 11% in 2012.
- The percentage of European countries having medium size warnings with all appropriate characteristics or large warnings missing some appropriate characteristics increased from 6% in 2007 to 32% in 2012.
- Only 4% of European countries have large warnings with all appropriate characteristics, the lowest percentage among all regions.

Tobacco consumption can be reduced by increasing public awareness of the health effects of tobacco use.

The WHO FCTC (Article 11) provides requirements regarding the packaging and labelling of tobacco products to be implemented within three years after entry into force of the Convention.

Guidelines for implementation of Article 11 were developed to assist Parties in meeting their obligations by proposing ways to increase the effectiveness of their packaging and labelling measures *(25)*.

Good progress has been made regarding the implementation of packaging and labelling requirements for tobacco products in the Region.

Fewer European countries have no warnings or small warnings. The proportion of European countries that had no warnings or only small warnings[4] decreased from 21% (11 countries) in 2007 to 11% (6 countries) in 2012.

In 2012, 32% of European countries had medium size warnings[5] with all appropriate characteristics[6] (or large warnings[7] missing some appropriate characteristics), which is an increase from 3 to 17 countries.

Improvements regarding the provision of pictorial warnings were also made. The proportion of countries requiring pictorial warnings increased from 8% (4 countries) in 2007 to 38% (20 countries) in 2012.

The ongoing revision of the Tobacco Products Directive (2001/37/EC) highlights the large potential and opportunity for advancement.

The 2001 Tobacco Products Directive, binding EU countries, provides rules concerning the manufacture, presentation and sale of tobacco products, including, for example, an obligation to display health warnings on tobacco products and comply with prescribed requirements about their size, format and other characteristics and a ban on any description suggesting that a product (such as “light”) is less harmful than others *(9)*.

[4] Average of front and back of package is less than 30%.
[5] Average of front and back of package is between 30% and 49%.
[6] Appropriate characteristics are: 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; and written in (all) the principal language(s) of the country.
[7] Average of front and back of the package is at least 50%.

In May 2005, the Commission of the European Communities adopted a library of 42 colour photographs and other illustrations its Member States can choose from to strengthen the impact of text warnings (Commission Decision C (2005) 1452 final) *(26)*.

In addition, a library of pictorial warnings is available to accompany warning messages noting that the display of pictorial warning is still voluntary *(27)*.

A revision of the Directive has been undertaken to adapt to recent market, scientific and international developments. Some of the proposals discussed relate to banning cigarettes with flavours, the regulation of electronic cigarettes, the increase of the size of combined warnings and pictures, and the voluntary introduction of plain packaging *(10–12)*.

The revised Directive is expected in spring 2014.

© WHO

While efforts undertaken so far are encouraging, evolving market strategies of the tobacco industry require further action to reinforce the packaging and labelling requirements.

In 2012, only two countries in the Region required large warnings with all appropriate characteristics (Table 5).[8] In contrast, other WHO regions have had more advancements in this area, particularly the Americas.

Table 5. Countries requiring large warnings with all appropriate characteristics on tobacco products in the WHO regions, 2012

WHO region	Countries	
	No.	%
Americas	12	34
South-East Asia	3	27
Western Pacific	6	22
Eastern Mediterranean	3	13
Africa	4	9
Europe	2	4

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

Not all packaging and labelling characteristics are equally covered by the law.

Some packaging and labelling characteristics are insufficiently regulated. Of the European countries, 38% (20 countries) have implemented picture warnings, 27% (9 countries) require quit lines on all packaging or labelling (if the country has a quit line), 4% (2 countries) require warnings placed at the top of the principal display area, and 2% (1 country) mandate qualitative information on constituents/emissions.

Some packaging and labelling requirements are completely missing in European countries. This is the case for: bans on expiry dates being displayed on the package, warnings not removing or diminishing the liability of the tobacco industry, bans on packaging and labelling using descriptors depicting flavours, and bans on display of quantitative information on emission yields and plain packaging.

[8] The countries are Ukraine since 2010 and Turkey since 2012.

HICs generally have broader regulations on tobacco packaging and labelling.

Disparities exist between HICs and LMICs regarding the regulation of some tobacco packaging and labelling requirements.

For example, more HICs (90%) than LMICs (77%) ban the use of deceitful terms on cigarette packaging for a regional average of 85%.

Similarly, more HICs (87%) than LMICs (68%) require display warnings on individual packages and on any outside packaging and labelling used in retail sale for a regional average of 79%.

The difference is even greater with 81% of HICs requiring display warnings on all tobacco products whether manufactured domestically, imported or for duty free sale compared to 55% of LMICs, with a regional average of 70%.

Finally, more than twice as many HICs (87%) than LMICs (41%) ban cigarette substitutes for using misleading terms, with a regional average of 68%.

Not all tobacco products are uniformly regulated. The labelling and packaging requirements are better for cigarettes than other forms of tobacco.

Packaging and labelling of tobacco products other than cigarettes (i.e. other smoked tobacco and smokeless tobacco) are less regulated than cigarettes in general and smokeless tobacco in particular.

For example, in the Region, pictorial health warnings are required for cigarettes in 20 countries, for other smoked tobacco in 19 countries and for smokeless tobacco in only seven countries.

The difference is even greater for the characteristic “rotating health warnings” required for cigarettes in 47 countries, for other smoked tobacco in 45 countries and for smokeless tobacco in just seven countries.

Article 12: need to implement effective campaigns

A summary of how European countries are implementing Article 12of the WHO FCTC is in Box 4.

Box 4. Key facts

- The proportion of European countries that conducted national campaigns with at least seven appropriate characteristics including airing on television and/or radio was 26% in 2010.
- In 2012, only 15% of European countries conducted national campaigns with at least seven appropriate characteristics including airing on television and/or radio, compared to the South-East Asia (27%) and Western Pacific (37%) regions.
- Forty-two per cent of European countries have not conducted a national campaign between January 2011 and June 2012 with duration of at least three weeks.

"Each Party shall promote and strengthen public awareness of tobacco control issues" (Article 12 WHO FCTC) *(5)*.

Campaigns play a key role provided that they are designed in a way that makes them effective (see Box 5). Only campaigns with duration of at least three weeks and conducted between January 2011 and June 2012 were considered for analysis.

The number of effective anti-tobacco mass media campaigns is limited.

The number of European countries that conducted a national campaign with at least seven appropriate characteristics including airing on television and/or radio decreased from 14 (26% of countries in the Region) in 2010 to 8 (15%) in 2012.[9]

Only the African Region had a lower proportion than the European Region as shown in Table 6.

Box 5. Mass media campaign characteristics

Characteristics used to review European countries' laws for the series of WHO reports on the global tobacco epidemic.

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 communications materials were pretested with the target audience and refined in line with campaign objectives.
4. Air time (radio, television) and/or placement (billboards, print advertising, etc.) was purchased or secured.
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 hadbeen implemented.
7. An outcome evaluation process was implemented to assess campaign impact.
8. The campaign was aired on television and/or radio.

- *Source*: WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship *(22)*.

[9] The countries are Belarus, Georgia, Luxembourg, Norway, the Russian Federation, Switzerland, Turkey and the United Kingdom.

Table 6. Countries conducting a national campaign with at least seven appropriate characteristics including airing on television and/or radio in the WHO regions, 2012

WHO region	Countries	
	No.	%
Western Pacific	10	37
South-East Asia	3	27
Americas	6	17
Eastern Mediterranean	4	17
Europe	8	15
Africa	6	13

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

LMICs show continuity in the number of effective anti-tobacco mass media campaigns.

The proportion of HICs conducting anti-tobacco mass media campaigns with at least seven appropriate characteristics, including airing on television and/or radio, declined from 32% in 2010 to 13% in 2012; the figure for LMICs held steady at 18% during this period.

Almost half of the European countries have not conducted national campaigns of at least three weeks in duration between January 2011 and June 2012.

With 42% of its countries not organizing a national campaign lasting at least three weeks, the European Region ranks second to last among WHO regions, performing better than only the South-East Asia Region at 27%. The corresponding figures for the African, Americas, Eastern Mediterranean and Western Pacific regions were: 70%, 57%, 57% and 52%, respectively.

Article 13: Europe failing to prohibit all indirect forms of TAPS

A summary of how European countries are implementing Article 13 of the WHO FCTC is in Box 6.

Box 6. Key facts

- The European Region lags behind all other WHO regions in implementing comprehensive bans on TAPS.
- Regulation of bans on direct forms of TAPS is generally satisfactory but greater efforts are needed to implement bans on indirect forms of TAPS.
- The most common bans on TAPS concern: national television and radio, local magazines and newspapers, billboards and outdoor advertising, international television and radio, Internet, product placement, free distribution of tobacco products, vending machines, sponsored events and promotional discounts.
- The least regulated forms of TAPS are indirect and include brand stretching, brand sharing, showing tobacco products in television and/or films, publicizing corporate social responsibility (CSR) and contributing to prevention media campaigns.

The adoption of a comprehensive ban on TAPS is essential to reduce tobacco use (Article 13.1 WHO FCTC) *(5).*

The WHO FCTC requires the Parties to adopt, within a period of five years after entry into force, a comprehensive ban on all forms of TAPS, whether direct or indirect, that aim to have the effect or likely effect of promoting a tobacco product or tobacco use *(5)*.

Guidelines for implementation of Article 13 were developed to assist Parties in meeting their obligations by giving Parties guidance for introducing and enforcing a comprehensive ban on TAPS *(25)*.

To date, few European countries have adopted comprehensive bans on TAPS.

In 2012, only three European countries[10] (representing about 6% of European countries) had adopted a comprehensive ban covering all forms of direct and indirect advertising.[11]

The European Region did not improve at the same rate as other WHO regions regarding the implementation of comprehensive bans on TAPS.

