



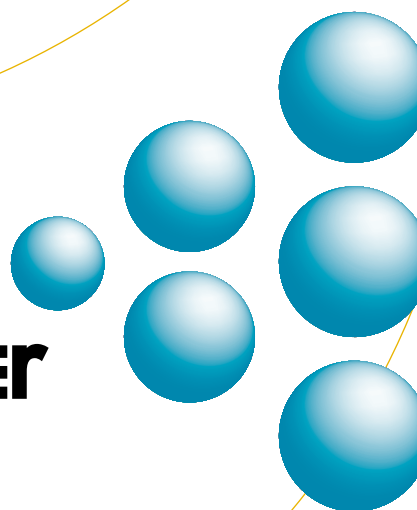
**World Health
Organization**

WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2015

Raising taxes on tobacco

fresh and alive

mpower



**Raising taxes on tobacco
is the most effective
way to reduce
tobacco use.**

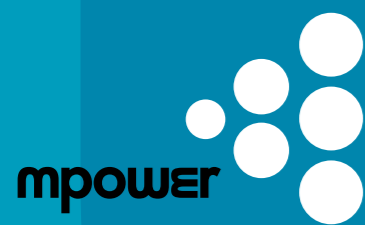


**The tobacco industry
will do whatever it can
to keep taxes low.**

UBER

Public support for tobacco tax increases is widespread.

WHO report on the global tobacco epidemic, 2015: Raising taxes on tobacco is the fifth in a series of WHO reports that tracks the status of the tobacco epidemic and the impact of interventions implemented to stop it.



- M**onitor Monitor tobacco use and prevention policies
- P**rotect Protect people from tobacco smoke
- O**ffer Offer help to quit tobacco use
- W**arn Warn about the dangers of tobacco
- E**nforce Enforce bans on tobacco advertising, promotion and sponsorship
- R**aise Raise taxes on tobacco

WHO Library Cataloguing-in-Publication Data

WHO report on the global tobacco epidemic, 2015: raising taxes on tobacco.

1.Smoking – prevention and control. 2.Tobacco Products – economics. 3.Tobacco Industry – legislation. 4.Taxes. 5.Health Policy. I.World Health Organization.

ISBN 978 92 4 150912 1 (NLM classification: WM 290)

ISBN 978 92 4 069460 6 (PDF)

ISBN 978 92 4 069461 3 (ePub)

© World Health Organization 2015

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for non-commercial distribution – should be addressed to WHO Press through the WHO web site (www.who.int/about/licensing/copyright_form/en/index.html).

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 and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Data for all maps presented in this report derive from data collected for the purpose of this report.

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 expressed 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.

Printed in Luxembourg



WHO REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2015

Raising taxes on tobacco

Made possible by funding
from **Bloomberg Philanthropies**

Contents

- 11 Foreword by Dr Oleg Chestnov, WHO Assistant Director-General
- 13 Foreword by Dr Vera Luiza da Costa e Silva, Head of the WHO FCTC Secretariat
- 15 Foreword by Dr Tim Evans and Patricio Marquez, World Bank Group

16 SUMMARY

20 A DECADE SAVING LIVES: WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

- 22 Article 6 – Price and tax measures to reduce the demand for tobacco
- 23 Guidelines for implementation of Article 6

26 RAISE TAXES ON TOBACCO

- 26 Tobacco tax increases are the single most effective policy to reduce tobacco use
- 34 The mechanics of raising tobacco taxes

46 TOBACCO INDUSTRY INTERFERENCE WITH TOBACCO CONTROL CAN BE NEUTRALIZED

51 STEADY PROGRESS CONTINUES BUT MORE IS NEEDED

- 52 Monitor tobacco use and prevention policies
- 56 Protect from tobacco smoke
- 62 Offer help to quit tobacco use
- 66 Warn about the dangers of tobacco
- 66 *Health warning labels*
- 71 *Anti-tobacco mass media campaigns*
- 74 Enforce bans on tobacco advertising, promotion and sponsorship
- 78 Raise taxes on tobacco
- 88 Countries must act decisively to end the epidemic of tobacco use

92 CONCLUSION

94 REFERENCES

- 100 TECHNICAL NOTE I: Evaluation of existing policies and compliance
- 106 TECHNICAL NOTE II: Smoking prevalence in WHO Member States
- 108 TECHNICAL NOTE III: Tobacco taxes in WHO Member States

- 117 APPENDIX I: Regional summary of MPOWER measures
- 131 APPENDIX II: Tobacco taxes and prices
- 171 APPENDIX III: Year of highest level of achievement in selected tobacco control measures
- 185 APPENDIX IV: Highest level of achievement in selected tobacco control measures in the 100 biggest cities in the world
- 191 APPENDIX V: Status of the WHO Framework Convention on Tobacco Control

197 ACKNOWLEDGEMENTS

- APPENDIX VI: Global tobacco control policy data
- APPENDIX VII: Country profiles
- APPENDIX VIII: Tobacco tax revenues
- APPENDIX IX: Tobacco taxes and prices
- APPENDIX X: Comparable prevalence estimates for smoking, 2013
- APPENDIX XI: Country-provided prevalence data
- APPENDIX XII: Maps on global tobacco control policy data
- APPENDIX XIII: Acknowledgements of national data collectors

Appendices VI to XIII are available online at http://www.who.int/tobacco/global_report/en/



GLOBALLY, THE NUMBER OF PEOPLE FULLY PROTECTED BY AT LEAST ONE MPOWER MEASURE HAS NEARLY TRIPLED SINCE 2007

When the WHO Framework Convention on Tobacco Control (WHO FCTC) entered into force in February 2005, it marked a momentous achievement in the history of tobacco control. In the decade that has ensued, the treaty has become one of the most rapidly embraced and measurably successful in United Nations history. This is testament to the conviction of countries worldwide, large and small, rich and poor, to combat the global tobacco epidemic and protect the health, and ultimately the lives, of their people. The MPOWER measures were established by WHO in 2008 to scale up key WHO FCTC demand reduction measures, with a focus on cost-effectiveness, practicality and impact.

Since publication of the first *WHO report on the global tobacco epidemic*, the number of people worldwide covered by at least one MPOWER measure at the highest level of achievement has nearly tripled from 1 billion to 2.8 billion: an increase representing one quarter of the world's population (the number of countries has more than doubled).

This report, the fifth in the series of WHO reports on the global tobacco epidemic, presents a country-level examination of the epidemic and identifies countries that have applied effective tobacco control measures. The number of people worldwide protected by effective tobacco control measures continues to grow, and countries that have adopted these measures at the highest level of achievement can be considered models for action for those countries that have yet to do so.

Progress in adopting MPOWER measures demonstrates countries' commitment to tobacco control. In 2007, only 1 in 10 people living in low- and middle-income countries were protected by at least one MPOWER measure at the highest level of achievement. Seven years later, this level of protection is enjoyed by nearly 1 in 3 people in those countries.

The focus of this report is raising taxes on tobacco, the 'R' component of MPOWER. Time and again, increasing taxes on tobacco products to increase retail prices has been proven to be the most effective and efficient of the best-buy demand reduction measures to reduce tobacco use. And yet it is also the least widely implemented measure.

For all the positive progress made, raising tobacco taxes lags behind implementation of the other MPOWER measures. In 2014, only 10% of the world's population were covered by taxes that total to more than 75% of retail price. Worryingly, the proportion of low- and middle-income countries that has implemented sufficiently high taxes on tobacco remains small, at only 9%. More effort is needed to advance progress under the 'R' measure to levels achieved with the other measures.

The big picture, however, is promising: we are moving in the right direction on all MPOWER measures, with great progress made on some. But it is not enough. Without significant tobacco taxation, cigarettes remain affordable to the world's billion-plus smokers, and we risk reversing the progress made on other measures.

This report comes at a crucial moment in the history of tobacco control: 2015 marks the end of the Millennium Development Goals (MDGs), and the advent of a new development era with new priorities and targets. Decisions made this year will shape the development landscape for years to come. The new Sustainable Development Goals (SDGs) are set to be far more comprehensive than the MDGs, encompassing a much broader definition of what successful development entails.

Effectively addressing noncommunicable diseases (NCDs) – primarily cancers, diabetes, cardiovascular disease and chronic lung disease – will be a key requirement to achieving the progress in health necessary for successful and sustainable development.

The progress and development of low- and middle-income countries around the world is threatened if disease, disability and death from NCDs are left unaddressed. Already, more than 80% of premature deaths from NCDs occur in developing countries. This burden is projected to rise unless we act.

As tobacco use is the largest preventable risk factor for NCDs, strong tobacco control efforts will have a huge role to play in reducing this burden and ensuring countries' development and prosperity. If we are to succeed in achieving the targets we set for ourselves this year, we must continue our fight to rid the world of its leading preventable cause of death.

Dr Margaret Chan, Director-General of WHO, has been a tireless champion of tobacco control worldwide. Her strong words against tobacco industry interference remind us that the fight is not over and that it is of the utmost importance, now more than ever, for all of us to work together across countries to implement these key MPOWER tobacco control measures. The fate of millions of lives depends upon all of us acting decisively to end this global epidemic.



Dr Oleg Chestnov

Progress in adopting MPOWER measures demonstrates countries' commitment to tobacco control.

The fate of millions of lives depends upon all of us acting decisively to end this global epidemic.

Dr Oleg Chestnov, Assistant Director-General, World Health Organization

MANY PARTIES IMPLEMENTED CHANGES IN THEIR TOBACCO TAXES IN LINE WITH ARTICLE 6 OF THE WHO FCTC AND ITS GUIDELINES

The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) Secretariat welcomes the publication of the *WHO report on the global tobacco epidemic, 2015*, which coincides with the 10th anniversary of the entry into force of the WHO FCTC. The 180 Parties to the WHO FCTC – the world’s first public health treaty under the auspices of WHO – have committed to making tobacco control and saving lives a priority.

Price and tax measures to reduce the demand for tobacco, the focus of this report, are one of the core demand reduction strategies that the WHO FCTC requires its Parties to implement: in Article 6, Parties recognize that, “price and tax measures are an effective and important means of reducing tobacco consumption...”. Further, the WHO FCTC calls on the Parties to adopt and maintain tax and price policies that will, “contribute to the health objectives aimed at reducing tobacco consumption”. To assist Parties in their efforts, the Conference of the Parties (COP) adopted a set of guiding principles and recommendations in 2012, and 2 years later, in October 2014, a full set of Guidelines for implementation of Article 6 (*Price and tax measures to reduce the demand for tobacco*) of the WHO FCTC.

This effort has already started to bear fruit. As detailed in this report, more than half of countries have increased their excise taxes since 2012, many of which implemented changes in their tobacco taxes in line with these new guidelines.

The WHO FCTC Secretariat, in collaboration with WHO and in partnership with the World Bank (an intergovernmental organization accredited as observer to the Conference of the Parties), has engaged with governments of more than 30 Parties to review their implementation of price and tax measures as part of a needs assessment exercise. Parties with identified needs were given targeted assistance in the area of tobacco taxation in line with the guidelines. Cook Islands, Gambia and Jamaica are just a few of the countries that have increased tobacco tax rates as part of this process.

But challenges remain. Tax increases have not been uniform – substantial differences

in prices and taxes still exist among neighbouring countries and even within subregions and regions of some countries. We will continue to work to ensure that WHO FCTC requirements and guidelines are appropriately addressed by each Party. Regional and subregional economic organizations have the unique opportunity to promote tobacco tax harmonization within their constituencies to eliminate differential tax treatment. Additionally, the WHO FCTC Secretariat strongly encourages WHO Member States who are not yet Parties to the WHO FCTC to put in place the evidence-based provisions of the treaty that serve as the foundations of meeting its requirements.

Article 5.3 of the WHO FCTC requires that, “in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry...”. However, Parties report that the tobacco industry often presents significant challenges to implementation of the WHO FCTC. Since increasing tobacco taxes is a potent public health tool that measurably reduces tobacco consumption, it is strongly opposed by the tobacco industry and its front groups, both openly and behind the scenes, who actively interfere with Parties’ development and introduction of strong tobacco taxation policies.

To identify industry attempts at interference, Parties, non-Parties and observers from intergovernmental and civil society organizations need to remain vigilant. Front groups such as chambers of commerce and international think tanks engage with governments to prevent, dilute, delay or derail taxation policy development. One preferred tactic is to instill false fears about the escalation of illicit tobacco trade due to higher taxes and prices and promote “solutions” for the illicit trade problem that are not in line with Article 15 (*Illicit trade in tobacco products*) of the WHO FCTC.

Governments have the power to counter industry interference and implement strong tax policies. The WHO FCTC Secretariat, in collaboration with WHO, the World Bank, the International Monetary Fund and other

observers to the COP, stands ready to promote and support Parties as they work to adopt taxation measures that achieve public health goals. The WHO FCTC provides three main policy approaches to do so: application of the provisions and guidelines for implementation of Article 6; addressing tobacco industry interference by adopting guidelines for implementation of Article 5.3; and implementation of Article 15 and entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products. These approaches, if used together, will have a combined effect that will ensure that tax and price policies lead to reduced tobacco consumption along with all the attendant health benefits.

We would like to congratulate our WHO colleagues at all levels (from headquarters to Regional and Country Offices), as well as the many Bloomberg Initiative partners, for the solid research findings published here. This high-quality information and comparable data on progress in implementing selected demand reduction measures, as well as the monitoring mechanisms that allow the tobacco epidemic to be measured and interventions evaluated, shows the advances that have been made and provides guidance for future progress.

We hope the *WHO report on the global tobacco epidemic, 2015*, series continues to contribute to the advancement of global tobacco control and that consideration will be made to discuss the remaining WHO FCTC demand and supply reduction measures in future editions. Providing countries with accurate and comparable information in areas as diverse as product regulation, illicit trade, sales to and by minors, alternative livelihoods, environmental protection and countering industry litigation strategies, among others, will lead to further reductions in tobacco use and additional improvements in global public health.

Dr Vera Luiza da Costa e Silva



Price and tax measures are one of the core demand reduction strategies that the WHO FCTC requires its Parties to implement.

Governments have the power to deflect industry interference and implement strong tax policies.

Dr Vera Luiza da Costa e Silva, Head of the WHO FCTC Secretariat

Tobacco use is a significant hurdle to development gains worldwide. It is the leading cause of preventable death. Smoking-related illness costs billions of dollars each year, imposing a heavy economic toll on countries, both in terms of direct medical care for adults and lost productivity.

Over the past 10 years, since entry into force of the WHO FCTC, efforts to control tobacco have intensified globally. MPOWER is being implemented across the world. WHO estimates that 2.8 billion people in 103 countries are now covered by at least one MPOWER measure at the highest level, up from 1 billion people in 42 countries in 2007.

In spite of these achievements, much more needs to be done to control this health scourge. Raising tobacco taxes to make these deadly products unaffordable is the most cost-effective measure to reduce tobacco use or to prevent its initiation among youth. The benefits of higher tobacco taxes and prices are obvious, as there are good health outcomes both for individuals and entire communities that result from reduced consumption of tobacco products. This fiscal measure also helps expand a country's tax base to mobilize additional revenue to fund vital health programmes and other essential public services.

Looking ahead, increased tobacco taxation (along with other taxes on potentially harmful products) could represent an important revenue stream for helping finance the UN's Sustainable Development Goals (SDGs) across the world.

Tobacco control is fully aligned with the World Bank Group's twin goals of ending extreme poverty by 2030, and boosting shared prosperity by increasing the income of the bottom 40% of the world's population. It makes solid economic sense, given the high costs of tobacco-related ill health and premature death and disability of adults in their most productive years.

Tobacco use also disproportionately affects the poorest people. More than 80% of the world's smokers live in low- and middle-income countries, harming health, incomes,

earning potential, labour productivity, and undermining human capital accumulation – a critical factor for sustainable economic growth and social development.

The World Bank Group has long been committed to tobacco control, and has had an unambiguous global policy on tobacco since 1999. This policy means the World Bank does not lend directly to, provide grants for investment in, or guarantee investments or loans or credits for tobacco production, processing, or marketing. Unmanufactured and manufactured tobacco, tobacco processing machinery and equipment, and related services are included in the negative list of imports in projects funded by the World Bank. Moreover, World Bank technical assistance programmes support efforts to increase taxes and prices on tobacco products.

Over the past two decades, the World Bank has carried out a substantial amount of work to increase knowledge of issues related to tobacco control. A 1999 World Bank report, *Curbing the epidemic: governments and the economics of tobacco control*, contributed to the successful negotiations of the WHO FCTC. The World Bank's Economics of Tobacco Toolkit helps researchers analyse the economics of tobacco policies in their countries, while other reports on the challenge posed by noncommunicable diseases in numerous regions and countries highlight the importance of tobacco control as a priority public policy intervention. World Bank teams, working with in-country, regional and global partners, have provided technical assistance to design and implement tobacco taxation reforms intended to reduce tobacco use by raising prices for these products.

In partnership with the Bill & Melinda Gates Foundation and Bloomberg Philanthropies, and in coordination with the WHO FCTC Secretariat and the World Health Organization, the World Bank is now launching a new global effort to promote, build national capacity for, and support priority middle- and low-income countries in the design, enactment, implementation, and monitoring of tax policy reforms to make tobacco products unaffordable,

reduce consumption and improve health conditions. Technical assistance will also be provided to strengthen the institutional capacity of countries to curtail illicit trade of tobacco. Support will be provided to develop knowledge-sharing platforms to facilitate peer-to-peer exchanges among policy-makers and other country officials on the economics of tobacco control.

To this end, the World Bank's health, macroeconomic and fiscal management, and governance practices are starting to work together, leveraging their access to ministries of finance, health and other related government agencies to take tobacco taxation efforts to scale, expand the use of policy advice, technical assistance, and funding instruments for supporting country efforts, and institutionalize tobacco taxation as part of the World Bank's country assistance strategies globally. The World Bank's multisectoral engagement will complement in a coordinated manner WHO's global and country work on tobacco control.

The World Bank is committed to support the implementation of the global tobacco control effort outlined in this report, particularly tobacco taxation. Effective tobacco tax regimens that make tobacco products unaffordable represent a 21st century intervention to tackle the growing burden of noncommunicable diseases. We are convinced that, working together with WHO and other partners in support of countries, we will be able to prevent the human tragedy of tobacco-related illness and death, and save countless lives each year. By doing so, not only we will be able to honour the memory of loved ones who suffered and were lost to tobacco-related diseases, but also contribute to sustainable economic and social development across the world.



Dr Tim Evans



Patricio Marquez

Raising tobacco taxes to make these deadly products unaffordable is the most cost-effective measure to reduce tobacco use or to prevent its initiation among youth.

The World Bank is committed to support the implementation of the global tobacco control effort outlined in this report, particularly tobacco taxation.

Dr Tim Evans, Senior Director, and Patricio Marquez, Lead Health Specialist
Health, Nutrition and Population Global Practice, World Bank Group

Summary

In the decade since the WHO Framework Convention on Tobacco Control came into force, and 7 years after the introduction of MPOWER to assist Parties in meeting some of their WHO FCTC obligations, there has been steady progress in global tobacco control. Today, more than half of the world's countries, with 40% of the world's population (2.8 billion people) have implemented at least one MPOWER measure at the highest level of achievement (not including the Monitoring and Mass media measures, which are assessed separately). This progress more than doubles the number of countries and nearly triples the number of people covered since 2007.

Raising tobacco taxes, the focus of this *WHO Report on the global tobacco epidemic, 2015*, is an area in particular need of attention. Despite the fact that raising tobacco taxes to more than 75% of the retail price is among the most effective and cost-effective tobacco control interventions (it costs little to implement and increases government revenues), only a few countries have increased tobacco taxes to best practice level. Raising taxes is the least implemented MPOWER measure – with only 10% of the world's people living in countries with sufficiently high taxes – and is the measure that has seen the least improvement since we started assessing these data. Even so, by 2014, 11 countries had raised taxes to represent

more than 75% of the retail price of a pack of cigarettes, joining the 22 countries that already had similarly high taxes in place in 2008. However, there are still many countries with extremely low tobacco tax rates, and some countries that do not levy any tobacco taxes at all.

Many countries have implemented multiple MPOWER measures at the highest level of achievement. A total of 49 countries with nearly 20% of the world's population are covered by two or more MPOWER measures at the highest level, tripling the number of people protected by at least two fully implemented tobacco control measures to 1.4 billion people since 2007. Seven countries, five of which are low- and middle-

More than half of the world's countries, with 40% of the world's population (2.8 billion people) have implemented at least one MPOWER measure at the highest level of achievement.

income, have implemented four or more MPOWER measures at the highest level. Six of these countries (four of which are low- and middle-income countries with more than 4% of the world's population – more than 300 million people), are only one step away from having all MPOWER measures in place at the highest level.

Over the past 2 years, there has been notable progress in global tobacco control. Since the previous *WHO Report on the global tobacco epidemic, 2013*, which reported data from 2012, the global population covered by at least one MPOWER measure at the highest level has

increased from 2.3 billion to 2.8 billion, an increase of half a billion people (7% of the world's population). The number of countries implementing at least one MPOWER measure at the highest level has increased by 11 since 2012, from 92 to 103. Each MPOWER measure saw new countries implementing best tobacco control practice since 2012.

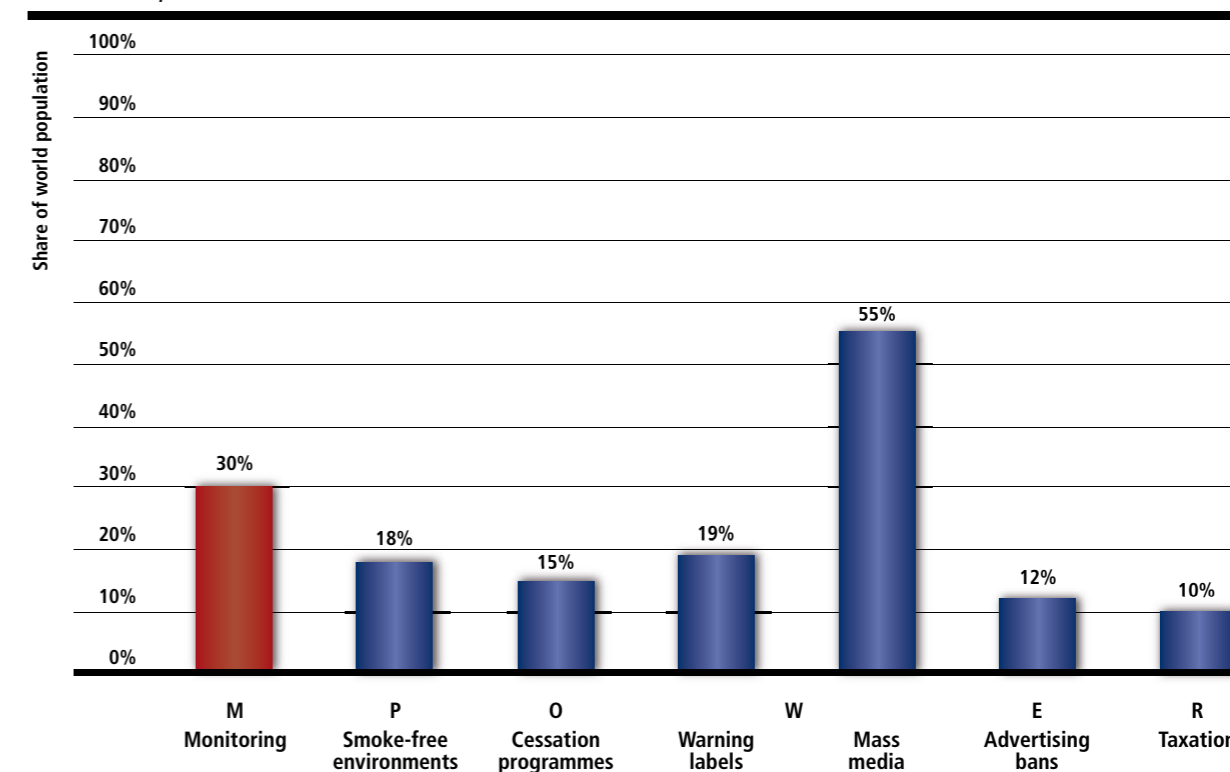
■ Five countries with a combined population of 187 million people, (Chile, Jamaica, Madagascar, Russian Federation and Suriname) implemented a comprehensive smoke-free law covering all indoor public places and workplaces.

■ Six countries (Argentina, Belgium, Brunei Darussalam, Malta, Mexico and the Netherlands) implemented appropriate cessation services. Because one country reduced services after 2012, the net gain for offering assistance to quit was five countries and 173 million people.

■ Twelve countries with a combined population 370 million people (Bangladesh, Costa Rica, Fiji, Jamaica, Namibia, Philippines, Samoa, Solomon Islands, Trinidad and Tobago, Turkmenistan, Vanuatu and Viet Nam) implemented large graphic pack warnings.



SHARE OF THE WORLD POPULATION COVERED BY SELECTED TOBACCO CONTROL POLICIES, 2014



Note: The tobacco control policies depicted here correspond to the highest level of achievement at the national level; for the definitions of these highest categories, refer to Technical Note I.

- Seven countries (Kiribati, Nepal, Russian Federation, Suriname, United Arab Emirates, Uruguay and Yemen) introduced a complete ban on all tobacco advertising, promotion and sponsorship (TAPS) activities, thus protecting an additional 209 million people from exposure to TAPS.
- Seven countries (Bangladesh, Bosnia and Herzegovina, Croatia, Kiribati, New Zealand, Romania and Seychelles) raised taxes on cigarettes to more than 75% of the retail price (because four countries did not maintain sufficiently high taxes after 2012, and one country did not provide data, the net gain for raising taxes was only two countries and 154 million people).

Low- and middle-income countries have been making significant progress. Nine low-

and middle-income countries that previously had no policies in place have introduced protections for their populations since 2012 by newly implementing one or more MPOWER measures at the highest level of achievement, so that an additional 363 million people are covered. Consequently, about 1.8 billion people – a third of all people living in low- and middle-income countries – are now protected by at least one MPOWER measure at the highest level.

Despite progress in implementing comprehensive tobacco control policies in a growing number of countries, more work is needed. Many countries have not put in place MPOWER measures at the highest level. The populations of these countries are not being effectively covered by evidence-based tobacco control best practices, leaving them at increased risk of tobacco

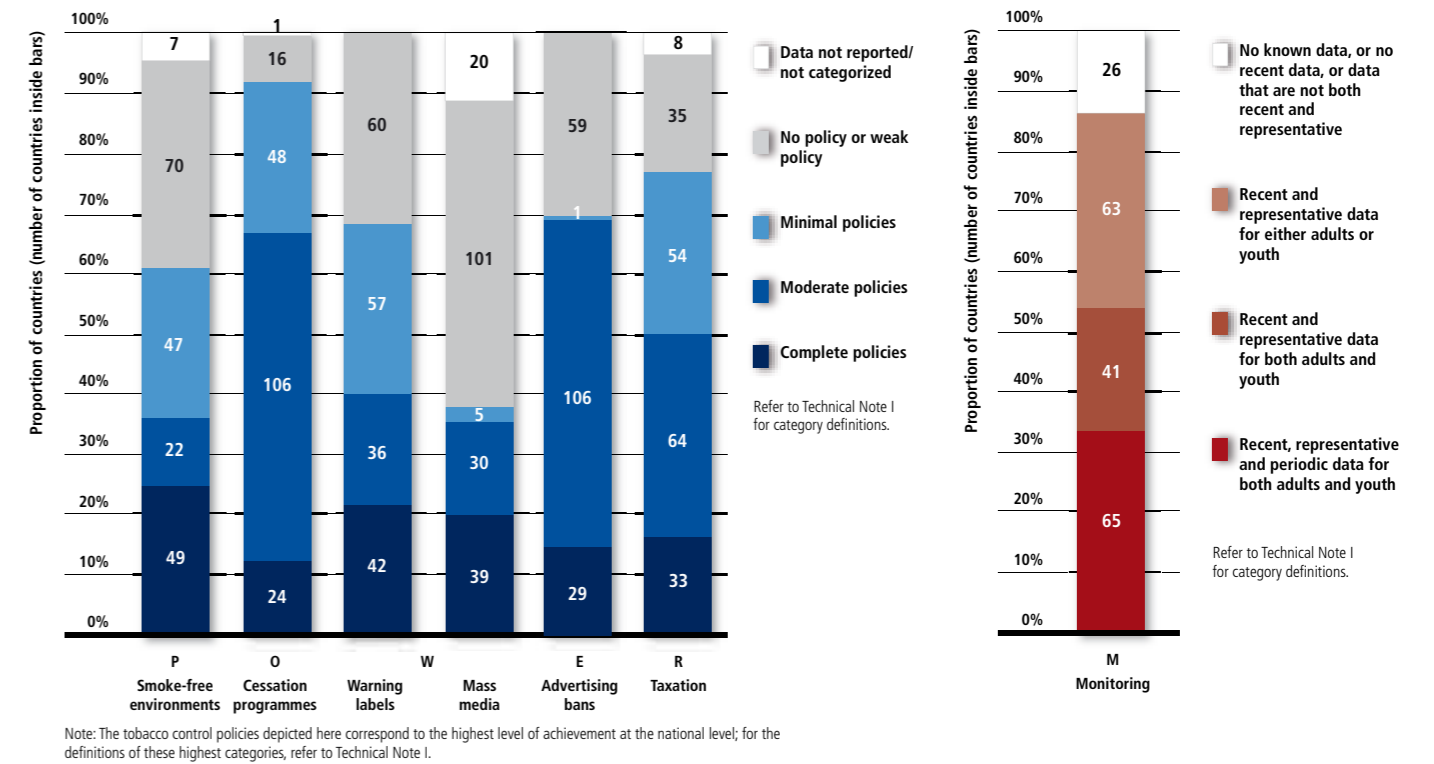
use, secondhand smoke exposure, and the illness, disability and death they cause.

All countries have the ability to implement strong tobacco control policies to protect their people. In the decade since the WHO FCTC came into force, there has been impressive progress in all regions and among countries of all income levels. This has provided a solid foundation for future progress, but we must continue the gains to ensure that all of the world's people benefit from the same strong protections that only some enjoy today. Millions of lives every year depend on our actions.

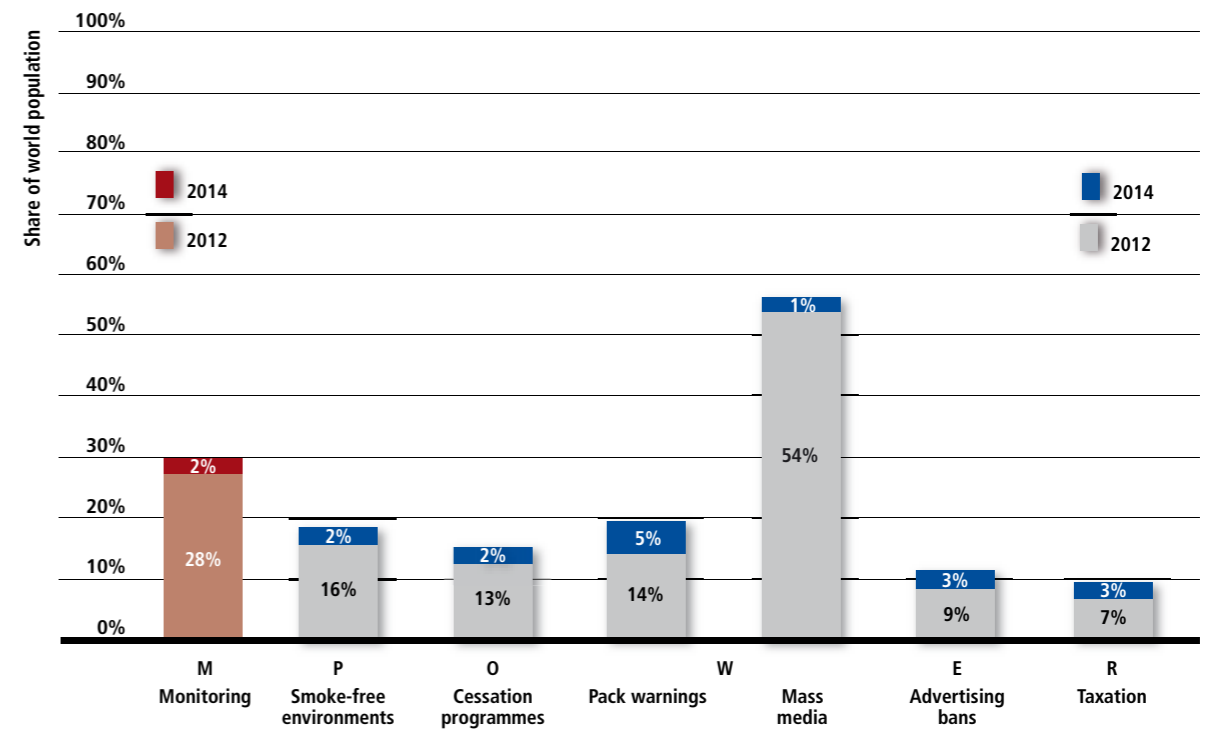
Seven countries raised taxes so that they represent more than 75% of the retail price of a pack of cigarettes.



THE STATE OF SELECTED TOBACCO CONTROL POLICIES IN THE WORLD, 2014



INCREASE IN THE SHARE OF THE WORLD POPULATION COVERED BY SELECTED TOBACCO CONTROL POLICIES, 2012 TO 2014



A decade saving lives: WHO Framework Convention on Tobacco Control



The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) (1) became binding law for its then 40 Parties on 27 February 2005. In the decade since, the number of Parties to the WHO FCTC has risen to 180, covering more than 90% of the world's population and making it one of the most successful and rapidly embraced treaties in United Nations history.

The WHO FCTC began as a response to a growing tobacco epidemic that saw ever-rising numbers of people becoming addicted to nicotine and a growing burden of death and disease as a result. Driving this global health threat was and still is an industry that by its own admission – as revealed in internal documents – seeks every opportunity to expand its market, including intensive targeting of women, children and poorer parts of society. Propelled by sophisticated advertising campaigns, liberalized global trade regimes and more pervasive tobacco industry interference

with public health policies and government affairs, tobacco use increased in most countries during the last decades of the 20th century.

To shift the balance in favour of public health, WHO Member States came together in 1999 under the authority of WHO's Constitution to negotiate their first treaty. Adopted by the World Health Assembly in 2003, the WHO FCTC gives countries the foundation and framework necessary to enact comprehensive, effective tobacco control measures that span all sectors of government. Following that success, Parties to the treaty then negotiated the WHO FCTC's first protocol, the Protocol to Eliminate Illicit Trade in Tobacco Products, which was adopted by the Conference of the Parties (COP) to the WHO FCTC at its 5th session in 2012.

The COP is the WHO FCTC's intergovernmental governing body, comprised of all Parties and responsible

for guiding WHO FCTC implementation through, inter alia, adoption of protocols and necessary decisions. The COP meets every 2 years to discuss progress, identify challenges and opportunities, and review ongoing business. Hosted by WHO, the Convention Secretariat supports WHO FCTC Parties in their implementation of the Convention and organizes and supports the COP and its subsidiary bodies. The Secretariat works closely with WHO to ensure complementarity and synergy.

Tobacco use claimed an estimated 100 million lives worldwide during the 20th century, and remains a serious and growing global health threat (2). With around 6 million lives lost annually, tobacco-related diseases claim more lives than HIV and AIDS, malaria and tuberculosis combined. Implementing the evidence-based, legally binding provisions of WHO's FCTC to their fullest extent represents the world's best chance of reducing this toll.

Provisions of the Convention

The WHO FCTC combines measures to reduce both the demand and supply of tobacco products, as well as other key provisions, including a requirement that Parties act to protect public health policies from interference by commercial and other vested interests of the tobacco industry. The treaty's scope covers the full chain of tobacco product production, distribution and sale.

The core **demand reduction provisions** in the WHO FCTC are contained in articles 6–14:

- Price and tax measures to reduce the demand for tobacco.
- Non-price measures to reduce the demand for tobacco, namely:
 - protection from exposure to tobacco smoke (Article 8)
 - regulation of the contents of tobacco products (Article 9)
 - regulation of tobacco product disclosures (Article 10)
 - packaging and labelling of tobacco products (Article 11)
 - education, communication, training and public awareness (Article 12)
 - tobacco advertising, promotion and sponsorship (Article 13)
 - demand reduction measures concerning tobacco dependence and cessation (Article 14).

The core **supply reduction provisions** in the WHO FCTC are contained in articles 15–17:

- Illicit trade in tobacco products (Article 15).
- Sales to and by minors (Article 16).
- Provision of support for economically viable alternative activities (Article 17).

The WHO FCTC also requires Parties to implement cross-cutting measures such as developing multisectoral tobacco control strategies, adopting tobacco control legislation and preventing tobacco industry interference with public health policies. The Convention also calls for research and surveillance programmes as well as reporting, exchange of information and scientific and technical cooperation (Articles 20, 21 and 22). It also recognizes and calls for provision of financial support for national tobacco control activities (Articles 2, 26).

It is important to note that the Convention is the world's only treaty under the auspices of WHO and a symbol and rallying point for global efforts to reduce tobacco use. The momentum and solidarity of the global tobacco control movement was ensured with the adoption and entry into force of the WHO FCTC, which is continually referenced as the milestone instrument for efforts to reduce the harms caused by tobacco use.

The World Health Assembly stressed the need for full implementation of the WHO FCTC by all Member States as a key policy measure for meeting the WHO global voluntary target of a 30% relative reduction in prevalence of current tobacco use among persons aged 15 years or older. Member States that have not yet become Party to the WHO FCTC should consider action to ratify, accept, approve, formally confirm or accede to it at the earliest opportunity, in accordance with resolution WHA56/8 (1) and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (3). In the same vein, the 6th Conference of the Parties called on Parties to accelerate implementation of the WHO FCTC and to consider setting national targets for reduction of tobacco use, given the global voluntary target of 30% relative reduction in prevalence of current tobacco use in persons aged 15 years and over (4).

The combination of countries coalescing behind a common goal, the power of international law and the focus of global intergovernmental bodies operating in concert gives countries confidence as they work to implement the treaty. This is despite ever-increasing pressure from the tobacco industry, which has become overtly aggressive in its attempts to undermine governments' tobacco control measures.



The WHO FCTC gives countries the foundation and framework necessary to enact comprehensive, effective tobacco control measures that span all sectors of government.

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

Using price and tax measures to increase the retail price of tobacco products is seen as the most effective way to curb demand for tobacco products. This was recognized by WHO Member States when they negotiated the WHO FCTC and, as a result, Article 6 (*Price and tax measures to reduce the demand for tobacco*) of the Convention states that, “price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons”.

It is also well documented that increasing taxes on tobacco products boosts government revenue. Appropriately structured, tax policy can provide the dual benefits of reducing the disease and death

caused by tobacco use as well as generating income for government treasuries.

Tobacco companies are also aware of this and make every effort to stop governments implementing public health-driven policies regarding tobacco product taxation. Industry tactics include interfering with the development of taxation policies and lobbying representatives of finance, economy and other relevant ministries and authorities where health expertise and knowledge of the requirements of the WHO FCTC is often deficient.

Article 6 gives countries the opportunity to act across government sectors to protect public health by using taxes to increase tobacco product prices. Specifically, Article

6 encourages each Party to, “take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include:

- (a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption; and
- (b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products.”



The guidelines for implementation of Article 6 of the WHO FCTC were adopted at the sixth session of the COP in October 2014, Moscow, Russian Federation.

Guidelines for implementation of Article 6

To assist with implementation of Article 6, Parties to the Convention developed guidelines that were adopted on 18 October 2014 (5).

Underpinning the Guidelines is a set of guiding principles. Emphasizing that tobacco use causes high direct health costs as well as other costs associated with disability and premature loss of life, and that effective tobacco taxation reduces those costs as well as the health consequences of tobacco use, the guiding principles of Article 6 are:

- Determining tobacco taxation policies is a sovereign right of the Parties.
- Effective tobacco taxes significantly reduce tobacco consumption and prevalence.
- Effective tobacco taxes are an important source of revenue.
- Tobacco taxes are economically efficient and reduce health inequalities.
- Tobacco tax systems and administration should be efficient and effective.
- Tobacco tax policies should be protected from vested interests.

The Guidelines focus on tobacco excise taxes, with a short section on value added tax. These are the two main tax-based economic policy tools countries use to raise the price of tobacco products relative to the prices of other goods or services. Additionally, the text emphasizes that while tobacco taxation is a powerful tobacco control tool, it does not exist in a vacuum. Restructuring tobacco tax policies to benefit public health should be implemented alongside other policies required under the WHO FCTC. Further, broader economic policy considerations, including the interrelationship between tax and price policies and national income growth, also need to be taken into account.

Recommendations of the Guidelines

The Guidelines contain a set of defined terms and are split into seven substantive sections, each containing recommendations for implementation. The document ends with a list of supporting references. What follows provides a synopsis of the substantive sections of the Guidelines and their recommendations.

Relationship between tobacco taxes, prices and public health

This section examines the relationship between raising taxes, increasing prices and reducing consumption and prevalence. The

inverse relationship between price and tobacco use has been demonstrated by numerous studies. Raising prices on tobacco products demonstrably reduces demand, particularly among young people and those of lower socioeconomic status. At the same time, higher taxes result in increased government revenues.

This section in the Guidelines recommends: when establishing or increasing their national levels of taxation, Parties should take into account – among other things – both price elasticity and income elasticity of demand, as well as inflation and changes in household income, to make tobacco products less affordable over time in order to reduce consumption and prevalence. Therefore, Parties should consider having regular adjustment processes or procedures for periodic re-evaluation of tobacco tax levels.

Tobacco taxation systems

Here, the Guidelines present (a) a possible structure of tobacco taxes (ad valorem, specific or a mixture of both, minimum taxes, other taxes on tobacco goods); (b) levels of tax rates to apply; and (c) ideas for comprehensive tax policies that result in similar tax burdens for different types of tobacco products. In some systems, tax rates vary based on price or other product characteristics (tiered taxes). Generally, more complex tax systems, particularly tiered systems, are more difficult to administer, and tax exemptions in particular may diminish the effectiveness of tax policies on public health outcomes. With regard to determining the levels of tax rates to apply, the Guidelines reflect that there is no single optimal level of tobacco taxation that will apply to all countries because of differences in tax systems, geographic and economic circumstances, and national public health and fiscal objectives. However, in setting tobacco tax levels, the final retail price rather than individual tax rates is an important outcome. The WHO technical manual on tobacco tax administration recommends that tobacco excise taxes account for at least 70% of the retail prices of tobacco products (6).

This section of the Guidelines contains six recommendations:

- Parties should implement the simplest and most efficient system that meets their public health and fiscal needs, taking into account their national circumstances. Parties should consider implementing specific or mixed excise systems with a minimum specific tax floor, as these systems have considerable advantages over purely ad valorem systems.

- Parties should establish coherent long-term policies on their tobacco taxation structure and monitor them on a regular basis, including targets for their tax rates, in order to achieve their public health and fiscal objectives within a certain period of time.
- Tax rates should be monitored, increased or adjusted on a regular basis, potentially annually, taking into account inflation and income growth developments in order to reduce consumption of tobacco products.
- All tobacco products should be taxed in a comparable way as appropriate, in particular where the risk of substitution [with another product] exists.
- Parties should ensure that tax systems are designed in a way that minimizes the incentive for users to shift to cheaper products in the same product category or to cheaper tobacco product categories as a response to tax or retail price increases, or other related market effects.
- In particular, the tax burden on all tobacco products should be regularly reviewed and, if necessary, increased and, where appropriate, be similar.

Tax administration

In addressing tax administration, the Guidelines cover areas such as authorization/licensing; warehouse systems/movement of excisable goods and tax payments; anti-forestalling measures (see below); fiscal markings; and enforcement.

The Guidelines indicate that maintaining control over the tobacco supply chain is important for efficient and effective tax administration. As such, licensing, or equivalent approval or control systems, should be applied to relevant entities to allow for control of the supply chain, in line with Article 6 of the Protocol to Eliminate Illicit Trade in Tobacco Products. Further, because controls need to be carried out in production and storage facilities to ensure that relevant tax levies are collected, it is necessary to maintain a system of warehouses, subject to authorization by the competent authorities, for the purpose of facilitating these controls.

In some cases, changes to tax structures can be anticipated by manufacturers or importers, who may attempt to take advantage of the current or lower tax and increase production or product stocks (known as forestalling). To prevent this, the Guidelines recommend that "... Parties should consider implementing anti-forestalling measures, such as:

- restricting the release of excessive volumes of tobacco products immediately prior to a tax increase; (and)
- levying the new tax on products already produced or kept in stock, and not yet supplied to the final consumer, including those in retail (known as a floor-stock or inventory tax)".

Monitoring the production and import of tobacco products using fiscal markings, such as tax stamps, enhanced tax stamps (also known as banderols) and digital tax stamps, is generally considered to be an effective method to increase compliance with tax laws. Moreover, fiscal markings can help distinguish between illicit and legal tobacco products. The Guidelines take care to note that developing a tracking and tracing system that includes marking of tobacco products with a unique identifier, in line with Article 15 of the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products, may further secure the distribution system and assist in investigations of illicit trade.

Effective tobacco tax administration requires clear designation of responsible enforcement authorities, information sharing among enforcement agencies and penalties that are strict enough to deter noncompliance.

The 10 recommendations from this section are:

- Parties should ensure that transparent licensing or equivalent approval or control systems are in place.
- Parties are urged to adopt and implement measures and systems of storage and production warehouses to facilitate excise controls on tobacco products.
- In order to reduce the complexity of tax collection systems, excise taxes should be imposed at the point of manufacture, importation, or release for consumption from the storage or production warehouses.
- Tax payments should be required by law to be remitted at fixed intervals or on a fixed date each month and should ideally include reporting of production and/or sales volumes, and price by brands, taxes due and paid, and may include volumes of raw material inputs.
- Tax authorities should also allow for the public disclosure of the information contained within the reports, through the available media, including those online, taking into account confidentiality rules in accordance with national law.
- In anticipation of tax increases, Parties should consider imposing effective anti-forestalling measures.
- Where appropriate, Parties should consider requiring the application of fiscal markings to increase compliance with tax laws.
- Parties should clearly designate and grant appropriate powers to tax-enforcement authorities.
- Parties should also provide for information-sharing among enforcement agencies in accordance with national law.
- In order to deter noncompliance with tax laws, Parties should provide for an appropriate range of penalties.

Use of revenues – financing of tobacco control

Bearing in mind Article 26.2 of the Convention, which requires Parties to, "provide financial support in respect of its national

activities intended to achieve the objective of the Convention, in accordance with its national plans, priorities and programmes", this section of the Guidelines reminds Parties that the Guidelines for implementation of Articles 8, 9, 10, 12 and 14 highlight that tobacco excise taxes provide a potential source of financing for tobacco control. In this vein, the section concludes with the recommendation that Parties consider dedicating revenue to tobacco-control programmes, such as those covering education and awareness raising, health promotion and disease prevention, cessation services, viable alternative economic activities, and financing of appropriate tobacco control structures.

Tax-free/duty-free sales

The Guidelines indicate that, "in duty-free shops in airports, on international transport vehicles and in tax-free shops, tobacco products are often sold without any excise taxes burden. Tax- and duty-free sales erode the positive public health effects of tax and price measures aimed at reducing tobacco use, since tax-free tobacco products are less expensive and relatively more affordable than those that are taxed. Moreover, these sales can adversely affect government revenues by creating a loophole in the tax structure, as tax- or duty-free products can be an origin of illicit trade. ... International actions to ban tax- or duty-free sales are built around three basic options:

- prohibiting tax- or duty-free sales of tobacco products;
- applying excise taxes on tobacco products sold in tax- or duty-free stores; or
- limiting travellers' allowances for tobacco products ... "

The Guidelines recommend that, "Parties should consider prohibiting or restricting the sale to and/or importation by international travellers of tax- or duty-free tobacco products."

International cooperation

The final section of the Guidelines reviews the usefulness of, and opportunities for, international cooperation as an important means of strengthening the capacity of Parties to meet their obligations under Article 6, in accordance with Articles 4.3, 5.4, 5.5, 20 and 22 of the WHO FCTC. This type of cooperation is most effective when implemented alongside the reports that Parties must regularly submit on their progress in implementing the WHO FCTC, which form a cornerstone for information exchange and cooperation under the Convention. Article 6 calls upon Parties to provide rates of taxation for tobacco products and trends in tobacco consumption in these reports. The current reporting instrument contains questions on both the absolute tax levels and share of price accounted for by tax. Reports of the Parties, as well as the global progress reports presented to each regular session of the Conference of the Parties, can be used to enhance each other's knowledge of experiences concerning taxation and pricing policies.

The full text of the Guidelines for implementation of Article 6 of the WHO FCTC, as adopted at the sixth session of the Conference of the Parties in October 2014, is available at: http://www.who.int/fctc/treaty_instruments/Guidelines_article_6.pdf?ua=1.

The Guidelines also include references used by the Working Group when writing the document.

Implementing the evidence-based, legally binding provisions of WHO's FCTC to their fullest extent represents the world's best chance of reducing tobacco use.

Raise taxes on tobacco

Tobacco tax increases are the single most effective policy to reduce tobacco use

Raising tobacco taxes is the most effective and cost-effective strategy for reducing tobacco use. The effectiveness of tobacco tax increases is enhanced when implemented as part of a comprehensive tobacco control strategy (6).

Higher tobacco taxes and prices reduce consumption and promote quitting

Hundreds of studies from countries around the world have examined the impact of tobacco taxes and prices on tobacco use (7). Before 2000, nearly all of this research was conducted in high-income countries (8). Since then, however, research from dozens of low- and middle-income countries confirms that higher tobacco taxes and

prices lead to significant reductions in tobacco use (7).

Research from high-income countries generally finds that a 10% price increase will reduce overall tobacco use by between 2.5% and 5% (4% on average) (7).

Estimates of the effect of price increases in low- and middle-income countries are more variable, but often point to larger reductions in overall consumption than those reported in high-income countries (7). Most estimates from low- and middle-income countries show that a 10% price increase will reduce tobacco use by between 2% and 8% (5% on average) (7).

Studies from a number of countries typically show that half of the decline in tobacco use associated with higher taxes and prices

results from reduced prevalence (i.e. from users quitting) (7). The remaining half comes from reduced intensity of use (i.e. users consuming less by switching from daily to occasional smoking, or reducing the number of cigarettes smoked each day) (7).

In the United States of America (USA), cigarette prices rose nearly 350% between 1990 and 2014, in large part because of a five-fold increase in average state cigarette taxes and a six-fold increase in the national cigarette tax (9). During this time the number of cigarettes smoked per capita dropped by more than half, and the percentage of adults who smoke fell nearly one third (9, 10). Tax and price increases in Brazil explain nearly half of the 46% reduction in adult smoking prevalence between 1989 and 2010 (11). Other

countries exhibit different proportions in the relative declines in prevalence and intensity based on their specific patterns of tobacco use and existing tax policies (7).

Higher tobacco taxes are inexpensive to implement

Not only is tobacco taxation extremely effective in reducing tobacco use, it is also relatively inexpensive to implement. A recent WHO study estimated the cost of implementing and administering tobacco tax increases at US\$ 0.05 per person per year in low- and middle-income countries, making it the least costly of all tobacco control policies (12). The *World health report 2002* previously showed that raising tobacco taxes has the greatest potential impact on global public health, as well

as being affordable and the most cost-effective tobacco-reduction measure in most countries (13).

In 2006, the Disease Control Priorities Project (DCP2) undertaken by WHO, the World Bank and other partners found that the cost per Disability Adjusted Life Year (DALY) saved from implementing a 33% price increase through higher taxation ranged from US\$3–42 per DALY saved in low-income countries, and US\$ 13–195 per DALY saved globally (14). This compares very favourably with the cost of non-price demand reduction interventions, which ranged from US\$ 233–2916 per DALY globally.

The Copenhagen Consensus Center, a non-profit organization seeking to establish priorities for advancing global welfare,

produced a benefit-cost assessment of the Sustainable Development Goals – the post-2015 successors to the Millennium Development Goals – and has classified tobacco tax increases as a “phenomenal” intervention (defined as having robust evidence for benefits more than 15 times higher than costs) (15).

Higher tobacco taxes and prices are especially effective in reducing tobacco use by vulnerable populations

Tobacco use among young people is very price sensitive, with reductions in tobacco use in this group two to three times larger with a given price increase than among adults (7). Higher taxes and prices prevent young people from initiating tobacco



Raising tobacco taxes is the most effective and cost-effective strategy for reducing tobacco use.

use, and keep them from moving beyond experimentation into regular daily use (7). Increasing tobacco taxes to deter smoking is especially important to stop and reverse the tobacco epidemic in low- and middle-income countries, given their large and growing populations of young people.

Tobacco use is increasingly concentrated in populations with the lowest income and socioeconomic status, and explains a large proportion of socioeconomic disparities in health (16). At the same time, lowest-income populations are also more responsive to price increases than higher-income users. The monetary burden of higher tobacco taxes falls more heavily on the wealthiest users, whose tobacco use declines less, while most of the health and economic benefits from reductions in tobacco use accrue to the most disadvantaged populations, whose tobacco use declines more when taxes increase (7,17). In Thailand, the Asian Development Bank estimates that 60% of the deaths averted by a 50% tobacco price increase would be concentrated in the poorest third

of the population, who would pay only 6% of the increased taxes (17).

Higher tobacco taxes avert tobacco-related deaths

Given the well-documented health and economic benefits of cessation, reduced adult smoking prevalence resulting from tax and price increases lead to substantial improvements in public health as well as reduced economic costs (7). With larger reductions in tobacco use by young people than older tobacco users, the societal benefits of higher tobacco taxes are predicted to grow over time as future generations quit at younger ages or never start in the first place (7). In China, research suggests that raising taxes on cigarettes so that they account for 75% of retail prices – up from 40% of the share of price in 2010 – would avert nearly 3.5 million deaths that would otherwise be caused by cigarette smoking (18).

In France, large price increases were followed by declines in smoking prevalence and lung cancer deaths (19–22).

As public health improves over time as a result of higher tobacco taxes and prices, the overall economic toll of tobacco use also declines. Countries' health systems benefit from having to devote less money and clinical care capacity to treat entirely avoidable tobacco-related diseases. Economic productivity rises when former tobacco users live longer and lead more productive lives. Gains to productivity and human capital from reduced tobacco use underscore how raising tobacco taxes is consistent with fiscal policies that enhance economic development (23).

Higher tobacco taxes generate new revenues

The positive impact of tobacco tax increases on tax revenues is seen in country after country (6). In Turkey, tobacco taxes increased steadily over the past decade; as

the tax rate rose from 58% to 65% of retail price, cigarette prices more than tripled and cigarette tax revenues more than doubled between 2005 and 2011 (24). These tax increases and other tobacco control efforts have been successful; between 2008 and 2012, tobacco sales declined by 12% in Turkey and tobacco smoking prevalence fell from 31.2% to 27.1% (24). In South Africa, total taxes on cigarettes rose from 32% to 52% of retail price between 1993 and 2009, contributing both to sizable reductions in tobacco use and to a nine-fold increase in government tobacco tax revenues (25).

Higher tobacco taxes are most effective when part of comprehensive tobacco control

Tobacco tax increases are a critical component of comprehensive efforts to reduce tobacco use. Simultaneous adoption

of other tobacco control policies enhances the effectiveness of tobacco tax increases; in turn, tobacco tax increases provide additional revenues that could be used to support, implement and enforce tobacco control and other health programmes and policies (6).

Offering help to tobacco users who attempt to quit in response to higher taxes boosts the number who quit successfully. Enforcing bans on tobacco advertising, promotion and sponsorship (TAPS) prevents the tobacco industry from using price-reducing promotions to offset the impact of higher taxes. High tobacco taxes and prices help reinforce messaging in graphic warning labels, media campaigns and other interventions that warn users about the health and economic damage caused by tobacco, and similarly reinforce strengthened social norms against tobacco use that result from comprehensive smoke-free air policies.

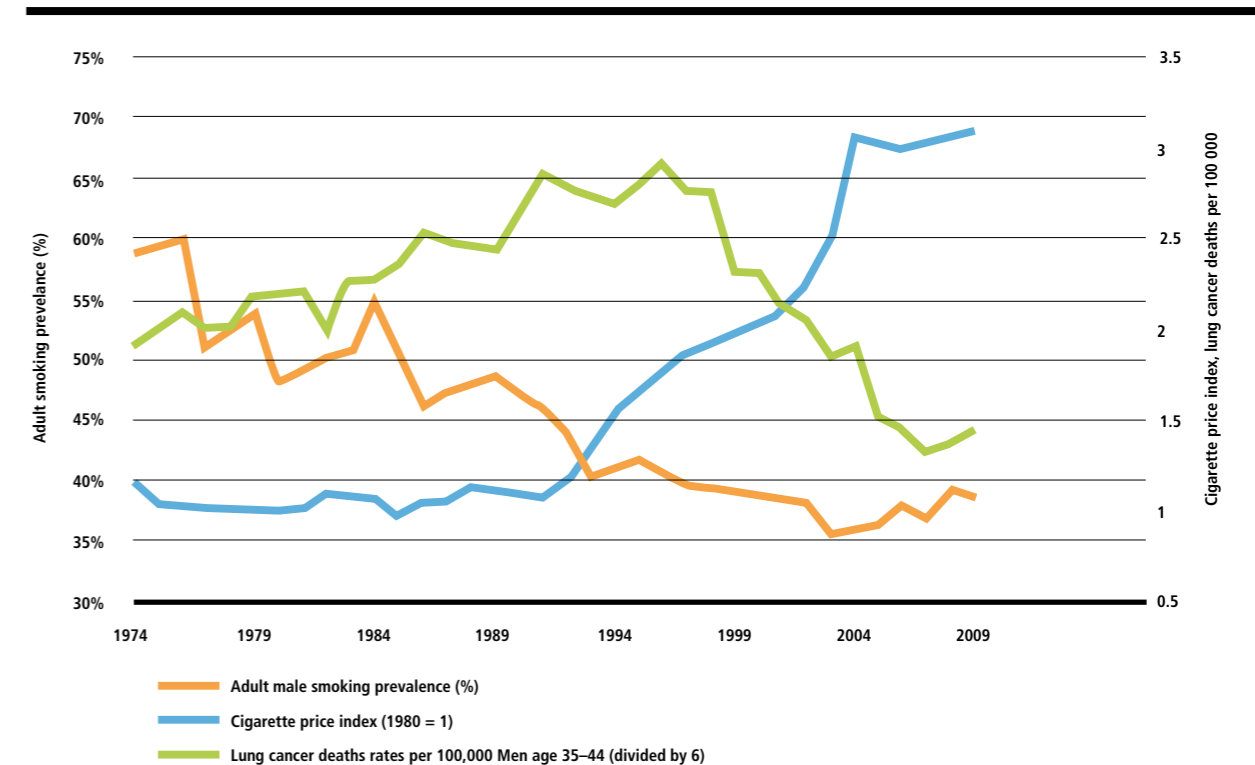
Comprehensive TAPS bans are an especially important policy. The tobacco industry uses price-reducing promotions including coupons, multipack deals and targeted price discounting to reduce tobacco prices and encourage increased tobacco use. In many countries, price-reducing marketing accounts for the majority of tobacco industry TAPS spending (7). Use of these strategies often expands soon after tobacco tax increases as companies try to reverse the impact of higher taxes and prices on consumers (26). Bans on price-reducing marketing strategies help prevent tobacco companies diluting the public health gains that result from tobacco tax increases (6).

Increased tobacco tax revenues can support tobacco control and other health initiatives

WHO's *World health report 2010*, which focused on health systems financing,



DECLINES IN SMOKING PREVALENCE AND LUNG CANCER DEATHS ACCOMPANY LARGE PRICE INCREASES IN FRANCE (DATA 1974–2009)



Source: (19–22).

Note: lung cancer death rates were divided by 6 to enable visual comparison.

recommended the use of tobacco excise taxes to fund health care programmes and recognized that the use of even a small proportion of the proceeds for health would greatly improve access to services (27).

Some governments dedicate at least some tobacco tax revenues to comprehensive tobacco control programmes, which often include mass media education campaigns that publicize the harm caused by tobacco use and exposure to tobacco smoke. Many fund tobacco quit lines, pharmacotherapies and other cessation support, increasing the likelihood that tobacco users who want to quit in response to tax increases will be successful (28). Others provide resources to enforce smoke-free policies, TAPS bans, limits on youth access and other tobacco control measures, further increasing the effectiveness of higher taxes in reducing tobacco use (28).

Some countries (e.g. Iceland and Viet Nam) devote a proportion of tobacco taxes to tobacco control, while others (e.g. Costa

Rica, Jamaica, Mongolia, the Philippines and Thailand) use the funds for more general health promotion activities or to finance the country's health system (data collected for this report; please refer to Appendix II, table 2.4 for more details).

When dedicated to tobacco control, tobacco tax revenues enable measurable improvements to health outcomes and savings to health systems. Since 1989, the US state of California has earmarked 20% of cigarette tax revenues from a US\$ 0.25 tax per pack to comprehensive tobacco control and 5% to tobacco-focused research (29). Between 1989 and 2008, the resulting US\$ 2.4 billion spent on tobacco control in California contributed to a halving of adult smoking prevalence between 1988 and 2010 to 11.9% (9, 30); a decline in lung and bronchus cancer rates nearly four times more than in the rest of the USA since 1998 (29); and cumulative reductions in health care spending of US\$ 134 billion (31).

Public support for tobacco tax increases is widespread

A majority of non-smokers and a substantial percentage of smokers support higher cigarette taxes. In a survey conducted in 2010 in 18 European Union (EU) countries, nearly four in five non-smokers supported tax increases that would raise prices by 5%, while about three in four supported a 20% price increase; among smokers, almost half supported the 5% increase and about one third supported the 20% increase (32). Support was generally higher for tax and price increases in countries with a stronger history of tobacco control and/or recent tax increases, with majority support among smokers in countries including Ireland, the United Kingdom, Sweden and Spain (32). Similarly, data from the Global Adult Tobacco Survey show majority support for increased tobacco taxes in most countries, including among smokers in many countries (33).

Dedicating increased tobacco tax revenues to tobacco control programmes and other health promotion initiatives increases public support for higher taxes, as it clearly links the higher taxes to goals of reducing tobacco use and improving health (7). In New Zealand, although 68% of smokers thought that current tax levels were too high, a majority (59%) nevertheless supported a tax increase if the new revenues were used to promote quitting and other health-promoting behaviours (34).

Governments can also use new revenues from tobacco tax to identify and devise effective strategies to help tobacco farmers make the transition to alternative crops and livelihoods, thereby allaying concerns about the economic impact of tobacco tax increases (6). In the Philippines, 15% of new tax revenues is dedicated to tobacco-growing provinces to promote alternative livelihoods for tobacco farmers and workers (35). A similar initiative was successfully developed by Turkey (36).

Large tax increases deliver significant public health gains

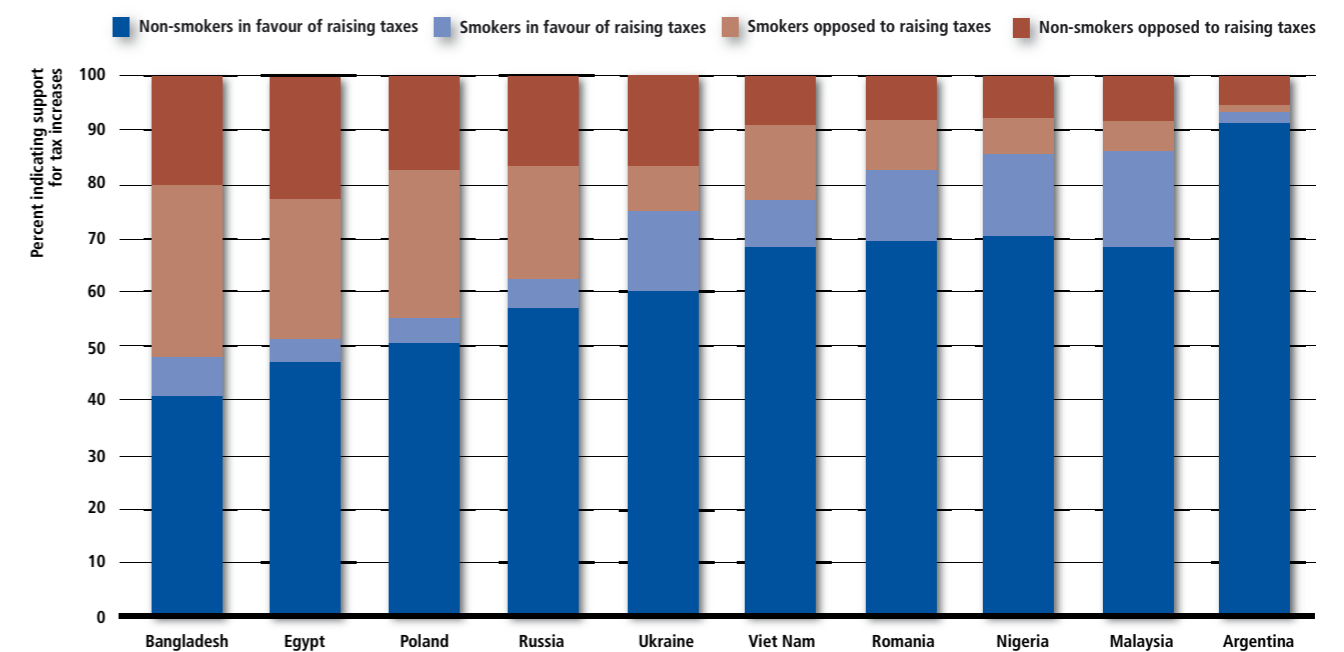
Experiences from around the world show that the bigger the tobacco tax increase, the larger the decline in tobacco use (7). Opponents of tax increases sometimes note that tax revenues may eventually fall in the long term because such large tax increases will diminish consumption. But this argument loses validity when considering that the public health impact will continue to grow over time (6) and that most countries are far from having sufficiently high tax rates – data from the current report show that in 2014, excises amounted to 45% of global cigarette prices, on average. Modest tax increases that fail to raise tobacco product prices faster than inflation or income growth are unlikely to produce significant reductions in tobacco use and its consequences (6).

Governments should raise taxes to achieve public health goals

To achieve the public health goals of tobacco taxation, as called for in Article 6 of the WHO FCTC, governments should establish clear policies for raising taxes and prices to discourage tobacco use and mitigate its consequences (5). Tax increases that are sustained over time result in larger sustained reductions in tobacco use than temporary tax increases (38, 39). In a 1999 report, the World Bank recommended that governments should raise total taxes so they account for between two thirds and four fifths of total retail price, "using as a yardstick the rates adopted by countries with comprehensive tobacco control policies where consumption has fallen" (23). Given more recent evidence, WHO reinforced this recommendation to suggest that excise taxes should account for at least 70% of the retail price of tobacco products, with continued increases above inflation and

A majority of non-smokers and a substantial percentage of smokers support higher cigarette taxes.

BROAD SUPPORT FOR CIGARETTE TAXES THAT IMPROVE HEALTH PROGRAMMES



Source: (37).

income growth after reaching this threshold (6).

The EU's tobacco tax directive is an example of comprehensive policy steps intended to maintain the public health impact of tobacco taxes, including a high absolute minimum tax of €90 per 1000 cigarettes and an obligation that excise taxes account for at least 60% of weighted average retail cigarette prices (effective January 2014) (40). By setting a floor on taxes, the EU also reduces price differentials among Member States while allowing governments to go further if they desire.

Tax increases and tax policy reforms are achievable

Despite the public health and revenue benefits – and being relatively inexpensive to implement – attaining substantial increases in tobacco taxes is perhaps the

most difficult tobacco control policy to achieve (6). In recent years, governments in a growing number of countries have demonstrated strong political will and commitment for tobacco tax increases by recognizing that higher taxes are not only a reliable revenue generation tool, but also an important public health tool to reduce tobacco use and associated harms.

Countries have different budgetary processes for implementing tobacco tax increases. Countries where taxes are determined directly by the ministry of finance, the president or the chief government executive differ from those where tax increases must receive legislative or parliamentary approval; the latter process tends to be more cumbersome because of the larger number of actors involved. Strong leadership and broad-based coalitions can overcome these obstacles to enact large tax increases that generate real public health benefits.

Partnerships are key to success in raising tobacco taxes

Partnerships strengthen the capacity of key decision-makers and build the political will to adopt meaningful tax increases, as well as to communicate economic evidence of the public health and revenue impact of tobacco taxes. WHO's close collaborations with ministries of finance from an increasing number of countries have added to the growing international evidence base on tobacco excise taxation and have helped to develop strategies to maximize the health and economic impact of tax and price increases (41).

Technical partnerships, while critical, are often most successful when part of a larger, multisectoral effort. This was the case in "sin tax" reform efforts in the Philippines in 2012, where two elements in particular

created an opportunity for significant reform: the need for new government revenues to fund a universal health insurance programme, and the timing of the periodic revision of the country's sin tax legislation governing tobacco and alcohol taxes (42). Key legislators and other government officials, including from the Philippines Ministry of Finance and Ministry of Health, strongly supported the call for significant tobacco tax increases. Various nongovernmental organizations, including a "white army" of health care professionals, supplemented government efforts to help build political and popular support for the tax increase (43). Tobacco farmers' concerns were addressed by dedicating 15% of new tobacco tax revenues to support transitioning tobacco farmers and workers to other livelihoods (43). Together, these efforts contributed to one of the largest cigarette tax increases ever adopted.

Regional economic and monetary unions can advance or hinder tobacco taxation policy

Regional agreements on tobacco taxation can be effective in reducing cross-border tax and price differentials, and minimizing opportunities for individual tax avoidance and larger scale illicit trade (44). However, regional economic agreements can sometimes create unanticipated barriers to effective tobacco taxation (44). The Economic Community of West African States (ECOWAS) and the West African Economic and Monetary Union (WAEMU – the customs union for eight of the ECOWAS countries) – were established to enhance regional economic integration by reducing barriers to trade and increasing harmonization of tax and other economic policies. ECOWAS requires all of its 15

Member States to adopt an ad valorem excise tax from 15% to 100% of the producer price of domestic products, or the cost, insurance and freight (CIF) value of imported products. WAEMU further constrains countries by setting the maximum ad valorem tax at 45% of producer price, or CIF value (44). Given the maximum rates allowed by these agreements, as well as use of the producer or CIF price as the base, these agreements restrict Member States' ability to set tobacco excise rates at the same high levels as countries that have implemented strong tobacco tax policies as part of a comprehensive approach to tobacco control.



Partnerships strengthen the capacity of key decision-makers and build the political will to adopt meaningful tax increases.

The mechanics of raising tobacco taxes

Nearly all countries tax tobacco products, levying excise taxes, value added taxes (VAT), general sales taxes, duties on imports, and/or other special taxes (6). Some also tax the value of the tobacco leaf crop, while others impose duties on the import of tobacco leaf (6).

Excise taxes are the most important type of tobacco tax

While all taxes tend to lead to higher tobacco product prices, tobacco excise taxes are particularly important in achieving the public health objectives of tobacco taxation, given that they apply uniquely to tobacco products and raise their prices relative to prices for other goods and services (6). In most countries, excise taxes account for a larger share of tobacco product prices than are accounted for by other taxes. Data from the current report show that, globally, about

90% of countries levy tobacco excise taxes (or other tobacco-specific taxes that act like excises).

There are two types of excise taxes:

- Specific excises on cigarettes are typically levied on a per stick basis (e.g. a tax per 1000 cigarettes or per pack), although some countries base specific taxes on weight. Specific excises are especially appropriate to protect public health because they lead to higher prices and smaller price differences across brands, both of which result in reduced tobacco use.
- Ad valorem excises are excises based on value. The base for these taxes varies; many levy taxes as a percentage of retail price (e.g. Turkey and EU countries), while others levy taxes on wholesale price (e.g. Venezuela) or on producer or CIF price (e.g. Myanmar, Senegal).

Most countries apply a general VAT or sales tax on tobacco products, though rates vary considerably, from as little as 1% of the retail price in some countries to more than 25% in others. These taxes apply to a wide variety of goods and services, generally not differentiating tobacco products from others, which limits their effectiveness in reducing tobacco use. At the same time, given their broad application, it is difficult to achieve significant increases in VAT rates alone that will generate large reductions in tobacco use.

Import duties and/or VAT or sales tax provide the main source of tobacco tax revenue in countries that do not impose tobacco excises, including Afghanistan, Angola, Antigua and Barbuda, Belize, Democratic People's Republic of Korea, Iran, Iraq, Libya, Maldives, Marshall Islands, Micronesia, Niue and member states of the Gulf Cooperation Council. Import duties vary widely, from relatively low in some

countries, to 100% or more of importers' declared CIF value in others. Import duties can also take the form of a specific amount per pack or 1000 cigarettes, or per kilogram of product.

The effectiveness of import duties in increasing retail prices and generating higher tax revenues is decreasing as more countries adopt bilateral, regional and global trade agreements that reduce duties and other trade barriers. For countries that currently rely heavily on tobacco import duties, an appropriate transition strategy would be to reduce import duties while adopting and increasing specific tobacco

excises so that total tobacco taxes increase over time (6).

Simpler tobacco tax structures are more effective

Tobacco excise tax structures in some countries are quite complex, with different (tiered) taxes applied to the same product based on differences in product characteristics.

Complex, tiered tax structures are difficult to administer and can undermine the health and revenue impacts of tobacco excise taxes

(6). Overall, 37 of 158 countries that levy cigarette excise taxes (and where data are available) use complex, tiered taxes that lead to greater variability in tobacco product prices. Large price gaps between brands create opportunities for consumers to switch to cheaper brands in response to increased taxes (45). They also create opportunities for tax avoidance and tax evasion (6).

In recent years, a growing number of countries have moved to simplify their complex tobacco tax systems.

Complex, tiered tax structures are difficult to administer and can undermine the health and revenue impacts of tobacco excise taxes.

COMPLEX TAX SYSTEMS CREATE LOOPHOLES

India levies tiered specific excise taxes on cigarettes, with seven brackets of basic excise duty (BED) based on cigarette length and whether or not there is a filter (46). But differential taxes lead to loopholes. One popular brand, Gold Flake, is sold in 84 mm, 74 mm and 64 mm lengths. The 74 mm version is marketed as a premium brand, but is subject to the second lowest excise applied to cigarettes (509 Indian Rupees (INR) (US\$ 7.98) per 1000 sticks) despite being priced similarly to the 84 mm version, which bears an excise of 2390 INR (US\$ 37.46) per 1000 sticks.

In **Indonesia**, taxes vary based on product type (kreteks vs. standard or "white" cigarettes), type of production (hand vs. machine made), production volume, and government estimates of retail price (47).

Until 2013, **Senegal** levied a two-tiered ad valorem tax structure. Premium brands were taxed at 45%, and economy brands at 20% of producer prices, with a minimum excise of 8 West African francs (CFA) (US\$ 0.017) and 3 CFA (US\$ 0.006) per stick respectively. In November 2011, the manufacturer of the premium brand reduced the per pack price from 650 CFA (US\$ 1.38) to 400 CFA (US\$ 0.85), repositioning it as an economy brand and thus reducing its tax burden (48). Senegal's Ministry of Finance then changed how it classified brands from a price-based system to one based on brand name, eliminating the opportunity for tobacco companies to manipulate pricing to reduce their tax liability. The company responded by raising the premium brand price to 700 CFA (US\$ 1.42) in 2013, higher than before (49).

Tax rates in many other countries also vary by product characteristics such as packaging, as in Brazil, Mozambique and Uganda (soft vs. hard packs); production origin, as in Tonga and Uzbekistan (domestic vs. imported); and leaf content, as in Fiji, Tanzania and Uganda (dark vs. light tobacco).

Solution: simplify tobacco taxation systems

In 2013, **Pakistan** replaced a complex, three-tier cigarette excise tax system with a simpler two-tier specific tax structure (50).

The 2012 "sin tax" reform in **the Philippines** replaced the country's four-tier specific tax structure with a two-tier system in 2013. In 2017 this is set to be replaced by a uniform specific tax (35). In addition, the reform abolished the price classification freeze that had fixed the tax rate for brands on the market in October 1996 on their net retail price at that time, regardless of any price changes since, which protected long-established brands (51). In 2017, all brands – regardless of price – will be taxed at a uniform 30 pesos (US\$ 0.67) per pack (35).

In 2013, **Senegal** narrowed the gap between its two tax tiers by raising the ad valorem rate on economy brands from 20% to 40%, then in November 2014 merging the two tiers into single 45% rate (49).

Greater reliance on specific excise taxes is important to achieve health goals

Greater emphasis on specific excises enhances the impact of tobacco taxes on public health by reducing price gaps between premium and lower-priced alternatives, which limits opportunities for users to switch to less expensive brands in response to tax increases (6). Applying the same specific tax to all brands sends the clear message that all brands are equally harmful (6). Countries that levy only specific cigarette excises or rely more heavily on specific excises as part of a mixed tax system have the highest average taxes and cigarette prices, while those that levy only ad valorem excises or rely more on the ad valorem component of a mixed system have lower taxes and prices (see graph on page 82). Ad valorem tobacco excises are less effective than specific excises in achieving health objectives because they are more difficult to administer, increase opportunities for tax avoidance and evasion, and create greater price gaps between brands – again

encouraging users to switch to cheaper brands when taxes and prices increase (6).

Ad valorem taxes are difficult to implement and weaken tax policy impact

Because ad valorem taxes are levied as a percentage of price, companies have greater opportunities to avoid higher taxes and preserve or grow the size of their market by manufacturing and selling lower priced brands. This also makes government tax revenues more dependent on industry pricing strategies and increases the uncertainty of the tobacco tax revenue stream (6). An analysis of data from 21 EU countries between 1998 and 2007 showed that countries relying more heavily on ad valorem taxes than specific taxes experienced greater instability in government tax revenues from cigarette excise taxes (52).

Governments increasingly recognize the public health and revenue benefits of high

specific tobacco excises and the challenges that result from reliance on ad valorem excises. For countries currently relying on an ad valorem tax or a mix of ad valorem and specific taxes, an appropriate first step is to set a large specific tax applied to all brands, on top of the ad valorem tax (6). Over time, the ad valorem rate can be reduced and the specific tax increased so that the total tax increases, with the specific tax accounting for a greater share of the total excise tax (6). The Russian Federation plans to gradually reduce its ad valorem excise rate and replace it with an increased specific excise by 2017 (53).