With 2% of its countries (one country) applying a comprehensive ban on TAPS in 2007, the European Region ranked third among WHO regions, behind the Eastern Mediterranean Region at 14% and the African Region at 9%. No

[10] The countries are Albania (in 2007 already categorized as a country implementing a comprehensive ban on all TAPS), Spain (since 2010) and Turkey (since 2012).

[11] Direct forms of TAPS used for analysis are: advertising on national television and radio, in local magazines and newspapers, on billboards and outdoor advertising and at points of sale.
Indirect forms of TAPS are: free distribution of tobacco products, promotional discounts, non-tobacco products identified with tobacco brand names (brand stretching), brand names of non-tobacco products used for tobacco products (brand sharing) appearance of tobacco brands or products in television and/or films (product placement), and sponsored events (including corporate social responsibility programmes).

country in the other three WHO regions implemented a comprehensive ban.

Between 2007 and 2012, the number of European countries applying a comprehensive ban has increased from one in 2007 to three in 2012 (Table 7).

Table7. Number of countries applying comprehensive TAPS bans in the WHO regions from 2007 to 2012

WHO region	No. of countries	
	2007	2012
Africa	4	9
Americas	0	3
South-East Asia	0	1
Europe	1	3
Eastern Mediterranean	3	5
Western Pacific	0	3

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

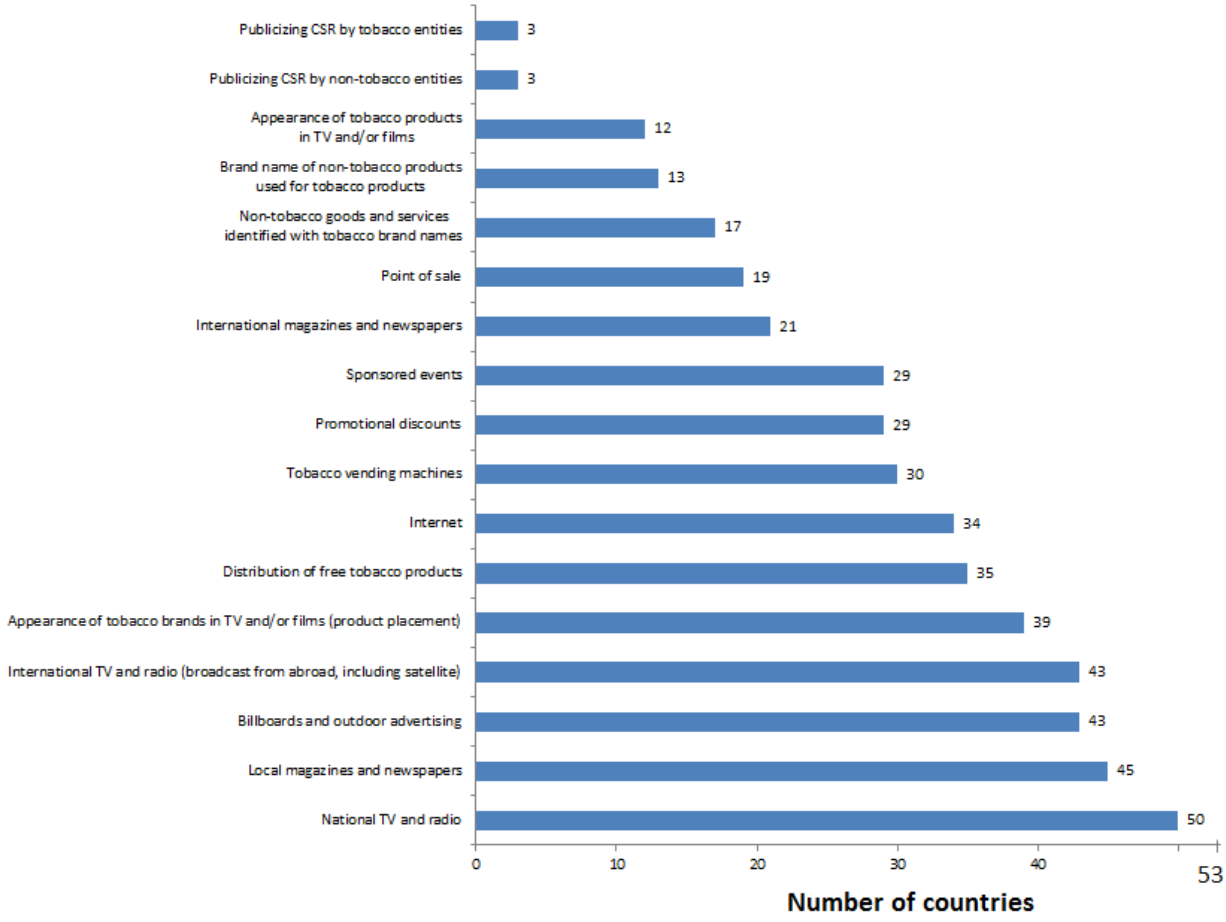
While the European Region lags behind in implementing comprehensive bans on TAPS, it nevertheless records very good results in regulating some forms of TAPS.

This is particularly true for the direct forms of TAPS.
European countries have widely adopted bans on tobacco advertising and promotion on national television and radio (50 countries), local magazines and newspapers (45 countries), billboards and outdoor advertising (43 countries) and international television and radio (43 countries) (Fig. 4).

Some indirect forms of TAPS are also banned in a majority of the countries, such as product placement (39 countries), distribution of free tobacco products (35 countries), tobacco vending machines (30 countries) and promotional discounts (29 countries). While 29 countries in the Region ban the sponsorship of events by the tobacco industry, only three countries ban CSR initiatives that publicize the tobacco industry or its products.

A majority of European countries regulate some indirect forms of TAPS, such as product placement, distribution of free tobacco products, tobacco vending machines, sponsorship of events by the tobacco industry and promotional discounts.

Fig. 4. Proportion of countries in the European Region banning TAPS



Source: WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship*(22).*

EU directives, binding the EU countries, have contributed to these good results.

Directive 2003/33/EC, on the advertising and sponsorship of tobacco products, prescribes the adoption of a ban on all forms of tobacco advertising and promotion in printed media, on radio and on Internet. It also prohibits sponsorship of international events by the tobacco industry together with the distribution of free tobacco products during international sponsored events *(13)*.

The Audiovisual Media Services Directive (2007/65/EC) bans tobacco advertising and sponsorship in all forms of audiovisual commercial communications including product placement *(28)*.

Between 2007 and 2012, improvements were noticeable particularly for the regulation of some TAPS.

The proportion of European countries banning product placement of tobacco and tobacco products has increased by 25% between 2007 and 2012 from 26 to 39 countries.

Bans on tobacco advertising and promotion in the Internet increased by 13% from 27 to 34 countries.

Similarly, between 2007 and 2012, nine additional European countries (representing about 17% of European countries) have adopted bans on tobacco vending machines, bringing the proportion of European countries banning tobacco vending machines in 2012 to 57%.

The Region leads globally in banning some forms of direct/indirect advertising.

The Region had the strongest TAPS regulations[12] in place in 2012 in some forms of tobacco advertising (Table 8).

Table 8. Countries banning tobacco advertising on national television, radio, print media and on some other forms of direct/indirect advertising, 2012

WHO region	Countries	
	No.	%
Europe	42	79
Western Pacific	18	67
South-East Asia	7	64
Eastern Mediterranean	13	57
Africa	14	30
Americas	9	26

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

While some forms of direct TAPS are insufficiently regulated within the Region, much larger gaps exist in regulating indirect forms of TAPS.

Regulating tobacco advertising in international magazines and newspapers and at points of sale remains limited. Of the European countries, only 21 (40%) adopted a ban in international magazines and newspapers and just 19 (36%) at points of sale.

Table 9 shows the main gaps that exist in regulating indirect forms of TAPS in the Region.

Table 9. Countries banning indirect forms of TAPS in the European Region, 2012

Bans on indirect forms of TAPS	Countries	
	No.	%
Brand stretching	17	32
Brand sharing	13	25
Appearance of tobacco products in television and/or films	12	23
Publicizing CSR by tobacco entities and by non-tobacco entities	3	6
Tobacco company contributions to prevention media campaigns	3	6
Required anti-tobacco ads in media depicting tobacco products, use or images	1	2

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

© WHO

Disparities exist between LMICs and HICs in regulating TAPS.

[12] In the series of WHO reports on the global tobacco epidemic, four different categories are used to classify TAPS restrictions implemented in countries. The top category (strongest regulation on TAPS) is a "ban on all forms of direct and indirect advertising". The second category is a "ban on national TV, radio and print media as well as on some but not all other forms of direct and/or indirect advertising". The third category is a "ban on national TV, radio and print media only". The last category is a "complete absence of ban, or ban that does not cover national TV, radio and print media" *(19–22)*.

LMICs are doing particularly well regulating tobacco vending machines, which are banned in 91% of LMICs compared to 32% of HICs.

Similarly, international forms of tobacco advertising are better regulated in LMICs. More LMICs (86%) than HICs (77%) ban tobacco advertising on international television and radio. More LMICs (59%) than HICs (26%) ban tobacco advertising in international magazines and newspapers.

However, LMICs need to strengthen their efforts. More HICs (71%) than LMICs (59%) ban the free distribution of tobacco products. Similarly, more HICs (65%) than LMICs (41%) ban promotional discounts.

Article 14: Despite improvements providing cessation services, more efforts are needed

A summary of how European countries are implementing Article 14 of the WHO FCTC is in Box 7.

Box 7. Key facts

- The proportion of European countries operating a national quit line and providing cost coverage for both nicotine replacement therapy (NRT) and some cessation services has increased by 5% from four to seven countries between 2007 and 2012.
- Of the European countries, 68% offer NRT and/or some cessation services (at least one of which is cost-covered) in 2012 compared to 42% in 2007.
- Globally, the Region is average regarding the provision of a national quit line and providing cost coverage for both NRTs and some cessation services but excels regarding the provision of NRT and/or some cessation services (at least one of which is cost-covered).