Another tax administration challenge with ad valorem taxes relates to the base on which the tax is applied. Governments may use producer prices, CIF prices, distributor prices or retail prices as the base for levying ad valorem taxes (6). When ad valorem taxes are levied early in the distribution chain, opportunities arise for companies to set prices artificially low at the point where the tax is levied to reduce their tax liability, with prices then raised

later in the distribution chain (known as “transfer pricing”) (6). This has led some governments that rely on ad valorem excises to include a minimum specific excise tax to reduce this type of tax avoidance. Using retail price as the base can help solve the problem of transfer pricing but it creates its own challenges given the difficulties with monitoring retail prices. Because they are based on a measure of quantity rather than value, specific taxes are not subject to this type of abusive transfer pricing, again increasing their effectiveness in achieving the health goals of tobacco taxation (6).

Specific excise taxes need to be adjusted for inflation to remain effective

While specific tobacco excise taxes have a number of advantages, their real value will be eroded by inflation unless they are periodically adjusted. If the real value of the tax is not maintained, inflation-adjusted tobacco product prices will likely fall, making tobacco relatively more affordable and leading to increased tobacco use (6).

Countries have adopted plans to reduce tobacco use through planned tobacco tax increases that protect against inflation and prevent erosion of the real value of the tax. In the UK, the government adopted a tobacco tax escalator that increases taxes above inflation each year to help reduce smoking prevalence, although this provision has been implemented unevenly from year to year with increases ranging between 1% and 5% above inflation between 2009 and 2012 (54).

Governments increasingly recognize the public health and revenue benefits of high specific tobacco excises.

AD VALOREM TAXATION IS PROBLEMATIC

Price wars threaten tobacco control efforts

Jordan's mixed excise system previously relied more on an ad valorem component. In early 2013, a price war broke out between two major multinational tobacco companies, leading to average cigarette prices falling by 20% and a large increase in cigarette sales. In response, in 2014 the government adopted a specific excise tax increase of more than 30% (55). A high specific tax restricts the ability of companies to undercut each other's prices.

A large ad valorem tax rate on a small base is ineffective

Togo applies the highest allowable excise tax on tobacco permitted by the WAEMU (West African Economic and Monetary Union; see discussion on page 33). This 45% ad valorem tax, however, applies to producer price (or CIF price in the case of imported brands). Due to the small base, the 45% tax effectively translates to only 8% of the price of the most sold brand in Togo.

Solution: include or increase a specific excise tax on tobacco

The **European Union's** Council Directive on excise taxation of tobacco products increased the mandatory minimum component of the specific excise in the total tax amount from 5% to 7.5% of retail price. Between 2012 and 2014 countries such as Cyprus, Greece, the Netherlands and Slovenia reduced their ad valorem rates, a reduction more than offset by an increase in the specific excise component (40).

Prior to 2009, **Mexico** levied an ad valorem excise at a rate of 150% of the pre-tax price to the retailer. Legislation adopted in 2009 added a specific tax of 0.80 pesos (US\$ 0.05) per pack beginning in 2010, with an annual 0.40 pesos (US\$ 0.025) per pack increase through to 2013. The early success of the new specific tax led to further reforms in 2011 that increased the ad valorem tax to 160% of the pre-tax price and raised the specific tax to 7 pesos (US\$ 0.45) per pack. The 2011 specific tax increase led to a sharp increase in cigarette prices, resulting in a significant decline in cigarette sales while simultaneously generating sizable new tax revenues (56).



Tax increases should reduce the affordability of tobacco products

In many countries where incomes and purchasing power are growing rapidly, tobacco has become increasingly affordable, which contributes to increases in its use (57). This has occurred despite increases in tobacco taxes in some of these countries, since the resulting price increases have not been large enough to offset growth in real incomes (58). Data from the current report show that this was the case for several countries, among them Botswana, Cambodia, India, Honduras, Jordan, Republic of Moldova, Romania

and South Africa between 2012 and 2014. This highlights the need for sufficiently large tax increases, particularly in countries experiencing rapid economic growth.

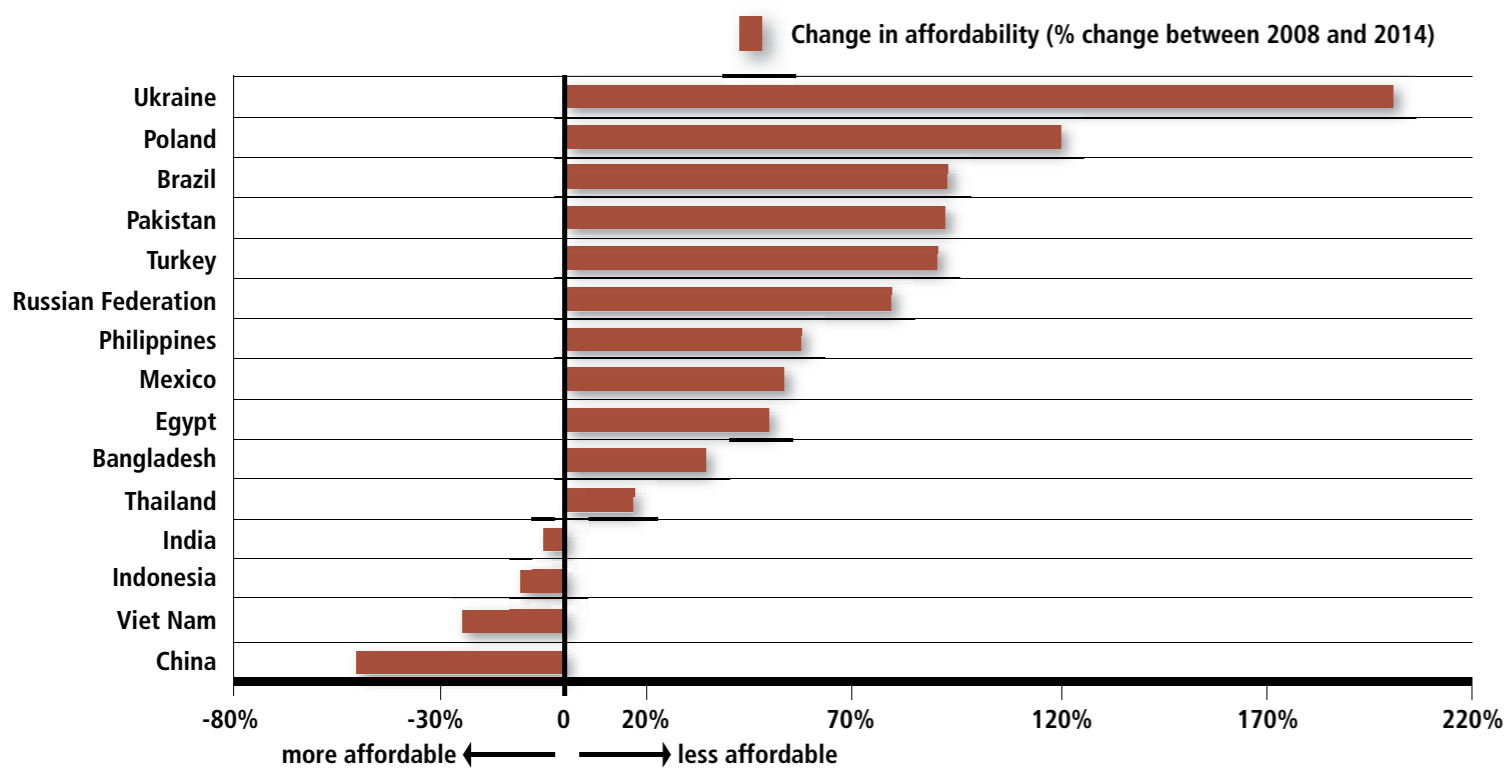
In countries that rely on specific excise taxes, tax increases that are adjusted to inflation but not to other economic indices may not be enough to reduce consumption if income growth outpaces inflation. One solution is to adjust specific excise taxes to income growth or an equivalent variable that takes into account increases in consumer purchasing power.

Cigarettes became less affordable between 2008 and 2014 in several countries. The

proportion of per capita income required to buy 100 packs of cigarettes rose in Bangladesh, Brazil, Egypt, Mexico, Pakistan, Philippines, Poland, the Russian Federation, Thailand, Turkey and Ukraine as the result of tax and price increases in those years, coupled with relatively slow income growth.

By contrast, cigarettes have become more affordable in China, India, Indonesia and Viet Nam. In these countries, price and taxes have either remained unchanged, or relatively modest increases were more than compensated by relatively higher income growth.

CHANGE IN AFFORDABILITY* OF CIGARETTES BETWEEN 2008 AND 2014, SELECTED COUNTRIES



Source: data collected for this report.

* Affordability is calculated as the percent of GDP per capita required to purchase 100 packs of the most sold brand of cigarettes in a country in a specific year. In this graph, the change in affordability is calculated by looking at the percentage difference between the affordability measure in 2008 and in 2014.

INFLATION CAN ERODE THE VALUE OF SPECIFIC TAXES

In the **United States**, failure to increase excise taxes eroded their impact over time and reduced government tobacco tax revenues. Real federal excise taxes and revenues both declined dramatically between the mid-1970s and mid-1980s. Excise rates and revenues started picking up slowly in the 1990s through a series of tax increases at both federal and state levels, but neither reached 1970s levels until 2006 (59).

Jamaica revised its excise tax structure in 2008 by removing its ad valorem tax component and raising its specific tax to 6000 Jamaican dollars (JMD) (US\$ 52) per 1000 cigarettes. The rate was further increased in 2010 to 10 500 JMD (US\$ 91) per 1000 cigarettes, though this change did not come into effect until 2015. However, the country's high inflation rate (7–10% per annum) has resulted in decreases in the real value of the excise tax. Had Jamaica adjusted its excise rate to increase in line with inflation since 2010, the tax rate would currently be set at around 15 000 JMD (US\$ 130) per 1000 cigarettes. In 2015 Jamaica increased its excise to 12 000 JMD (US\$ 104) per 1000 cigarettes (60), which – although an encouraging development – is still insufficient to help excise taxes keep pace with inflation.

Solutions

One-time tax increases can address past declines in the real value of taxes

In 2014, **Canada** adjusted its tobacco excise tax rates to account for increased inflation since 2002 and eliminated preferential tax treatment of tobacco products available through duty free markets. Effective from 12 February 2014, the measure increased the excise rate on all cigarettes to 21.03 Canadian dollars (US\$ 17.13) per carton of 200 cigarettes, with corresponding increases on other tobacco products (e.g. fine-cut tobacco for use in roll-your-own cigarettes, chewing tobacco and cigars) (61).

Sustained tax increases help preserve the share of specific taxes in tobacco prices

The 2012 "sin tax" reform in the **Philippines** includes a provision for cigarette taxes to be automatically increased by 4% every year starting in 2018 (35).

South Africa achieved steady growth in prices by setting targets for the share of price accounted for by tax, moving in 1994 to raise the share of all taxes from 32% to 50% of cigarette prices by 1997, and further raising the share to 52% in 2002. As a result, inflation-adjusted taxes and prices have risen steadily, which has increased tax revenues and reduced cigarette consumption (25).

In the **European Union**, the requirement that cigarette excise taxes account for a minimum 60% of weighted average retail prices similarly leads to price increases that generally remain in line with inflation and maintain the real value of the tax.

Automatic adjustments to specific taxes address inflation

In **Canada**, to ensure that tobacco taxes retain their real value in the future, excise rates will be indexed to the Consumer Price Index and automatically adjusted every 5 years. The first such inflationary rate adjustment will be effective from 1 December 2019 (61).

New Zealand increases tobacco taxes each year by the amount of inflation to maintain the real value of the tax (62), and also periodically implements much larger tobacco tax increases to raise inflation-adjusted prices and further discourage tobacco use.

Automatic adjustments to specific taxes address affordability

In 2013, **Australia** – as part of its comprehensive efforts to reduce tobacco use and its harms – announced a series of four 12.5% cigarette tax increases beginning 1 March 2014, with subsequent biannual increases scheduled for 1 March and 1 September of each year through 2016, with increases based on average weekly earnings to ensure that tobacco products do not become relatively more affordable over time (63). In 2015, many common brands of cigarettes (pack of 20) already cost more than 20 Australian dollars (US\$ 15.50), which are among the highest prices in the world (64).

Governments should guard against industry adaptations to tobacco tax policy

Although uniform specific excise tax systems are the most effective type of tobacco taxation, they can also be exploited by tobacco companies to create product lines with greater diversity, price and purported “quality” differences. These factors can help the industry maintain and increase profitability and political influence at the expense of public health, underscoring the importance of non-price tobacco measures, including restrictions on product packaging and descriptors, as part of a comprehensive tobacco control approach. Similarly, tobacco companies have an incentive to gain market

share by cross-subsidizing less expensive brands, especially in countries with a low tax base, and even in some high-income countries such as the United Kingdom (65). With an increasingly global tobacco industry, larger multinational corporations now tend to supply to all price segments, not just the more expensive premium end.

Taxing all tobacco products comparably reduces incentives for substitution

Differences in tax levels on different tobacco products create incentives for substitution to less expensive, lower-taxed products when taxes are increased (6). In general, taxes

on cigarettes account for a greater share of prices than do taxes on other tobacco products.

Until recently, taxation of non-cigarette tobacco products received relatively little attention in many countries. However, as evidence accumulates about patterns of use and resulting health consequences from water pipe tobacco, bidis, smokeless tobacco and other products, the need for comparable taxation of all tobacco products is increasingly clear (6).

Complex tax structures not only make it harder for smokers to quit, they also create tax avoidance opportunities that tobacco companies exploit by changing product

characteristics or production processes. In India, taxes are levied on bidis made by larger producers but not by small producers; as a result, bidi production in India has largely remained a small-scale cottage industry (70). Similarly, the presence of thousands of small-volume cigarette and kretek producers in Indonesia, in contrast to other countries where production is highly concentrated, reflects Indonesia’s complicated excise tax structure that has long favoured small-scale producers (71).

As the health and revenue consequences of taxing different products at different rates become clearer, some governments have taken steps to harmonize rates across all tobacco product types. For example, Turkey

imposes the same tax rate (65% of retail price) on all tobacco products (72).

Strong tax administration is critical to maximize the public health impact of tobacco taxes

Effective tax administration minimizes tax avoidance and tax evasion to ensure that tobacco tax increases lead to higher tobacco product prices and tax revenues, as well as reductions in tobacco use and its consequences (6). Effective tax administration includes strong control over the distribution chain, aggressive efforts to minimize illicit tobacco trade, and capacity

of tax administrators to fully understand the impact of tax increases on tobacco product markets (6). Strong tax administration requires multisectoral, cross-country collaborations given that the problems of illicit trade cross national boundaries and various government agency jurisdictions (6). When tax administration is most effective, governments can maximize the health and revenue impact of tobacco tax increases while reducing tax avoidance and tax evasion (6).

By contrast, weak tax administration, caused by factors ranging from lack of production monitoring and control over the distribution chain to insufficient resources for enforcing tobacco tax policies, creates

Complex tax structures not only make it harder for smokers to quit, they also create tax avoidance opportunities that tobacco companies exploit.



SELECTIVELY IMPLEMENTED TAX INCREASES ENCOURAGE SUBSTITUTION

In **Bangladesh**, a complex tiered ad valorem tax structure results in substantial differences in excise tax rates both within and across product lines. Excise taxes account for as little as 43% of retail price on the least expensive brands of cigarettes and up to 61% on premium cigarettes, while the excise on bidis is 18% of retail price (66).

In **Thailand**, while cigarette excises have increased over time, the excise on roll-your-own tobacco has remained consistently low. In addition, roll-your-own products using so-called indigenous tobacco leaf are exempt from the excise system (67). As a consequence, the consumption of roll-your-own cigarettes in Thailand increased from 2009 to 2011, with the prevalence of roll-your-own cigarette smoking among men during this period rising from 27% to 28.1% (68).

In the **United States**, when cigarette taxes were increased in April 2009, the tax on roll-your-own tobacco was also sharply increased from US\$ 1.10 to US\$ 24.78 per pound. However, the United States fell short of fully harmonizing its tobacco taxes, with taxes on pipe tobacco increasing from US\$ 1.10 to only US\$ 2.83 per pound. The lack of a clear definition distinguishing roll-your-own and pipe tobacco created a loophole, and manufacturers simply re-labelled roll-your-own tobacco as pipe tobacco. This shifted sales from roll-your-own to pipe tobacco and reduced the health and revenue impact of the tax increases (69).

Solutions

While the minimum excise tax on cigarettes in the **European Union** was set at 60% of the weighted average price, or €90 (US\$ 99) per 1000 cigarettes in 2011, the tax burden on other products varied and rates were all lower than those applied to cigarettes. To address this problem, the minimum excise on fine-cut smoking tobacco (used for roll-your-own cigarettes) was increased from 40% of the weighted average price, or €40 (US\$ 44) per kilogram, to 43%, or €47 (US\$ 52) per kilogram in 2013. Regular increases are planned until 2020 to reach a 50% rate, or €60 (US\$ 73) per kilogram (40). However, tax rates for cigarettes continue to remain higher overall than for loose tobacco.

New Zealand recently raised its roll-your-own tobacco tax rate to make it equivalent to the tax on manufactured cigarettes (based on 0.7 grams of loose tobacco per roll-your-own cigarette) (62).

opportunities for tax avoidance and evasion that can undermine the effectiveness of tax policies (6). Legitimate production can be underreported, illegal production can occur, licit tobacco products can be diverted to illicit markets while in transit, and tax stamps can be forged while corrupt tax and customs officials can turn a blind eye to these activities (6).

Controlling illicit trade helps maximize the impact of tax increases

The tobacco industry and its allies perpetuate the myth that tobacco tax

increases automatically lead to rampant smuggling – despite evidence to the contrary – hoping to deter governments from adopting significant tax increases (73). Indeed, experiences from around the world show that even in the presence of illicit trade, tax increases still lead to higher tax revenues and real reductions in tobacco use (7).

Illicit trade is a complex and diverse phenomenon affected by more than tobacco taxes alone. Tax increases that widen gaps in prices between jurisdictions create incentives for individuals to cross borders to purchase tobacco products at lower prices, as well as for bootleggers to buy products in

low-tax/price jurisdictions for resale in high tax/price jurisdictions. However, the large-scale smuggling that accounts for most illicit trade aims to avoid all taxes (7). Growing evidence shows that although these large-scale efforts are often most problematic in countries with relatively low taxes and prices, other factors including weak governance and corruption, ineffective tax administration, and the presence of criminal networks and informal distribution networks are the most important determinants of illicit trade (7).

Rather than foregoing tax increases, governments should actively crack down on illicit trade (23). The experience of

several countries, including Hungary, Italy, Romania and Spain led the International Agency on Research and Cancer to conclude in 2011 that there was strong evidence that, “a coordinated set of interventions that includes international collaborations, strengthened tax administration, increased enforcement, and swift, severe penalties reduces illicit trade in tobacco products” (7).

Strong control over the distribution chain is important

The WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products highlights the need for strong control of the tobacco product distribution chain as part of an effective approach to curbing illicit trade (74). Such control can include several

components, from monitoring of production and/or distribution to licensing of all parties involved in manufacturing, distribution and retailing. Sophisticated, comprehensive tobacco product tracking-and-tracing systems will include these components, which have been effective in curbing tobacco smuggling, illegal production and other illicit trade in several countries (74).

Rather than foregoing tax increases, governments should actively crack down on illicit trade.

WORLD NO TOBACCO DAY 2015 FOCUSES ON ILLICIT TRADE IN TOBACCO PRODUCTS



Eliminating the illicit trade in tobacco would generate an annual tax windfall of US\$ 31 billion for governments, improve public health, help cut crime and curb an important revenue source for the tobacco industry. Those were the key themes of World No Tobacco Day on 31 May 2015 when WHO urged Member States to sign the Protocol to Eliminate the Illicit Trade in Tobacco Products.

So far, eight countries have ratified the Protocol, short of the target of 40 needed for it to become international law. Once that happens, the Protocol's provisions on securing the supply chain, enhanced international cooperation and other safeguards will come into force.

The Protocol requires a wide range of measures relating to the tobacco supply chain, including the licensing of imports, exports and manufacture of tobacco products; the establishment of tracking and tracing systems and the imposition of penal sanctions on those responsible for illicit trade. It would also criminalize illicit production and cross border smuggling.

TOBACCO TAXATION IN THE FACE OF ILLICIT TRADE

Governments have successfully raised taxes and reduced illicit trade

The UK has continued to raise tobacco taxes while actively combating illicit trade (75). In 2000, illicit cigarettes accounted for more than one in five of all cigarettes consumed in the UK, prompting the government to implement an anti-smuggling strategy that was strengthened over time (75). Key elements of this strategy included: consolidation of existing agencies into Her Majesty's Revenue & Customs as the UK's tax authority; improved cooperation among relevant organizations, including HM Border Agency and Border Force; the creation of the Serious Organised Crime Agency; pack markings to enable ready identification of licit and illicit products; use of x-ray scanners on imported products; increased and targeted enforcement; and stronger penalties for noncompliance (76). By 2012, the illicit market share had fallen to 9%, despite tax increases above inflation in prior years, allowing the UK government to raise taxes by 5% above inflation in 2012 (54). Together, these efforts contributed to significant declines in smoking prevalence and cigarette consumption in the UK, with a concurrent increase in cigarette excise tax revenues (54).

Coordinated international action combats illicit trade

An emerging concern identified by international agencies including the World Customs Organization, the EU Star Project (77) and WHO, is the presence of illegal cigarettes that are legally produced in low-tax jurisdictions with all taxes paid, but in volumes much higher than needed to meet legitimate local demand. They are then smuggled out to higher-tax jurisdictions and sold without additional taxes being collected. Because governments of low-tax jurisdictions benefit from this surplus production by collecting higher excise revenue than otherwise would be the case, they may have little incentive to restrain this overproduction. Cross-agency and cross-border collaboration can counter the threat that inexpensive smuggled cigarettes pose to effective domestic tax policies.

New technologies can improve tax administration

Controls over the distribution chain, improved technologies and better use of data help to reduce illicit trade and complement tobacco tax reforms.

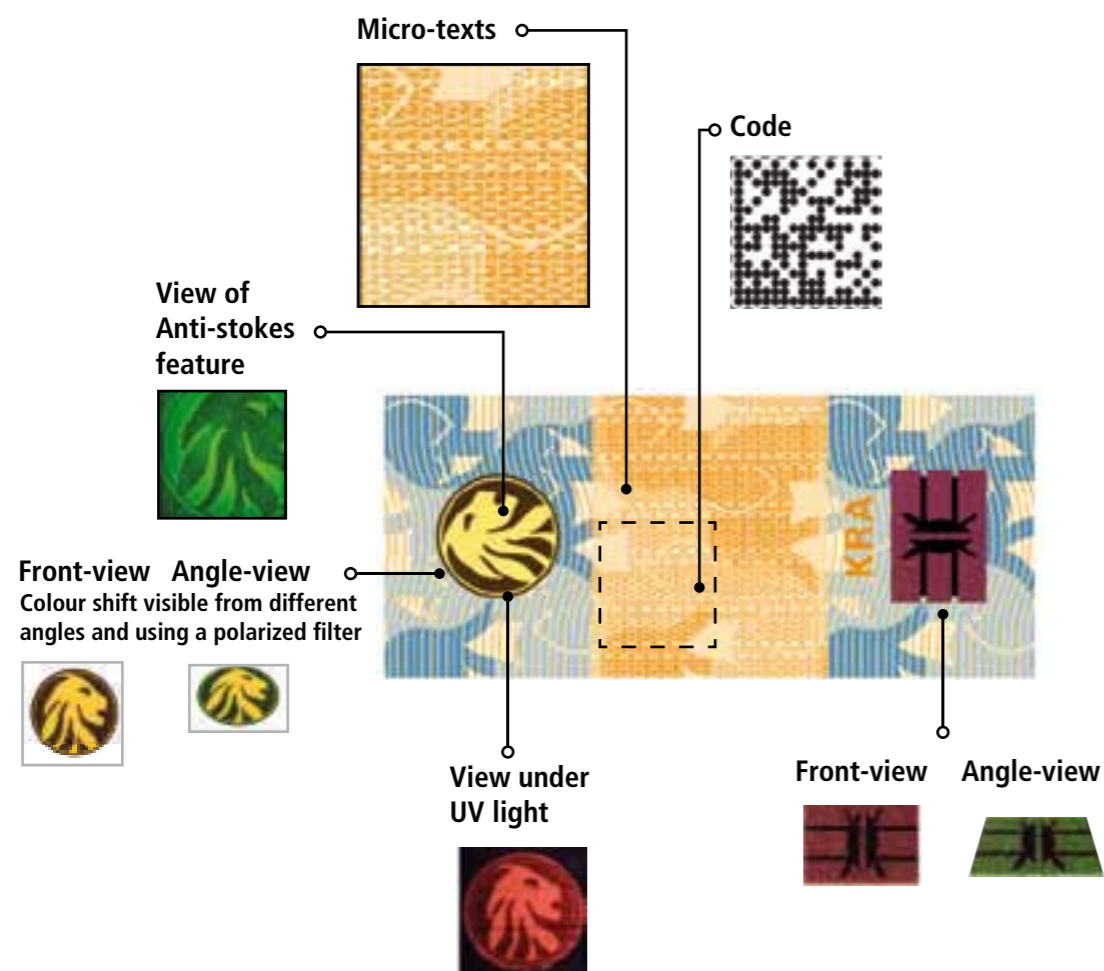
A growing number of countries, beginning with Turkey and Brazil,

have implemented sophisticated systems for monitoring production and distribution (6). Brazil's system was instrumental in identifying under-reporting of production by 14 cigarette companies, leading to sharp reductions in the illegal production that accounted for much of the country's illicit trade in the early 2000s. Brazil also introduced harsh penalties that included closing down several companies (78).

Similarly, Kenya implemented a strong system for monitoring tobacco production and tobacco products in transit by using electronic seals that track locations of trucks and note deviations from planned routes. The government indicates that this system has greatly reduced illicit trade and increased revenues substantially in Kenya (79).

Controls over the distribution chain, improved technologies and better use of data help to reduce illicit trade and complement tobacco tax reforms.

SECURITY FEATURES OF THE KENYA REVENUE AUTHORITY TOBACCO TAX STAMPS



TECHNOLOGY IN THE SERVICE OF TAX ADMINISTRATION

The WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products recommends that tracking-and-tracing systems should include the following features: (74).

- unique, secure, non-removable identification markings (e.g. stamps or codes) affixed to or forming part of all cigarette packaging;
- markings that include or can be used to identify: date and location of production; production facility, machine and production shift or time of manufacture; and name, invoice, order number and payment records of the first customer not affiliated with the manufacturer;
- market in which the product is intended to be sold and the intended shipping route, date, destination, point of departure and consignee;
- product description, including brand, sub-brand and other information;
- shipping information;
- identity of known subsequent purchasers; and maintenance of appropriate records by all involved in the supply chain.

As technologies have improved, the tax stamps used by many countries have become more sophisticated and include encrypted information that enhances enforcement capacity by thwarting counterfeiting (6).

Encrypted tax stamps and/or other pack markings that are difficult to counterfeit are an integral component of more comprehensive tracking-and-tracing systems that track tobacco products through each stage of the supply chain, from production through to retail sale, and can also be used to trace products back through the supply chain to identify all those involved in production, distribution and sale (6).

Jurisdictions that use enhanced tax stamps typically adopt related systems that facilitate monitoring the application of stamps and distribution of stamped products (6). Digital stamps are also useful for ensuring tax compliance and identify, at least to some extent, where licit products enter the illicit market. Some key features of these stamps are clearly visible, such as colour-shifting ink, design, unique stamp numbers and other characteristics. Other security features can only be observed with special scanners, including encrypted codes containing information on the distributor's name, the date on which the stamp was applied, the tax value of the stamp and more.

Effective tracking-and-tracing systems help maintain supply chain integrity by strengthening authorities' ability to identify illicit products and determine diversion points from legal supply chains into illicit markets, enabling them to identify who was in control of the products at that point (6). The enforcement capacity of tax authorities using these systems is further enhanced when governments adopt licensing requirements for all involved in production, distribution and/or sale of tobacco products, and when penalties for non-compliance include licence suspension or revocation (6).

Tobacco industry interference with tobacco control can be neutralized

Tobacco industry interference takes many forms

Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC) have committed to overcoming tobacco industry interference by implementing Article 5.3 of this treaty, which states, "In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law" (1).

The tobacco industry strongly opposes all tobacco control efforts. It devotes substantial amounts of money and effort to the systematic employment of a wide range of tactics to interfere with the comprehensive implementation of provisions of the WHO FCTC by its Parties, and with any significant tobacco control measure taken by non-Parties

Tobacco industry interference takes many forms, but all have the goal of weakening, undermining, and obstructing effective tobacco control policies. Some activities are

conducted openly, while others are more covert. Tactics used by the tobacco industry to interfere with tobacco control efforts include (80):

- manoeuvring to hijack the political and legislative process;
- exaggerating the economic importance of the industry;
- manipulating public opinion to gain the appearance of respectability;
- fabricating support through front groups;
- discrediting proven science;
- intimidating governments with litigation or the threat of litigation.

Although an increasing number of countries have begun to implement some recommendations included in the WHO FCTC Article 5.3 guidelines, no country has yet fully implemented these provisions at best practice level. A new Tobacco Industry Interference Index based on the Article 5.3 guidelines, designed with the help of tobacco control experts and validated through focus group discussions, has been developed to assess the levels of tobacco industry influence on countries' tobacco control policy development (81). Used initially in seven South-East Asian countries, this index is a useful advocacy

tool to identify both progress and gaps in national efforts to prevent tobacco industry interference in tobacco control, and can be adapted for use by other countries and regions.

The tobacco industry has traditionally tried to lobby government agencies responsible for health, education, family protection and others interested in or affected by tobacco control policies. Due to obligations created by the WHO FCTC in implementing tax-related measures, the non-health sector is aware of the issues involved and is increasingly interested in raising tobacco

taxes and fighting illicit tobacco trade. As a result, tobacco companies are now intensifying their efforts to influence the decision-making process within ministries of finance, customs departments, diplomatic missions and other agencies with oversight of tax and trade policy.

Industry tactics to interfere with taxation policy

Because raising the price of tobacco by increasing taxes is one of the most effective measures to reduce smoking consumption

All industry attempts at interference – if identified and regularly monitored – can be successfully countered.



and prevalence, the tobacco industry employs a variety of tactics to hinder effective implementation of tobacco tax increases and, thus, protect their goal of increasing profits (82).

Countering industry tactics

All industry attempts at interference – if identified and regularly monitored – can be successfully countered, but understanding the various practices the industry employs is critical to the success of this. Clear, practical and comprehensive recommendations have been included in guidelines issued by the Conference of the Parties to assist Parties in meeting their legal obligations to implement Article 5.3, drawing on the best available scientific evidence and experience in countering tobacco industry interference (83).

Regular research to identify and monitor industry interference in tobacco control

policy, and sharing this information among countries and the wider public, are key to countering interference. Research information provides the evidence needed to better understand interference strategies and help governments make all necessary efforts, including enacting legislation and regulations to counter interference and implement effective tobacco control measures. Involving civil society in identifying and unveiling industry tactics helps to inform and mobilize public participation, and is an important contributor to success.

Although the industry tirelessly attempts to position itself as a “legitimate” partner and stakeholder in tobacco control, its interests are in irreconcilable conflict with the interests of public health policy, and thus no element of the tobacco industry as defined by the WHO FCTC can be allowed to have any involvement in developing and implementing tobacco control measures.

Legal mechanisms that define roles and responsibilities must be put in place to ensure monitoring. Additionally, firewalls between government and the tobacco industry must be in place to block industry attempts to influence the tobacco control decision-making and implementation process, as well as prevent any conflict of interest by government officials and elected representatives. Transparency and disclosure of tobacco industry conduct and finances, including lobbying activities, campaign contributions and tobacco advertising, promotion and sponsorship expenditures, are also important.

Effective government action to counter tobacco industry tactics designed to undermine taxation policy includes (82):

- monitoring tobacco sales, product prices, brand proliferation and tax revenues before and after a tax increase to assess industry strategies;

- implementing a uniform tax structure that levies the same tax rate on all tobacco products regardless of their characteristics, prices or production process, with no exceptions;
- implementing a specific taxation system in which tobacco tax is based on quantity rather than price;
- increasing taxes to a sufficiently high level so that artificial price changes have minimal impact on industry profit margins;
- setting a minimum tax floor, which is especially effective in ad valorem or multiple tiered tax systems;
- banning price-related promotional activity and discounts.

To ensure effective monitoring of the industry for possible tax avoidance, companies should be required by law and/or specific regulations to report relevant information, while relevant government agencies should develop their capacity to

- collect such data, which should include (82):
 - sales and removals from warehouses by brand and/or price categories;
 - tax revenue by brand and/or price categories;
 - changes in tobacco product prices by product categories and brands;
 - data on price-related promotions, including discount coupons, promotional gifts, contest prizes etc;
 - changes in product characteristics, such as pack size, weight, length etc;
 - introduction of new products or brands, their specifications, and their prices;
 - total promotional expenditures and promotional spending by product categories.

It is common for tobacco companies to attempt to forge various partnerships with the government to “ensure” transmission of the above information, but in light of the Article 5.3 guidelines there is no need or justification for such partnerships.

Overall, a comprehensive, national, multisectoral tobacco control programme that puts specific measures into effect based on the WHO FCTC provisions and implementation guidelines with clear mandates and responsibilities for authorities, as well as effective firewalls against tobacco industry interference, is ultimately the best protection from the vested interests of the tobacco industry.

Lessons learned from countries’ successes include enacting and enforcing evidence-based tobacco control measures at best practice level; communicating to the public and relevant authorities about tobacco control policies and regulations; building strong anti-tobacco coalitions across government agencies as well as with civil society; and enlisting credible and popular tobacco control champions capable of convincingly revealing the truth about the harms of tobacco use and industry tactics.

Tax-specific tobacco industry tactics

- **Stockpiling.** Tobacco companies often oversupply products to the market before a tax increase takes effect, thus delaying paying the new, higher tax until the overstock is cleared.
- **Changing product attributes or production processes.** Because of complex tobacco tax structures that levy different tax rates based on different characteristics (e.g., length, weight, price or product type), the tobacco industry may exploit different tax classifications by changing physical product attributes or production methods to achieve lower tax rates.
- **Lowering prices.** To reduce tax liability or meet sales revenue targets, tobacco companies may simply lower prices, which may not reduce overall profits if lower prices generate more sales.
- **Over-shifting of prices.** By increasing prices more than the amount of a tax increase, the industry can compensate for revenue reductions resulting from decreased sales and potentially increase profit margins.
- **Under-shifting prices.** Increasing prices by less than the amount of a tax increase lowers the impact of the increase on demand and allows the industry to lessen the effect of the increase on consumers.
- **Timing of price increases.** Increasing prices before a tax increase comes into effect allows tobacco companies to sensitize customers to new, higher prices, thus preventing “sticker shock” and simultaneously generating additional profits.
- **Price discrimination and promotions.** Selling the same product at different prices to different customers, often through targeted price-related promotions, can preserve affordability of products across all income groups following a tax increase, prevent price-sensitive users from quitting or reducing consumption, and ensure that potential new customers are not deterred by high prices.

COP 6 opposes International Tax and Investment Center’s interference attempt



Through government officials in Latin America, the WHO FCTC Secretariat was informed about a meeting organized by the International Tax and Investment Center (ITIC), being held in Moscow immediately before the WHO FCTC’s Sixth Conference of Parties (COP6) in 2014. Despite its claim to be independent, the International Tax and Investment Centre is in fact heavily influenced by the tobacco industry. It has several tobacco companies sitting on its board, and has published extensively in favour of the tobacco industry’s false positions on excise taxation, investment and illicit trade in tobacco products. The purpose of the

meeting in Moscow was to influence WHO FCTC Party delegations around Article 6 (Price and tax measures to reduce the demand for tobacco) guidelines. After

having received information about the planned meeting, the WHO FCTC Secretariat informed civil society groups and warned Parties’ delegations about the true nature of ITIC and conducted media work to expose the industry attempts to influence Parties’ positions. During COP6, civil society kept the spotlight on any country associated with ITIC and the tobacco industry, effectively silencing them during Article 6 discussions. As a result, strong Article 6 guidelines were passed and ITIC was effectively discredited as being profoundly influenced by the tobacco industry on an international stage.

Steady progress continues but more is needed



Monitor tobacco use and prevention policies



Protect from tobacco smoke



Offer help to quit tobacco use



Warn about the dangers of tobacco



Enforce bans on tobacco advertising, promotion and sponsorship



Raise taxes on tobacco

Monitor tobacco use and prevention policies

Article 20 of the WHO Framework Convention on Tobacco Control states: "... Parties shall establish ... surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke ... Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at the regional and international levels ..." (7).

RECENT ACHIEVEMENTS AND DEVELOPMENTS

Tobacco Questions for Surveys (TQS) increasingly incorporated in national surveys

Accurate monitoring of tobacco use and related measures is key to implementing effective policies to combat the tobacco epidemic, protect health and save lives. Surveys conducted periodically and that are representative of the population provide the data needed to determine the extent of the problem and identify which interventions need to be targeted to specific populations or regions. To ensure comparability between surveys over time and between countries, it is essential that the same questions are included in each survey instrument used. The Tobacco Questions for Surveys (TQS), a subset of 22 core

questions from the Global Tobacco Surveillance System (GTSS), provides a standard set of questions on tobacco use and key tobacco control measures as defined by the WHO Framework Convention on Tobacco Control that can be used as a stand-alone module or included in other surveys in any combination. Currently, 26 countries have integrated TQS into their national surveys, which will provide benchmarks to enable assessment of their progress on implementation and effectiveness of tobacco control measures.