"Each Party shall …take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence" (Article 14 WHO FCTC) *(5).*

Guidelines for implementation of Article 14 were developed to assist Parties in meeting their obligations by identifying key effective measures needed to promote tobacco cessation and incorporate tobacco dependence treatment into national tobacco control programmes and healthcare systems.

The guidelines highlight the importance of promoting tobacco cessation and treatment of tobacco dependence as key elements of a comprehensive, integrated tobacco control program. "Support for tobacco users in their cessation efforts and successful treatment of their tobacco dependence will reinforce other tobacco control policies, by increasing social support for them and increasing their acceptability"*(25*).

The Region has progressed slowly in providing comprehensive cessation services.

In 2012, only 13%[13] of European countries operated a national quit line and provided cost coverage for both NRT and some cessation services compared to 8% in 2007. In this regard, the European Region is average compared to other WHO regions (Table 10 and Fig. 5).

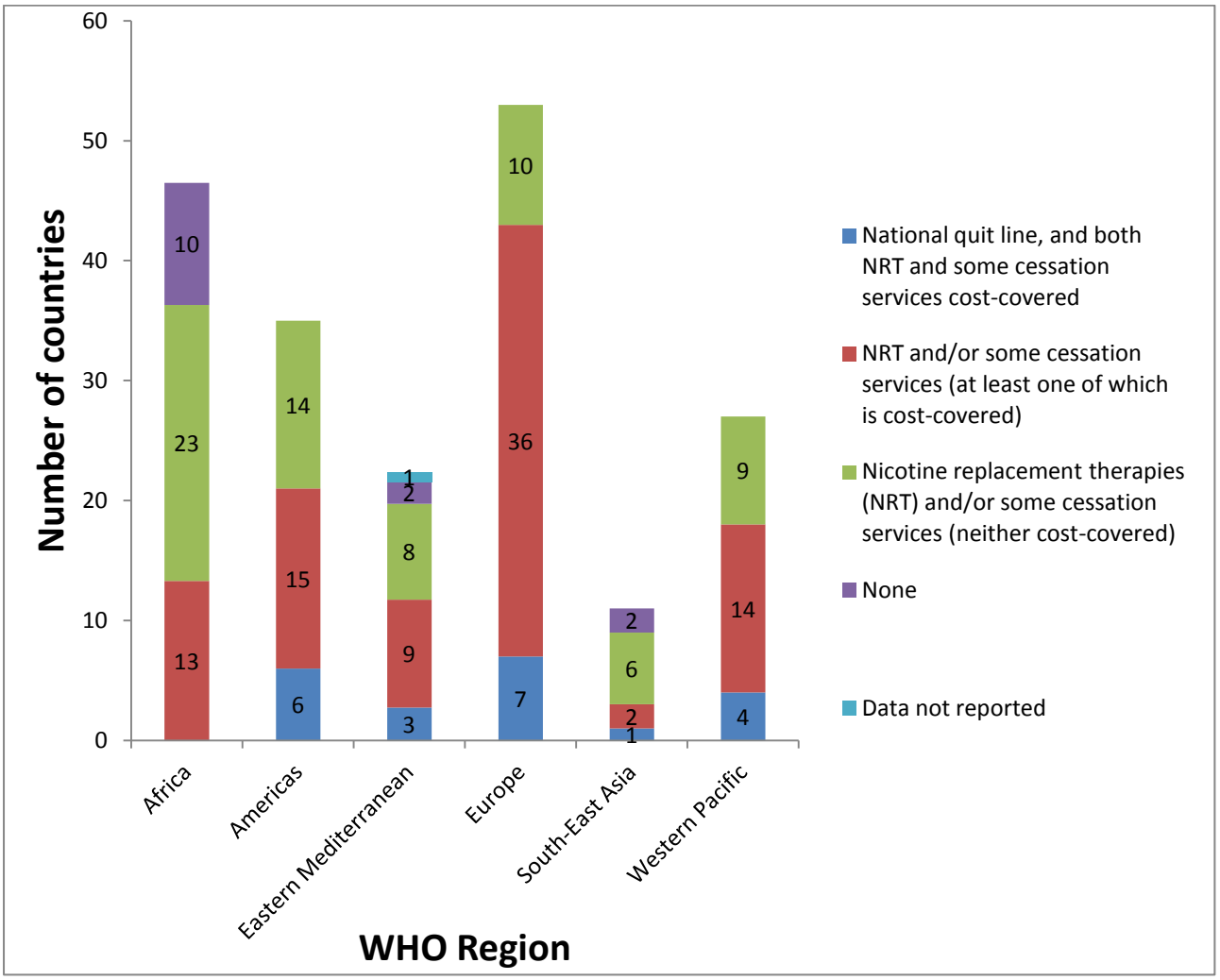
Table 10. Countries providing a national quit line and both nicotine NRT and some cessation services cost-covered in the WHO regions, 2012

WHO region	Countries	
	No.	%
Americas	6	17
Western Pacific	4	15
Europe	7	13
Eastern Mediterranean	3	13
South-East Asia	1	9
Africa	0	0

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*

[13] The countries are Denmark, France, Ireland, Israel, Romania, Turkey and the United Kingdom.

Fig. 5. Distribution of cessation services and/or medications offered across WHO regions



Source: WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco *(21)*.

In contrast, the Region improved greatly in providing NRT and/or some cessation services (at least one of which is cost-covered).

The number of European countries offering NRT and/or some cessation services (at least one of which is cost-covered) has increased from 22 in 2007 to 36 in 2012.

In this regard, the European Region leads the way globally as shown in Table 11.

Table 11. Countries offering NRT and/or some cessation services (at least one of which is cost-covered) in the WHO region, 2012

WHO region	Countries	
	No.	%
Europe	36	68
Western Pacific	14	52
Americas	15	43
Eastern Mediterranean	9	39
Africa	13	28
South-East Asia	2	18

Source: Dataset for the WHO report on the global tobacco epidemic 2013 *(14)*.

Quit lines are more broadly implemented in HICs.

In 2012, 77% of HICs in the Region had a national quit line compared to 41% of LMICs.

Conclusion

The WHO FCTC is a powerful legal instrument to help tackle the tobacco epidemic. Momentum is growing and more governments are taking strong measures.

Since the WHO FCTC adoption 10 years ago, there has been good progress made in the Region, signifying commitment to combat tobacco, while at the same time, progress regarding tobacco control policies has been quite disparate. A heat map depicting the regional summary of the implementation of measures within the WHO FCTC is shown in Annex 1.

The most significant advancement has been made regarding tax measures (Article 6). In 2012, with 47% of its countries providing strong tax measures (tax representing at least 75% of the CRP), the Region provided a positive role model for all other WHO regions.

HICs in the Region have been doing particularly well with 61% of them providing strong tax measures, compared to 27% of LMICs.

Still, the persistence of great disparities in CRPs raises the issue of cross-border sales and illicit trades and calls for stronger action in the Region. To date (as of 31 October 2013), 10 WHO FCTC Parties from the Region have signed the Protocol to Eliminate Illicit Trade in Tobacco Products – Belgium, Cyprus, Finland, France, Germany, Greece, Lithuania, Montenegro, Norway and Turkey*(29)*.

While the Region shows good results regarding the implementation of Article 6, important efforts need to be made regarding the implementation of non-price measures.

Progress regarding the regulation of exposure to tobacco smoke (Article 8) has been too limited. Not only is the number of European countries implementing a comprehensive smoking ban too low, the problem of non-compliance arises as well.

Protection from exposure to tobacco smoke has not advanced quickly enough and remains significantly insufficient in government facilities, public transport, restaurants, pubs and bars, and indoor offices, although LMICs lead the way regarding banning smoking in public places, such as health care facilities, universities, government facilities, pubs and bars, and restaurants.

Achievements regarding penalties for violation of smoking bans, especially in HICs (of which 77% provide fines on both the smoker and the establishment) are very encouraging and exemplary but must be strengthened towards comprehensive smoking bans in the Region. Some progress regarding the regulation of tobacco packaging and labelling (Article 11) has been made within the Region with, for example, an increase in the proportion of countries providing pictorial warnings (8% in 2007 compared to 38% in 2012) or an increase in the percentage of countries with medium size warnings with all appropriate characteristics or large warnings missing some appropriate characteristics (6% in 2007 to 32% in 2012). In general, HICs led in the implementation of packaging and labelling requirements.

However, stronger action is needed to adapt to evolving tobacco industry marketing strategies and new tobacco products. European countries need, for example, to regulate further smokeless tobacco products, adopt more broadly pictorial warnings, expand further the size of health warnings, ban packaging and labelling using descriptors depicting flavours, and require national quit line numbers on packages.

The Tobacco Products Directive (2001/37/EC) includes an obligation to display health warnings on tobacco products and comply with prescribed requirements about their size, format and other characteristics, among other regulations *(9)*. The Directive is currently being revised with a proposed increase of the size of combined text and picture warnings. The revision represents an opportunity to advance good practices in tobacco

packaging and labelling in the EU countries and beyond.

In addition, comprehensive bans on TAPS should be expanded to encompass all forms of TAPS as prescribed by Article 13.

While direct forms of TAPS are well covered within the Region, the regulation of indirect forms of TAPS needs to be strengthened considerably to encompass, for example, advertising at points of sale, brand-stretching, brand-sharing orCSR.

LMICs have notably stronger bans than HICs on various specific forms of TAPS such as banning tobacco vending machines and banning advertisement in international magazines/newspapers and international television/radio.

Finally, the Region needs to keep up its efforts towards the development of cessation services and tobacco dependence treatment. In 2012, while 68% of the European countries provide NRT and/or some cessation services (at least one of which is cost-covered), only 13% of European countries provided a national quit line along with both NRT and cost-coverage of some cessation services.