Monitoring is critical to tobacco control efforts

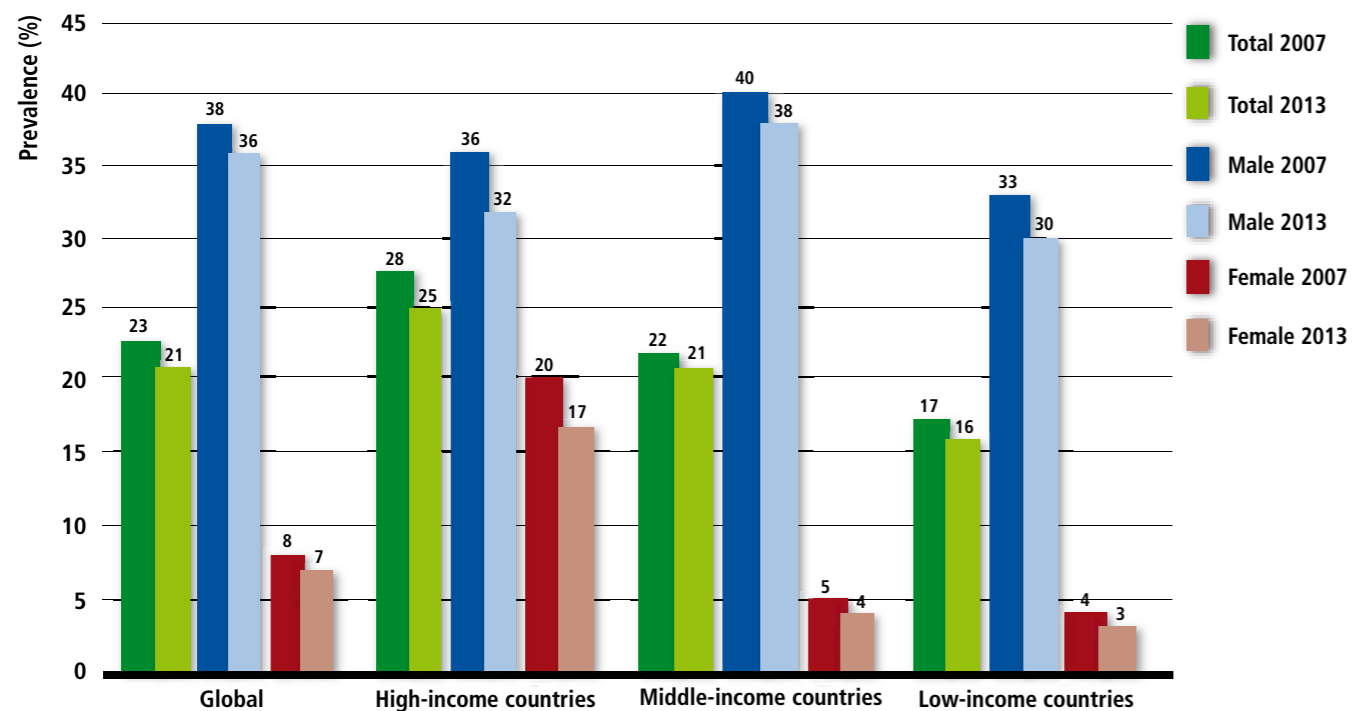
Monitoring patterns of tobacco use and the impact of tobacco control programmes is critical to effectively address the epidemic and assess the effects of the MPOWER measures in line with the WHO FCTC in each country (84). Monitoring systems should track tobacco use indicators – including cigarette smoking and other forms of smoked tobacco (e.g. cigars, pipe, bidis, water pipe); smokeless tobacco products; novel tobacco products such as tobacco vaporizers; and non-tobacco forms of nicotine use (e.g. e-cigarettes). It is equally important to monitor the impact of tobacco control policy interventions and tobacco

industry activities (84). Data that are accurate and current facilitate appropriate policy implementation, precise measurement of policy impact and adjustment of strategies as required, all of which greatly increase the likelihood of success (84).

Global smoking prevalence has decreased slightly

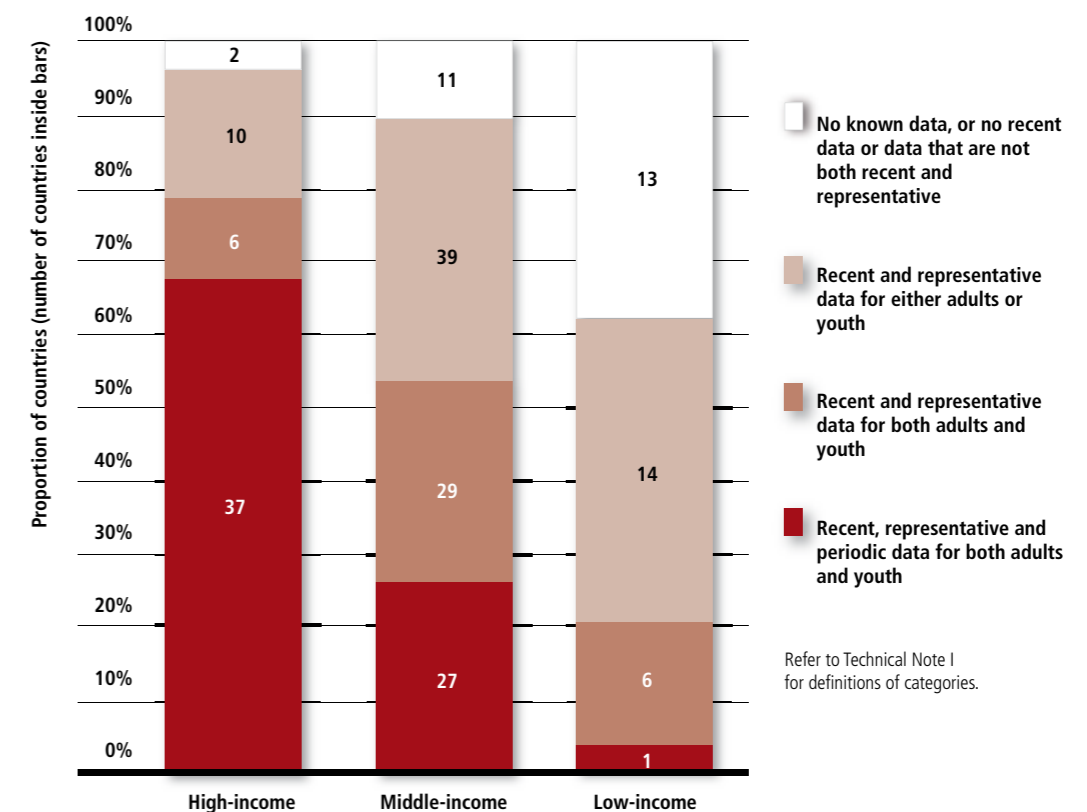
In 2013, 21% of adults globally were current smokers – 950 million men and 177 million women. Despite increasing global population between 2007 and 2013, smoking prevalence has actually declined worldwide from 23% in 2007, preventing an increase in the number of smokers in the world. The total remains at 1.1 billion smokers globally in 2013. Smoking prevalence is highest in high-income countries, with a quarter of adults (25%) in 2013 being current smokers. In contrast, 21% of adults living in middle-income countries and 16% of adults in low-income countries were current smokers.

CURRENT ADULT TOBACCO SMOKING PREVALENCE, 2007–2013



Source: WHO prevalence estimates. Please refer to Appendix X (online) for more information.

MONITORING



Refer to Technical Note 1 for definitions of categories.

Tobacco use monitoring continues to expand slowly

Despite the acknowledged importance of monitoring and the success of surveys such as the Global Adult Tobacco Survey, overall global monitoring of tobacco use is increasing only slightly. This is because some countries that had conducted representative adult and youth surveys at one time did not repeat them at least once in the past

5 years, or have made no plans to do so in the future, even as other countries conduct surveys for the first time.

As a result, 2.2 billion people in 65 countries (30% of the world's population) were covered by effective tobacco use surveillance in 2014 through recent, representative and periodic surveys of both adults and youth, up slightly from the 2 billion people in 65 countries (28%

of the world's population) covered by effective tobacco use surveillance in 2012. More than two thirds of high-income countries adequately monitor tobacco use among both adults and youth, a level of achievement accomplished by a quarter of middle-income countries and one low-income country (Nepal).

In the previous 5 years, more countries monitored youth than adults (145 vs 127),

largely as a result of promotion by WHO and its partners of international surveys such as the Global Youth Tobacco Survey (GYTS) and Health Behaviour in School-Aged Children (HBSC) survey. Youth surveys also saw a greater repeat rate than adult surveys, with 111 countries recently repeating a national youth survey. Only 81 countries had run two national adult surveys within 5 years.

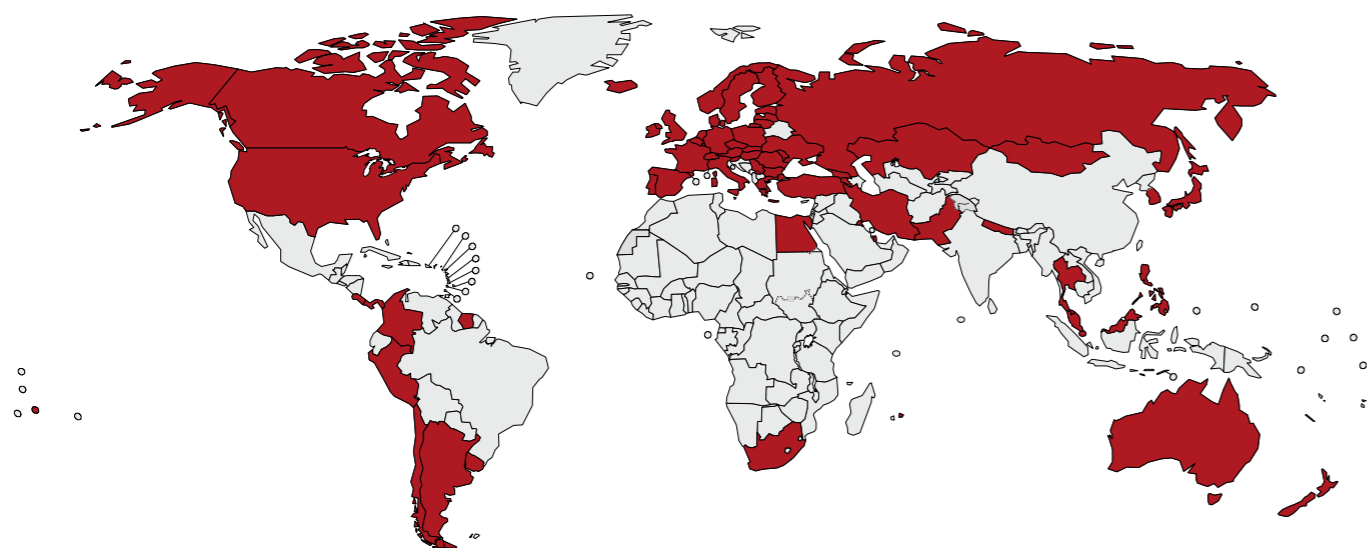
There are 63 countries that did not collect representative data for both adults and youth, and 26 that collected no data at all in the previous 5 years. There are 41 countries (35 of which are low- or middle-income) that conducted recent adult and youth surveys but have not done so periodically, complicating attempts to detect trends in tobacco use. An additional 3.8 billion people could be covered by high-level

monitoring if these countries were to repeat existing surveys at least once every 5 years.

Countries can add Tobacco Questions for Surveys into existing national surveys to minimize surveillance system and survey costs – and increase the likelihood that they can achieve the most comprehensive monitoring levels.

2.2 billion people in 65 countries are covered by effective tobacco use surveillance.

MONITOR THE PREVALENCE OF TOBACCO USE – HIGHEST ACHIEVING COUNTRIES, TERRITORIES AND AREAS, 2014



Countries, territories and areas with the highest level of achievement: Argentina, Armenia, Australia, Austria, Belgium, Bulgaria, Canada, Chile, Colombia, Costa Rica, Czech Republic, Denmark, Egypt, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Italy, Japan, Kazakhstan, Kuwait, Latvia, Lithuania, Luxembourg, Malaysia, Mauritius, Mongolia, Nepal, Netherlands, New Zealand, Niue, Norway, Pakistan,* Panama, Peru, Philippines, Poland, Portugal, Qatar,* Republic of Korea, Republic of Moldova,* Romania, Russian Federation, Serbia, Singapore, Slovakia, Slovenia, South Africa, Spain, Suriname,* Sweden, Switzerland, Thailand, Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay, and West Bank and Gaza Strip.

*Country newly at the highest level since 31 December 2012.

Strengthening tobacco monitoring and surveillance in Cambodia



It used standardized survey questions with adapted sampling methodology from the benchmark Global Adult Tobacco Survey (GATS). The survey design was comparable to previous national surveys on tobacco use, but was more comprehensive, with data collected on additional topics including cessation, secondhand smoke exposure, economics, media, and knowledge and perceptions of tobacco. The successful completion of the expanded 2011 NATSC was a significant step in building Cambodia's capacity for tobacco surveillance, monitoring and research. In 2014 the NIS completed a fourth NATSC with support from the South-East Asia Tobacco Control Alliance

and WHO Cambodia, demonstrating its strong capacity to provide periodic and nationally representative data that can be used to monitor trends in tobacco use, measure the impact of policies being implemented to reduce tobacco consumption, and serve as a basis for action to curb the country's tobacco epidemic.

Since 2005, Cambodia has regularly collected and reported data on tobacco use and related measures. The 2011 National Adult Tobacco Survey of the Royal Government of Cambodia (NATSC) was the third such national survey, conducted by the country's National Institute of Statistics (NIS) in partnership with a number of national and global partners led by WHO Cambodia.

Article 8 of the WHO Framework Convention on Tobacco Control states: "... scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability ... [Parties] shall adopt and implement ... measures providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places" (1). WHO FCTC Article 8 guidelines (83) are intended to assist Parties in meeting their obligations under Article 8 of the Convention and provide a clear timeline for Parties to adopt appropriate measures (within 5 years after entry into force of the WHO FCTC for a given Party).

RECENT ACHIEVEMENTS AND DEVELOPMENTS

The number of tobacco-free sporting events and venues continues to increase

The world of sport increasingly recognizes the incompatibility of associating tobacco use with athletic competition and more generally with physical fitness and healthy lifestyles. To help emphasize this point, and to protect the health of the large numbers of fans who attend sporting events, more and more sporting organizations are making their stadiums and arenas 100% smoke- and tobacco-free. Not only is smoking increasingly disallowed in these venues, so are sales of tobacco products and the conducting of any tobacco advertising, promotion or sponsorship (TAPS) activities. This was the case for numerous large international sporting events, such as the 2012 tobacco-free Union of European Football Associations (UEFA) cup in Poland and Ukraine, the 20th Commonwealth Games held completely smoke-free in Glasgow, UK in July/August 2014, and the tobacco-free 2014 Winter Olympics in Sochi, Russia. In some countries, existing laws already prohibit smoking and TAPS activities in sporting venues, while in others, individual venues or leagues have implemented these policies ahead of action by national or subnational governments. The guidelines of the WHO Framework Convention on Tobacco Control recommend including outdoor or quasi-outdoor places such as sports stadiums in the definition



of public places that should be made 100% smoke-free. Other large events that attract substantial numbers of people, including social, cultural, religious and political events, are also increasingly becoming smoke-free. Smoke-free sporting and other events are shown to reduce smoking prevalence, reduce levels of secondhand smoke both in venues and other nearby businesses such as restaurants, facilitate implementation and public acceptance of policy changes, and help change social norms and attitudes around smoking.

Completely smoke-free environments with no exceptions are the only proven way to fully protect people from the harms of secondhand tobacco smoke.

Secondhand smoke kills

Scientific evidence has long proven that there is no safe level of exposure to secondhand smoke and that exposure leads to serious and often fatal diseases, including cardiovascular and respiratory disease as well as lung and other cancers (85–87). Children, fetuses and newborns may also suffer severe, long-term harm – or even die – as a result of secondhand smoke exposure (88–93).

Smoke-free laws save lives

Completely smoke-free environments with no exceptions are the only proven way to fully protect people from the harms of secondhand tobacco smoke (94). Separate smoking rooms, ventilation systems and other measures intended to accommodate smoking are not effective in preventing exposure (95–100). Governments must

enact and enforce comprehensive smoke-free laws to achieve high compliance and maintain public and political support (101).

Smoke-free laws are popular, do not hurt business, and improve health

As the number of countries and subnational areas with comprehensive smoke-free legislation continues to rise, it has become clear that effective laws are relatively easy to pass and enforce, and that doing so is generally overwhelmingly supported by the public (102), improves the health of non-smokers as well as smokers (103), and does not cause financial harm to businesses (104). Smoke-free environments encourage smokers to reduce tobacco use and help those who want to quit succeed over the long term (105, 106). They can also encourage people to make their homes smoke-free, which protects children and

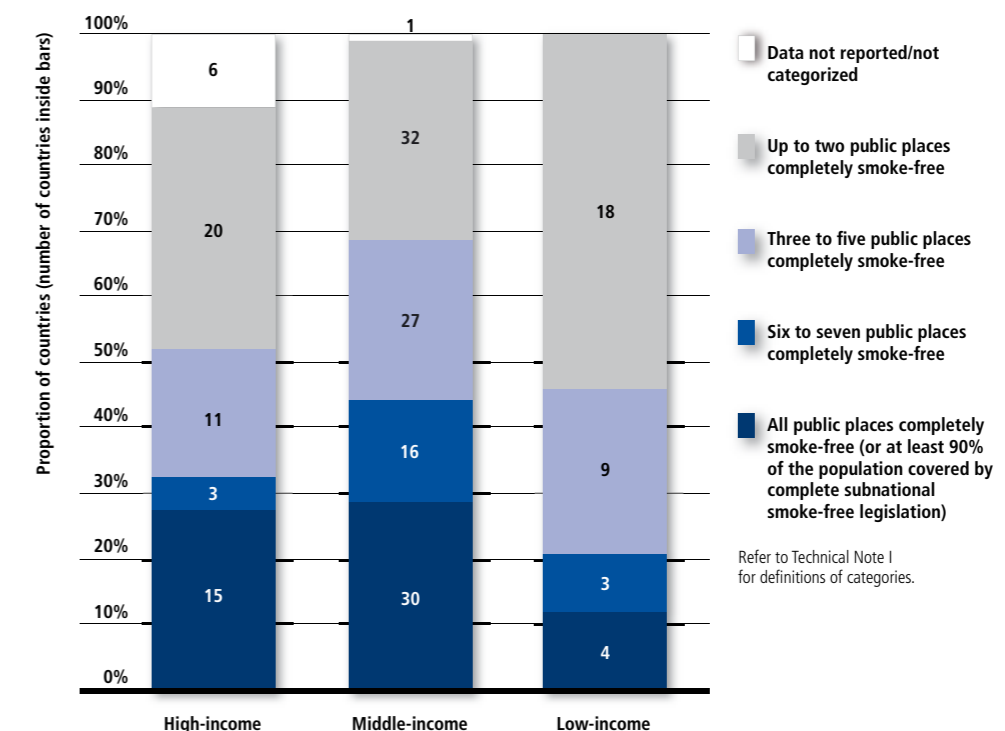
other non-smokers and reduces both adult and youth smoking (107–113).

Comprehensive smoke-free legislation is the most widely adopted policy measure

Strong smoke-free legislation continues to be the most widely adopted measure (49 countries). In 2014, 1.3 billion people (18% of the world's population) were covered at the most comprehensive level – an increase of about 200 million people since 2012.

Fifteen countries strengthened their existing smoke-free laws since 2012 by increasing the number of smoke-free places (13 of which improved by at least one category level). However, only five countries (Chile, Jamaica, Madagascar, Russian Federation and Suriname) – home to 3% of the world's population – implemented a comprehensive smoke-free law covering all public places

SMOKE-FREE LEGISLATION



and workplaces, bringing the global total to 49.

Another nine countries could attain the highest level of achievement by making a single category of public place completely smoke-free; for six of these the missing place is private offices and workplaces. An additional 13 countries would attain the highest level by implementing smoking bans in two additional places, with restaurants, pubs and bars the places most often remaining unprotected. Three countries with weak smoke-free laws in 2012 eroded them even further by newly allowing designated smoking rooms to exist under the law.

New smoking bans have been enacted by countries since 2012 in each type of public place and workplace. Globally, educational facilities are the best-protected public place, with two thirds of countries legislating such a ban. A close second are health facilities, with 63% of countries banning smoking in these facilities. The lowest level of protection from secondhand smoke is afforded to employees and patrons of restaurants, pubs and bars; only one third of countries completely ban smoking in these establishments.

Among high-income countries, the public places with the best smoke-free law

coverage are educational facilities, and the places least protected are offices. Among low- and middle-income countries, the public places best covered by smoke-free laws are health care facilities, and the places least protected are restaurants, pubs and bars. Although there has been progress, three-quarters of all countries – including 88% of low-income countries – continue to leave their populations vulnerable to the dangers of secondhand smoke through weak or absent smoke-free laws.

Of the 460 million people (6.5% of the world's population) who live in one of the world's 100 largest cities, only 164

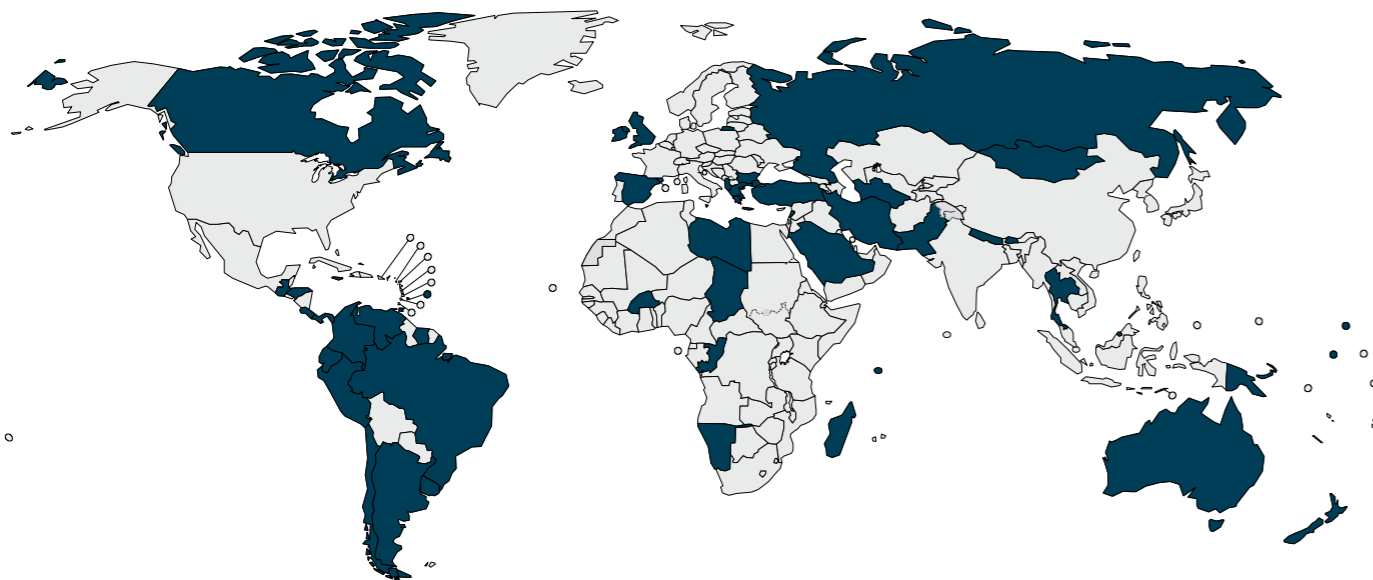
million (in 28 cities) are protected by a comprehensive smoke-free law. This is an increase of seven cities since 2012. Two large cities (Hong Kong Special Administrative Region of China, and Houston) and six states or provinces containing a large city (Chicago, Jakarta, Melbourne, Mexico City, New York City and

Sydney) have introduced comprehensive smoke-free laws independently of national authorities to protect their citizens from secondhand smoke. Beijing has adopted a comprehensive smoke-free law, which took effect on 1 June 2015. People living in the other 19 smoke-free cities are covered under national legislation. An additional

14 cities among the 100 largest, with a combined population of 59 million people, are one step away from going completely smoke-free, needing only to ban designated smoking rooms to achieve this.

Strong smoke-free legislation continues to be the most widely adopted policy measure, covering 1.3 billion people.

SMOKE-FREE ENVIRONMENTS – HIGHEST ACHIEVING COUNTRIES, TERRITORIES AND AREAS, 2014



Countries, territories and areas with the highest level of achievement: Albania, Argentina, Australia, Barbados, Bhutan, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Canada, Chad, Chile,* Colombia, Congo, Costa Rica, Ecuador, Greece, Guatemala, Honduras, Iran (Islamic Republic of), Ireland, Jamaica,* Lebanon, Libya, Madagascar,* Malta, Marshall Islands, Mongolia, Namibia, Nauru, Nepal, New Zealand, Pakistan, Panama, Papua New Guinea, Peru, Russian Federation,* Saudi Arabia, Seychelles, Spain, Suriname,* Thailand, Trinidad and Tobago, Turkey, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Venezuela (Bolivarian Republic of), West Bank and Gaza Strip.

* Country newly at the highest level since 31 December 2012.



Russia goes 100% smoke-free



Ministry of Health officials at a press conference.

Russia took a huge step towards controlling its tobacco epidemic in February 2013 when it passed strong, comprehensive and nationwide tobacco control legislation. The legislation, championed by the Ministry of Health and passed by wide margins in both houses of Parliament, went into effect in two stages. On 1 June 2013 smoke-free provisions were made for all educational, cultural, athletic and medical facilities; most forms

of public transport; government, social, and workplaces; elevators and communal areas of apartment buildings; and children's playgrounds, beaches and gas stations. A year later, on 1 June 2014, smoke-free coverage was extended to the remaining forms of public transport (including train platforms) as well as hotels, restaurants, cafés, bars and markets. Despite concerns about the law's implementation and fears kindled by the tobacco industry that some businesses might see reduced profits, monitoring conducted 6 months later showed near universal compliance in cafés, bars and restaurants, with an overall increase in sales in these establishments year-on-year. However, some discotheques and nightclubs continue to permit smoking even with the new restrictions, which is a major concern because of the large numbers of guests and employees who continue to be exposed to secondhand smoke. The most common violation, the lack of required no-smoking signage, has been easily remedied. The overall good compliance with the smoke-free law demonstrates that political will, coupled with effective enforcement, can sharply reduce smoking and exposure to secondhand smoke in all venues where smoking is outlawed.

Smoke-free Beijing sets an example for all of China

China's tobacco use has historically been high, especially among men. In November 2014, China's capital Beijing adopted an historic tobacco control law that is set to make the city one of the world's largest smoke-free municipalities. Once enforced, Beijing's exemplary action will reduce smoking and secondhand smoke exposure for the city's 21 million people, and provide powerful momentum for urgently needed nationwide action to reduce tobacco use. Beijing's new law, which took effect in on 1st June 2015, mandates 100% smoke-free indoor public places, workplaces and public transport, as well as many types of outdoor areas catering for young people and sports activities, and will provide significant health benefits for millions of Beijing workers, residents and visitors. The law also outlaws most forms of tobacco advertising, promotion and sponsorship, including sales to minors. Implemented well, these smoke-free policies will immediately improve public health by reducing exposure to secondhand smoke, decreasing cigarette consumption and helping smokers



Congratulations to Beijing – thank you.

quit. Establishing Beijing as a smoke-free city sets the stage for China to adopt and implement strong tobacco control measures on a national level; action that is urgently needed to protect the country's 300 million smokers and hundreds of millions more non-smokers who are routinely exposed to secondhand smoke. Smoke-free laws remain an effective solution for cities and countries around the world to combat tobacco use.

Madagascar passes 100% smoke-free legislation

Compared to other African countries, Madagascar has a relatively high male smoking prevalence rate (28% of Malagasy men are current cigarette smokers). Madagascar, which has been strengthening its tobacco control legislation for more than a decade, took the important step of making all indoor public places and indoor workplaces – as well as all public transport – 100% smoke-free. The law was adopted in October 2013 and entered into force one year later. The legislation further strengthens the country's tobacco control programmes, which already include bans on all forms of tobacco advertising, promotion and sponsorship; tobacco packaging labelling requirements, and strong pictorial warning labels.



Article 14 of the WHO Framework Convention on Tobacco Control states: "Each Party shall ... take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence ... Each Party shall ... design and implement effective programmes aimed at promoting the cessation of tobacco use" (7). WHO FCTC Article 14 guidelines (83) are intended to assist Parties in meeting their obligations under Article 14 of the Convention.

RECENT ACHIEVEMENTS AND DEVELOPMENTS

WHO issues a training package for tobacco cessation in primary care



Treatment of tobacco use and dependence is mandated in the WHO Framework Convention on Tobacco Control (WHO FCTC) Article 14 (Demand reduction measures concerning tobacco dependence and cessation) as a key component of a comprehensive tobacco control strategy. Tobacco dependence treatment is also recommended by WHO as part of a comprehensive package of essential services for the prevention and control of noncommunicable diseases (NCDs) in primary care in accordance with the WHO Global Action Plan for the Prevention and Control of NCDs. To help countries meet the goal of providing comprehensive tobacco dependence treatment for all tobacco users, in 2013 WHO issued *Strengthening health systems for treating tobacco dependence in primary care*, a training package focused on integration of basic cessation advice into the primary care setting. Training modules have been developed for policy-makers, primary care service managers and primary care providers, as well as a "train the trainers" curriculum. WHO recommends that countries use this capacity-building and training tool to improve the delivery of brief tobacco interventions in primary care as part of their WHO FCTC obligations and implementation of the WHO Global Action Plan for the Prevention and Control of NCDs.

WHO and the ITU harness the power of mobile technology for tobacco cessation

Extensive trials published in journals such as *The Lancet* and the *European Journal of Health Economics* by experts in the United Kingdom, the USA, New Zealand, and China indicate that personalized smoking cessation advice and support from mobile phone messages can be an efficient and cost-effective tool, improving both individual health and the overall health system. As a result, in 2013, WHO and the International Telecommunication Union (ITU) launched the Be He@lthy Be Mobile initiative to scale up national NCD control using mobile technology. The initiative supports governments by increasing access to national health services for noncommunicable diseases and information about their risk factors to the general population. The most popular of these so far has been tobacco cessation, partly due to the strong evidence base for tobacco cessation services delivered through mobile phones.

Costa Rica was one of the first countries to launch a national mTobaccoCessation programme using the global evidence base to create tailored messages for tobacco smokers. The initiative is supporting the use of mobile phones to improve access to cessation services, sensitize health workers on tobacco addiction and cessation, and change long-term attitudes to tobacco use. The country has built its own national software platform and is partly funding the programme through an innovative financing mechanism using tobacco tax revenue. Preparations for additional mTobaccoCessation programmes are currently under way in India, the Philippines and Tunisia. These countries will utilize the global evidence base, the experiences of Costa Rica, and additional tobacco cessation tools offered by other countries such as the United Kingdom and Norway. This pool of resources will enable them to create mobile health components that target the local population and reduce national tobacco consumption.



Most smokers want to quit

Most smokers want to quit, especially if they are aware of the full range of harms caused by tobacco use, but many find it difficult to do so unaided because of the extreme addictiveness of nicotine (114). Although most smokers who quit are able to do so without assistance, cessation interventions greatly increase quit rates (115). People who quit tobacco experience immediate and significant health benefits, and reduce most of their excess health risk within a few years (116, 117).

Tobacco cessation interventions are effective

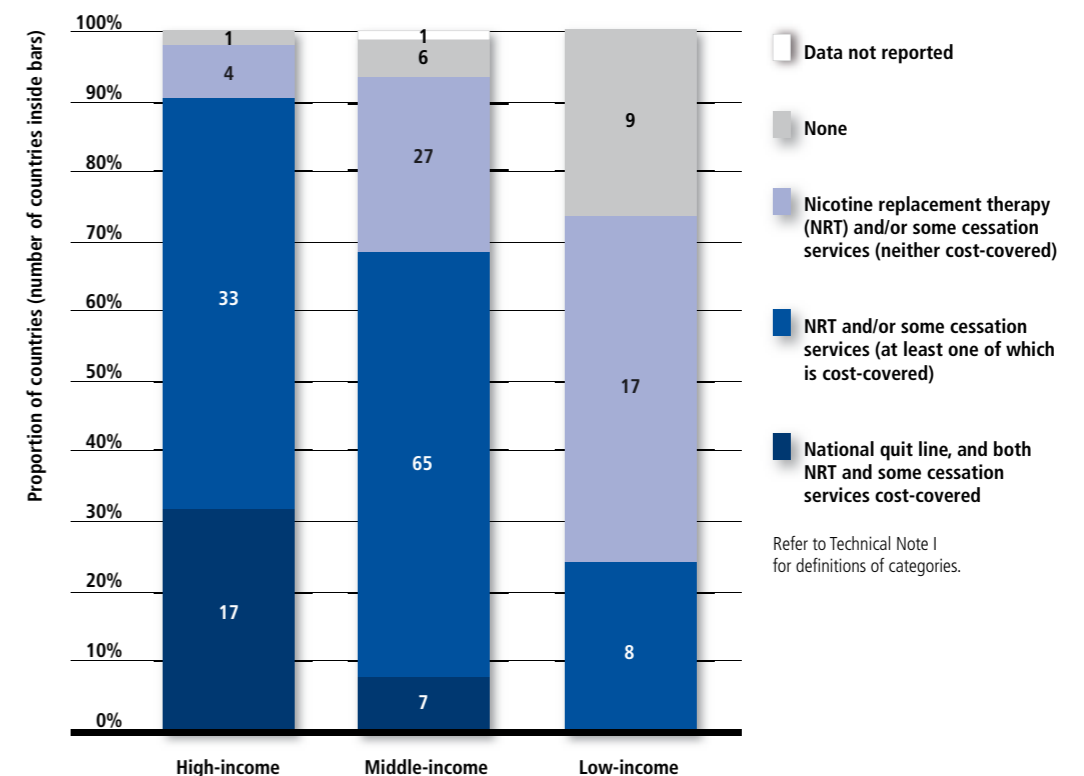
Clinical cessation interventions are effective, and are also extremely cost-effective when compared to other health care system interventions (118). At least three types of clinical treatment should be included in any tobacco control programme (115).

■ *Cessation advice in primary health care systems.* Brief advice from doctors and other health care workers increases quit rates (115).

- *Quit lines.* Cessation advice and counselling can also be provided through free telephone help lines (known as quit lines) (115).
- *Pharmacological therapy.* Clinical cessation treatment should, at a minimum, include nicotine replacement therapy (NRT), which is available over the counter in most countries (115). Pharmacological therapy with NRT alone or in combination with other prescription cessation medications can double or triple quit rates (115).

Most smokers want to quit but find it difficult because of the extreme addictiveness of nicotine.

TOBACCO DEPENDENCE TREATMENT



Government must support cessation treatment

Each country's health care system should assume primary responsibility for smoking cessation programmes (1). Cessation services are most effective when incorporated into a comprehensive national tobacco control programme (28). Each country should also strongly consider including NRT in its Essential Medicines list.

There has been little progress in providing access to essential help to quit smoking

While there has been improvement in implementing comprehensive tobacco cessation services, this is nonetheless a most under-implemented MPOWER measure in terms of the number of countries that have fully implemented it. About 1.1 billion people had access to appropriate cessation support, an increase from 13% in 2012 to 15% of the world's population

in 2014. Six countries (Argentina, Belgium, Brunei Darussalam, Malta, Mexico and the Netherlands – all middle- or high-income) implemented best practice cessation services in the past 2 years. However, because one country reduced services since 2012, the net gain was only five countries, bringing the global total to 24.

While comprehensive cost-covered services are available in only one in eight countries globally, more than 80% of countries have cessation services available in one or more settings, and three quarters of these provide some cost coverage for these services.

One in four countries provides some cost coverage for nicotine replacement therapy, and almost a third provide a toll-free quit line. In total, over 90% of countries (with more than 98% of the world's population) provide at least some form of assistance to quit.

There are 106 countries (with two thirds of the world's population) that come close to attaining the highest level of achievement. In most cases they are missing either a

toll-free national quit line or cost coverage for NRT. A third of countries, down from nearly half in 2012, still have minimal or no cessation programmes.

The provision of cessation services is strongly associated with country income group. More than 90% of high-income countries cost-cover cessation services, and more than half support a toll-free quit line. Low-income countries have the lowest rates of service provision, with only 18% of low-income countries cost-covering cessation services and only 9% funding a quit line.

Of the 460 million people (6.5% of the world's population) who live in one of the world's 100 largest cities, only about 104 million people (in 22 cities) have access to appropriate cessation support. All but one city is located in a country that provides such access to its entire population. Only one city (Hong Kong Special Administrative Region of China) has established a strong cessation programme ahead of the national policy.

Success of Malaysia's smoking cessation services spurs expansion plans



Malaysia has been providing smoking cessation services as part of its primary care since 2000, offering both pharmacological treatment and education and counselling. All patients using primary health clinics care are screened, and smokers are offered basic advice and support to quit smoking. Nearly 80% of the country's 900-plus health clinics provide smoking cessation services, an increase of more than 5% between 2011 and 2014, and achieve quit rates of between 15–17%. A Quit Smoking

Infoline was launched in January 2007 to support and strengthen the National Anti-Smoking Program. The service operates during normal working hours and is staffed by two officers trained to provide information on the harmful effects of smoking and secondhand smoke exposure; give advice, basic counselling and educational materials to help smokers quit; and link people to smoking cessation services throughout the country. About 20% of Infoline callers had maintained cessation after six months. Plans to improve Malaysia's smoking cessation programme include enhancing services in primary care and government hospitals, enlisting other health care partners including general practitioners and pharmacists, and upgrading the Infoline to a fully-fledged quit line which is able to provide more centralized and comprehensive services 24 hours a day. By building on already successful programmes, countries can extend the impact of their tobacco control efforts even further.

TOBACCO DEPENDENCE TREATMENT – HIGHEST ACHIEVING COUNTRIES, 2014



Countries with the highest level of achievement: Argentina,* Australia, Belgium,* Brazil, Brunei Darussalam,* Canada, Denmark, El Salvador, Iran (Islamic Republic of), Ireland, Israel, Kuwait, Malta,* Mexico,* Netherlands,* New Zealand, Panama, Republic of Korea, Singapore, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America, and Uruguay.

* Country newly at the highest level since 31 December 2012.

In 2014 about 1.1 billion people had access to appropriate cessation support.

Health warning labels

Article 11 of the WHO Framework Convention on Tobacco Control states: "Each Party shall ... adopt and implement ... effective measures to ensure that ... tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions ... [Parties shall adopt and implement effective measures to ensure that] each unit packet and package of tobacco products and any outside packaging and labelling of such products also carry health warnings describing the harmful effects of tobacco use ... These warnings and messages ... should be 50% or more of the principal display areas but shall be no less than 30% of the principal display areas... [they] may be in the form of or include pictures or pictograms" (7). WHO FCTC Article 11 guidelines (83) are intended to assist Parties in meeting their obligations under Article 11 of the Convention, which provides a clear timeline for Parties to adopt appropriate measures (within 3 years after entry into force of the WHO FCTC for a given Party).

RECENT ACHIEVEMENTS AND DEVELOPMENTS

WHO FCTC Secretariat promotes a new resource of pictorial health warnings for Africa and elsewhere



Tobacco packaging is the most direct line of communication to the consumer, so graphic, pictorial health warnings (as required by Article

11 of the WHO FCTC and its guidelines) are an essential component of any comprehensive strategy to reduce tobacco use. An online resource containing 43 pictorial health warning label images covering four broad categories (smoking health harms; secondhand smoke exposure; cigarette contents and toxic emissions; and socioeconomic consequences of tobacco use), with accompanying text in either English or French, have been developed for use in sub-Saharan African countries.

The images and text are designed to meet specific needs of countries in the WHO African Region, including consideration of subregional cultural contexts and language variations, and were extensively field tested across sub-Saharan Africa to ensure their effectiveness. This large library of images will facilitate the recommended best practice of using 8–12 graphic warnings simultaneously, and rotating their use every 1 to 2 years in order to achieve the desired impact. This resource has been developed as part of the South-South cooperation demonstration project mandated by the Conference of the Parties. The WHO FCTC Secretariat owns the copyright and can grant countries permission to use the health warnings. For more information please visit www.who.int/tobacco/healthwarningsdatabase/africa/en/.