Only a comprehensive approach to tobacco control can effectively stem and/or eliminate the tobacco epidemic and help realize the voluntary global NCD target for a 30% reduction of tobacco use by 2025.

However, only a few countries in the Region have taken such a comprehensive approach.

Preliminary projections into 2025 reveal that stronger action in comprehensive implementation of the WHO FCTC in the Region needs to be taken to meet the global target.

One of the primary challenges that Parties in the Region have identified in the Conference of Parties reports is lack of political will. Nothing shows more political will than countries that have approached the WHO FCTC comprehensively and have been inspired from it to even go beyond, contemplating standardized packaging and indicating plans to even exceed the voluntary global target by considering the endgame of tobacco.

A strong and comprehensive approach to the WHO FCTC has shown that tough laws work – therein lies the key to saving lives.

Part II – The vision for an endgame

Part I of the report shows that although most Member States in the Region and the EU are legally bound to the WHO FCTC,[14] and despite visibly advancing in the implementation of tobacco control measures, many countries in the Region still lack mechanisms to address or properly enforce the core provisions outlined in the treaty, even after almost a decade of its entering into force. Besides competing priorities and reported political inattention, many still consider confronting the tobacco epidemic as a health sector's responsibility and part of the problem may be lack of consideration given to the issue by non-health sectors. Furthermore, as in the rest of the world, the tobacco industry's strong presence in the Region poses a threat to effectively implementing further tobacco control measures.

The success of some countries in the Region in implementing comprehensive tobacco control policies is evident with a sharp reduction in smoking prevalence. A natural next step for these countries and for their followers is the increased interest on what are coined "endgame" strategies. This discussion has only been reflected in the political agenda or national tobacco control strategies in the last four years, with the exception of Bhutan who banned the sale of tobacco products in 2004 *(30)*.

But what does endgame mean? The expression comes from chess and chess-like games, where the endgame (or end game or ending) is defined as the stage of the game when there are few pieces left on the board *(31)*. By analogy, some governments have outlined a strategic plan to further reduce tobacco prevalence to a defined low level – usually close to zero – within a set period using the "tobacco endgame" approach. The strategic plan may grant or not exceptions to products such as smokeless tobacco electronic nicotine delivery systems (ENDS).

Strategies that can result in an endgame consider tobacco as a systemic – as opposed to an individual behaviour – issue, go beyond the demand reduction measures by addressing, with priority, the supply side, and involve a fundamental de-normalization not just of tobacco use, but of the tobacco industry, by removing profitability and by making the industry liable *(32,33)*. Furthermore, a focus on disadvantaged groups and policy action with tobacco control address the wider social determinants of inequalities and health.

While countries in the Region are expressing interest in the matter, a firm commitment to a tobacco endgame was already made by Finland, Ireland and the United Kingdom (Scotland) who have publicly announced a target year to end tobacco use in their populations. These countries are committed to decrease tobacco use to below 5% by the target year.

In 2010, Finland passed legislation to abolish smoking with the Tobacco Act No. 693/1976 (as amended through 2011) by preventing, in particular, children and adolescents from taking up smoking with a number of measures restricting marketing and supply of tobacco products including a ban on the sale of snuff *(34)*. Finnish civil society calls for 2040 as a potential endgame deadline with a 10% annual reduction perspective *(35)* while a recent Government declaration aims for 2030 *(36)*.

Ireland has revisited its tobacco control strategy in 2013 and has proposed 60 recommendations towards a tobacco-free Ireland projecting that less than 5% of the population will smoke by 2025 *(37)*.

An ongoing discussion on the endgame for tobacco control is moving the agenda in the United Kingdom *(38)*. Scotland has introduced a new tobacco control strategy in 2013, focusing on creating an environment where young people choose not to smoke, helping people to quit and protecting people from second hand smoke, setting out the actions leading to creating a tobacco-free generation by 2034, defined as a smoking prevalence among the adult population of 5% or lower *(39)*.

[14] Tajikistan was the 177th country in the world and the 50th country in the European Region to become a Party to the WHO FCTC *(6)*.

Many governments elsewhere have pioneered new initiatives. Australia's recent ground-breaking move to introduce plain packaging in all tobacco products[15] eliminated the role of packaging as an advertisement strategy *(41)*. The civil society in New Zealand has launched in 2009 a target and a series of interventions to achieve close to zero tobacco smoking prevalence by 2020, subsequently postponed to 2025 by a Māori Affairs Parliamentary Select Committee report recommendation that was officially supported by the Government *(42, 43)*. The Australian state of Tasmania has passed in its Upper House the tobacco-free millennium generations, banning cigarette use to anyone born after 2000 *(44)*, following Singapore's civil society proposal *(45)*.

Tobacco control measures considered more radical are already part of a strategy or a regulation in some countries while some new ideas aimed to move from "tobacco control" to "the end of the tobacco problem" are flourishing in academic papers. Some examples of existing and proposed tobacco endgame proposals are listed in Table 12.

Nevertheless, despite being an evolving topic, the endgame proposals do not seem to be developing for most WHO regions, including the European Region, where some countries are taking the lead in endgame approaches while others are still struggling to implement the core demand reduction measures. Furthermore, it was recently acknowledged that countries may lack the structure needed to engage in an endgame exercise *(55)*.

Tobacco is a drug that is promoted and consumed within the framework of a legal product that is still cultivated apart from being heavily manufactured and traded in the Region. It could be argued that the future of tobacco should be framed considering tobacco as a legal product and commodity besides its well-known health-related attribute as a drug. Addressing these three conditions poses a major challenge in the mid- and long-term public health vision of the Region.

The next sections of the report explore some ideas of future scenarios considering the three conditions: tobacco as a legal product, as a drug and as a commodity.

[15]The law went into effect on December 2012 in Australia after the dismissal of a tobacco industry challenge by the High Court of Australia. Ukraine and some Latin American countries have challenged Australia over the issue at the World Trade Organization, citing "technical barriers" to trade and violations of intellectual property rights.*(40)*.

Table 12. Examples of existing and proposed tobacco endgame proposals

Proposed measure	Examples of involved actions	Implemented initiatives or academic proposals
Ban the sales and import of tobacco products	Eliminate all tobacco sales and imports, with the goal of reducing consumption to near-zero	Bhutan ban on sales and imports of all tobacco products, 2004 *(46)* New Zealand's decision, 2011 *(47)*
Smoke-free generation: cohort of newborn	Re-write the current sales restriction on under18s to include a generation of young people born after a certain date, e.g. 1 January 2000	Proposed by a Singapore advocacy group (TTFS – Towards Tobacco-Free Singapore), 2011 *(45)* and by the Australian state of Tasmania *(44)*
License to smoke	Require mandatory smart card to buy tobacco conditioned to acknowledgement of the risk and agreement to limited consumption	Proposed by Chapman, 2012 *(48)*
Content regulation	Reduce dependence induction factors and product appeal: ban additives and flavours, reduce nicotine to non-dependence levels and eliminate ventilated filters	Ban on additives: • draft EU directive, 2013*(12)* • Canada, 2010*(49)* • Brazil,2012*(50)* Proposed by Benowitz&Henningfield, 2013 *(51)*
Reduce availability: a "sinking lid" on tobacco supply	Reduce progressively the number and types of establishments that sell tobacco, prohibit new licenses and transfers of licenses	Proposed by Wilson et al., 2013 *(52)*
Limiting profits: price-cap regulation	Introduce a system of price-cap regulation to address the market failure inherent to the tobacco industry	Proposed by Branston&Gilmore *(53)*

Source: ASH Action: an end-date for tobacco sales *(54).*

Future scenario: limiting the legality of tobacco

In an ideal world, tobacco would have never been legalized *(55)*. Alternatively, it could have been converted into an illegal good immediately after the first reports on the harmful consequences of smoking were released in the early 1950s in Europe *(56)*. However, although the tobacco industry was aware of the damages of smoking *(57)*, it took decades for governments to consider a regulatory framework to tackle the tobacco epidemic, first as the pioneering initiatives in countries such as Finland and Norway and later by negotiating an international treaty, the WHO FCTC.

As a legal product, the right to advertise, promote and manipulate smoked and non-smoked tobacco has historically been granted to the tobacco industry throughout the 20th century and is still allowed in most places, including in European

countries, where the TAPS ban is less regulated than in all other WHO regions *(22)*. **In the future, on a supposed strictly regulated tobacco market, no TAPS will be used or even remembered by the population,** thus making tobacco products unappealing, socially unacceptable and more difficult to use.
Legal products are also subject to taxes and price policies, and tobacco is no different from any other good, becoming a desirable source of government revenue. Even though the Region is exemplary in increasing taxes and prices, this report identifies a great disparity in CRPs, perhaps as a result of high- and low-tax jurisdictions. The resulting price differences point to the need to harmonize taxes and prices in the Region in order to prevent consumers from purchasing less expensive products from low-tax jurisdictions, thereby increasing consumption *(58).* **Ideally, in the future, all European countries would have similar high prices on tobacco products** as one element of the tobacco endgame in the Region.

Legal products can, in principle, be used in social gatherings; a decade ago, this was the case for smoking in many countries, although some already considered tobacco smoke a nuisance. Some studies have proven that second hand smoke harms others bringing the scientific evidence needed to support total bans. With the introduction of smoke-free regulations, the picture has changed and fines for violating the smoking ban on both the establishment and the smoker transformed smoking into an anti-social behaviour for many societies. Most countries in the Region provide some form of protection from smoke exposure in schools, universities and health care facilities, but **the majority of countries do not provide smoke-free laws in all public places**. Some countries in Europe still have not fully implemented this simple, easily enforced, core measure of the WHO FCTC, a situation that hopefully the Region will not need to confront in the future.

Whether a product such as tobacco should be legal or illegal is a popular discussion. Comparing policies to counter tobacco use with those to control cannabis[16] use can provide governments with interesting insights as experiences in decriminalizing and discussions to legalise advance in Europe. Apart from the relevant perspective of consumers as polydrug users (e.g. cannabis is usually smoked with tobacco and associated with alcohol drinking) "what-if" scenarios on how market controls could be transposed from tobacco to cannabis in a post-legalization environment are ignored *(59).*

The fact that tobacco is by far the most important psychoactive drug used in Europe and that users are becoming increasingly marginalized due to stronger tobacco control regulations might unite tobacco products with a restrictive liberalization of certain drugs such as marijuana in a similar legal framework. The fact that Bhutan – the only country in the world that made selling tobacco illegal – has apparently not been successful in ending tobacco use[17] points towards regulation rather than prohibition *(46)*. This scenario would leave the Region with the challenge of framing future tobacco control policies in Europe with an eye on how the illicit drugs policies are progressing towards legalization. Eventually, both could be subject to the same system, sold in designated stores and dependent on a comprehensive education programme associated with a strong regulatory approach enforced by all countries in the Region. In any case, despite the fact that some European countries are recognized for setting a global example for tobacco control, most countries still need to fully engage in the process of building population awareness and change social norms by implementing the WHOFCTC; countries more advanced in the treaty implementation can consider testing new waters towards a tobacco endgame.

Future scenario: tobacco as a drug

Dependence caused by any tobacco product has been diagnosed as a mental and behavioural disorder due to psychoactive substance use *(60)*. Many or most of tobacco products' contents and emissions were barely known or studied in the last century and many research gaps still exist to inform policies. The addictive nature of nicotine contained in tobacco products has only recently raised sufficient public health attention to engage

[16] Cannabis is the illegal drug most used in the EU.

[17] Bhutan had already one of the lowest prevalence of smokers in the world by 2004 *(46)*.

the health sector in offering information and treatment to tobacco users. Seventy-three per cent of countries in the Region would have to consider going well beyond the existing arrangements by increasing the availability and display of quit lines information on all packages. Mandatory qualitative information on constituents and emissions should, in the future, equally cover the present information gap in 98% of European countries. Interventions to reduce symptoms of nicotine dependence varies across the Region *(61)* and different views exist regarding research and policy gaps that can only be addressed after identifying how many tobacco users need treatment and drugs to quit*(62)*. In any case, the use of combustible tobacco products is becoming socially unacceptable as smoking areas are becoming more restricted, progressively leaving the smoker with few remaining options than to quit.

Harm reduction strategies such as nicotine reduction have been debated for years. But tobacco product regulation initiatives have not followed suit and this is one of the topics that, due to the evolving scientific evidence associated with limited best practices at country level, has not yet been fully established.[18]

Flavours, such as menthol, vanilla and strawberry, are increasingly added to tobacco products to facilitate experimentation and initiation by teens and disadvantaged groups *(64, 65)*. A ban on additives has been included in the ongoing revision of the EU directive proposal banning flavours and increasing health warnings in tobacco packages. Nevertheless, the tobacco industry is attempting to interfere in the process *(66)*.

Some Nordic countries claim success in policies that switch smokers from combustible tobacco products to moist snuff as a harm reduction strategy *(67)* while other European countries ban snus *(68)*. New alternative products such as ENDS attract consumers by offering what is claimed to be a “safer cigarette”, although no scientific evidence of their safety as a harm-reduction product or their efficacy as a cessation product exists. E-cigarettes fall into a regulatory gap in most countries, escaping regulation as drugs and avoiding the controls levied on tobacco products. **WHO recommends that e-cigarettes should be regulated through a two-pronged approach as both tobacco and medicinal products to prevent a situation in which loopholes are exploited and e-cigarettes escape control** *(69)*.

Oftentimes, European countries either regulate e-cigarettes as medicines or tobacco products, if at all *(70)*. Among other concerns, there is the fear raised by the scientific community on the impact of e-cigarettes on experimentation and initiation into smoking cigarettes, particularly by young people *(71)*. In any case, it seems that regulating any product that contains nicotine, whether it is part of a tobacco product or not, and establishing progressive reduction of nicotine to decrease drug dependence potential seems to be a way forward that is gaining increasing acceptance, provided it is based on scientific evidence.

In any regulatory framework, information about a legal drug is a government responsibility and a consumer right. Informing about the potential dependence; the social, economic, environmental and health consequences; access to and forms of treatment; and warning against the strategies of the tobacco industry to mislead the public, among other issues, has been granted to the population by many countries in the Region. Nevertheless, the number of campaigns has decreased overtime, at times because the message has already been delivered. Moreover, information to vulnerable populations, such as young people and the poorly educated is contradictory with the social tolerance to tobacco use, a factor that has high importance in shaping behaviour. Finally, as one of the most simple, non-costly and far reaching health information policies, it is worrisome that many European countries still have no pictorial warnings or even warnings on all tobacco products including smokeless tobacco, showing that there is still a long way to go to meet the obligations of Article 11 of the WHO FCTC and its respective guidelines before considering a tobacco endgame *(7,25)*.

[18] The WHO FCTC guidelines for Articles 9 and 10 are in progress, as many relevant product regulation aspects need further development *(63)*.

In this future scenario, tobacco products persist in the legal market but no additives will be permitted. Tobacco products will be less appealing, socially unacceptable and less palatable, harsher and more difficult to use. Plain packaging with large pictorial warnings and inserts with cessation tips will be the norm. Furthermore, the decreasing social tolerance to tobacco smoke – and consequently the marginalization of smoking – will naturally increase the demand for new products. They can work as alternatives to tobacco consumption provided they do not stimulate experimentation and initiation of tobacco use. In the case that combustible tobacco products are progressively replaced by ENDS, a strict regulated market with an adequate enforcement structure should be considered. This includes new nicotine delivery devices that will enter the market, an intention already announced by a major tobacco company, raising concerns in the public health community *(72)*.

Future scenario: tobacco as a commodity

In the framework of exchange economics, a commodity is a good that can be traded *(73)* and in the case of tobacco, a commodity that has a global economic significance. It is therefore appropriate to consider the implication the tobacco trade has on the international and national political scenario and potential implications for health policies by understanding:

- the trends of national and international markets and how they affect European countries;
- the tobacco production chain, from growing to manufacturing to selling and their economic and social implications;
- the illicit trade of tobacco products and its direct and indirect consequences; and
- the tobacco industry: private and state-owned, transnational and national, and direct and indirect interference with tobacco control.

Discussion of a future endgame in the Region should focus on tobacco as a commodity.

Europe´s share in the world cultivation of tobacco is small and accounts for about 4.7% of global production. In the last years, the EU has implemented a successful package of reforms eliminating tobacco subsidies and developing funding programmes to support farmers in transition to alternative production activities.[19] Turkey has also provided subsidies on an elimination programme with Government support to growers willing to grow other crops. As a result, tobacco production fell by 48% in the Region and hectares earmarked for tobacco cultivation decreased by 54%. This trend is driven mainly by decreases in production in some European countries in both the western and eastern parts of the Region. The EU accounts for approximately 82% of Europe's total production – 13 of its members are tobacco producers– with the main producer countries Italy, Bulgaria, Poland, Spain and Greece with the first two countries accounting for 50% of tobacco production in the Region. Nevertheless, some countries of the former Soviet Union, the Russian Federation in particular, have increased production due to large investments from multinational tobacco companies in the local cigarette industry *(76)*. The number of tobacco farmers in the Region is around 86 000, of which 50% come from Bulgaria, followed by Poland and Greece (both accounting for 17%) *(77)*. In Turkey, 207 000 families were involved in tobacco growing in 2006 *(78)*.

Trade of tobacco products is important to the Region. In 2011, Europe imported 1 308 278 tons of tobacco and the main importer countries were Belgium, France, Germany, Greece, the Netherlands, Poland, the Russian Federation and the United Kingdom. In the same year, the Region exported 499 821 tons of tobacco and the main exporter countries were Belgium, Turkey, Germany, Greece and Spain *(76)*. There is an intense trade flow internally among the EU member countries themselves.

Effective tobacco control policies pose a threat to the tobacco industry and their business *(79)*. Therefore, the economic success of the tobacco industry depends not only on appropriate strategies to put the products on the market, but

[19] See Council Regulations (EC) No. 1782/2003 (consolidated version) *(74)* and No. 864/2004 *(75)*.

also on the macroeconomic environment and the political and regulatory frameworks *(80)*. Additionally, the globalization of goods has brought new challenges to the Region with the introduction of new tobacco products such as kreteks and waterpipes into the market *(81)* and illicit trade showing alarming statistics. EU losses associated with tax evasion from smuggling and counterfeit products are estimated to be 10 billion euros per year *(82)*. In order to join efforts against the illicit tobacco market, the European Commission has made a multiyear agreement in 2010, which consisted of a legally binding arrangement signed by the European Commission, the European Anti-Fraud Office and British American Tobacco. The main pathways for smuggled cigarettes in Europe are located in eastern Europe and the former Soviet Union *(83)*.

The numbers above give an idea of the complexities involved in the agriculture, production, trade and distribution of tobacco products in a region that has fundamental differences in programmes and policies for and against tobacco use and where trade arguments are part of the discussion. Four major multinational tobacco companies operating in the Region (Phillip Morris International; British American Tobacco, including later acquisitions of Turkish TEKEL and Scandinavian Skandinavisk Tobakskompagni; Japan Tobacco International; and Imperial Tobacco Group) have market shares and develop well-known strategies to oppose advances in tobacco control.