Countries are beginning to implement plain packaging for tobacco products

Plain (standardized) packaging of tobacco products is one tobacco control intervention that is beginning to be implemented. As defined in Guidelines to Article 11 of the WHO Framework Convention on Tobacco Control, plain packaging restricts or prohibits the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style. Plain packaging reduces the attractiveness of tobacco products, minimizes misleading packaging and enhances the effectiveness of health warnings. In December 2012, Australia became the first country to implement plain packaging on all tobacco products. Despite the tobacco industry's concerted efforts to block plain (standardized) packaging, such as through legal claims, an increasing number of countries are taking this step. Ireland, the United Kingdom and France all passed legislation in 2015 to implement plain packaging. The

intervention is also under active consideration in a number of countries, including Burkina Faso, Chile, New Zealand, Norway, Panama, a Singapore,



Minister for Children and Youth Affairs, Ireland, with an example of a plain package of cigarettes.

South Africa and Turkey. The European Union's Tobacco Products Directive permits Member States to introduce plain (standardized) packaging. By banning the use of logos, colours, brand images or promotional information other than brand and product names in a standard colour and font style, an important element of advertising and promotion can be neutralized.

Health warnings provide needed information about the dangers of smoking

People have a fundamental right to health information, including accurate information about the harms of tobacco use (119–121). Despite clear evidence, many smokers do not fully understand the risk of tobacco use to their health or the health of others (122). Accurate warnings about the harms of tobacco use and secondhand smoke exposure will influence people to decide

against using tobacco (123–125). Health warnings also change social norms about tobacco use, which reduces tobacco use and increases support for tobacco control measures (126).

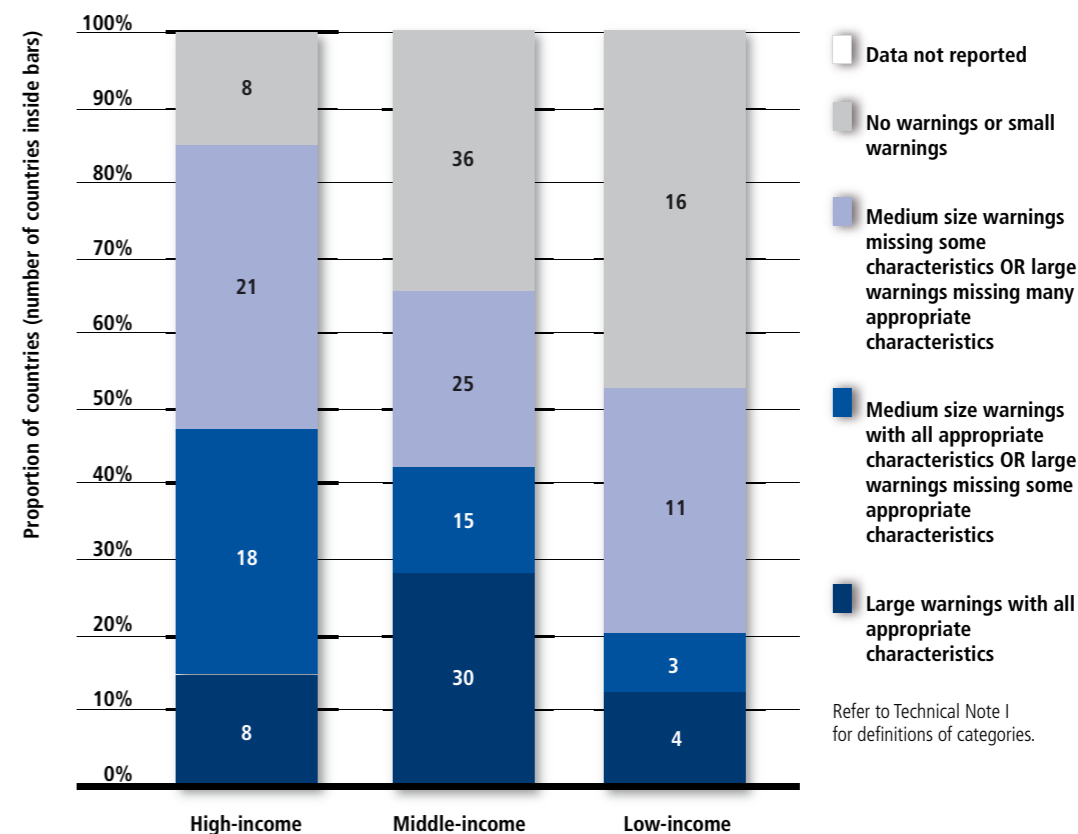
Warning labels on tobacco packaging are effective

Effective health warning labels provide direct health messages to smokers, raising awareness of their health risks and

increasing the likelihood that they will reduce or quit tobacco use (122). Large graphic warnings that cover at least half of both primary tobacco package surfaces (front and back) are more effective than smaller warnings or those that contain only text (122, 127, 128).

Warning labels can be implemented at virtually no cost to governments (127, 128), and generally are more strongly supported by the public than most other tobacco control interventions (129, 130). They

WARNING LABELS



Accurate warnings about the harms of tobacco use and secondhand smoke exposure will influence people to decide against using tobacco.

should be specific in describing the health effects of tobacco use, and be periodically rotated to maintain their impact (83). Deceptive terms (e.g. "light" or "mild") that suggest some products are less harmful should be banned (83). Plain (standardized) packaging enhances the impact of health warnings and other packaging and labelling measures, and reduces the marketing impact of package design (131, 132).

Use of graphic pack warnings is increasing

Use of graphic pack warnings has increased; more people are protected by this MPOWER measure than by any other. Around 1.4

billion people (almost 20% of the world's population) were protected by strong pack warnings in 2014, up from 14% in 2012.

Twelve more countries (Bangladesh, Costa Rica, Fiji, Jamaica, Namibia, Philippines, Samoa, Solomon Islands, Trinidad and Tobago, Turkmenistan, Vanuatu and Viet Nam) implemented large graphic pack warnings in the past 2 years that include all appropriate characteristics, making this the measure with the greatest improvement in the past 2 years in terms of the number of countries newly adopting it. Ten middle-income countries and one low-income country (Bangladesh) were among the 12 countries adopting this measure since 2012.

Although 86% of countries have pack warning legislation, only a third have successfully mandated graphic warnings, and less than a third have mandated that warnings be sufficiently large to cover at least 50% of the main package surfaces (front and back). There are 36 countries (with 18% of the world's population) that would reach the highest level of achievement by either increasing the size of warnings so that they cover at least half of both the package front and back, or by adding additional label characteristics to already large warnings. About 30% of countries, including half of low-income countries, have not implemented any warning label policies or require only small

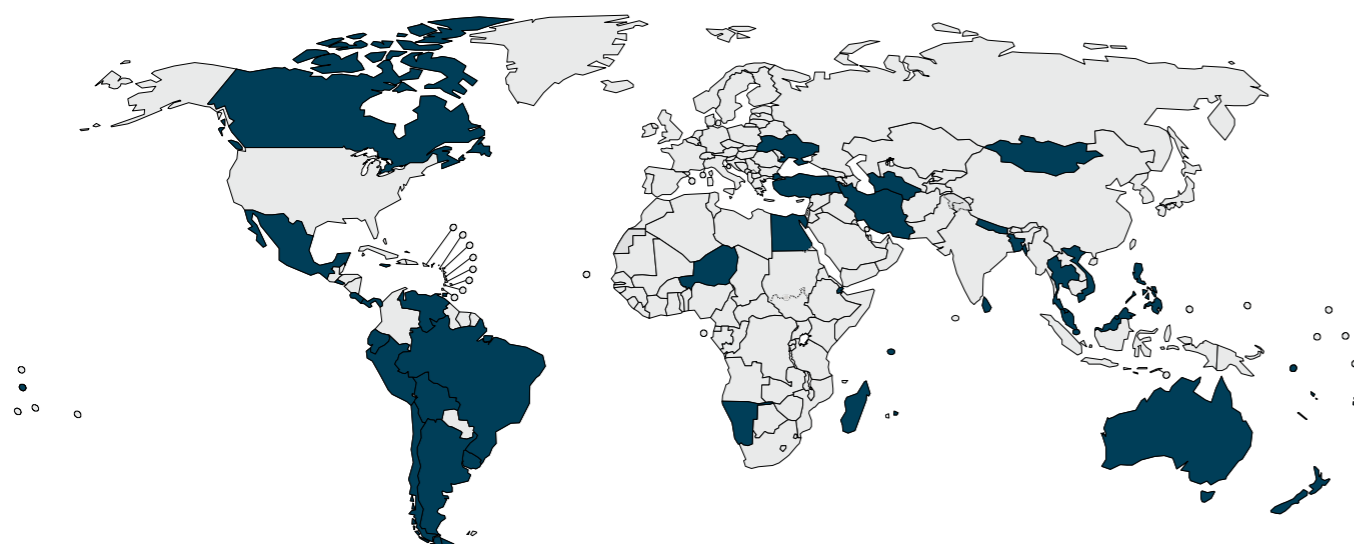
warnings that cover less than 30% of the main package surfaces (36% of all countries and 53% of low-income countries had no warnings or small warnings in 2012).

Of the 460 million people (6.5% of the world's population) who live in one of the world's 100 largest cities, more than 109 million people (in 23 cities) are exposed to large graphic pack warnings. All but one of these cities is located in a country

with national legislation stipulating strong pack warnings; only one city (Hong Kong Special Administrative Region of China) has established graphic pack warnings ahead of national policy.

Twelve more countries implemented large graphic pack warnings in the past 2 years, making this the measure with the greatest improvement.

HEALTH WARNING LABELS ABOUT THE DANGERS OF TOBACCO – HIGHEST ACHIEVING COUNTRIES, 2014



Countries with the highest level of achievement: Argentina, Australia, Bangladesh,* Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Canada, Chile, Costa Rica,* Djibouti, Ecuador, Egypt, El Salvador, Fiji,* Iran (Islamic Republic of), Jamaica,* Madagascar, Malaysia, Mauritius, Mexico, Mongolia, Namibia,* Nepal, New Zealand, Niger, Panama, Peru, Philippines*, Samoa,* Seychelles, Singapore, Solomon Islands,* Sri Lanka, Thailand, Trinidad and Tobago,* Turkey, Turkmenistan,* Ukraine,* Uruguay, Vanuatu,* Venezuela (Bolivarian Republic of), and Viet Nam.*

* Country newly at the highest level since 31 December 2012.

Thailand successfully protects warning label requirements from legal challenge

สูบบุหรี่ทำให้เป็น มะเร็งกล่องเสียง



เลิกบุหรี่ โทร 1600 www.thailandquitline.or.th

Smoking causes Laryngeal Cancer. Quit line 1600.

One tactic adopted by the tobacco industry is to challenge tobacco control legislation in the courts. In Thailand, a transnational tobacco company mounted a legal challenge in 2013 to an order by the Ministry of Health mandating the display of combined pictorial and text health warnings covering at least 85% of the two largest surfaces of cigarette packs and cartons. The lower court temporarily suspended implementation of the pack warning requirements while the case was ongoing.

However, in May 2014 Thailand's Supreme Administrative Court reversed the lower court's temporary order, noting that the warning label requirements were issued to "protect the people and our youth", and found that they were within the intended scope of the tobacco control law, and that their implementation would not burden either party while the case continued to be decided on its merits. Although the court case continues, the Supreme Administrative Court's reversal of the lower court ruling is a strong indication that the warning label requirements are likely to be upheld. As in this case, unjustified legal challenges made by the tobacco industry do not stand up in courts of law.

Egypt successfully phases-in strong health warning label requirements



التدخين
يسبب
سرطان
الفم

١٦٨٠٥ تليفون المساعدة للإقلاع عن التدخين
احترس التدخين يدمر الصحة ويسبب الوفاة

Tobacco use causes cancer of the mouth.

The Ministry of Health in Egypt successfully phased-in implementation of pictorial health warnings on tobacco products over a period of several years, with support of the WHO Eastern

Mediterranean Regional Office (EMRO) and WHO Country Office. These efforts started in 2001 with the country's first tobacco control legislation, which among other provisions included a requirement for the first text warnings on packaging. In June 2007, updated legislation increased the size of health warnings to cover at least half of the packaging and included a provision for pictorial warnings – a cost-effective means of increasing public awareness about the dangers of tobacco use which was implemented later that year. An Executive By-Law issued by the Minister of Health in 2010 further strengthened the warning label requirements by specifying pictorial content. A new set of pictorial images is introduced every 2 years, with the most recent set introduced in 2014. To date, six different sets of graphic images have been included on both cigarette and waterpipe tobacco packages. Egypt plans to further increase the size of its pictorial health warnings to 80% of both front and back package display areas in the future, although timing of this strengthened requirement has not yet been set.



Anti-tobacco mass media campaigns

Article 12 of the WHO Framework Convention on Tobacco Control states: "Each Party shall promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. ... each Party shall ... promote ... broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristic of tobacco consumption and exposure to tobacco smoke; ... [Each party shall promote] public awareness about the risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles; ... [each party shall promote] public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption" (1). WHO FCTC Article 12 guidelines (83) are intended to assist Parties in meeting their obligations under Article 12 of the Convention.

RECENT ACHIEVEMENTS AND DEVELOPMENTS

Tobacco control mass media campaigns are cost-effective in low- and middle-income countries

Tobacco control mass media campaigns are effective in preventing and reducing tobacco use, but there are limited studies of the cost-effectiveness of mass media campaigns in low- and middle-income countries. To address this knowledge gap and expand the evidence base of the effectiveness of tobacco control interventions, three recent campaigns in China, India and Viet Nam were studied for cost-effectiveness (the results of the study have not yet been published). In each country, campaign impact was assessed through nationally representative, post-campaign household surveys using standard statistical methodology to determine campaign-attributable changes in the public's tobacco-related knowledge, attitudes and behaviours. Survey results and campaign expenditure data

were then analysed to identify costs associated with these changes and calculate cost-effectiveness ratios. Preliminary analyses indicate that being aware of the campaign was associated with increased quit attempts among tobacco users in all three countries, with associated per person costs per quit attempt of US\$ 0.07 in India, US\$ 0.21 in China and US\$ 0.56 in Viet Nam. Additional cost-benefit analyses are currently underway. The early findings from the study suggest that in addition to having high reach, mass media campaigns have the potential to be cost-effective in low- and middle-income countries, as they have been shown to be in high-income countries, and should be incorporated into all countries' tobacco control programmes.

By increasing awareness of the harms of tobacco use, hard-hitting anti-tobacco mass media campaigns reduce tobacco use, increase quit attempts and reduce secondhand smoke exposure.

Well designed, sustained anti-tobacco mass media campaigns reduce tobacco use

By increasing awareness of the harms of tobacco use, hard-hitting anti-tobacco mass media campaigns reduce tobacco use, increase quit attempts and reduce secondhand smoke exposure (133–136). Campaigns should ideally be sustained over long periods to have a lasting effect, although more limited campaigns can have some impact if they are run for at least a few weeks (137–139).

Despite the expense involved, mass media campaigns can quickly and efficiently reach large populations (138). Television advertising with graphic imagery is especially effective in convincing tobacco users to quit (138, 140–142).

Billions of people are being exposed to anti-tobacco mass media campaigns

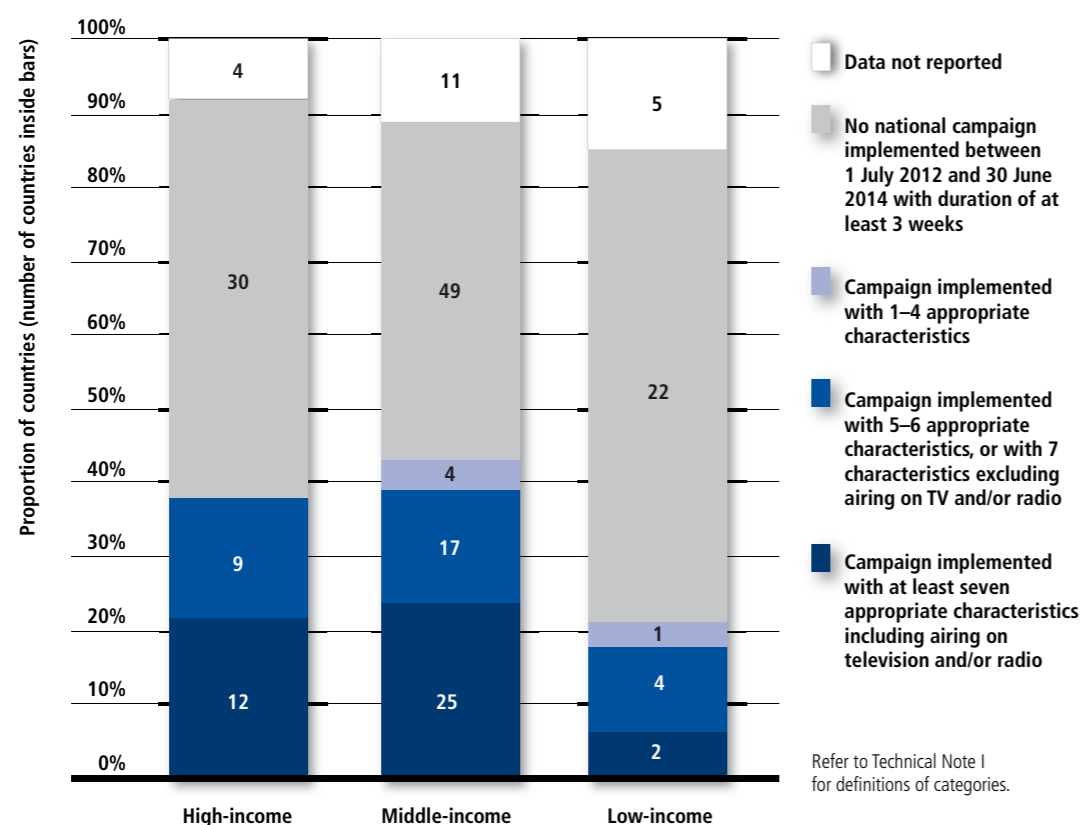
More than half of the world's people live in a country that in the past 2 years aired at least one national anti-tobacco mass media campaign with all appropriate characteristics on TV and/or radio for a duration of at least 3 weeks. This is similar to the level of coverage in 2012. The proportion of countries airing such campaigns has remained steady over time at about 20%.

Another 20% of countries conducted a mass media campaign of at least 3 weeks' duration, with some but not all of the best practice criteria. Among low-income countries, one in five ran a sustained campaign, although some of these did not feature all characteristics of a fully

effective campaign. Compared with 2012, the number of low- and middle-income countries running some type of sustained campaign increased by nine in the past 2 years.

Around half of all countries have not run any kind of sustained mass media campaign in the past 2 years – one quarter of the world's population has not been exposed to an anti-tobacco campaign during that time. People in low-income countries are the least likely to be exposed to anti-tobacco mass media: 65% of low-income countries, with 60% of the total low-income country population, have not had any kind of campaign in the past 2 years to inform people about the harms of tobacco use or to encourage them to quit.

MASS MEDIA CAMPAIGNS



Senegal shows how mass media campaigns can work in Africa

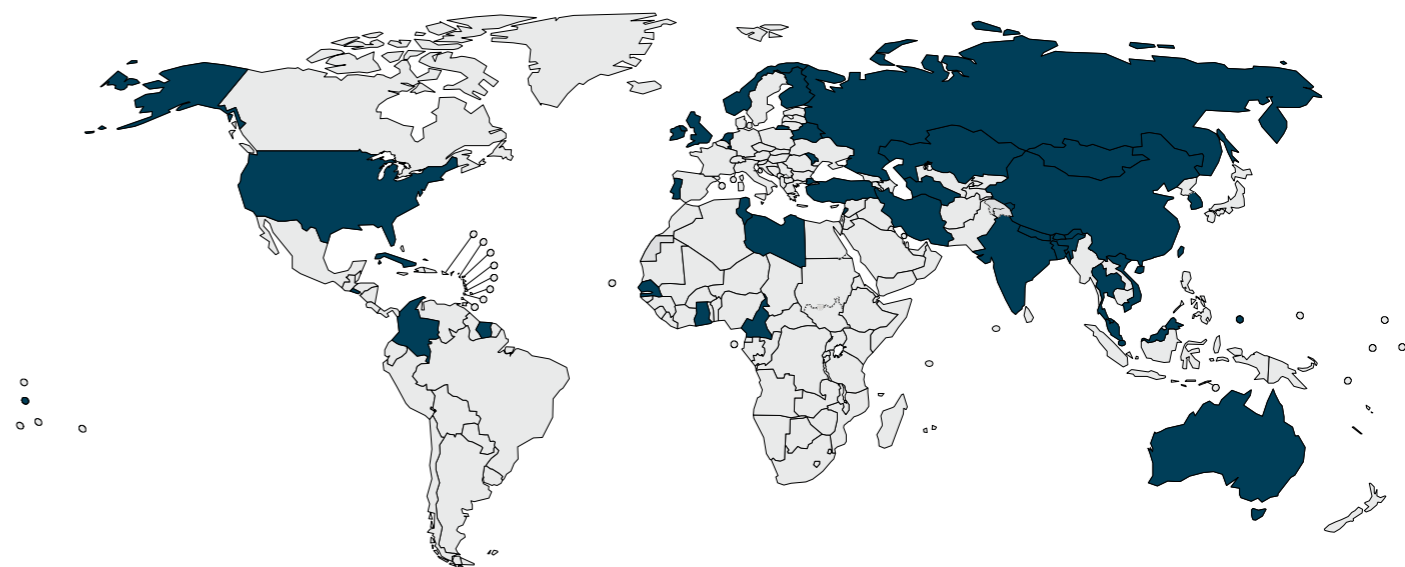
Tobacco control mass media campaigns have proved to be an effective tobacco control intervention, promoting cessation, deterring initiation and building support for tobacco control policies. There is a particular need for such campaigns in Africa, where tobacco consumption is increasing among youth. However, until recently there has been limited evidence of the effectiveness of such campaigns in Africa. In Senegal, the first nationwide anti-smoking "Sponge" campaign – used successfully in a number of other countries – aired on television and radio as well as on outdoor billboards in April and May 2013, and its effects were closely studied, making it the first such campaign in Africa to be so comprehensively assessed. A household survey using standard statistical methods was developed and undertaken by the World Lung Foundation to measure campaign awareness, reactions to the campaign, and changes in smoking-related knowledge, attitudes and behaviours; calls to a national quit line were also monitored. Survey results showed that 63% of people in Senegal recalled the campaign, primarily through television, rating it as comprehensible, relevant and creating concern. The campaign was associated with an increase in non-smokers' intentions to not smoke, greater concern over smoking among smokers, increased intentions to quit by smokers, and greater support for other



Anti-tobacco mass media campaign "Sponge" in Dakar, Senegal.

government tobacco control programmes including establishment of smoke-free places. Calls to the quit line reflected campaign activity, increasing six-fold during the campaign period. The mass media campaign also included a social media component. Ten thousand people signed a petition supporting a tobacco control bill which was adopted soon after. These results highlight the importance and effectiveness of mass media campaigns as part of any national tobacco control strategy, even where smoking rates are comparatively low.

ANTI-TOBACCO MASS MEDIA CAMPAIGNS – HIGHEST ACHIEVING COUNTRIES, 2014



Countries with the highest level of achievement: Australia, Bangladesh, Belarus, Bhutan, Cameroon,* China, Colombia,* Cuba, El Salvador, Finland,* Ghana, India, Iran (Islamic Republic of),* Ireland,* Kazakhstan,* Lebanon,* Libya,* Luxembourg, Malaysia, Mongolia,* Nepal,* Netherlands,* Norway, Palau, Portugal,* Republic of Korea, Republic of Moldova,* Russian Federation, Samoa, Senegal,* Singapore, Suriname,* Thailand,* Tunisia, Turkey, Turkmenistan,* United Kingdom of Great Britain and Northern Ireland, United States of America, and Viet Nam.

* Country newly at the highest level since 31 December 2012.

mpower **Enforce bans on tobacco advertising, promotion and sponsorship**

Article 13 of the WHO Framework Convention on Tobacco Control states: "... a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products. Each Party shall ... undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship" (1). WHO FCTC Article 13 guidelines (83) are intended to assist Parties in meeting their obligations under Article 13 of the Convention.

RECENT ACHIEVEMENTS AND DEVELOPMENTS

Countries in WHO Eastern Mediterranean Region take action against tobacco use in films and TV programming



WHO Eastern Mediterranean Region consultative meeting on tobacco use in films and TV, Cairo, Egypt, August 2014.

many countries. Countries with only partial TAPS bans that do not cover film and TV content often see an increase in displays of tobacco use in these media. In the WHO Eastern Mediterranean Region (EMR), films and TV drama continue to be used extensively to advertise and promote tobacco products and brands, with more than 90% of people in some EMR countries regularly exposed to this type of content. A regional consultative meeting held in Cairo in August 2014 brought together international and regional tobacco control experts, film and TV programme creators, television and satellite channels, academics and rating agencies to address this issue in EMR Member States, with a particular focus on countries such as Egypt, Lebanon, Kuwait, United Arab Emirates and Syria, which produce the most TV and film content in the region. Participants identified a need for legislation, professional codes of conduct and increased research and awareness of the problem. Participants also developed recommendations and outlined next steps for action on implementing a multisectoral approach to eliminate these TAPS activities – especially those with a large potential youth audience – as there is strong scientific evidence that exposure to depictions of tobacco use in films promotes teenage smoking.

Enacting and enforcing a total ban on tobacco advertising, promotion and sponsorship (TAPS) is fundamental to the success of tobacco control efforts, and is a key obligation of the WHO Framework Convention on Tobacco Control. Bans on showing tobacco brands or depicting tobacco use and products in television programming and motion pictures have been enacted by 106 countries (covering 74% of the world's population). However, display of tobacco brands and depictions of tobacco use are still common on television and in cinema in

Comprehensive TAPS bans hinder the industry's ability to promote and sell its products, and reduce tobacco consumption in all countries regardless of income level.

Comprehensive bans are necessary

Tobacco companies spend tens of billions of US dollars worldwide each year on tobacco advertising, promotion and sponsorship (TAPS) activities (143). The primary purpose of TAPS is to increase tobacco sales (134), and they are effective in encouraging nonsmokers to start (particularly youth and women in low- and middle-income countries) (144), and current smokers to continue (134). TAPS also blunt tobacco control efforts by "normalizing" tobacco use and influencing media and other businesses that benefit from TAPS expenditures.

To counteract this, complete bans on all TAPS activities are needed as a key tobacco control strategy. Partial bans and voluntary restrictions are ineffective, having little or no effect (134, 145, 146).

Bans are effective at reducing smoking

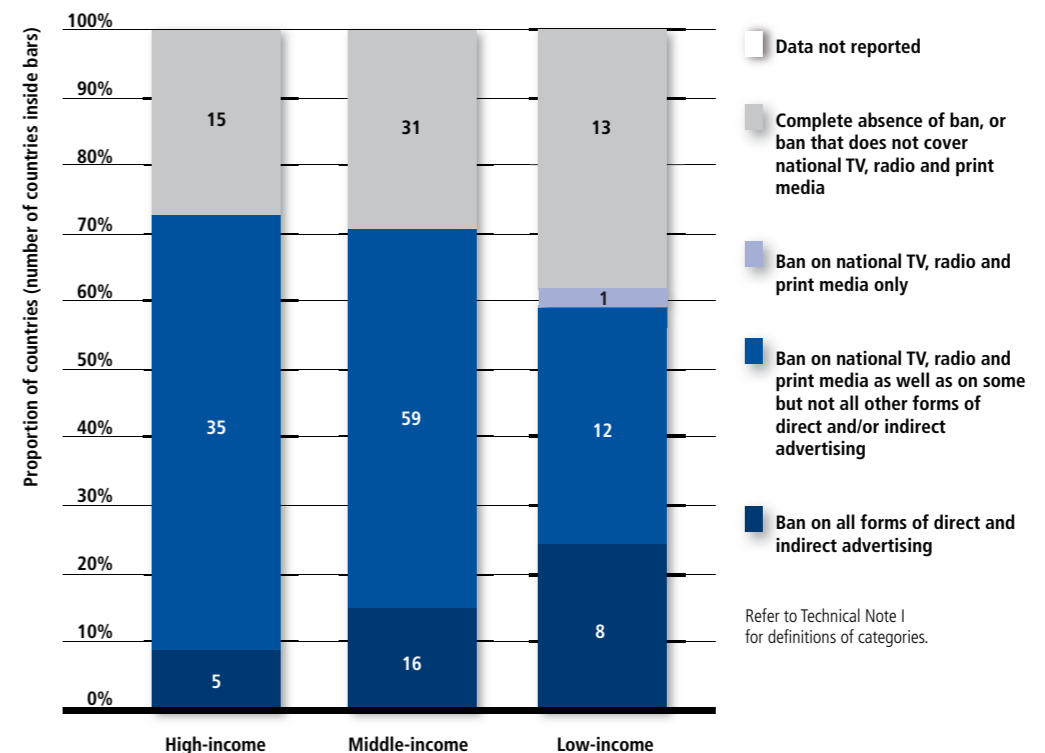
Comprehensive TAPS bans hinder the industry's ability to promote and sell its products, and reduce tobacco consumption in all countries regardless of income level (145). In particular, TAPS bans reduce youth smoking initiation and prevalence rates,

which may lead to lower levels of adult smoking in future years (147).

Bans must be complete and well enforced

To be effective, bans must completely cover all types of TAPS activities, both direct advertising in all types of media, and indirect advertising including promotion and sponsorship (101, 145, 148). It is also important to ban point-of-sale advertising in retail stores (149). So-called "corporate social responsibility" initiatives should also be outlawed, as they are intended to

BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP



persuade governments not to implement strong tobacco control programmes (150).

Because TAPS bans are highly effective in reducing tobacco use and initiation, the tobacco industry strongly opposes them and is increasingly aggressive in circumventing their proscription (134). Legislation banning TAPS should be written in uncomplicated language, with clear definitions, strong monitoring and enforcement mechanisms, and high financial penalties (83).

Bans on TAPS activities are underused

Despite their effectiveness, few countries implement TAPS bans to their full effect. Only 29 countries with 832 million people (12% of the world's population) passed a comprehensive ban by 2014, an increase

from 9% of the world's people covered by TAPS bans in 2012. Seven countries (Kiribati, Nepal, Russian Federation, Suriname, United Arab Emirates, Uruguay and Yemen) implemented a complete ban on all TAPS activities between 2012 and 2014.

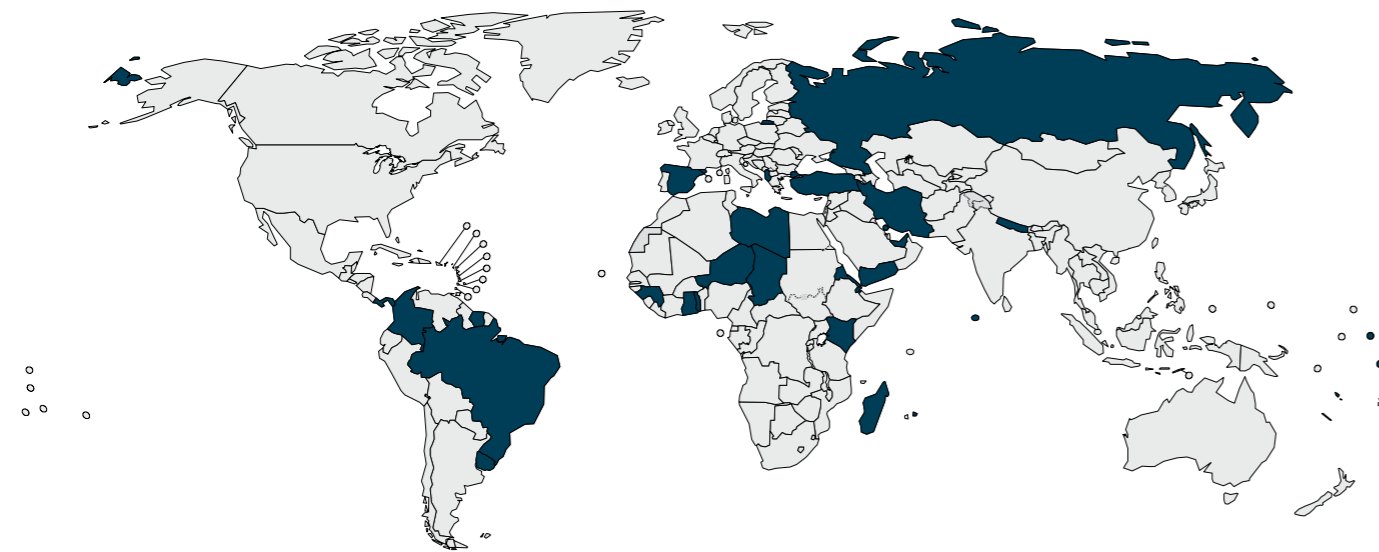
A higher proportion of low-income countries have implemented this measure than any other MPOWER measure, with eight low-income countries (24% of low-income countries, compared to only 15% of middle-income and 9% of high-income countries) having comprehensive TAPS bans in place. Of the 66% of countries (128 total) that have moved to ban TAPS but have not yet done so comprehensively, 107 prohibit direct advertising in print and broadcast media but have been unsuccessful in extending their bans to all other forms of direct and indirect advertising.

Countries that have yet to implement a comprehensive TAPS ban have generally found bans on promotional discounts, brand sharing and stretching, point-of-sale advertising and event sponsorship to be the most difficult to implement. Except for banning promotional discounts, high-income countries tend to have more difficulty implementing these particular provisions than do low- and middle-income countries.

Of the 460 million people (6.5% of the world's population) who live in one of the world's 100 largest cities, less than 67 million people (in 13 cities) are completely protected from exposure to TAPS by national level legislation. Only one city (Shenzhen in China) has completely banned TAPS in the absence of national legislation.

Only 29 countries with 832 million people have passed a complete TAPS ban.

ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP – HIGHEST ACHIEVING COUNTRIES, 2014



Countries with the highest level of achievement: Albania, Bahrain, Brazil, Chad, Colombia, Djibouti, Eritrea, Ghana, Guinea, Iran (Islamic Republic of), Kenya, Kiribati,* Libya, Madagascar, Maldives, Mauritius, Nepal,* Niger, Panama, Russian Federation,* Spain, Suriname,* Togo, Turkey, Tuvalu, United Arab Emirates,* Uruguay,* Vanuatu, and Yemen.*

* Country newly at the highest level since 31 December 2012.

Yemen plans strict enforcement of its ban on tobacco advertising, promotion and sponsorship

Yemen established its National Tobacco Control Programme in 2007, and with the cooperation of WHO Eastern Mediterranean Regional Office developed its National Strategy and Action Plan for tobacco control in 2009. Strong lobbying by the tobacco industry thwarted the government's intensive efforts to pass comprehensive tobacco control laws initially, but in 2013 Yemen successfully enacted a complete ban on all tobacco advertising,

promotion and sponsorship, both direct and indirect, that met WHO Framework Convention on Tobacco Control guidelines. Notably, the ban covered point-of-sale advertising and the manufacture or importation of any non-tobacco products advertising tobacco brands. The government intends to enforce strict compliance with the law, and is actively investigating all reported violations.

Uruguay completely bans tobacco advertising, promotion and sponsorship



Before the ban

In 2008, Uruguay introduced a total ban on tobacco promotion and sponsorship and outlawed most tobacco advertising except at the point-of-sale, with a requirement that health warnings of equivalent size and visibility appear alongside in-store tobacco displays. These measures, which were incorporated into a comprehensive tobacco control programme, helped contribute to a substantial reduction in Uruguay's smoking prevalence – one of the fastest declines on record. However, the partial advertising ban proved difficult to enforce, as the tobacco industry employed various advertising, promotion and sponsorship tactics that

violated the law, such as the use of brand elements without the corresponding required health warnings. In the face of strong opposition from the tobacco industry and merchant associations, which claimed that a ban on point-of-sale displays would violate the country's constitution and lead to an increase in illicit trade, Uruguay mobilized a coalition of governmental and civil society partners to make its advertising ban complete to ensure compliance with the WHO Framework Convention on Tobacco Control requirements. The successful expansion of Uruguay's TAPS ban shows that even strong tobacco control measures can be made even stronger.



After the ban

High tobacco taxes are effective at reducing consumption, but are underused

Raising the price of tobacco through increased tobacco taxes is the most effective and efficient way to reduce tobacco use, yet it is the least-used MPOWER measure, with only 10% of the world's population living in countries with a sufficiently high tax of more than 75% of the retail price of cigarettes in 2014. This was a small improvement on the 7% population coverage in 2012. Because cigarettes are by far the most commonly used form of tobacco – and the form for which data are more readily available – the analysis in this report focuses on cigarette taxation.

Of the 460 million people (6.5% of the world's population) who live in one of the world's 100 largest cities, less than 17 million (in Amman, Paris, Madrid, Santiago de Chile, and Rome) are covered by sufficiently high taxes on cigarette products. Each of these five cities implements the nationally set rate of tax on cigarettes. And though it is within the power of many cities, no city has yet independently introduced taxes on tobacco products so that more than 75% of the retail price is tax.

Only a very small proportion (9%) of low- and middle-income countries (13 countries) implement sufficiently high taxes on cigarettes. Since 2012, five low- and middle-income countries (Bangladesh, Bosnia and Herzegovina, Kiribati, Romania and

Seychelles) joined the highest tax category. Two low- and middle-income countries dropped from the highest taxes group – one dipping slightly under the threshold (Tunisia) and the other joining the no-data group (Cuba) in 2014. In the past 2 years there was very little change in the number of countries in any of the four classifications of the 'R' measure (total tax over 75%, between 51% and 75%, between 26% and 50%, or between 0 and 25% of retail price).

Although most countries levy at least some excise tax on cigarettes in addition to taxes applied to all consumer products (i.e. value added or sales taxes), there are still a number of countries that have not yet taken this important step. Of the 31 low-

income countries with data, only two did not levy any tobacco excises. Nine of 101 middle-income countries with data levied no tobacco excise, as was the case for seven of 54 high-income countries.

Several countries have raised cigarette taxes in recent years, though many not substantially

As discussed in Technical Note III on tobacco taxes, calculating the change in tax as a share of price over time can be complicated. Determination of tax rates as a proportion of total cigarette retail price is not only dependent on changes in tax rates but also on changes in retail prices, and occasionally on other changes (e.g. countries applying a tax on the declared customs value of imported tobacco products priced in other

countries' currencies, which are then subject to changes in exchange rates). Therefore, despite an increase in the tax on cigarettes, the share of excise and total taxes in the retail price could remain the same or shrink; similarly, the share of taxes in the final retail price might increase, even if there is no change in the tax levied on a pack of cigarettes.