In this scenario, any endgame proposal will be unrealistic if tobacco is not considered as a commodity. If sectors as diverse as agriculture, trade, antifraud and finances are not serious about shifting the focus from trade to health, not prioritizing trade over health. Governments wishing to give priority to public health and to resist the financial pressure of the tobacco industry should consider certain steps:

- eliminate financial incentives to the establishment of the tobacco industry in new markets;
- limit trade by taxing heavily all cross-border moves of tobacco products;
- reduce profits of the tobacco industry by systems such as price-cap regulations or any other process;
- divest shares in pension funds and other investments sources; and
- combat illicit trade.

Reducing the financial power of the tobacco industry is an important move to allow public health to take priority. Creating mechanisms to ensure transparency in government officials' interactions with the tobacco industry to resist their lobbies is part of this equation.

The WHO FCTC and the Protocol to Eliminate Illicit Trade[20] are key in providing the basic framework on how Parties can address some of these elements *(84)* and should be considered as a priority now and in the future.

Furthermore, the specific endgame policies addressing tobacco as a commodity should be sufficiently robust to withstand challenges under the World Trade Organization and other trade agreements within Europe (Porter G, van der Eijk Y. Would a tobacco phase-out violate world trade law?, unpublished observations).

A roadmap for a tobacco-free Europe

The future of tobacco products can be addressed taking into consideration three major characteristics:

1. the drug that causes dependence
2. the product that enjoys a legal status
3. the commodity that is traded.

In preparing to engage in a tobacco endgame, these characteristics should be considered in the mid-and-long term with an ultimate focus in public health.

[20] Ten out of 37 signatories of the Protocol to Eliminate Illicit Trade are Parties from the European Region by October 2013 *(29)*.

In the Region, Finland, Ireland and the United Kingdom (Scotland) are paving the way for other countries to move to the projected reduction of less than 5% of smokers or tobacco users in their population. In order to reach the "readiness" to engage in the endgame, evidence-based policies should be implemented while some innovative approaches should be tested according to the tobacco control status and the level of the tobacco epidemic in the country. This could include some possible next steps:

1. In line with global best practices and success stories, implement fully the WHO FCTC and its guidelines as the first major step forward for most countries in the Region; this is a requirement especially because the treaty measures provide the minimum that should be done and to confront the epidemic.
2. Become a Party to the Protocol to Eliminate Illicit Trade of Tobacco Products and implement fully the Protocol after entry into force.
3. Prevent the undue interference of the tobacco industry and their interest groups in public health and tobacco control policies, by ensuring transparency in the eventual interactions between government representatives and the tobacco industry and a full implementation of WHO FCTC Article 5.3 and guidelines.
4. Move towards de-normalizing the tobacco industry by reducing their economic power and influence is essential to restrict the importance of the global tobacco market and consequent threats to public health in the name of trade arguments.
5. Consider establishing an increasingly stricter regulatory framework for tobacco products in line with the needed enforcement structure to restrict to a maximum limit tobacco affordability and availability while ensuring comprehensive support to tobacco users in their demand for quitting.
6. Consider harm reduction strategies as part of the endgame scenario outlining carefully a strict regulatory framework. Nevertheless, ensure that these strategies, including novel products, are cost-effective and that no adverse effects, such as increasing experimentation and initiation are identified.

All in all, the immediate and full implementation of the WHO FCTC will already provide a better and healthier world to the Region's future generations.

References

1. Tobacco fact sheet No. 339. In: World Health Organization [website]. Geneva: World Health Organization; 2013 (http://www.who.int/mediacentre/factsheets/fs339/en/, accessed 31 October2013).
2. Death from tobacco. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/data-and-statistics/death-from-tobacco, accessed 31 October2013).
3. Deaths from NCDs. In: World Health Organization [website]. Geneva: World Health Organization; 2013 (http://www.who.int/gho/ncd/mortality_morbidity/ncd_total_text/en/, accessed 31 October 2013).
4. Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016. Copenhagen: WHO Regional Office for Europe; 2011 (http://www.euro.who.int/__data/assets/pdf_file/0003/147729/wd12E_NCDs_111360_revision.pdf, accessed 31 October 2013).
5. WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2003 (http://whqlibdoc.who.int/publications/2003/9241591013.pdf, accessed 15 October 2013).
6. Parties to the WHO Framework Convention on Tobacco Control. In: WHO Framework Convention on Tobacco Control [website]. Geneva: WHO; 2013 (http://www.who.int/fctc/signatories_parties/en/index.html, accessed 15 October 2013).
7. Countries. In: European Union [website]. Brussels: European Union; 2013 (http://europa.eu/about-eu/countries/, accessed 31 October 2013).
8. Council Directive 2011/64/EU of 21 June 2011 on the structure and rates of excise duty applied to manufactured tobacco (codification). O. J. E. U. 2011, L 176:24–31 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:176:0024:0036:EN:PDF, accessed 15 October 2013).
9. Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products. O. J. E. C.2001, L 194:26 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32001L0037:EN:HTML, accessed 15 October 2013).
10. Revision of the Tobacco Products Directive. In European Commission Public Health [website]. Brussels: European Commission; 2013 (http://ec.europa.eu/health/tobacco/products/revision/index_en.htm, accessed 31 October 2013).
11. Council agrees its position on revised EU tobacco directive, Luxembourg, 21 June 2013, 11388/13 PRESSE 284 [press release]. Brussels: Council of the European Union; 2013 (http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/137571.pdf, accessed 31 October 2013).

12. Proposal for a Directive of the European Parliament and of the Council of 21 June 2013 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products. Brussels: Council of the European Union; 2013 (http://register.consilium.europa.eu/pdf/en/13/st11/st11483.en13.pdf, accessed 31 October 2013).

13. Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products. O. J. E. U.2003, L 152:16–9 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:152:0016:0019:EN:PDF, accessed 15 October 2013).

14. Tobacco Free Initiative. Dataset for the WHO report on the global tobacco epidemic 2013: enforcing bans on tobacco advertising, promotion and sponsorship [online data set]. Geneva: World Health Organization; 2013 (http://www.who.int/tobacco/global_report/access_form/en/index.html, accessed 31 October2013).

15. WHO global report: mortality attributable to tobacco. Geneva: World Health Organization; 2012 (http://whqlibdoc.who.int/publications/2012/9789241564434_eng.pdf, accessed 31 October2013).

16. Ten facts about health in the WHO European Region. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/en/media-centre/sections/press-releases/2010/09/rc-to-convene-in-moscow/10-facts, accessed 1 November 2013).

17. Set of 9 voluntary global NCD targets for 2025. NCD Global Monitoring Framework [website].Geneva: World Health Organization; 2013 (http://www.who.int/nmh/global_monitoring_framework/en/, accessed 15 October 2013).

18. Health 2020. A European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf, accessed 15 October 2013).

19. WHO report on the global tobacco epidemic, 2008: the MPOWER package? Geneva: World Health Organization; 2008 (http://whqlibdoc.who.int/publications/2008/9789241596282_eng.pdf, accessed 15 October 2013).

20. WHO report on the global tobacco epidemic, 2009: implementing smoke-free environments. Geneva: World Health Organization; 2009 (http://whqlibdoc.who.int/publications/2009/9789241563918_eng_full.pdf, accessed 15 October 2013).

21. WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco. Geneva: World Health Organization; 2011 (http://whqlibdoc.who.int/publications/2011/9789240687813_eng.pdf, accessed 15 October 2013).

22. WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85380/1/9789241505871_eng.pdf, accessed 16 October 2013).

23. Raising cigarette taxes reduces smoking, especially among kids (and the cigarette companies know it). Washington (DC): Campaign for Tobacco-Free Kids; 2012 (http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf, accessed 1 November 2013).

24. Raise taxes on tobacco. Geneva: World Health Organization (http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_r.pdf, accessed 1 November 2013).

25. WHO Framework Convention on Tobacco Control: guidelines for implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 – 2013 edition. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/80510/1/9789241505185_eng.pdf, accessed 1 November 2013).

26. Commission Decision C(2005) 1452 final of 26 May 2005 on the library of selected source documents containing colour photographs or other illustrations for each of the additional warnings listed in annex 1 to Directive 2001/37/EC of the European Parliament and of the Council (http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/com_1452_en.pdf, accessed 1 November 2013).

27. Library of pictorial warnings developed in accordance with in accordance with the Commission Decision of 5 September 2003 on the use of colour photographs or other illustrations as health warnings on tobacco packages (2003/641/EC); European Commission (http://ec.europa.eu/health/archive/ph_determinants/life_style/tobacco/documents/com_1452_a_en.pdf, accessed 1 November 2013).

28. Directive 2007/65/EC of the European Parliament and of the Council of 11 December 2007 amending council directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities. O. J. E. U.2007, L 332:27–45(http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:332:0027:0045:EN:PDF, accessed 1 November 2013).

29. Status and signature of ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products. In: United Nations Treaty Collection [website]. New York (NY): United Nations; 2013 (http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4-a&chapter=9&lang=en, accessed 4 November 2013).

30. Edwards R, Russell M, Thomson G, Wilson N, Gifford H. Daring to dream: reactions to tobacco endgame ideas among policy-makers, media and public health practitioners. BMC Public Health. 2011;11(1):580.

31. Endgame. In: TheFreeDictionary [website]. Huntingdon Valley (PA): Farlex, Inc.; 2013 (http://www.thefreedictionary.com/Chess+ending, accessed 1 November 2013).

32. Lansell G. WHO Director-General Margaret Chan attacks Big Tobacco: The 15th World Conference celebrates Australia's plain packaging and explores endgame ideas. Tob Info CA Mag. Smoke-Free Can. 2012 (http://www.tobaccoinfo.ca/mag10/worldconference.htm, accessed 30 October 2013).

33. Srinath Reddy K. Tobacco control: the end-game [presentation]. In: World Health Summit Regional Meeting, Asia, Singapore, 8–10 April 2013. Berlin: World Health Summit; 2013 (http://www.worldhealthsummit.org/fileadmin/downloads/2013/WHSRMA_2013/Presentations/Day_3/Reddy%20Srinath%20-%20Tobacco%20Control%20The%20End-Game.pdf, accessed 30 October 2013).

34. The aim of the Tobacco Act is to put an end to smoking in Finland [press release 224/2010]. Helsinki: Ministry of Social Affairs and Health; 18 August 2010 (http://www.stm.fi/tiedotteet/tiedote/-/view/1522179#en, accessed 30 October 2013).

35. Finland Tobacco-Free by 2040 [website]. Helsinki: SavutonSuomi 2040 [Finland Smoke-Free by 2040] (http://www.savutonsuomi.fi/en.php, accessed 30 October 2013).

36. Puska P. Farewell to tobacco - global end game has started [website]. Helsinki: National Institute for Health and Welfare; 2013 (http://www.thl.fi/en_US/web/en/news?id=34204, accessed 30 October 2013).

37. Tobacco free Ireland. Report of the Tobacco Policy Review Group. Dublin: Department of Health; 2013 (http://static.rasset.ie/documents/news/tobacco-free-ireland.pdf, accessed 30 October 2013).

38. Bauld L, Amos A, Fong G, Gilmore A. The "end game" for tobacco control in the UK: key priorities for science and policy to reduce smoking. In: 9th National Cancer Research Institute Cancer Conference, Liverpool, United Kingdom, 3–6 November 2013. London; 2013 (http://conference.ncri.org.uk/tuesday/bauld/, accessed 30 October 2013).

39. Creating a tobacco-free generation: a tobacco control strategy for Scotland. Edinburgh: The Scottish Government; 2013 (http://www.scotland.gov.uk/Resource/0041/00417331.pdf, accessed 30 October 2013).

40. World Trade Organization dispute settlement DS434: Australia - Certain measures concerning trademarks and other plain packaging requirements applicable to tobacco products and packaging. Geneva: World Trade Organization; 2012 (http://www.wto.org/english/tratop_e/dispu_e/cases_e/ds434_e.htm, accessed 30 October 2013).

41. Plain packaging of tobacco products. In: The Department of Health [website]. Canberra: Commonwealth of Australia; 2013 (http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-plain, accessed 30 October 2013).

42. TupkeaKoreAotearoa 2020 Tobacco Free New Zealand 2020. Achieving the vision. Wellington: Smokefree Coalition; 2010 (http://www.sfc.org.nz/documents/100701AchievingtheVisionweb.pdf, accessed 30 October 2013).

43. Māori Affairs Select Committee Report. In: TupkeaKoreAotearoa 2020 Tobacco Free New Zealand 2020 [website]. Wellington: Smokefree Coalition; 2013 (http://www.sfc.org.nz/masci.php, accessed 30 October 2013).

44. Darby A, Corderoy A. Bid to ban cigarettes for anyone born after 2000. The Sydney Morning Herald. 22 August 2012 (http://www.smh.com.au/national/bid-to-ban-cigarettes-for-anyone-born-after-2000-20120822-24liy.html, accessed 30 October 2013).

45. Tobacco-free generation proposal receives praise. In: Towards Tobacco-Free Singapore [website] Tobacco Free Singapore; 2013 (http://www.tobaccofreesingapore.info/2012/03/tobacco-free-generation-proposal-receives-praise/, accessed 30 October 2013).

46. Givel MS. History of Bhutan's prohibition of cigarettes: implications for neo-prohibitionists and their critics. Int J Drug Policy. 2011 Jul;22(4):306-10. doi:10.1016/j.drugpo.2011.05.006. Epub 2011 Jun 23.

47. Government final response to the Report of the Māori Affairs Committee on its inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, presented to the House of Representatives in accordance with Standing Order 248 (J.1), 14 March 2011. Wellington: New Zealand Parliament; 2011 (http://www.parliament.nz/resource/0000157432, accessed 30 October 2013).

48. Chapman S. The case for a smoker's license. PLoS Med. 2012;9(11): e1001342. doi:10.1371/journal.pmed.1001342 (http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001342, accessed 30 October 2013).

49. Government of Canada ban on flavoured tobacco products now in full force, News release 2010–112, 5 July 2010. In: Health Canada [website]. Ottawa: Health Canada; 2010 (http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2010/2010_112-eng.php, accessed 1 November 2013).

50. Anvisa approves the withdrawal of flavored cigarettes. In: ANVISA Brazilian Health Surveillance Agency [website]. Brasília: ANVISA Brazilian Health Surveillance Agency; 2012 (http://portal.anvisa.gov.br/wps/portal/anvisa-ingles/anvisaingles/News/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os3hfRw8jD0NnA3cLSw83A08jS18nMwNnAxN3I6B8pFm8AQ7gaIBPt4EBRDdCPsTfBSjvGOpsZu5naGFsTkO7TSnRTZndA6w7HBTH-EMdJI_HfD-P_NxU_YLcUDCIMMgyAQCV0tq-/dl3/d3/L0lDU0lKSWdrbUEhIS9JRFJBQUlpQ2dBek15cXchLzRCRWo4bzBGbEdpdC1iWHBBRUEhLzdfTUFIMkgxQzBHODlIRjBJMjlNQjYwQzA0NDEvQTFqa041NTUzMDAxNQ!!/?WCM_PI=1&PC_7_MAH2H1C0G89HF0I29MB60C0441020591_WCM_Page.4cce300045272e05aba0fb2475bf1155=3, accessed 4 November 2013).

51. Benowitz NL, Henningfield JE. Reducing the nicotine content to make cigarettes less addictive. Tob Control. 2013;22(suppl 1):i14–7.doi:10.1136/tobaccocontrol-2012-050860.

52. Wilson N, Thomson GW, Edwards R, Blakely T. Potential advantages and disadvantages of an endgame strategy: a "sinking lid" on tobacco supply. Tob Control. 2013;22(suppl 1):i18–i21.doi:10.1136/tobaccocontrol-2012-050791.

53. Branston JR, Gilmore AB. The case for Ofsmoke: the potential for price cap regulation of tobacco to raise £500 million per year in the UK. Tob Control. 2013; doi:10.1136/tobaccocontrol-2011-050385 (http://tobaccocontrol.bmj.com/content/early/2013/01/04/tobaccocontrol-2011-050385.abstract, accessed 4 November 2013).

54. ASH Action: an end-date for tobacco sales [website]. Woolloomooloo, NSW: Action on Smoking and Health (ASH) Australia; 2013 (http://www.ashaust.org.au/lv4/enddate.htm, accessed 30 October 2013).

55. WHO Director-General considers the tobacco endgame. In: World Health Organization [website]. Geneva: World Health Organization; 2013 (http://www.who.int/dg/speeches/2013/tobacco_endgame_20130911/en/index.html, accessed 4 November 2013).

56. Webb P, Bain C. Epidemiology is … In: Essential epidemiology: an introduction for students and health professionals. Cambridge: Cambridge University Press, 2011:1–28 (http://books.google.com.br/books/about/Essential_Epidemiology.html?id=aTJrbvPzu10C&redir_esc=y, accessed 4 November 2013).

57. King C 3rd, Siegel M. The Master Settlement Agreement with the tobacco industry and cigarette advertising in magazines. N Engl J Med. 2001;345(7):504–11.

58. vanWalbeek C, Blecher E, Gilmore A, Ross H. Price and tax measures and illicit trade in the framework convention on tobacco control: What we know and what research is required. Nicotine Tob Res. 2013;(4):767–76. doi:10.1093/ntr/nts170. Epub 2012 Sep 17.

59. A cannabis reader: global issues and local experiences. Lisbon: European Monitoring Centre for Drugs and Drug Addiction; 2008 (EMCDDA Monographs Issue 8; http://www.emcdda.europa.eu/publications/monographs/cannabis, accessed 4 November 2013).

60. Nicotine dependence F17-. In: ICD10Data.com [website]. Seattle (WA): ICD10Data.com; 2013 (http://www.icd10data.com/ICD10CM/Codes/F01-F99/F10-F19/F17-, accessed 8 November 2013).

61. Stead M, Angus K, Holme I, Cohen D, Tait G; PESCE European Research Team. Factors influencing European GPs' engagement in smoking cessation: a multi-country literature review. Br J Gen Pract. 2009;59(566):682–90. doi:10.3399/bjgp09X454007.

62. Chapman S, Wakefield MA. Large-scale unassisted smoking cessation over 50 years: lessons from history for endgame planning in tobacco control. Tob Control. 2013;22:i33–5.doi:10.1136/tobaccocontrol-2012-050767 (http://tobaccocontrol.bmj.com/content/22/suppl_1/i33.full, accessed 4 November 2013).

63. New 36. Partial guidelines for implementation of Articles 9 and 10 of the WHO Framework Convention on Tobacco Control (including amendments adopted at COP5 in 2012). Geneva: World Health Organization; 2012 (http://www.who.int/fctc/guidelines/Guideliness_Articles_9_10_rev_240613.pdf, accessed 4 November 2013).

64. Connolly GN. Sweet and spicy flavours: new brands for minorities and youth. Tob Control. 2004;13(3):211–2. doi:10.1136/tc.2004.009191.

65. Oliver AJ, Jensen JA, Vogel RI, Anderson AJ, Hatsukami DK. Flavored and nonflavored smokeless tobacco products: rate, pattern of use, and effects. Nicotine TobRes. 2013; 15(1):88-92. doi:10.1093/ntr/nts093. Epub 2012 Apr 22.

66. Doward J. Tobacco giant Philip Morris "spent millions in bid to delay EU legislation". The Guardian. 7 September 2013 (http://www.theguardian.com/business/2013/sep/07/tobacco-philip-morris-millions-delay-eu-legislation, accessed 4 November 2013).

67. Gartner CE, Hall WD, Vos T, Bertram MY, Wallace AL, Lim SS. Assessment of Swedish snus for tobacco harm reduction: an epidemiological modelling study. Lancet. 2007;369(9578):2010-4 (http://www.ncbi.nlm.nih.gov/pubmed/17498798, accessed 4 November 2013).