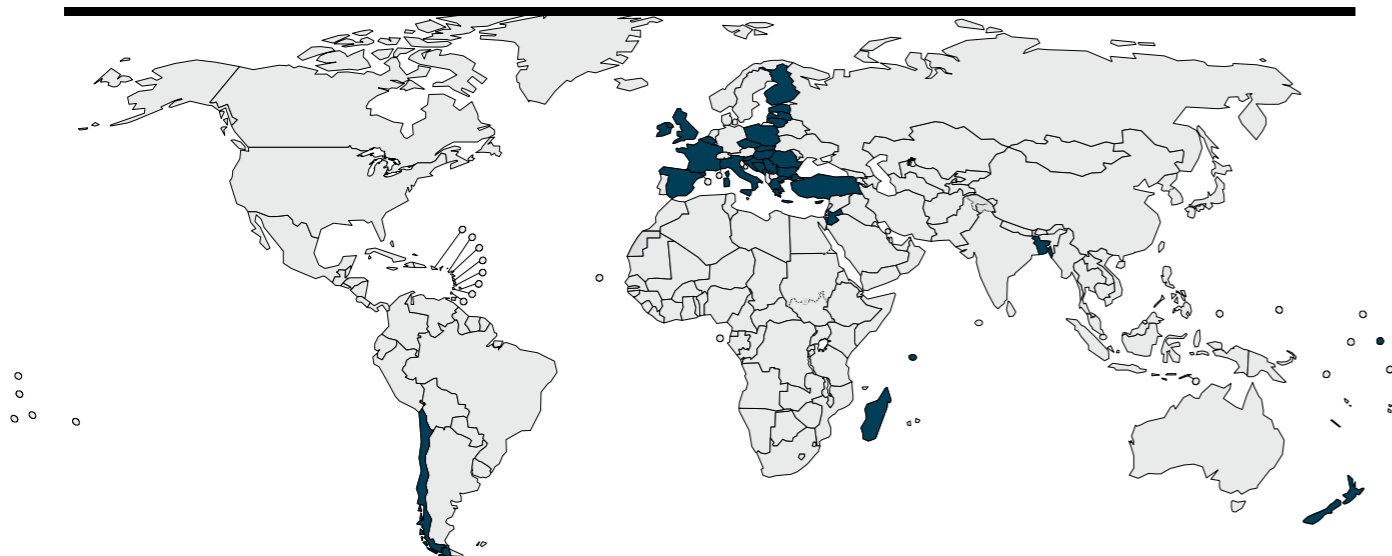
Several countries have increased their tax rates on cigarettes since 2012, even if many did not move to a higher grouping category of tobacco taxation. Of the 183 countries for which data were available in both 2012 and 2014, 106 countries increased their excise taxes in various ways: increasing both specific and ad valorem excise tax components; increasing ad valorem or specific excise alone; introducing new excises or a specific type of excise in addition to an existing ad valorem;

increasing specific taxes while at the same time reducing or eliminating an ad valorem tax; or introducing specific and increasing ad valorem tax.

The increase in tax on a pack of cigarettes was only a few percentage points in some countries, but in others it was substantial. For example, the Philippines' total tax share increased by 45% points between 2012 and 2014 because of revisions to the "sin tax" law (see case study on page 87), and in the Bahamas' total tax increased by more than 16% points because of the introduction of a specific excise tax, and elimination of the ad valorem tax. Overall, these 106 countries show great diversity in the approaches taken to raise cigarette taxes. This suggests that governments worldwide have several policy options available to raise taxes considerably if they choose to do so.

Only 33 countries with 690 million people have sufficiently high tax rates.

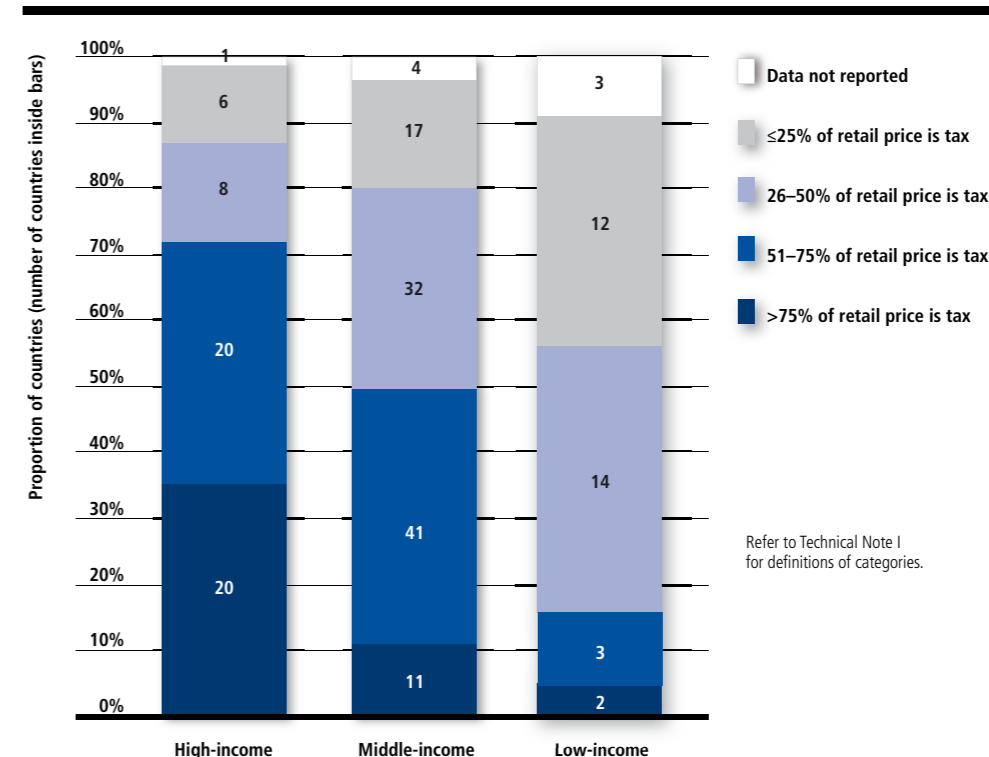
RAISE TAXES ON TOBACCO – HIGHEST ACHIEVING COUNTRIES, TERRITORIES AND AREAS, 2014



Countries, territories and areas with the highest level of achievement: Bangladesh, * Belgium, Bosnia and Herzegovina, * Bulgaria, Chile, Croatia, * Cyprus, Czech Republic, Estonia, Finland, France, Greece, Hungary, Ireland, Israel, Italy, Jordan, Kiribati, * Latvia, Lithuania, Madagascar, Montenegro, New Zealand, * Poland, Romania, * Serbia, Seychelles, * Slovakia, Slovenia, Spain, Turkey, United Kingdom of Great Britain and Northern Ireland, and West Bank and Gaza Strip.

* Country newly at the highest level since 31 December 2012.

TOTAL TAX ON CIGARETTES



Refer to Technical Note I for definitions of categories.

Cigarettes are still inexpensive in much of the world

Price and tax levels continue to be the highest in high-income countries, even when adjusting for differences in purchasing power.

The global average pack price was 3.51 international dollars, while the average for high-income countries was 5.53 international dollars. Cigarette pack prices, total taxes and the tobacco excise component as a share of pack prices are all lower in low- and middle-income countries, with total tax as a proportion of price varying between 46% and 55%, and running at almost 65% in high-income countries. This shows that low- and middle-income countries can and should increase their excise taxes further to effectively make cigarettes more expensive.

More countries are strengthening their tax systems by moving away from ad valorem taxes

Data collected between 2008 and 2014 for various editions of this report show that countries are increasingly moving away from purely ad valorem tax systems and are instead adopting mixed excise systems, and in some cases purely specific excise systems. Of 180 countries that had comparable data for all 4 years, roughly equal numbers levied specific, mixed and ad valorem taxes in 2008. However, by 2014, 61 and 57 countries had mixed and specific tax systems respectively, while the number of countries with a purely ad valorem tax had fallen to 45.

Between 2012 and 2014, three countries switched from an ad valorem to a mixed

system (Congo, Morocco and Turkey) and two countries switched to a specific excise system (Bahamas and Pakistan). Countries that move from ad valorem to specific or mixed taxes generally find that tax revenues are more predictable because specific taxes are less susceptible to tobacco industry price manipulation and tax avoidance strategies.

Four countries that previously had no excise tax newly introduced one (Kiribati, Mauritania, Palau and Sierra Leone). The 18 remaining countries that still have not begun to levy excise taxes on tobacco products should strongly consider introducing taxes at a sufficiently high level to have a measurable public health impact.

Within mixed tax systems, more countries rely on specific taxes than on ad valorem taxes

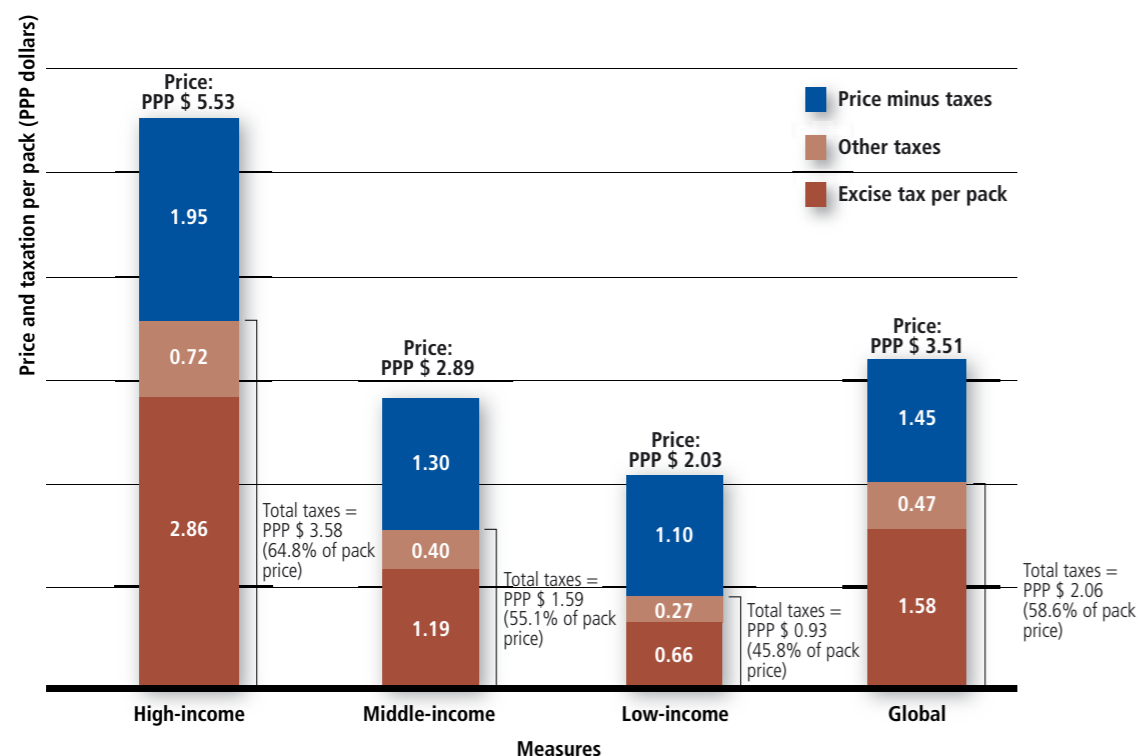
Mixed tax systems that incorporate both specific and ad valorem components became the most common type of tax structure between 2008 and 2012, and countries with mixed systems have begun relying more on specific taxes. The share

of specific tax exceeded the share of ad valorem tax in the price of the most sold cigarette brand in 35 countries with mixed tax regimes, while 26 countries relied more on ad valorem taxes. Between 2012 and 2014, 20 countries (or territories) with mixed taxes increased their specific excise component while reducing the ad valorem component. Of those, five moved from relying more on ad valorem to relying more on specific taxes (Greece, Latvia, Slovenia,

The former Yugoslav Republic of Macedonia, and West Bank and Gaza Strip).

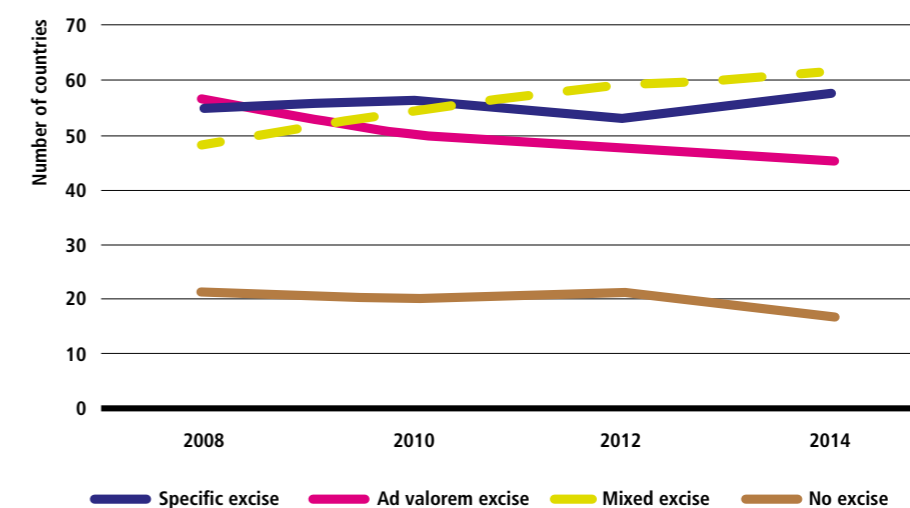
Systems that rely exclusively or predominantly on specific taxes have advantages for public health – they are usually simpler to administer, and governments can discourage the growth of cheap cigarette brands that benefit from low taxes by raising the specific tax component frequently and substantially.

WEIGHTED AVERAGE RETAIL PRICE AND TAXATION (EXCISE AND TOTAL) OF MOST SOLD BRAND OF CIGARETTES, 2014

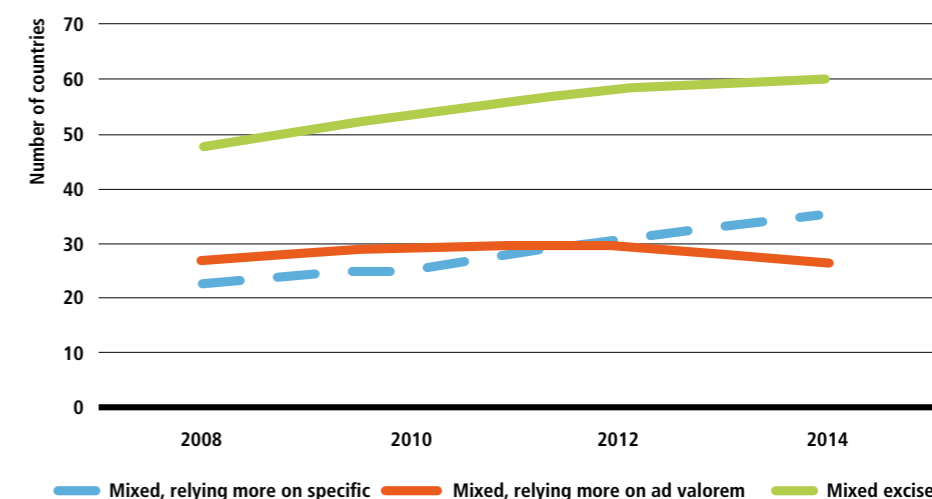


Note: Averages are weighted by WHO estimates of number of current cigarette smokers in each country. Prices are expressed in Purchasing Power Parity (PPP) adjusted dollars or international dollars to account for differences in the purchasing power across countries. Based on 53 high-income, 98 middle-income and 29 low-income countries with data on price of most sold brand, excise and other taxes, and PPP conversion factors. Numbers may not add exactly due to rounding.

CHANGES IN EXCISE TAX STRUCTURES, 2008–2014



GREATER RELIANCE ON SPECIFIC EXCISE WITHIN MIXED TAX SYSTEMS, 2008–2014



Note (both graphs): Data cover 180 countries that had confirmed data on tax structure available for all 4 years. Excludes Andorra, Bhutan, Cuba, Democratic People's Republic of Korea, Haiti, Monaco, Nauru, San Marino, Solomon Islands, Somalia, South Sudan, Syrian Arab Republic, Tajikistan, Timor-Leste and Tuvalu.

Cigarette prices are higher in countries that rely more on specific excises

Weighted averages of prices and excise taxes (converted to international dollars for comparison) were calculated by type of excise tax implemented in each country: specific excise, ad valorem, mixed (and whether relying more on specific or ad valorem components), and no excise.

Within the set of countries applying mixed tax structures, prices tend to be higher in countries where specific taxes are larger as a proportion of the price compared to the ad valorem proportion (average price of 3.90 international dollars) in comparison to countries where the ad valorem component dominates (average price 3.19 international dollars). Sustained increases in the specific tax component can help the latter group of countries raise their tax share and product prices.

Cigarette excise tax levels and prices both tend to be higher in countries that apply a specific excise system or a mixed system that relies more heavily on the specific component. Tax and price levels are lower for mixed systems that rely more heavily on ad valorem excises, and lower still for those with a purely ad valorem system. Unsurprisingly, the lowest price level is among countries that apply no excise tax.

Cigarette excise tax levels and prices tend to be higher in countries that apply, or rely more on a specific excise tax.

Cigarette prices have risen faster than income in several countries, but have become more affordable in many other parts of the world

When per capita income growth outpaces the rise in the price of tobacco products, such products become relatively more affordable. Tax increases that are sufficiently high can ensure that cigarettes do not become more affordable over time, particularly if provisions in the law automatically and regularly increase taxes to keep pace with other economic indicators (e.g., inflation, income growth).

Examining affordability by country income group shows that relative prices rose consistently among high-income countries, indicating that cigarette prices rose faster than real per capita income over the 6-year

period 2008–2014. The trend was similar in middle-income countries, though the greatest increase in relative prices was between 2008 and 2010, with no change since 2012. However, in low-income countries the trend is for cigarettes to become more affordable over time.

Of 170 countries with data in both 2008 and 2014, most instances of decreased cigarette affordability were seen in high- and middle-income countries. In 17 high-income countries, 17 middle-income countries and only two low-income countries, more than 1.5 times as much per capita income was required to purchase the most sold brand in 2014 than in 2008. By contrast, in three high-income countries, 35 middle-income countries and 12 low-income countries, cigarettes became more affordable relative to per capita GDP; it is urgent that these countries act to raise

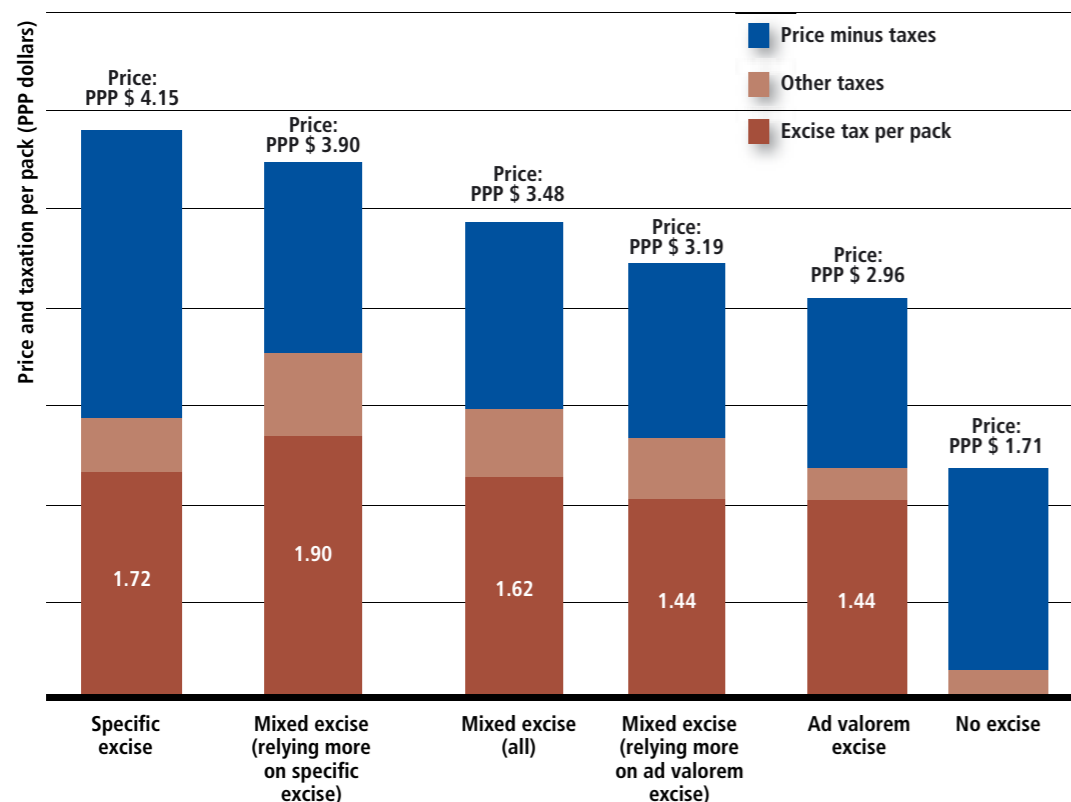
taxes to decrease affordability and reduce consumption.

Implementing best practices makes tobacco taxation more effective

Countries can make tobacco taxation policies more effective in raising revenues and reducing consumption by reforming their tax structures in line with identified best practices. Additional data on taxation collected for this report (Appendix II, table 2.3) allow analysis of how closely countries meet recommended best practices.

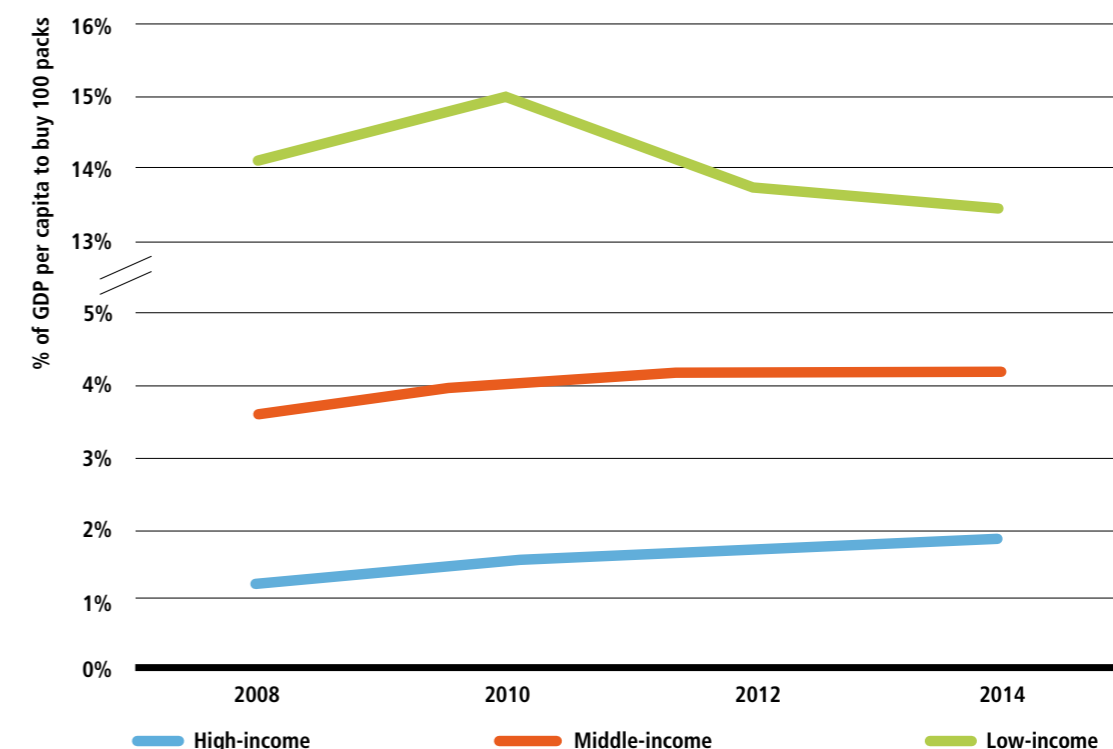
Complicated tax systems make it more difficult for countries to raise tobacco product prices through taxation policy – the presence of tiered taxes and various loopholes (e.g., differential tax treatment

WEIGHTED AVERAGE PRICES AND TAXES PER PACK BY TAX STRUCTURE



Note: Averages are weighted by WHO estimates of number of current cigarette smokers in each country. Prices are expressed in Purchasing Power Parity (PPP) adjusted dollars or international dollars to account for differences in the purchasing power across countries. Based on 53 high-income, 98 middle-income and 29 low-income countries with data on price of most sold brand, excise and other taxes, and PPP conversion factors.

CIGARETTES HAVE BECOME LESS AFFORDABLE IN HIGH- AND MIDDLE-INCOME COUNTRIES BUT MORE AFFORDABLE IN LOW-INCOME COUNTRIES, 2008–2014



Source: Combined data for 2008, 2010, 2012 and 2014 from this series of reports.

Note: Data compiled for 170 countries that had complete data in all 4 years. Income groupings pertain to 2014 (52 high-income countries and 117 low- and middle-income countries).

based on product characteristics) tends to result in tax increases not being equally applied to the full range of product types and prices. In this respect, 94 countries (36 of which exclusively employ specific excise taxes) impose a uniform tax on all tobacco products without variations in rates.

Specific tax systems have advantages for public health, and 96 countries rely on specific taxes or on a mixed system with a larger contribution from a specific tax component than from ad valorem taxes.

Ad valorem tax regimes tend to result in lower pack prices and encourage the presence of cheap or discounted cigarettes. One way to counter this is to impose a minimum tax floor that discourages manufacturers to set prices too low. There

are 47 countries with ad valorem or mixed tax systems that impose such a minimum tax.

Systems reliant on ad valorem taxes are also associated with problems related to using product value as the tax basis. When the tax base is the factory or wholesale price, authorities have little means to verify the value of the product, which can therefore be subject to manipulation and undervaluation. One way to address this valuation problem is to use the final retail price (a value that can easily be verified in the market) as the tax base. In this respect, 48 countries with either an ad valorem or a mixed tax system reported using the final retail price (or retail price minus VAT) as the base for the ad valorem tax.

Specific taxes need to be frequently adjusted upwards to prevent erosion of their value because of inflation. One way to accomplish this is to legislate higher specific taxes on a regular basis; however, not all governments address fiscal and taxation policies every year, and if taxes are increased once but not in successive years, the real (i.e. inflation-adjusted) value of tax revenues declines and taxes lose their effectiveness in reducing and preventing tobacco use. A second way to address the effect of inflation is for governments to make the process of raising taxes automatic. However, only 14 countries (five high-income and nine middle-income) automatically adjust their specific excise taxes in this manner.

Less than a fifth of countries dedicate tobacco tax revenues to health

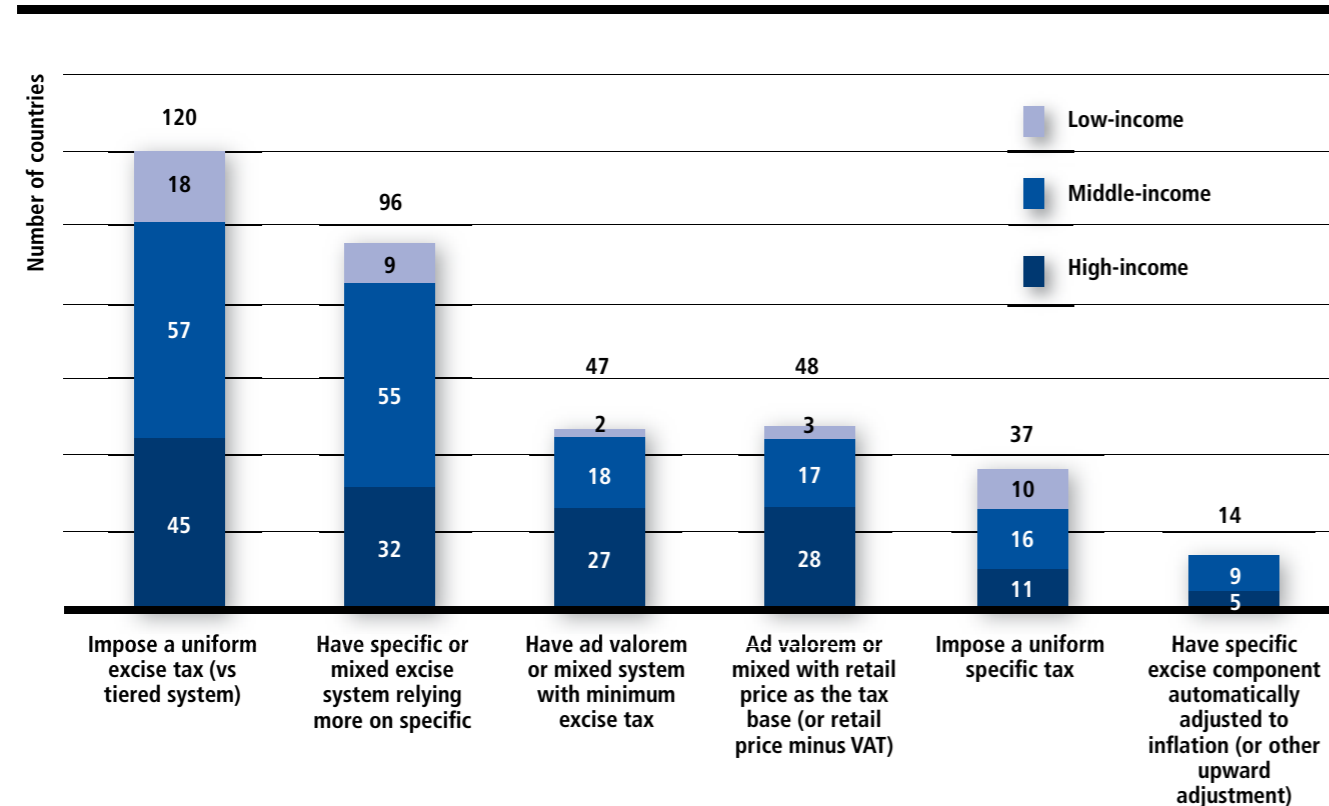
Thirty countries reported earmarking tobacco tax revenues for a health purpose (see Table 2.4, page 168). Of those, five were high-income countries, 21 middle-income and four low-income. Countries may choose to levy earmarked taxes in many different ways: through an additional

amount per cigarette pack or stick (e.g. Egypt, Algeria, Republic of Korea); through an incremental proportional levy on excises (e.g. Thailand, Indonesia); or through a proportion of excise revenues (e.g. Iceland, Panama, Philippines). Tobacco tax revenues can be harnessed to support vital health programmes. Targeted programmes can vary from a strict focus on tobacco control (e.g. Iceland, Switzerland, Viet Nam), attention to a specific disease of public health

importance (e.g. AIDS in the case of Côte d'Ivoire), health promotion programmes (e.g. Mongolia, Thailand) or even more general health-related initiatives (e.g. Bangladesh, Cabo Verde, Colombia). Surveys in several countries have shown that tax increases are more readily accepted by the public, and even among smokers, if at least some of the increased tax revenues are dedicated to health programmes.

Tobacco tax revenues can be harnessed to support vital health programmes.

TOBACCO TAX STRUCTURES. NUMBER OF COUNTRIES APPLYING SELECTED CHARACTERISTICS



Brazil's tax stamp system improves tax collection and facilitates a tobacco tax increase



Cigarettes manufactured for export display unique visible code.

In 2007, Brazil began requiring cigarette manufacturers to install equipment to count output, as well as devices to control, register, record and transmit information about the quantity of cigarettes manufactured. Implementation of this system, known as Scorpions,

improved control of cigarettes provided by Scorpions allowed Brazil to increase excise taxes on cigarettes by 30% in 2009 and an additional 105% (in phases) from 2012 to 2015 of cigarettes controlled by the Scorpions system.

was completed in March 2008 and enabled nationwide control and tracing of all domestically produced cigarettes. The Scorpions system applies a unique invisible and traceable code on tax stamps to ensure their correct use to identify the origin of cigarettes and suppress illegal production, imports and counterfeiting. The Scorpions system was further strengthened in 2011 to include cigarettes manufactured for export, with unique visible codes directly on the packs that include all required fiscal information and country of destination to facilitate field inspections. Legislation requires cigarette manufacturers to pay for system maintenance through an excise fee applied to each pack of cigarettes controlled by the Scorpions system. This system has gained the support of manufacturers as it improves tax collection, facilitates quick and effective action in the event of any irregularities, and automates and streamlines tax-related reporting. The

Higher tobacco taxes in the Philippines are a win-win for both health and revenues

In 2012, soon after guidelines were issued for implementing WHO FCTC Article 6 (Price and tax measures to reduce the demand for tobacco), the Philippines passed its landmark Sin Tax Reform Law. This legislation, which became effective on 1 January 2013, simplified what had been a complex tobacco excise tax structure and increased excise rates by as much as 341% (for low-priced brands) compared to those of the previous year.

The tax reforms were promoted primarily as a public health measure with attendant revenue implications, based on the fact that annual losses to the economy related to tobacco use were at least 177 billion Philippines pesos (PHP) (US\$ 4.2 billion), compared to annual tobacco excise revenues of only PHP 32.9 billion (US\$ 779.1 million) in 2012. Prior to the law's passage, tobacco excise revenues for 2013 were projected at PHP 52 billion (US\$ 1.2 billion), but actual tobacco excise collections that year were PHP 70.4 billion (US\$ 1.6 billion) – an increase of 114% in its first year of implementation.

Of this amount, the additional revenues totalled PHP 41.8 billion (US\$ 984.7 million), far exceeding the projected revenue-increase target of PHP 23.4 billion (US\$ 551.2 million). A national survey in 2009 showed that 28.3% of adults aged over 15 years smoked, with nearly half of men and one in 10 women being current smokers. With such a substantial increase in tobacco tax, an upcoming national survey is

expected to show its impact on smoking prevalence. In addition, the incremental revenues generated from the Sin Tax Law are earmarked to ensure a source of sustainable financing for the country's Universal Health Care Programme. Incremental revenues generated by the Sin Tax Law enabled the National Government to subsidize the health insurance premiums of 14.7 million poor members in 2014, up from only 5.2 poor members of the programme registered in 2013. These members and their dependents account for about half of the Philippines' population.



President Benigno S. Aquino III signs into law Republic Act 10351, the Sin Tax Reform Law of 2012.

Kenya implements excise tax management system to enhance tax collection and eliminate illicit trade

The Kenya Revenue Authority's Excisable Goods Management System features an enhanced excise stamp with multiple security layers for various stakeholders along the supply chain; production accounting; and track and trace modules. The system, used for both alcohol and tobacco products, also provides for online forecasting, application and processing of stamps, management of manufacturer and distributor tax accounts, a stock control module, and tax forecasting and business intelligence modules. This has led to reduced costs to government for tax compliance, faster access to stamps by manufacturers and distributors, and enhanced service delivery throughout the supply chain. This system enabled the Kenya Revenue Authority to seize more than 300 000 illegal products from about 900 outlets and to prosecute more than 150 offenders between February and June 2014. Controls over the distribution chain and improved technologies such as these – as used by the



Destruction of seized smuggled cigarettes by members of the Kenya Revenue Authority and the police.

Kenya Revenue Authority – can improve tax administration and complement tobacco tax reforms.

Countries must act decisively to end the epidemic of tobacco use

Article 5 of the WHO Framework Convention on Tobacco Control states: "Each Party shall develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes ... [and] establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control" (1). In addition, WHO FCTC Article 26.2 indicates that, "Each Party shall provide financial support in respect of its national activities intended to achieve the objective of the Convention" (1).

RECENT ACHIEVEMENTS AND DEVELOPMENTS

Countries are increasingly regulating electronic nicotine delivery systems

Electronic nicotine delivery systems (ENDS) and electronic non-nicotine delivery systems (ENNDS), of which electronic cigarettes are the most common type, are devices that do not burn or use tobacco but instead vaporize a solution that the user inhales. The main constituents of the solution, in addition to nicotine when nicotine is present, are propylene glycol, with or without glycerol and flavouring agents. ENDS and ENNDS solutions and emissions contain other chemicals, some of them considered to be toxicants.

The World Health Organization submitted a report on electronic nicotine delivery systems to the Sixth session of Conference of the Parties to the WHO Framework Convention on Tobacco Control (COP 6) in Moscow in 2014. The Conference of Parties invited members to take careful note of the WHO report and to consider taking measures to achieve at least the following objectives:

- Prevent the initiation of ENDS/ENNDS use by non-smokers and youth, with special attention to vulnerable groups.
- Minimize, as far as possible, potential health risks to ENDS/ENNDS users and protect non-users from exposure to their emissions.
- Prevent unproven health claims from being made about ENDS/ENNDS.
- Protect tobacco-control activities from all commercial and other vested interests related to ENDS/ENNDS, including the interests of the tobacco industry.

The Conference of Parties also invited members to consider prohibiting or regulating ENDS/ENNDS, including as tobacco

products, medicinal products, consumer products or other categories, as appropriate, taking into account a high level of protection for human health. The COP also urged them to consider banning or restricting flavourings, advertising, promotion and sponsorship of ENDS as well as their use in indoor public places and workplaces.

Several Member States are beginning to take action to regulate ENDS and ENNDS:

- 32 countries have legislation regulating ENDS/ENNDS (12 countries have legislation regulating ENDS/ENNDS as a therapeutic product; 18 countries have legislation regulating ENDS as a tobacco product; for 2 countries, regulation is unclear).
- 25 countries have legislation banning the sale of ENDS/ENNDS.
- 17 countries include ENDS/ENNDS in national legislation on smoke-free environments.
- 9 countries include ENDS/ENNDS in national legislation on health warnings on packages.
- 13 countries include ENDS/ENNDS in national legislation on advertising, promotion and sponsorship.

As continuing research provides more scientific evidence about the long-term health effects of ENDS/ENNDS use on both direct users and those exposed to exhaled vapors, and about their effectiveness as potential aids to quit smoking, countries may regulate these products accordingly.

Each country needs a national tobacco control programme (NTCP) to lead tobacco control efforts

The WHO FCTC strongly suggests that every Party should establish and adequately finance a national tobacco control coordination mechanism to build needed capacity for implementing effective and sustainable policies to reverse the tobacco epidemic (1). The ministry of health or equivalent government agency should take the lead on strategic tobacco control planning and policy setting, with other ministries or agencies reporting to this centralized authority (101).

Subnational tobacco control implementation is important

In larger countries or those with federal political systems that divide governing powers between a centralized national authority and constituent political units, decentralizing NTCP authority to subnational levels may allow more flexibility in programme implementation and be more effective in reaching all regions and populations in the country (101).

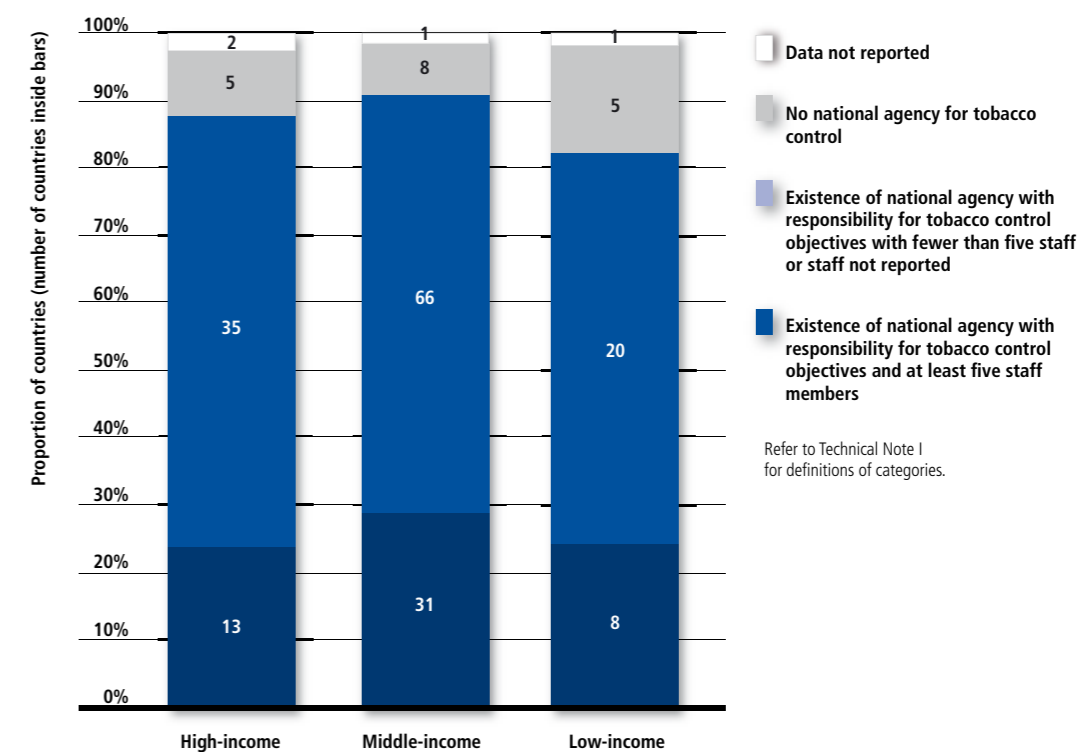
Since many tobacco control interventions are carried out at regional and community levels, public health and government leaders at subnational levels need

adequate resources to build sustainable implementation capacity (84). NTCPs should also ensure that population subgroups with disproportionately high rates of tobacco use are effectively reached by policies and programmes that will eliminate these social inequities (151).