68. Snus: EU ban on snus sales. In: Tobacco Tactics [website]. Bath: University of Bath; 2013 (http://www.tobaccotactics.org/index.php/Snus:_EU_Ban_on_Snus_Sales, accessed 4 November 2013).

69. Conference of the Parties to the WHO Framework Convention on Tobacco Control. Fifth session. Seoul, Republic of Korea, 12–17 November 2012.

70. EverSmoke e-cigarette experts break down vapor smoking regulations and legislation in other countries. In: EverSmoke [website]. Wood Dale (IL): EverSmoke; 2013 (http://www.learn.eversmoke.com/e-cig-world-regulations.html, accessed 4 November 2013).

71. Notes from the field: electronic cigarette use among middle and high school students – United States, 2011–2012. MMWR. 2013;62(35);729–30 (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a6.htm, accessed 4 November 2013).

72. Warner KE. An endgame for tobacco? Tob Control. 2013;22(suppl 1):i3–5. doi:10.1136/tobaccocontrol-2013-050989.

73. Geman H. Commodities and commodity derivatives: modeling and pricing for agriculturals, metals and energy. Chichester: Wiley & Sons; 2005.

74. Commission staff working document of 19 December 2012 Part 3. Impact assessment. Accompanying the document Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products (http://www.europarl.europa.eu/meetdocs/2009_2014/documents/swd/com_swd(2012)0452(par3)_/com_swd(2012)0452(par3)_en.pdf, accessed 8 November 2013).

75. Corrigendum to Council Regulation (EC) No 864/2004 of 29 April 2004 amending Regulation (EC) No 1782/2003 establishing common rules for direct support schemes under the common agricultural policy and establishing certain support schemes for farmers, and adapting it by reason of the accession of the Czech Republic, Estonia, Cyprus, Latvia, Lithuania, Hungary, Malta, Poland, Slovenia and Slovakia to the European Union. O. J. E. U. 2004, L 206:20–30 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:206:0020:0036:EN:PDF, accessed 4 November 2013).

76. FAOSTAT [online database]. Rome: Food and Agriculture Organization of the United Nations., 2013 (http://faostat.fao.org/DesktopModules/Admin/Logon.aspx?tabID=0, accessed 4 November 2013).

77. Commission staff working document of 19 December 2012 Part 1. Impact assessment. Accompanying the document Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products (http://ec.europa.eu/health/tobacco/docs/com_2012_788_ia_en.pdf 2012, accessed 22 November 2013).

78. Yürekli A, Önder Z, Elibol M, Erk N, Cabuk A, Fisunoglu M et al. The economics of tobacco and tobacco taxation in Turkey. Paris: International Union Against Tuberculosis and Lung Disease; 2010 (http://www.who.int/tobacco/en_tfi_turkey_report_feb2011.pdf, accessed 4 November 2013).

79. Tobacco industry interference in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/166748/Tobacco-Industry-Interference-In-the-WHO-European-Region.pdf, accessed 4 November 2013).

80. Hastings G, Angus K. The influence of the tobacco industry on European tobacco-control policy. In: Tobacco or health in the European Union. Past, present and future. Luxembourg: Office for Official Publications of the European Communities; 2004.

81. Baska T, Pudule I, Tilgale N, Warren CW, Lee J, Lea V et al. Smoking tobacco in waterpipes among adolescents in Europe: the case of Latvia and Slovakia. Tob Control. 2008;17(6):432. doi:10.1136/tc.2008.027128.

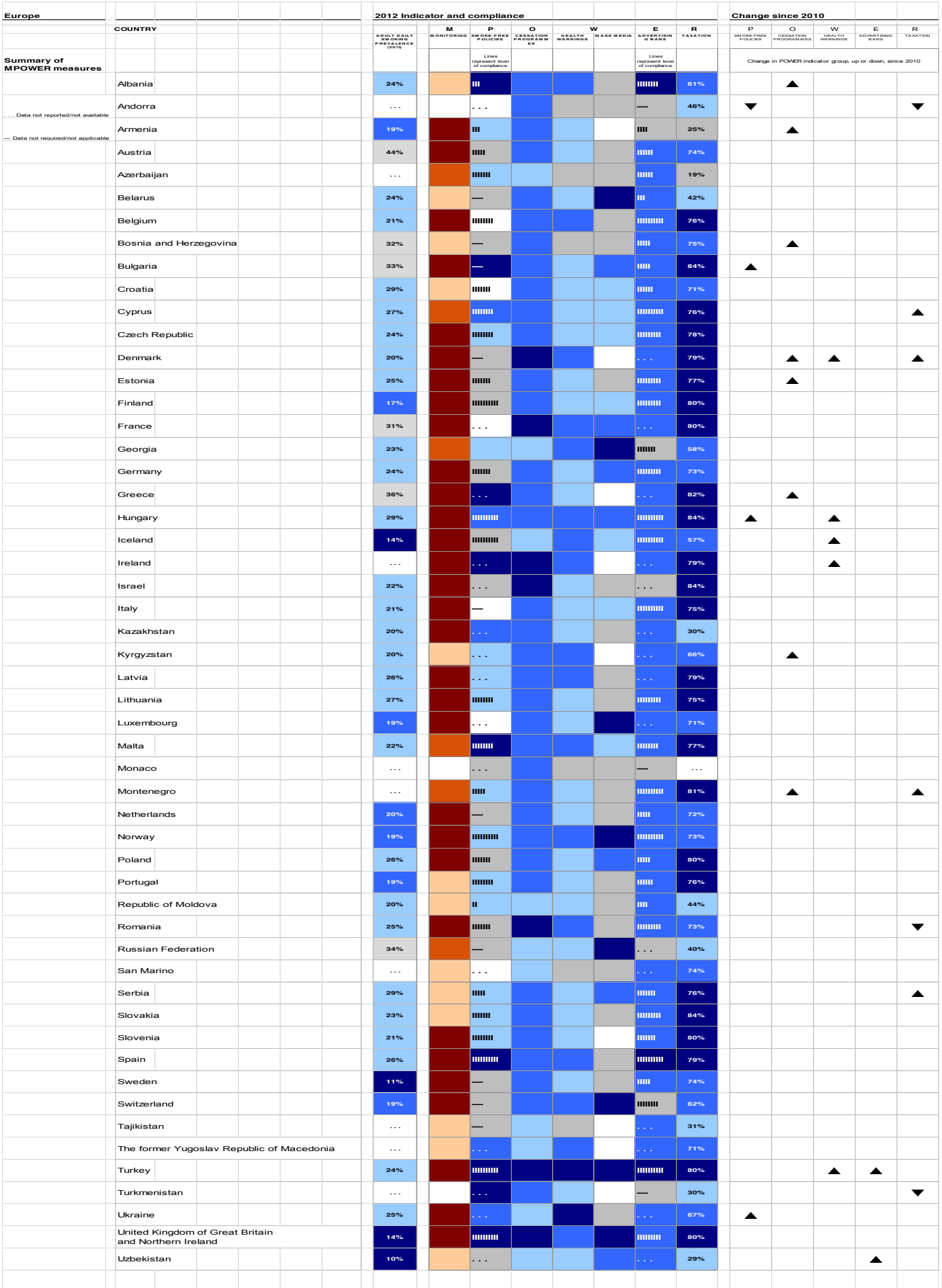
82. Joossens L, Raw M. Cigarette smuggling in Europe: who really benefits? Tob Control. 1998;7(1):66–71. doi:10.1136/tc.7.1.66.

83. Cooperation agreement between British-American Tobacco (Holdings) Limited and the European Union as represented by the European Commission and the Signatory Member States of the European Union, 15 July 2010 (http://ec.europa.eu/anti_fraud/documents/cigarette_smug/2010/bat_main_agreement.pdf, accessed 4 November 2013.

84. Protocol to eliminate illicit trade in tobacco products. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/80873/1/9789241505246_eng.pdf, accessed 4 November 2013).

Annex 1. Regional summary of measures within WHO FCTC

Table 1.Summary of MPOWER measures in the Region



ADULT DAILY SMOKING PREVALENCE* : AGE-STANDARDIZED PREVALENCE RATES FOR ADULT DAILY SMOKERS OF TOBACCO (BOTH SEXES COMBINED), 2011

...	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 POLICIES: POLICIES ON SMOKE-FREE ENVIRONMENTS

	Data not reported/not categorized
	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 January 2011 and June 2012 with duration of at least three weeks
	National campaign conducted with 1 - 4 appropriate characteristics
	National campaign conducted with 5 - 6 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

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
	26–50% of retail price is tax
	51–75% 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 POLICY

	Complete compliance (8/10 to 10/10)
	Moderate compliance (3/10 to 7/10)
	Minimal compliance (0/10 to 2/10)

SYMBOLS LEGEND

	Separate, completely enclosed smoking rooms are allowed if they are separately ventilated to the outside and/or kept under negative air pressure in relation to the surrounding areas. Given the difficulty of meeting the very strict requirements delineated for such rooms, they appear to be a practical impossibility but no reliable empirical evidence is presently available to ascertain whether they have been constructed.
	Policy adopted but not implemented by 31 December 2012
	Data not substantiated by a copy of the legislation
	Change in POWER indicator group, up or down, between 2010 and 2012. Some 2010 data were revised in 2012. 2012 grouping rules were applied to both years.

PLEASE REFER TO TECHNICAL NOTE I FOR DEFINITIONS OF CATEGORIES

Source: WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. Geneva: World Health Organization; 2013 (http://www.who.int/tobacco/global_report/2013/en/index.html, accessed 16 October 2013).

The WHO Regional Office for Europe
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States
Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 33 70 01 Email: contact@euro.who.int
Website: www.euro.who.int