Civil society must be actively involved in tobacco control

NTCPs require support from partners within government as well as from all segments of civil society (with the exception of the tobacco industry and its allies) (84). Continued involvement by legitimate

NATIONAL TOBACCO CONTROL PROGRAMMES



National Tobacco Control Programmes require support from partners within government as well as from all segments of civil society.

nongovernmental organizations and other civil society groups is essential to continued progress on national and global tobacco control efforts (101).

More countries have a national agency for tobacco control

One in every four countries globally has a national agency with responsibility for tobacco control objectives, with at least five full-time equivalent staff members.

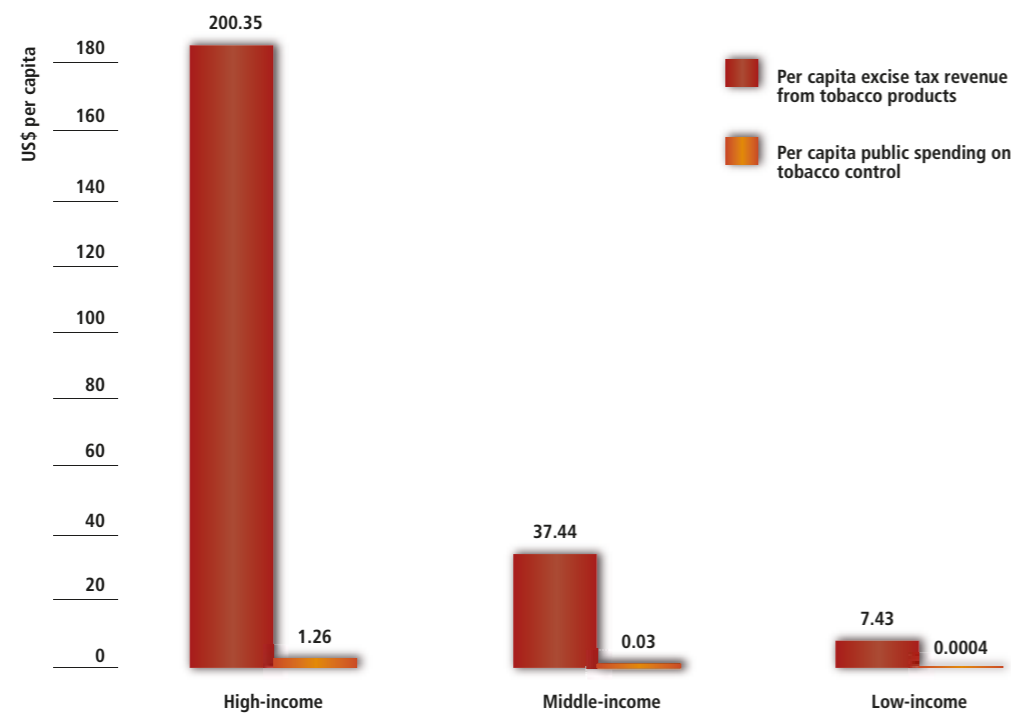
Two thirds of countries are working on tobacco control objectives with fewer staff, or with an unknown number. Only 18 countries do not have a national agency for tobacco control, 13 of which are low- and middle-income countries. This situation has improved over the past 2 years, with 17 countries newly reporting establishment of a national agency working towards tobacco control objectives, nine of which are low- and middle-income countries.

Governments collect nearly US\$ 269 billion in tobacco excise tax revenues each

year, but spend only around US\$ 1 billion combined on tobacco control – with 91% of this spent by high-income countries. Low- and middle-income countries can greatly strengthen their national tobacco control efforts by spending a greater proportion of tax revenues on effective tobacco control programmes.

Governments collect nearly US\$ 269 billion in tobacco excise tax revenues each year, but spend only around US\$ 1 billion combined on tobacco control – with 91% of this spent by high-income countries.

TOBACCO CONTROL IS UNDERFUNDED



Note: Based on 76 countries with available tobacco excise revenue data for 2013 or 2014; expenditure on tobacco control for several of these countries was estimated from figures between 2004 and 2014, adjusting for inflation (average consumer prices, IMF World Economic Outlook 2015). Tax revenues are tobacco product (or cigarette) excise revenue in 2013–2014 for the countries covered. Per capita value is calculated by using 2014 UN forecasted population age 15+.

Republic of Moldova passes comprehensive tobacco control law



Prime Minister of the Republic of Moldova receives the World No Tobacco Day award from WHO Regional Director for Europe.

Moldova, a middle-income country of under 4 million people in WHO's European Region, has a high smoking rate among men. According to the STEPS 2013 Survey, 43.6% of men were current

smokers compared to 5.6% among women. After years of small steps culminating in Moldova ratifying the WHO FCTC in 2007, the country began efforts to strengthen its tobacco control activities in 2011. Multiple actions were taken, including cost-effectiveness analysis of tobacco control interventions; development and approval of a National Tobacco Control Programme for the years 2012–2016 with multisectoral coordination; a nationwide communication and media campaign; and development of a comprehensive tobacco control law. Many stakeholders, including international organizations, public health and health authorities, and leaders from other governmental and civil society sectors were involved in developing the new tobacco control law, which closely adheres to WHO FCTC requirements. The new law has strong public support with more than 90% in favour of smoke-free public places and more than half saying they would be more likely to visit restaurants if they were smoke-free. Despite strong opposition from the tobacco lobby and special interest groups, the law was adopted by the Parliament in May 2015 and has yet to be signed by the President.

India's comprehensive tobacco control programme expanding to cover entire nation

In 2003, India enacted the landmark Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), with the objectives of discouraging tobacco use and protecting the public, especially youth, from the harms of tobacco use. COTPA incorporates comprehensive tobacco control provisions consistent with WHO FCTC requirements. Enforcement of COTPA has been challenging at the subnational level as India has a federal governmental structure with state governments responsible for funding and implementing health programmes. In addition, India is a leading tobacco producer with substantial small-scale, locally based industry. Recognizing these complexities and challenges, India launched its dedicated National Tobacco Control Programme (NTCP) in 2007 as a pilot with the twin objectives of building the capacity of states to enforce COTPA and creating awareness about the harmful effects of tobacco use and secondhand smoke exposure. After evaluation of the pilot phase, the NTCP is now being expanded to cover all 36 states and 672 districts in phases between 2012 and 2017, with a budget allocation of INR 700

crore (US\$ 115 million). Under NTCP, tobacco control units have been established at the national, state and district government level, with dedicated personnel to carry out specific activities. Once India's NTCP is fully implemented, there will be more than 1700 dedicated staff at all levels throughout the country. Establishment of a dedicated national programme for tobacco control with adequate financial and human resources is the cornerstone for advancing tobacco control in a large and complex tobacco-producing country, and serves as an excellent model that other countries can replicate.



Choose life not tobacco.

Conclusion

Progress spurred by the WHO Framework Convention on Tobacco Control and the consistent MPOWER measures over the past decade has helped protect nearly half of the world's people through at least one MPOWER measure at the highest level of achievement. As countries continue the process of adopting and implementing effective tobacco control strategies, they can look for inspiration and guidance to other countries that have successfully moved to advance their policies to the best practice level.

There was never an expectation that implementing strong tobacco control measures in every country would be quick or easy. There were, and still are, barriers and setbacks, as well as political difficulties and interference by the tobacco industry to attempt to stop necessary and life-saving actions. Even so, progress made thus far is extremely encouraging. Since 2007, the number of countries that have adopted at least one MPOWER measure at

the highest level has more than doubled, and the number of people covered by comprehensive policies has nearly tripled.

As a result of concerted efforts to strengthen and expand global tobacco control efforts, tens of millions of lives and hundreds of billions of dollars will be saved because of decreases in tobacco use. But while progress in implementing comprehensive tobacco control policies has been steady, it has also been slower than is needed. Many countries still have only weak tobacco control measures in place, and some have none at all. Billions of people continue to have little or no protection from the adoption of evidence-based tobacco control best practices, leaving them at risk of the health and economic harms caused by tobacco use. Even in countries that have some best practice policies in place, implementation of other policies lags. Only one country has implemented all MPOWER measures at their most comprehensive level and only a handful of countries have more

than two measures in place at the highest level of achievement.

The focus of this report, Raising tobacco taxes, is the MPOWER measure that has experienced least progress. Only one in 10 of the world's people live in the 33 countries that levy taxes of more than 75% of the cigarette retail price, making it the least-implemented MPOWER measure and the one with least improvement since 2007. More than 80% of countries do not have tobacco taxation in place at the highest level of achievement despite clear evidence that increasing taxes to a sufficiently high level is an extremely effective – including cost-effective – intervention; it reduces tobacco use, costs governments relatively little to implement, and increases government revenues, sometimes substantially.

It can be difficult to generate sufficient political will to overcome opposition – including from the tobacco industry – to

raising tobacco taxes. The tobacco industry has long opposed any strengthening of tobacco control measures, and is particularly active in attempting to prevent any type of tax increase leading to actual higher prices. The industry makes spurious claims of economic harm caused by higher taxes, which are not borne out by the evidence. One particular claim is that higher taxes lead to increased smuggling and illicit trade, but again the evidence does not support this.

But because tobacco taxes are generally better accepted than other types of taxes, it is possible to achieve widespread public support, even among tobacco users, especially if at least some of the new tax revenues are used for tobacco control, health promotion and other public health programmes.

Although taxes on tobacco should comprise at least 75% of the retail price of tobacco, taxation is almost always more complex

than simply deciding on a tax rate. Details of the taxation policy structure – types of tax, and at what base they are imposed – and adjustment to inflation and income growth, are as important as the rate itself. In the past, many countries had a system where different tax rates from multiple types of taxes were levied on different tobacco products. With the realization that simplified taxation structures are the easiest to implement and less subject to tobacco industry manipulation, more countries are opting to take this approach. Additionally, more countries are moving away from purely ad valorem excise systems and there are now fewer countries with no excise tax.

The information in this report provides guidance to countries on the health and economic benefits of higher tobacco taxes, as well as specific detailed steps that they can take to accomplish this goal. While more than 80% of countries do not yet levy taxes at the highest level of achievement, 16 countries have made good progress

since 2008 in raising taxes to at least 50% of the retail price. These countries have the opportunity to further increase taxes and improve their tax administration systems to achieve better health outcomes. All countries can learn from successful efforts as they work to raise taxes and implement the other MPOWER measures that will protect their people from the harms of tobacco use.

All countries have an obligation to protect the health of their people, and all Parties to the WHO FCTC have made specific commitments to implement strong tobacco control policies as an important means of providing that protection. There has been substantial progress in the past decade, but we must now recommit ourselves to continuing our global tobacco control efforts so that all the people of the world are fully protected from the tobacco epidemic and its harms.



References

1. WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2003 (updated 2004, 2005; http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf, accessed 10 June 2015).
2. Peto R, Lopez AD. Future worldwide health effects of current smoking patterns. In: Koop CE, Pearson CE, Schwarz MR, editors. Critical issues in global health. San Francisco : Jossey-Bass; 2001:154–161.
3. Global action plan for the prevention and control of noncommunicable diseases, 2013–2020. Geneva: World Health Organization; 2013 (http://www.who.int/nmh/events/ncd_action_plan/en, accessed 10 June 2015).
4. Decision FCTC/COP6(16) Towards a stronger contribution of the Conference of the Parties to achieving the noncommunicable disease global target on reduction of tobacco use. Conference of the Parties to the WHO Framework Convention on Tobacco Control. Sixth session, Moscow, 18 October 2014. Geneva: World Health Organization; 2014 ([http://apps.who.int/ib/ib/pdf/2014/06/FCTC_COP6\(16\)-en.pdf](http://apps.who.int/ib/ib/pdf/2014/06/FCTC_COP6(16)-en.pdf), accessed 10 June 2015).
5. Conference of the Parties to the WHO Framework Convention on Tobacco Control. Guidelines for implementation of Article 6 of the WHO FCTC. Geneva: World Health Organization; 2014 (http://www.who.int/tobacco/implementation/guidelines/article_6.pdf, accessed 10 June 2015).
6. WHO technical manual on tobacco tax administration. Geneva: World Health Organization; 2010 (http://www.who.int/tobacco/publications/tax_administration/en/index.html, accessed 10 June 2015).
7. IARC handbooks of cancer prevention: tobacco control. Volume 14: effectiveness of tax and price policies for tobacco control. Lyon, France: International Agency for Research on Cancer; 2011 (<http://www.iarc.fr/en/publications/pdfs-online/prev/handbook14/handbook14.pdf>, accessed 10 June 2015).
8. Chaloupka FJ, Hu T-W, Warner KE, Jacobs R, Yurekli A. The taxation of tobacco products. In: Jha P, Chaloupka FJ, editors. Tobacco control in developing countries. Oxford: Oxford University Press; 2000:237–272.
9. The tax burden on tobacco. Historical compilation, volume 49. Arlington, VA: Orzechowski and Walker; 2014 (http://www.taxadmin.org/fta/tobacco/papers/tax_burden_2014.pdf, accessed 10 June 2015).
10. The health consequences of smoking – 50 years of progress. A report of the Surgeon General. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014 (<http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf>, accessed 10 June 2010).
11. Levy D, de Almeida LM, Szklo A. The Brazil SimSmoke policy simulation model: the effect of strong tobacco control policies on smoking prevalence and smoking-attributable deaths in a middle-income nation. PLoS Med. 2012;9:e1001336. doi:10.1371/journal.pmed.1001336.
12. Scaling up action against noncommunicable diseases: how much will it cost? Geneva: World Health Organization; 2011 (http://www.who.int/nmh/publications/cost_of_inaction/en, accessed 10 June 2015).
13. The world health report 2002: reducing risks, promoting healthy life. Geneva: World Health Organization; 2002 (<http://www.who.int/whr/2002/en>, accessed 10 June 2015).
14. Jha P, Chaloupka FJ, Moore J, Gajalakshmi V, Gupta PC, Peck R et al. Tobacco addiction. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB et al., editors. Disease control priorities in developing countries, 2nd ed. Disease Control Priorities Project. New York: Oxford University Press and The World Bank; 2006:869–885 (<http://www.who.int/surgery/challenges/disease-control-priorities.pdf>, accessed 10 June 2015).
15. Preliminary benefit-cost assessment for 12th session Open Working Group goals. Lowell, MA: Copenhagen Consensus Center; 2014 (http://www.copenhagenconsensus.com/sites/default/files/owg12_cost-benefit-assessment_0.pdf, accessed 10 June 2015).
16. Systematic review of the link between tobacco and poverty. Geneva: World Health Organization; 2011 (http://www.who.int/tobacco/publications/economics/syst_rev_tobacco_poverty/en, accessed 10 June 2015).
17. Jha P, Joseph R, Li D, Gauvreau C, Anderson I, Moser P et al. Tobacco taxes: a win-win measure for fiscal space and health. Mandaluyong City, Philippines: Asian Development Bank; 2012 (<http://www.cghr.org/wordpress/wp-content/uploads/ADB-tobacco-taxes.pdf>, accessed 10 June 2015).
18. Levy D, Rodriguez-Buno RL, Hu TW, Moran AE. The potential effects of tobacco control in China: projections from the China SimSmoke simulation model. British Medical Journal. 2014;348:g1123. doi:10.1136/bmj.g1123.
19. Hill C. Cancer prevention and screening (Prévention et dépistage des cancers). Bulletin of Cancer. 2013;100:547–554. doi:10.1684/bdc.2013.1770 (in French).
20. Beck F, Guignard R, Richard J-B, Wilquin J-L, Peretti-Watel P. Increasing trends in smoking in France: main results of the French Health Barometer, France, 2010 [Augmentation récente du tabagisme en France: principaux résultats du Baromètre santé, France, 2010]. Bulletin épidémiologique hebdomadaire (Paris). 2011;20–21:230–233 (in French).
21. Guignard R, Beck F, Richard J-B, Peretti-Watel P. Tobacco use in France: analysis of findings of the French Health Barometer 2010 [Le tabagisme en France: analyse de l'enquête Baromètre santé 2010]. Saint-Denis, France: Institut national de prévention et d'éducation pour la santé; 2013 (<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1513.pdf>, accessed 10 June 2015) (in French).
22. Jha P. Avoidable deaths from smoking: a global perspective. Public Health Review. 2012;33:569–600 (http://www.publichealthreviews.eu/upload/pdf_files/10/13_jha.pdf, accessed 10 June 2015).
23. Jha P, Chaloupka FJ, editors. Curbing the epidemic: governments and the economics of tobacco control. Washington: The World Bank, 1999 (<http://documents.worldbank.org/curated/en/1999/05/437174/curbing-epidemic-governments-economics-tobacco-control>, accessed 10 June 2015).
24. Tobacco tax success story: Turkey. Washington: Campaign for Tobacco-Free Kids; 2012 (http://global.tobaccofreekids.org/files/pdfs/en/success_Turkey_en.pdf, accessed 10 June 2015).
25. Tobacco tax success story: South Africa. Washington: Campaign for Tobacco-Free Kids; 2012 (http://global.tobaccofreekids.org/files/pdfs/en/success_SoAfrica_en.pdf, accessed 10 June 2015).
26. Chaloupka FJ, Cumming KM, Morley CP, Horan JK. Tax, price and cigarette smoking: evidence from the tobacco documents and implications for tobacco company marketing strategies. Tobacco Control. 2002;11 Suppl 1:i52–i72.
27. World health report. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (<http://www.who.int/whr/2010/en>, accessed 10 June 2015).
28. Best practices for comprehensive tobacco control programs. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014 (http://www.cdc.gov/tobacco/stateandcommunity/best_practices, accessed 10 June 2015).
29. Roeseler A, Burns D. The quarter that changed the world. Tobacco Control. 2010;19 Suppl 1:i3–i15.
30. California adult smoking rate reaches historic low [press release]. Sacramento, CA: California Department of Public Health; 2011 (<http://www.cdph.ca.gov/Pages/NR11-031.aspx>, accessed 10 June 2015).
31. Lightwood J, Glantz SA. The effect of the California tobacco control program on smoking prevalence, cigarette consumption and healthcare costs: 1989–2008. PLoS One. 2013;8:e47145. doi:10.1371/journal.pone.0047145. Epub 2013 February 13.
32. Gallus S, Lugo A, LaVecchia C, Boffetta P, Chaloupka FJ, Colombo P et al. Pricing Policies and Control of Tobacco in Europe (PPACTE) project: cross-national comparison of smoking prevalence in 18 European countries. European Journal of Cancer Prevention. 2014;23:177–185. doi:10.1097/CEJ.000000000000009.
33. Global Adult Tobacco Survey, unpublished data, 2014.
34. Wilson N, Weerasekera D, Edwards R, Thomson G, Devlin M, Gifford H. Characteristics of smoker support for increasing a dedicated tobacco tax: national survey data from New Zealand. Nicotine Tobacco Research. 2010;12:168–173. doi:10.1093/ntr/ntp178. Epub 2009 Dec 17.
35. Briefing on the Sin Tax Law (R.A. No. 10351 “An Act Restructuring the Excise Tax on Alcohol and Tobacco Products”). Manila: Philippines Department of Finance; 2013 (<http://www.dof.gov.ph/wp-content/uploads/2013/02/Briefing-on-Sin-Tax-Law-FINAL.pdf>, accessed 10 June 2015).
36. Yürekli A, Önder Z, Elibol M, Erk N, Cabuk A, Fisinoglu 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/ti_turkey_report_feb2011.pdf, accessed 10 June 2015).
37. Global Tobacco Surveillance System data (GTSSData) [online database]. Country reports. Atlanta: Centers for Disease Control and Prevention; 2014 (<http://nccd.cdc.gov/gtssdata/Ancillary/DataReports.aspx?CAID=3>, accessed 10 June 2015).
38. Chaloupka FJ, Tauras JA, Grossman M. The economics of addiction. In: Tobacco control in developing countries. Jha P, Chaloupka FJ, editors. Oxford: Oxford University Press; 2000:107–129.
39. Becker GS, Grossman M, Murphy KM. An empirical analysis of cigarette addiction. American Economic Review 1994; 84:398–418 (<http://www.jstor.org/stable/2118059>, accessed 10 June 2015).
40. European Union. Council directive 2011/64/EU, 21 June 2011, on the structure and rates of excise duty applied to manufactured tobacco. Brussels: European Commission, Taxation and Customs Union; 2011 (<http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32011L0064>, accessed 10 June 2015).
41. WHO engagement with Member States on tobacco taxation. Geneva: World Health Organization, Department of Prevention of Noncommunicable Diseases, Tobacco Control Economics Unit; 2014 (<http://www.who.int/tobacco/publications/economics/9789241507301/en>, accessed 10 June 2015).
42. Faustino J. Amid staunch opposition, ‘sin taxes’ move forward in Philippines. The Asia Foundation, Weekly Insight and Analysis in Asia [web site]. 19 December 2012 (<http://asiafoundation.org/in-asia/2012/12/19/amid-staunch-opposition-sin-taxes-move-forward-in-philippines>, accessed 10 June 2015).
43. Paul J. Sin tax reform in the Philippines. Presentation at the 6th European Conference on Tobacco or Health, Istanbul, 28 March 2014.
44. Blecher E, Drope J. The rewards, risks and challenges of regional tobacco tax harmonisation. Tobacco Control. 2014;23:e7–e11. doi:10.1136/tobaccocontrol-2013-051241. Epub 2014 March 7.
45. Chaloupka FJ, Kostova D, Shang C. Cigarette excise tax structure and cigarette prices: evidence from the Global Adult Tobacco Survey and the US National Adult Tobacco Survey. Nicotine and Tobacco Research. 2014;16 Suppl 1:S3–S9. doi:10.1093/ntr/ntt121. Epub 2013 August 9.
46. Central Excise Tariff 2013–14. Chapter 24: tobacco and manufactured tobacco substitutes. New Delhi: Government of India, Ministry of Finance, Department of Revenue, Central Board of Excise and Customs; 2013 (<http://www.cbec.gov.in/excise/cxt2013-14/chap24.pdf>, accessed 10 June 2015).
47. Regulation of the Minister of Finance of the Republic of Indonesia number 179/PMK.011/2012. Excise tariff of tobacco products. Jakarta, Indonesia: Ministry of Finance; 2012 (<http://www.kemenkeu.go.id/en/Peraturan/regulation-minister-finance-republic-indonesia-number-179pmk0112012>, accessed 10 June 2015).
48. Conway-Smith E. Senegal: outrage over \$0.79 packs of Marlboro cigarettes. GlobalPost. Boston: Global News Enterprises LLC; 2011 (<http://www.globalpost.com/dispatches/globalpost-blogs/weird-wide-web/senegal-cigarettes-price-marlboro-philip-morris>, accessed 10 June 2015).
49. Ministère de l’Economie et des finances du Sénégal (Ministry of Economy and Finance of Senegal), Dakar, unpublished data, 2014.
50. Burki SJ, Pasha AG, Pasha HA, John R, Jha P, Baloch AA et al. The economics of tobacco and tobacco taxation in Pakistan. Paris: International Union against Tuberculosis and Lung Disease; 2013 (http://www.tobaccofreeunion.org/images/stories/economic-report/Pakistan-Report-March2014F_Web.pdf, accessed 10 June 2015).
51. Quimbo SLA, Casorla AA, Miguel-Baquilod M, Medalla FM, Xu X, Chaloupka FJ. The economics of tobacco and tobacco taxation in the Philippines. Paris: International Union against Tuberculosis and Lung Disease; 2012 (http://global.tobaccofreekids.org/files/pdfs/en/Philippines_tobacco_taxes_report_en.pdf, accessed 10 June 2015).
52. Chaloupka FJ, Peck R, Tauras JA, Xu X, Yurekli A. Cigarette excise taxation: The impact of tax structure on prices, revenues and cigarette smoking. NBER Working Paper no. 16287. Cambridge, MA: National Bureau of Economic Research; 2010 (<http://www.nber.org/papers/w16287>, accessed 10 June 2015).
53. Russian Federation, Ministry of Finance, Moscow, unpublished data, 2013.
54. Tobacco tax success story: United Kingdom. Washington: Campaign for Tobacco-Free Kids; 2012 (http://global.tobaccofreekids.org/files/pdfs/en/success_UK_en.pdf, accessed 10 June 2015).
55. Hashemite Kingdom of Jordan, Ministry of Finance, Amman, unpublished data, 2013.
56. Tobacco tax success story: Mexico. Washington: Campaign for Tobacco-Free Kids; 2012 (http://global.tobaccofreekids.org/files/pdfs/en/success_Mexico_en.pdf, accessed 10 June 2015).
57. Blecher E, van Walbeek C. An analysis of cigarette affordability. Paris: International Union against Tuberculosis and Lung Disease; 2008 (<http://www.worldlungfoundation.org/ht/a/GetDocumentAction/i/6561>, accessed 10 June 2015).
58. Tobacco price and taxation: ITC cross-country comparison report. International Tobacco Control Policy Evaluation Project. Waterloo, Canada: University of Waterloo; 2012 (http://www.itcproject.org/files/ITC_CrossCountry-Price-Tax_Apr20-v11-web.pdf, accessed 10 June 2015).
59. Chaloupka F. Unpublished analysis using data from: The tax burden on tobacco. Historical compilation, volume 43. Arlington, VA: Orzechowski and Walker; 2008.
60. Government of Jamaica, Ministry of Finance and Planning, Kingston, unpublished data, 2014 and 2015.
61. The road to balance: Creating jobs and opportunities. Economic action plan 2014. Ottawa: Department of Finance Canada; 2014 (<http://www.budget.gc.ca/2014/docs/plan/pdf/budget2014-eng.pdf>, accessed 10 June 2015).
62. Budget economic and fiscal update 2012. Wellington: Government of New Zealand, The Treasury; 2012 (<http://www.treasury.govt.nz/budget/forecasts/befu2012>, accessed 10 June 2015).
63. Taxation: the history of tobacco excise arrangements in Australia since 1901. Canberra: Australian Government, Department of Health; 2014 (http://www.wholesale.pattersonroad.com.au/rp_cigarettes.jsp, accessed 10 June 2015).
64. Recommended retail price list – cigarettes. Current price list, 1 March 2015. Bentleigh, Australia: Gedsan Trading Pty Ltd, Patterson Road Wholesalers; 2015 (http://wholesale.pattersonroad.com.au/rp_cigarettes.jsp, accessed 10 June 2015).
65. Currie L, Townsend J, Leon Roux M, Godfrey F, Gallus S, Gilmore AB et al. Policy recommendations for tobacco taxation in the European Union: integrated research findings from the PPACTE project. Dublin: The PPACTE Consortium; 2012 (http://www.academia.edu/1257661/Policy_Recommendations_for_Tobacco_Taxation_in_the_European_Union_Integrated_research_findings_from_the_PPACTE_project, accessed 10 June 2015).
66. WHO calculations from data available from the People’s Republic of Bangladesh, Ministry of Finance, Internal Resources Division, National Board of Revenue, Dhaka, unpublished data, 2014.
67. Thailand, Ministry of Finance, Bangkok, unpublished data, 2013.
68. Global Adult Tobacco Survey. Comparison fact sheet: Thailand 2009 & 2011. Geneva: World Health Organization; 2014 (http://www.who.int/tobacco/surveillance/survey/gats/thailand_fact_sheet_thailand_2009_2011.pdf?ua=1, accessed 10 June 2015).
69. Tobacco taxes – large disparities in rates for smoking products trigger significant market shifts to avoid higher taxes. Report to congressional committees. Washington: United States Government Accountability Office; 2012 (<http://www.gao.gov/assets/600/590192.pdf>, accessed 10 June 2015).
70. John RM, Rao RK, Rao MG, Moore J, Deshpande RS, Sengupta J et al. The economics of tobacco and tobacco taxation in India. Paris: International Union against Tuberculosis and Lung Disease; 2010 (http://wtc.theunion.org/images/stories/economic-report/India_Tobacco_Economics_full_en.pdf, accessed 10 June 2015).
71. Barber S, Adioetomo SM, Ahsan A, Setyanaluri D. Tobacco economics in Indonesia. Paris: International Union against Tuberculosis and Lung Disease; 2008 (<http://wtc.theunion.org/images/stories/economic-report/Tobacco%20Economics%20in%20Indonesia%20-%20EN.pdf>, accessed 10 June 2015).
72. Republic of Turkey, Ministry of Finance, Ankara, unpublished data, 2014.
73. Smith KE, Savell E, Gilmore A. What is known about tobacco industry efforts to influence tobacco tax? A systematic review of empirical studies. Tobacco Control. 2013;22:144–153. doi:10.1136/tobaccocontrol-2011-050098. Epub 2012 August 12.
74. Protocol to eliminate illicit trade in tobacco products. Geneva: World Health Organization, Framework Convention on Tobacco Control; 2013 (<http://www.who.int/tobacco/protocol/en>, accessed 10 June 2015).
75. Tackling tobacco smuggling – building on our success. A renewed strategy for HM Revenue & Customs and the UK Border Agency. London: HM Revenue & Customs and Home Office, UK Border Agency; 2011 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398461/Tackling_tobacco_smuggling_-_building_on_our_success.pdf, accessed 10 June 2015).

76. Nagy J. Tackling cigarette smuggling with enforcement: case studies reviewing the experience in Hungary, Romania and the United Kingdom. *World Customs Journal*. 2012;6:29–39 (<http://www.worldcustomsjournal.org/media/wcj/-2012/2/Nagy.pdf>, accessed 10 June 2015).
77. Stepping up the fight against smuggling and other forms of illicit trade in tobacco products – a comprehensive EU strategy. Communication from the Commission to the Council and the European Parliament. Brussels: European Commission; 2013 (http://ec.europa.eu/anti_fraud/documents/2013-cigarette-communication/communication_en.pdf, accessed 10 June 2015).
78. The use of technology to combat the illicit tobacco trade. Geneva: Framework Convention Alliance; 2008 (http://www.fctc.org/publications/bulletins/doc_download/124-technology-and-the-fight-against-illicit-tobacco-trade, accessed 10 June 2015).
79. Republic of Kenya, Ministry of National Treasury, Nairobi, 2014.
80. Tobacco industry interference: a global brief. Geneva: World Health Organization; 2012 (http://whqlibdoc.who.int/hq/2012/WHO_NMH_TFL_12.1_eng.pdf?ua=1, accessed 10 June 2015).
81. Assunta M, Dorotheo EU. SEATCA Tobacco Industry Interference Index: a tool for measuring implementation of WHO Framework Convention on Tobacco Control Article 5.3. *Tobacco Control*. 2015 Apr 23. doi: 10.1136/tobaccocontrol-2014-051934. [Epub ahead of print].
82. Ross H, Tesche J. Undermining government tax policies: common strategies employed by the tobacco industry in response to increases in tobacco taxes. Chicago: University of Cape Town, School of Economics, Economics of Tobacco Control Project and University of Illinois at Chicago, Institute for Health Research and Policy, Health Policy Center, Tobaccconomics; 2015 (http://tobaccconomics.org/wp-content/uploads/2015/03/Ross_Industry_Manipulation_Tax_Increases_03-20-15.pdf, accessed 10 June 2015).
83. Guidelines for implementation: Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, Article 14. Geneva: World Health Organization, Framework Convention on Tobacco Control; 2013 (http://www.who.int/fctc/guidelines/adopted/guidel_2011/en, accessed 10 June 2015).
84. MPOWER: a policy package to reverse the tobacco epidemic. Geneva: World Health Organization; 2008 (http://www.who.int/tobacco/mpower/mpower_english.pdf, accessed 10 June 2015).
85. Summary of data reported and evaluation. In: *Tobacco smoke and involuntary smoking*. IARC monographs on the evaluation of carcinogenic risks to humans, vol. 83. Lyon, France: World Health Organization, International Agency for Research on Cancer; 2004:1409–1413 (<http://monographs.iarc.fr/ENG/Monographs/vol83/mono83.pdf>, accessed 10 June 2015).
86. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006 (<http://www.surgeongeneral.gov/library/reports/secondhandsmoke/fullreport.pdf>, accessed 10 June 2015).
87. Scientific Committee on Tobacco and Health. Secondhand smoke: review of evidence since 1998. Update of evidence on health effects of secondhand smoke. London: Department of Health; 2004 (http://web.archive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcid=GET_FILE&ldid=13632&Rendition=Web, accessed 10 June 2015).
88. Fantuzzi G, Aggazzotti G, Righi E, Facchinetti F, Bertucci E, Kanitz S et al. Preterm delivery and exposure to active and passive smoking during pregnancy: a case-control study from Italy. *Paediatric and Perinatal Epidemiology*. 2007;21:194–200.
89. Fantuzzi G, Vaccaro V, Aggazzotti G, Righi E, Kanitz S, Barbone F et al. Exposure to active and passive smoking during pregnancy and severe small-for-gestational-age at term. *Journal of Maternal, Fetal and Neonatal Medicine*. 2008;21:643–647. doi: 10.1080/14767050802203744.
90. Anderson HR, Cook DG. Passive smoking and sudden infant death syndrome: review of the epidemiological evidence. *Thorax*. 1997;52:1003–1009.
91. Law MR, Hackshaw AK. Environmental tobacco smoke. *British Medical Bulletin*. 1996;52:22–34.
92. Gilbert SG. Scientific consensus statement on environmental agents associated with neurodevelopmental disorders. Bolinas, CA: Collaborative on Health and the Environment, Learning and Developmental Disabilities Initiative; 2008 (<http://www.healthandenvironment.org/?module=uploads&func=download&fileid=618>, accessed 10 June 2015).
93. Herrmann M, King K, Weitzman M. Prenatal tobacco smoke and postnatal secondhand smoke exposure and child neurodevelopment. *Current Opinion in Pediatrics*. 2008;20:184–190. doi: 10.1097/MOP.0b013e3182f56165.
94. Conference of the Parties to the WHO Framework Convention on Tobacco Control. Second session: first report of committee A (draft). Geneva: World Health Organization; 2007 (http://apps.who.int/gb/fctc/PDF/cop2/FCTC_COP2_17P-en.pdf, accessed 10 June 2015).
95. Gan Q, Hammond SK, Jiang Y, Yang Y, Hu TW. Effectiveness of a smoke-free policy in lowering secondhand smoke concentrations in offices in China. *Journal of Occupational Environmental Medicine*. 2008;50:570–575. doi: 10.1097/JOM.0b013e3181638640.
96. Cains T, Cannata S, Poulos R, Ferson MJ, Stewart BW. Designated “no smoking” areas provide from partial to no protection from environmental tobacco smoke. *Tobacco Control*. 2004;13:17–22.
97. Ventilation for acceptable indoor air quality. ANSI/ASHRAE Standard 62.1-2013. Atlanta: American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc.; 2013.
98. ASHRAE position document on environmental tobacco smoke. Approved by ASHRAE Board of Directors October 22, 2010. Reaffirmed by ASHRAE Technology Council June 25, 2013. Atlanta: American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc.; 2010 (https://www.ashrae.org/File%20Library/docLib/About%20Us/PositionDocuments/ASHRAE_PD_Environmental_Tobacco_Smoke_2013.pdf, accessed 10 June 2015).
99. Health effects of exposure to environmental tobacco smoke. Sacramento, CA: California Environmental Protection Agency, Office of Environmental Health Hazard Assessment; 1997 (http://oehha.ca.gov/air/environmental_tobacco/finalets.html, accessed 10 June 2015).
100. Institute for Health and Consumer Protection: activity report 2003. Ispra, Italy: European Commission Joint Research Centre, Institute for Health and Consumer Protection; 2004 (<http://publications.jrc.ec.europa.eu/repository/bitstream/JRC28175/EUR%2021198%20EN.pdf>, accessed 10 June 2015).
101. Building blocks for tobacco control: a handbook. Geneva: World Health Organization, WHO Tobacco Free Initiative; 2004 (http://www.who.int/tobacco/resources/publications/tobaccocontrol_handbook/en, accessed 10 June 2015).
102. Smoke-free policies receive public support. Atlanta: Centers for Disease Control and Prevention; 2014 (http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/public_support, accessed 10 June 2015).
103. Smoke-free policies improve health. Atlanta: Centers for Disease Control and Prevention; 2014 (http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/improve_health, accessed 10 June 2015).
104. Smoke-free laws do not harm business at restaurants and bars. Washington: Campaign for Tobacco-Free Kids; 2014. (<https://www.tobaccofreekids.org/research/factsheets/pdf/0144.pdf>, accessed 10 June 2015).
105. Smoke-free policies reduce smoking. Atlanta: Centers for Disease Control and Prevention; 2014 (http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/reduce_smoking, accessed 10 June 2015).
106. Smoke-free laws encourage smokers to quit and discourage youth from starting. Washington: Campaign for Tobacco-Free Kids; 2014 (<https://www.tobaccofreekids.org/research/factsheets/pdf/0198.pdf>, accessed 10 June 2015).
107. Cheng KW, Glantz SA, Lightwood JM. Association between smokefree laws and voluntary smokefree-home rules. *American Journal of Preventive Medicine*. 2011;41:566–572. doi: 10.1016/j.amepre.2011.08.014.
108. Borland R, Yong HH, Cummings KM, Hyland A, Anderson S, Fong GT. Determinants and consequences of smoke-free homes: findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*. 2006;15 Suppl 3:iii42–iii50.
109. Wipfli H, Avila-Tang E, Navas-Acien A, Kim S, Onicescu G, Yuan J et al.; Famri Homes Study Investigators. Secondhand smoke exposure among women and children: evidence from 31 countries. *American Journal of Public Health*. 2008;98:672–679. doi: 10.2105/AJPH.2007.126631. Epub 2008 February 28.
110. Borland R, Mullins R, Trotter L, White V. Trends in environmental tobacco smoke restrictions in the home in Victoria, Australia. *Tobacco Control*. 1999;8:266–271.
111. After the smoke has cleared: evaluation of the impact of a new smokefree law. Wellington: New Zealand Ministry of Health, 2006 (<https://www.health.govt.nz/system/files/documents/publications/smokefree-evaluation-report-with-appendices-dec06.pdf>, accessed 10 June 2015).
112. Evans DS, Byrne C, Mulcahy M. Smoking in the home: attitudes and perceptions and the impact of the 2004 Irish smoking ban. Castlebar, Ireland: Health Promotion Services and the Department of Public Health, Health Service Executive West; 2006 (<http://lenus.ie/hse/bitstream/10147/44864/1/6524.pdf>, accessed 10 June 2015).
113. Albers AB, Biener L, Siegel M, Cheng DM, Rigotti N. Household smoking bans and adolescent antismoking attitudes and smoking initiation: findings from a longitudinal study of a Massachusetts youth cohort. *American Journal of Public Health*. 2008;98:1886–1893. doi: 10.2105/AJPH.2007.129320. Epub 2008 August 13.
114. Centers for Disease Control and Prevention. Quitting smoking among adults – United States, 2001–2010. *Morbidity and Mortality Weekly Report*. 2011;60:1513–1519.
115. Fiore MC, Jaén CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ et al. Treating tobacco use and dependence: 2008 update. Clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2008 (http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf, accessed 10 June 2015).
116. The health benefits of smoking cessation: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1990 (<http://profiles.nlm.nih.gov/NN/BB/CT>, accessed 10 June 2015).
117. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years’ observations on male British doctors. *British Medical Journal*. 2004;328:1519–1527. Epub 2004 June 22.
118. Cromwell J, Bartosch WJ, Fiore MC, Hasselblad V, Baker T. Cost-effectiveness of the clinical practice recommendations in the AHCPR guideline for smoking cessation. Agency for Health Care Policy and Research. *Journal of the American Medical Association*. 1997;278:1759–1766.
119. Committee on Economic, Social and Cultural Rights. Report on the twenty-second, twenty-third and twenty-fourth sessions. Economic and social council official records, 2001. Supplement no. 2. New York and Geneva: United Nations; 2001 (<http://www.un.org/documents/ecosoc/docs/2001/e2001-22.pdf>, accessed 10 June 2015).
120. Kozlowski LT, Edwards BQ. “Not safe” is not enough: smokers have a right to know more than there is no safe tobacco product. *Tobacco Control*. 2005;14 Suppl 2:ii3–ii7.
121. Chapman S, Liberman J. Ensuring smokers are adequately informed: reflections on consumer rights, manufacturer responsibilities, and policy implications. *Tobacco Control*. 2005;14 Suppl 2:iii8–iii13.
122. Hammond D, Fong GT, McNeill A, Borland R, Cummings KM. Effectiveness of cigarette warning labels in informing smokers about the risks of smoking: findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*. 2006;15 Suppl 3:iii19–iii25.
123. Borland R, Hill D. Initial impact of the new Australian tobacco health warnings on knowledge and beliefs. *Tobacco Control*. 1997;6:317–325.
124. Borland R. Tobacco health warnings and smoking related cognitions and behaviours. *Addiction*. 1997;92:1427–1435.
125. Fathelrahman AI, Omar M, Awang R, Borland R, Fong GT, Hammond D et al. Smokers’ responses toward cigarette pack warning labels in predicting quit intention, stage of change and self-efficacy. *Nicotine Tobacco Research*. 2009;11:248–253. doi: 10.1093/ntr/ntn029. Epub 2009 February 26.
126. Hammond D, Fong GT, Zanna MP, Thrasher JF, Borland R. Tobacco denormalization and industry beliefs among smokers from four countries. *American Journal of Preventive Medicine*. 2006;31:225–232. Epub 2006 July 24.
127. Borland R, Wilson N, Fong GT, Hammond D, Cummings KM, Yong HH et al. Impact of graphic and text warnings on cigarette packs: findings from four countries over five years. *Tobacco Control*. 2009;18:358–364. doi: 10.1136/tc.2008.028043. Epub 2009 June 28.
128. Hammond D, Fong GT, Borland R, Cummings KM, McNeill A, Driezen P. Text and graphic warnings on cigarette packages: findings from the International Tobacco Control Four Country Study. *American Journal of Preventive Medicine*. 2007;32:202–209.
129. FCTC Article 11: tobacco warning labels. Evidence and recommendations from the ITC project. Waterloo, Ontario: International Tobacco Control Policy Evaluation Project; 2009 (http://www.itcproject.org/files/ITC_Tobacco_Labels_Bro_V3.pdf, accessed 10 June 2015).
130. Kamyab K, Nonnemaker JM, Farrelly MC. Public support for graphic health warning labels in the U.S. *American Journal of Preventive Medicine*. 2015;48:89–92. doi: 10.1016/j.amepre.2014.07.032. Epub 2014 Sep 11.
131. Maynard OM, Leonards U, Attwood AS, Bauld L, Hogarth L, Munafo MR. Effects of first exposure to plain cigarette packaging on smoking behaviour and attitudes: a randomised controlled study. *Biomed Central Public Health*. 2015;15:240. doi: 10.1186/s12889-015-1586-8.
132. Yong HH, Borland R, Hammond D, Thrasher JF, Cummings KM, Fong GT. Smokers’ reactions to the new larger health warning labels on plain cigarette packs in Australia: findings from the ITC Australia project. *Tobacco Control*. 2015;Feb 19. doi: 10.1136/tobaccocontrol-2014-051919. [Epub ahead of print].
133. Reducing tobacco use: a report of the Surgeon General. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000 (http://www.cdc.gov/tobacco/data_statistics/sg/2000, accessed 10 June 2015).
134. The role of the media in promoting and reducing tobacco use. *Tobacco Control Monograph No. 19*. NIH Pub. No. 07-6242. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 2008 (http://cancercontrol.cancer.gov/brp/ctrb/monographs/19/m19_complete.pdf, accessed 10 June 2015).
135. Siegel M. Mass media antismoking campaigns: a powerful tool for health promotion. *Annals of Internal Medicine*. 1998;129:128–132.
136. McAfee T, Davis KC, Alexander RL Jr, Pechacek TF, Bunnell R. Effect of the first federally funded US antismoking national media campaign. *Lancet*. 2013;382:2003–2011. doi: 10.1016/S0140-6736(13)61686-4. Epub 2013 Sep 9.
137. Bala MM, Strzeszynski L, Topor-Madry R, Cahill K. Mass media interventions for smoking cessation in adults. *Cochrane Database Systematic Review*. 2013;6:CD004704. doi: 10.1002/14651858.CD004704.pub3.
138. Durkin S, Brennan E, Wakefield M. Mass media campaigns to promote smoking cessation among adults: an integrative review. *Tobacco Control*. 2012;21:127–138. doi: 10.1136/tobaccocontrol-2011-050345.
139. Schar E, Gutierrez K, Murphy-Hoefler R, Nelson DE. Tobacco use prevention media campaigns: lessons learned from youth in nine countries. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006 (<http://www.cdc.gov/tobacco/youth/report/pdfs/youthMedia.pdf>, accessed 10 June 2015).
140. Dunlop SM, Wakefield M, Kashima Y. The contribution of antismoking advertising to quitting: intra- and interpersonal processes. *Journal of Health Communication*. 2008;13:250–266. doi: 10.1080/10810730801985301.
141. Leshner G, Bollis P, Thomas E. Scare ‘em or disgust ‘em: the effects of graphic health promotion messages. *Health Communication*. 2009;24:447–458. doi: 10.1080/10410230903023493.
142. Davis KC, Nonnemaker JM, Farrelly MC, Niederdeppe J. Exploring differences in smokers’ perceptions of the effectiveness of cessation media messages. *Tobacco Control*. 2011;20:26–33. doi: 10.1136/tc.2009.035568. Epub 2010 Sep 18.
143. Cigarette report for 2003. Washington: Federal Trade Commission; 2005 (<https://www.ftc.gov/sites/default/files/documents/reports/annual-report-congress-regarding-operation-hart-scott-rudino-premerger-notification-program-federal/050809cigrpt.pdf>, accessed 10 June 2015).
144. Lee S, Ling PM, Glantz SA. The vector of the tobacco epidemic: tobacco industry practices in low- and middle-income countries. *Cancer Causes Control*. 2012;23 Suppl 1:117–129. doi: 10.1007/s10552-012-9914-0. Epub 2012 February 28.
145. Saffer H, Chaloupka F. The effect of tobacco advertising bans on tobacco consumption. *Journal of Health Economics*. 2000;19:1117–1137.
146. Select Committee on Health. Second report. London: Government of Great Britain, House of Commons; 2000 (<http://www.parliament.the-stationery-office.co.uk/pa/cm199900/cmselect/cmhealth/27/2702.htm>, accessed 10 June 2015).
147. Centers for Disease Control and Prevention. Decline in smoking prevalence – New York City, 2002–2006. *Morbidity and Mortality Weekly Report*. 2007;56:604–608.
148. Saffer H. Tobacco advertising and promotion. In: Jha P, Chaloupka FJ, editors. *Tobacco control in developing countries*. Oxford: Oxford University Press; 2000:215–236.
149. Cohen JE, Planinac L, Lavack A, Robinson D, O’Connor S, DiNardo J. Changes in retail tobacco promotions in a cohort of stores before, during, and after a tobacco product display ban. *American Journal of Public Health*. 2011;101:1879–1881. doi: 10.2105/AJPH.2011.300172. Epub 2011 August 18.
150. Fooks GJ, Gilmore AB, Smith KE, Collin J, Holden C, Lee K. Corporate social responsibility and access to policy elites: an analysis of tobacco industry documents. *PLoS Med*. 2011;8:e1001076. doi: 10.1371/journal.pmed.1001076. Epub 2011 August 23.
151. David A, Esson K, Perucic A-M, Fitzpatrick C. Tobacco use: Equity and social determinants. In: Blas E, Sivasankara Kurup A, editors. *Equity, social determinants and public health programmes*. Geneva: World Health Organization; 2010:199–217.



TECHNICAL NOTES

- TECHNICAL NOTE I Evaluation of existing policies and compliance
- TECHNICAL NOTE II Smoking prevalence in WHO Member States
- TECHNICAL NOTE III Tobacco taxes in WHO Member States

APPENDICES

- APPENDIX I Regional summary of MPOWER measures
- APPENDIX II Tobacco taxes and prices
- APPENDIX III Year of highest level of achievement in selected tobacco control measures
- APPENDIX IV Highest level of achievement in selected tobacco control measures in the 100 biggest cities in the world
- APPENDIX V Status of the WHO Framework Convention on Tobacco Control

- APPENDIX VI Global tobacco control policy data
- APPENDIX VII Country profiles
- APPENDIX VIII Tobacco revenues
- APPENDIX IX Tobacco taxes and prices
- APPENDIX X Age-standardized prevalence estimates for smoking, 2013
- APPENDIX XI Country-provided prevalence data
- APPENDIX XII Maps on global tobacco control policy data

Appendices VI to XII are available online at http://www.who.int/tobacco/global_report/en/

Evaluation of existing policies and compliance

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

Data sources

Data were collected using the following sources:

- For all areas: official reports from WHO FCTC Parties to the Conference of the Parties (COP) and their accompanying documentation.¹
- For M (monitoring): tobacco prevalence surveys not reported under the COP reporting mechanism were collected mainly through WHO Regional and WHO Country Offices. Technical Note II provides further details.
- For P (protect), W (warn about the dangers of tobacco) and E (enforce bans on tobacco advertising, promotion and sponsorship): original tobacco control legislation, including regulations, adopted in all Member States related to smoke-free environments, packaging and labelling measures and tobacco advertising, promotion and sponsorship. In cases where a law had been adopted by 31 December 2014 but had not yet entered into force, the respective law was assessed and reported with an asterisk denoting “law adopted but not implemented by 31 December 2014”.
- For W (mass media): data on anti-tobacco mass media campaigns were obtained from Member States. In order to avoid unnecessary data collection, WHO conducted a screening for anti-tobacco mass media campaigns in all WHO Country Offices. In countries where potentially eligible mass media campaigns were identified, focal points in each country were contacted for

further information on these campaigns, and data on eligible campaigns were gathered and recorded systematically.

- For R (raise taxes on tobacco): the prices of the most sold brand of cigarettes, the cheapest brand and the brand Marlboro were collected through regional data collectors. Information on the taxation of cigarettes (and, for some countries in South-East Asia Region, bidis) and revenues from tobacco taxation, as well as any supporting documents, were collected from ministries of finance. Technical Note III provides the detailed methodology used.

Based on these sources of information, WHO assessed each indicator as of 31 December 2014. Exceptions to this cut-off date were tobacco product prices and taxes (cut-off date 31 July 2014) and anti-tobacco mass media campaigns (cut-off date 30 June 2014).

Data validation

For each country, every data point for which legislation was the source was assessed independently by two different expert staff from two different WHO offices, generally one from WHO headquarters and the other from the respective Regional Office. Any inconsistencies were reviewed by the two WHO expert staff involved and a third expert staff member not yet involved in the appraisal of the legislation. These were resolved by: (i) checking the original text of the legislation; (ii) trying to obtain consensus from the two expert staff involved in the data collection; and (iii) the decision of the third expert in cases where differences remained. Data were also checked for completeness and logical consistency across variables.

Data sign-off

Final, validated data for each country were sent to the respective government for review and sign-off. To facilitate review by governments, a summary sheet was generated for each country and was sent for review prior to the close of the report

database. In cases where national authorities requested data changes, the requests were assessed by WHO expert staff according to both the legislation and the clarification shared by the national authorities, and data were updated or left unchanged. In cases where national authorities explicitly did not agree with the data assessment, this is specifically noted in the appendix tables. Further details about the data processing procedure are available from WHO.

Data analysis

The report provides summary measures or indicators of country achievements for each of the six MPOWER measures. It is important to note that data for the report are based on existing legislation and reflect the status of adopted but not necessarily implemented legislation, as long as the law clearly indicates a date of entry into force and is not undergoing a legal challenge. The summary measures developed for the *WHO report on the global tobacco epidemic, 2015* are the same as those used for the 2013 report.

The report provides analysis of progress made since 2012 and since the first report (2007). For each indicator, 2012 and 2007 data were compared with 2014 data. To calculate the change in the percentage of the population covered by each policy or measure over time, population estimates for the year 2014² were used. Using a static year eliminates the effect of population growth when measuring change over time. Indicators from previous years have been recalculated, according to legislation/materials received after the assessment period of the respective report or according to changes in the methodology, so that the results are comparable across years. All income groups used for this report derive from the World Bank income-group classification published on 1 July 2014 by the World Bank.³ Upper-middle and lower-middle income groups are combined into one group for this report.

When country or population totals for MPOWER measures are referred to collectively in the analysis

section of this report, only the implementation of tobacco control policies (smoke-free legislation, cessation services, warning labels, anti-tobacco mass media campaigns, advertising and promotion bans, and tobacco taxes) is included in these totals. Monitoring of tobacco use is reported separately. When changes in population coverage since 2012 or 2007 are presented, again only implementation of policies is included.

Correction to previously published data

The 2012 data published in the last report were reviewed, and about 3% of data points were corrected. In most cases, review was conducted because legislation or policies were in place at the time of the last report but details were not available to WHO in time for publication.

Monitoring of tobacco use and prevention policies

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

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

Surveys were considered recent if conducted in the past 5 years. For this report, this means 2009 or later. Surveys were considered representative only if a scientific random sampling method was used to ensure nationally representative results. (Although they provide useful information, subnational surveys or national surveys of specific population groups provide insufficient information to enable tobacco control action for

the total population.) Surveys were considered periodic if the same survey or a similar survey was repeated at least once every 5 years. The following definitions were applied for youth and adult surveys:

Youth surveys: School-based surveys of students in grades for boys and girls aged 13–15 years. The questions asked in the surveys should provide indicators that are consistent with those specified in the Global Youth Tobacco Survey questionnaires and manuals.

Adult surveys: Household surveys that can provide indicators, for adults aged 15 years and over, consistent with those specified in the Global Adult Tobacco Survey questionnaires and manuals.

The groupings for the Monitoring indicator are listed below.

	No known data or no recent* data or data that are not both recent* and representative**
	Recent* and representative** data for either adults or youth
	Recent* and representative** data for both adults and youth
	Recent*, representative** and periodic*** data for both adults and youth

* Data from 2009 or later.

** Survey sample representative of the national population.

*** Collected at least every 5 years.

Smoke-free legislation

There is a wide range of places and institutions that can be made smoke-free by law. Smoke-free legislation can take place at the national or subnational level. The report includes data on national legislation as well as legislation in subnational jurisdictions. The assessment of subnational smoke-free legislation includes first-level administrative boundaries (first administrative subdivisions of a country), as determined by the United Nations Geographical Information Working Group. Subnational data reported in Appendix IV only reflect the status of subnational legislation

while provisions covered by national legislation are indicated by an informative note next to the subnational data. In cases where the status of smoke-free legislation is not reported for any subnational jurisdictions we assume the existing national law applies. Legislation was assessed to determine whether smoke-free laws provided for a complete⁴ indoor smoke-free environment at all times, in all the facilities of each of the following eight places:

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

Groupings for the smoke-free legislation indicator are based on the number of places where indoor smoking is completely prohibited. In addition, countries where at least 90% of the population was covered by complete subnational indoor smoke-free legislation are grouped in the top category.

In a few countries, in order to significantly expand the creation of smoke-free places, including restaurants and bars, it was politically necessary to include exceptions to the law that allowed for the provision of designated smoking rooms (DSRs) with requirements so technically complex and strict that, for practical purposes, few or no establishments are expected to implement them. In order to meet the criteria for “very strict technical requirements”, the legislation had to include at least three out of the six following characteristics (and must include at least criteria 5 or 6).

The designated smoking room must:

1. be a closed indoor environment;
2. be furnished with automatic doors, generally kept closed;

3. be non-transit premises for non-smokers;
4. be furnished with appropriate forced-ventilation mechanical devices;
5. have appropriate installations and functional openings installed, and air must be expelled from the premises;
6. be maintained, with reference to surrounding areas, in a depression not lower than 5 Pascal.

The few countries whose laws provide for DSRs with very strict technical requirements for five or more of the assessed public places have not been categorized in the analyses for this section because their smoke-free legislation substantially departs from the recommendations of WHO FCTC Article 8 guidelines, and it has been difficult to obtain evidence indicating that the law resulted in the intended very low number of DSRs these countries. The countries whose laws provide for DSRs with very strict technical requirements for less than five of the assessed public places have been grouped according to the number of completely smoke-free public places.

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

	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)

In addition to the data being used for the above groupings of the smoke-free legislation indicator, other related data such as information on fines and enforcement were collected and are reported in Appendix IV.

Tobacco dependence treatment

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

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

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

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

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

	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)
*	Nicotine replacement therapy.
**	Smoking cessation support available in any of the following places: health clinics or other primary care facilities, hospitals, office of a health professional, the community.

In addition to data used for the grouping of the Tobacco dependence treatment indicator, other related data such as information on countries' essential medicines lists, etc. were collected and are reported in Appendix IV.

Warning labels on tobacco packaging

The section of the report devoted to assessing each country's achievements in health warnings notes the following information about cigarette pack warnings:

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

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

The groupings for the health warnings indicator are listed below.

	Data not reported
	No warnings or small warnings ¹
	Medium size warnings ² missing some ³ appropriate characteristics ⁴ OR large warnings ⁵ missing many ⁶ appropriate characteristics ⁴
	Medium size warnings ² with all appropriate characteristics ⁴ OR large warnings ⁵ missing some ³ appropriate characteristics ⁴
	Large warnings ⁵ with all appropriate characteristics ⁴

¹ Average of front and back of package is less than 30%.

² Average of front and back of package is between 30 and 49%.

³ One or more.

⁴ Appropriate characteristics:

- specific health warnings mandated;
- appearing on individual packages as well as on any outside packaging and labelling used in retail sale;
- describing specific harmful effects of tobacco use on health;
- are large, clear, visible and legible (e.g. specific colours and font style and sizes are mandated);
- rotate;
- include pictures or pictograms;
- written in (all) the principal language(s) of the country.

⁵ Average of front and back of the package is at least 50%.

⁶ Four or more.

In addition to the data used for the grouping of the health warnings indicator, other related data such as the appearance of the quit line number, etc. were collected and are reported in Appendix IV.

Anti-tobacco mass media campaigns

Countries undertake communication activities to serve varied goals, including improving public relations, creating attention for an issue, building support for public policies, and prompting behaviour change. Anti-tobacco communication campaigns, which are a core tobacco control intervention, must have specified features in order to be minimally effective: they must be of sufficient

duration and must be designed to effectively support tobacco control priorities, including increasing knowledge, changing social norms, promoting cessation, preventing tobacco uptake, and increasing support for good tobacco control policies.

With this in mind, and consistent with the definition of "anti-tobacco mass media campaigns" in the last report, only mass media campaigns that were: (i) designed to support tobacco control; (ii) at least three weeks in duration and (iii) implemented between 1 July 2012 and 30 June 2014 were considered eligible for analysis. For the sake of logistical feasibility and cross-country comparability, only national level campaigns were considered eligible. Consistent with the last report and to enable greater accuracy, materials from campaigns had to be submitted and verified based on the eligibility criteria for all countries.

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

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

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

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

	Data not reported
	No campaign conducted between July 2012 and June 2014 with a duration of at least three weeks
	Campaign conducted with one to four appropriate characteristics
	Campaign conducted with five to six appropriate characteristics
	Campaign conducted with at least seven appropriate characteristics including airing on television and/or radio

Bans on advertising, promotion and sponsorship

The report includes data on legislation in national as well as subnational jurisdictions. The assessment of subnational legislation on advertising, promotion and sponsorship bans includes first-level administrative boundaries (first administrative subdivisions of a country), as determined by the United Nations Geographical Information Working Group. Subnational data reported in Appendix IV only reflect the status of subnational legislation while provisions covered by national legislation are indicated by an informative note next to the subnational data. In cases where the status of advertising, promotion and sponsorship legislation is not reported for any subnational jurisdictions we assume the existing national law applies.

Country-level achievements in banning tobacco advertising, promotion and sponsorship were assessed based on whether the bans covered the following types of advertising:

- national television and radio;
- local magazines and newspapers;
- billboards and outdoor advertising;
- point of sale;

- free distribution of tobacco products in the mail or through other means;
- promotional discounts;
- non-tobacco products identified with tobacco brand names (brand stretching);⁵
- brand names of non-tobacco products used for tobacco products (brand-sharing);⁶
- appearance of tobacco brands (product placement) or tobacco products in television and/or films;
- sponsorship, including corporate social responsibility programmes.

The first four types of advertising listed are considered “direct” advertising, and the remaining six are considered “indirect” advertising. Complete bans on tobacco advertising, promotion and sponsorship usually start with bans on direct advertising in national media and progress to bans on indirect advertising as well as promotion and sponsorship.

Bans that cover national television, radio and print media were used as the basic criteria for the two lowest groups, and the remaining groups were constructed based on how comprehensively the law covers bans of other forms of direct and indirect advertising included in the questionnaire.

In cases where the law did not explicitly address cross-border advertising, it was interpreted that advertising at both domestic and international levels was covered by the ban only if advertising was totally banned at national level.

The groupings for the Bans on advertising, promotion and sponsorship indicator are listed below.

	Data not reported
	Complete absence of ban, or ban that does not cover national television (TV), radio and print media
	Ban on national TV, radio and print media only
	Ban on national TV, radio and print media as well as on some (but not all) other forms of direct* and/or indirect** advertising
	Ban on all forms of direct* and indirect** advertising

* Direct advertising bans:

- national television and radio;
- local magazines and newspapers;
- billboards and outdoor advertising;
- point of sale.

** Indirect advertising bans:

- free distribution of tobacco products in the mail or through other means;
- promotional discounts;
- non-tobacco goods and services identified with tobacco brand names (brand stretching);
- brand names of non-tobacco products used for tobacco products (brand sharing);
- appearance of tobacco brands (product placement) or tobacco products in television and/or films;
- sponsorship, including corporate social responsibility programmes.

In addition to the data being used for the grouping of the Bans on advertising, promotion and sponsorship indicator, other related data, such as bans on Internet sales or on display of tobacco products at points of sale were collected and are reported in Appendix IV.

Tobacco taxes

Countries are grouped according to the percentage contribution of all tobacco taxes to the retail price. Taxes assessed include excise tax, value added tax (sometimes called “VAT”), import duty (when the cigarettes were imported) and any other taxes levied. Only the price of the most popular brand of cigarettes is considered. In the case of countries where different levels of taxes applied to cigarettes are based on length, quantity produced, or type (e.g. filter vs. non-filter), only

the rate that applied to the most popular brand is used in the calculation.

Given the lack of information on country and brand-specific profit margins of retailers and wholesalers, their profits were assumed to be zero (unless provided by the national data collector).

The groupings for the Tobacco tax indicator are listed below. Please refer to Technical Note III for more details.

	Data not reported
	< 25% of retail price is tax
	26–50% of retail price is tax
	51–75% of retail price is tax
	>75% of retail price is tax

National tobacco control programmes

Classification of countries’ national tobacco control programmes is based on the existence of a national agency with responsibility for tobacco control objectives. Countries with at least five full-time equivalent staff members working at the national agency with responsibility for tobacco control meet the criteria for the highest group.

The groupings for the National tobacco control programme indicator are listed below.

	Data not reported
	No national agency for tobacco control
	Existence of national agency with responsibility for tobacco control objectives with no or < five full-time equivalent staff members
	Existence of national agency with responsibility for tobacco control objectives and at least five full-time equivalent staff members

Compliance assessment

Compliance with national and comprehensive subnational smoke-free legislation as well as with advertising, promotion and sponsorship bans (covering both direct and indirect marketing)

was assessed by up to five national experts, who assessed the compliance in these two areas as “minimal”, “moderate” or “high”. These five experts were selected according to the following criteria:

- person in charge of tobacco prevention in the country’s ministry of health, or the most senior government official in charge of tobacco control or tobacco-related conditions;
- the head of a prominent nongovernmental organization dedicated to tobacco control;
- a health professional (e.g. physician, nurse, pharmacist or dentist) specializing in tobacco-related conditions;
- a staff member of a public health university department;
- the tobacco control focal point of the WHO Country Office.

The experts performed their assessments independently. Average scores were calculated by WHO from the five individual assessments by assigning two points for highly enforced policies, one point for moderately enforced policies and no points for minimally enforced policies, with a potential minimum of 0 and maximum of 10 points in total from these five experts.

The compliance assessment was obtained for legislation adopted by 1 April 2014. For countries with more recent legislation, compliance data are reported as “not applicable”. Compliance with smoke-free legislation was not assessed in case the law provides for DSRs with very strict technical requirements.

The country-reported answers are listed in Appendix IV. Appendix I summarizes this information. Compliance scores are represented separately from the grouping (i.e. compliance is not included in the calculation of the grouping categories).

1 Parties report on the implementation of the WHO Framework Convention on Tobacco Control according to Article 21. The objective of reporting is to enable Parties to learn from each other’s experience in implementing the WHO FCTC. Parties’ reports are also the basis for review by the COP of the implementation of the Convention. Parties submit their initial report 2 years after entry into force of the WHO FCTC for that Party, and then every subsequent 3 years, through the reporting instrument adopted by COP. Since 2012, all Parties report at the same time, once every 2 years. For more information please refer to <http://www.who.int/fctc/reporting/en/>

2 United Nations Department of Economic and Social Affairs, Population Division in *World population prospects: the 2012 revision* (median fertility projection for the year 2014). For more information please refer to <http://esa.un.org/wpp>.

3 The World Bank: World development indicators 2014. For more information please refer to <http://data.worldbank.org/sites/default/files/wdi-2014-book.pdf>

4 “Complete” is used in this report to mean that smoking is not permitted, with no exemptions allowed, except in residences and indoor places that serve as equivalents to long-term residential facilities, such as prisons and long-term health and social care facilities such as psychiatric units and nursing homes. Ventilation and any form of designated smoking rooms and/or areas do not protect from the harms of secondhand tobacco smoke, and the only laws that provide protection are those that result in the complete absence of smoking in all public places.

5 When legislation did not explicitly ban the identification of non-tobacco products with tobacco brand names (brand stretching) and did not provide a definition of tobacco advertising and promotion, it was interpreted that brand stretching was covered by the existing ban of all forms of advertising and promotion when the country was a Party to the WHO FCTC, assuming that the WHO FCTC definitions apply.

6 When legislation did not explicitly ban the use of brand names of non-tobacco products for tobacco products (brand sharing) and did not provide a definition of tobacco advertising and promotion, it was interpreted that brand sharing was covered by the existing ban of all forms of advertising and promotion when the country was a Party to the WHO FCTC, assuming that the WHO FCTC definitions apply.

Smoking prevalence in WHO Member States

Monitoring the prevalence of tobacco use is central to efforts to control the global tobacco epidemic. Reliable prevalence data on the magnitude of the tobacco epidemic and its influencing factors provide the information needed to plan, implement and evaluate the impact of tobacco control interventions. This report contains country-generated data for both smoking¹ and smokeless tobacco use among young people and adults (Appendix XI). It also presents WHO-modelled, age-standardized prevalence estimates for smoking for people aged 15 years and over (Appendix X). This technical note provides information on the method used to generate the age-standardized estimates.

Sources of information

For the analysis, the following sources of information were explored:

- information on surveys provided by Parties to the WHO FCTC Secretariat;
- information collected through WHO tobacco-focussed surveys conducted under the aegis of the Global Tobacco Surveillance System – in particular, the Global Adult Tobacco Survey (GATS);
- tobacco information collected through other WHO surveys including WHO STEPwise surveys and World Health Surveys;
- other systems-based surveys undertaken by other organizations, including surveys such as the Demographic and Health Surveys (DHS) and the Behavioural Risk Factor Surveillance System (BRFSS) surveys; and
- an extensive search through WHO Regional and WHO Country Offices to identify country-specific surveys not part of international surveillance systems – such as the Survey of Lifestyles, Attitude and Nutrition in the Republic of Ireland, or the Social Weather Station Surveys in the Philippines.

For the analysis, information from surveys conducted since 1990 was used if it:

- was officially recognized by the national health authority;
- included randomly selected participants who were representative of the general population;
- provided country survey summary data for one or more of six tobacco use definitions: daily tobacco user, current tobacco user, daily tobacco smoker, current tobacco smoker, daily cigarette smoker, or current cigarette smoker; and
- presented prevalence values by age and sex (in the absence of age-specific data, total-age data were used).

The above indicators provide for the most complete representation of tobacco smoking across countries and at the same time help minimize attrition of countries from further analysis because of lack of adequate data.

Although differences exist in the types of tobacco products used in different countries and grown or manufactured in different regions of the world, data on cigarette smoking and tobacco smoking are the most widely reported and are common to all countries, thereby permitting statistical analyses.² Member States were contacted to obtain an official report from recently undertaken surveys.

The information identified above is stored in the WHO Tobacco Control Global DataBank (<http://www.who.int/tobacco/surveillance/globaldatabank/>) as well as in the WHO Global Infobase, a portal of information on eight risk factors for noncommunicable diseases including tobacco (<http://www.who.int/infobase>).

Analysis and presentation of tobacco use prevalence indicators

Estimation method

A statistical model based on a Bayesian negative

binomial meta-regression was used to derive modelled crude and age-specific estimates for four indicators of tobacco smoking (current and daily tobacco smoking as well as current and daily cigarette smoking) for countries for men and women separately. A full description of the applied method is available as a peer-reviewed article in *The Lancet*, Volume 385, No. 9972, p966–976 (2015). The age-specific rates derived were used to generate the age-standardized estimates. The data for this report refer to estimates for 2013.

Once the prevalence rates from surveys were compiled into a dataset, a two-step process was used to calculate trend estimates for the indicators specified above. These steps involved: (a) adjusting for differences between surveys, and (b) running the regression model to generate both the underlying trend as well as the 95% credible interval around the estimate.

Depending on the completeness of country-generated survey data, the model at times makes use of data from other countries to fill information gaps. Countries with less data or broadly inadequate data “borrow information” from neighbouring countries³ in the calculation of their estimates. It was not possible to generate estimates for countries with insufficient survey data (e.g., no existing surveys or where these were too old).

Differences in age groups covered by each survey

Survey results for any one country were sometimes reported for a variety of different age groups. The model fills in missing ages in the data by examining the association between age and tobacco use prevalence by sex and survey year. Where data were missing for any age group, the model uses available data from a country's other surveys to estimate the age pattern of tobacco use. For ages that the country has never surveyed, the average age pattern seen in countries in the same geographical region is applied to the country's data.

Differences in the types of indicators of tobacco use measured

Similarly, countries may report different indicators across surveys (e.g. current smoking in one survey and daily smoking in another, or tobacco smoking in one and cigarette smoking in another). Where data were missing for any category, the model uses available data from a country's other surveys to estimate the missing information. For indicators on which the country has never reported, the average relationships seen in countries in the same geographical region are applied to the country's data.

The regression models were run separately for males and females in order to obtain age-specific prevalence rates for each region.

Age-standardized prevalence

Comparison of crude rates between two or more countries at one point in time, or of one country at different points in time, can be misleading if the two populations being compared have significantly different age distributions or differences in tobacco use by sex. The method of age-standardization is commonly used to overcome this problem and allows for meaningful comparison of prevalence between countries, once all other comparison issues described have been addressed. The method involves applying the age-specific rates by sex in each population to one standard population (this report uses the WHO Standard Population, a fictitious population whose age distribution is largely reflective of the population age structure of low- and middle-income countries). The resulting age-standardized rates refer to the number of smokers per 100 WHO Standard Population. As a result, the rates generated using this process are only hypothetical numbers with no inherent meaning. They are only meaningful when comparing rates obtained from one country with those obtained in another country. The age-standardized rates are shown in Appendix X.

- 1 Tobacco smoking includes cigarette, cigar, pipe, hookah, shisha, water-pipe and any other form of smoked tobacco.
- 2 For countries where prevalence of smokeless tobacco use is reported, we have published these data.
- 3 For a complete listing of countries by UN region, please refer to *Composition of macro geographical (continental) regions, geographical sub-regions, and selected economic and other groupings* published by the UN Statistics Division at <http://millenniumindicators.un.org/unsd/methods/m49/m49regin.htm> (accessed Dec 18, 2014). Please note that, for the purposes of this analysis, the *Eastern Africa* subregion was divided into two regions: *Eastern Africa Islands* and *Remainder of Eastern Africa*, the *Central Asia* region was combined with the *Eastern Europe* region, the countries Armenia, Azerbaijan, Estonia, Georgia, Latvia and Lithuania were changed to the *Eastern Europe* region, Cyprus, Israel and Turkey were changed to the *Southern Europe* region, and the *Melanesia*, *Micronesia* and *Polynesia* subregions were combined into one subregion.

Tobacco taxes in WHO Member States

This report includes appendices containing information on the share of total and excise taxes in the price of the most widely sold brand of cigarettes, based on tax policy information collected from each country. This note contains information on the methodology used by WHO to estimate the share of total and tobacco excise taxes in the price of a pack of 20 cigarettes using country-reported data. It also provides information on additional data collected for this report in relation to tobacco taxation.

1. Data collection

All data were collected between June 2014 and January 2015 by WHO regional data collectors. The two main inputs into calculating the share of total and excise taxes were (1) prices and (2) tax rates and structure. Prices were collected for the most widely sold brand of cigarettes, two other popular brands, the least-expensive brand and the brand Marlboro for July 2014.

Data on tax structure were collected through contacts with ministries of finance. The validity of this information was checked against other sources. These sources, including tax law documents, decrees and official schedules of tax rates and structures and trade information, when available, were either provided by data collectors or were downloaded from ministerial websites or from other United Nations databases such as Comtrade (<http://comtrade.un.org/db/>). Other secondary data sources were also purchased for data validation.

The tax data collected focus on indirect taxes levied on tobacco products (e.g. excise taxes of various types, import duties, value added taxes), which usually have the most significant impact on the price of tobacco products. Within indirect taxes, excise taxes are the most important because they are applied exclusively to tobacco, and contribute the most to increasing the price of tobacco products and subsequently reducing

consumption. Thus, rates, amounts and point of application of excise taxes are central components of the data collected.

Certain other taxes, in particular direct taxes such as corporate taxes, can potentially impact tobacco prices to the extent that producers pass them on to final consumers. However, because of the practical difficulty of obtaining information on these taxes and the complexity in estimating their potential impact on price in a consistent manner across countries, they are not considered.

The table below describes the types of tax information collected.

2. Data analysis

The price of the most popular brand of cigarettes was considered in the calculation of the tax as a share of the retail price reported in Appendix table 2.1. In the case of countries where different levels of taxes are applied on cigarettes based on length

of cigarette, quantity produced, or type (e.g. filter vs. non-filter), *only the relevant rate that applied to the most sold brand* was used in the calculation. In the case of Canada and the United States of America, national average estimates calculated for prices and taxes reflect the fact that different rates are applied by state/province over and above the applicable federal tax. In the case of Brazil, where state VATs vary, an average VAT rate was applied. In India, which also has varying VAT rates across states, the VAT rate applicable to the state where price data was collected (Delhi) was used. Similarly, VAT rates vary in the Federated States of Micronesia and the rate of Pohnpei was used.

The import duty was only used in the calculation of tax shares if the most sold brand of cigarettes was imported into the country. Import duty was not applied in total tax calculation for countries reporting that the most sold brand, even if an international brand, was produced locally. In cases where the imported cigarettes originated from a country with which a bilateral or multilateral trade agreement waived the duty, care was taken to ensure that the import duty was not taken into account in calculating taxes levied.

“Other taxes” are all other indirect taxes not reported as excise taxes or VAT. These taxes were, however, treated as excises if they had a special rate applied to tobacco products. For example, Thailand reported the tax earmarked from tobacco and alcohol for the ThaiHealth Promotion Foundation as “other tax”. However, since this tax is applied only on tobacco and alcohol products, it acts like an excise tax and so was considered an excise in the calculations.

The next step of the exercise was to convert all taxes to the same base – in our case, the tax-inclusive retail sale price (hereafter referred to as P). Standardizing bases is important in calculating tax share correctly, as the example in the table shows. Country B apparently applies the same ad valorem tax rate (20%) as Country A, but in fact ends up with a higher tax rate and a higher final price because the tax is applied later in the distribution chain.

	COUNTRY A (US\$)	COUNTRY B (US\$)
[A] Manufacturer’s price (same in both countries)	2.00	2.00
[B] Country A: ad valorem tax on manufacturer’s price (20%) = 20% x [A]	0.40	-
[C] Countries A and B: specific excise	2.00	2.00
[D] Retailer’s and wholesaler’s profit margin (same in both countries)	0.20	0.20
[E] Country B: ad valorem tax on retailer’s price (20%) = 20% x ([A]+[C]+[D])	-	0.84
[F] Final price = P = [A]+[C]+[D]+([B]or[E])	4.60	5.04

Comparing reported statutory ad valorem tax rates without taking into account the stage at which the tax is applied could therefore lead to biased results.

A similar methodology was used to calculate the price and tax share of the most common type of smoked (other than cigarettes) and smokeless tobacco products, as reported by each country. The calculation was made for the price of a product for 20 grams for any smoked or smokeless tobacco product except for cigars, for which the price and tax was reported per piece. Price and tax for smoked tobacco products (including bidis, cheroots, cigarillos, cigars, e-cigarettes, pipe tobacco, roll-your-own or waterpipe tobacco) was calculated for 65 countries, while the calculation for smokeless tobacco products (chewing tobacco, dry snuff, moist snuff nose tobacco or snus) was made for 25 countries (see table 9.6 in online Appendix IX).

3. Calculation

Denote S_{ts} as the share of taxes on the price of a widely consumed brand of cigarettes (20-cigarette pack or equivalent). Then

$$S_{ts} = S_{as} + S_{av} + S_{id} + S_{vat} \quad \textcircled{1}$$

Where:

S_{ts} = Total share of taxes in the price of a pack of cigarettes;

S_{as} = Share of amount-specific excise taxes (or equivalent) in the price of a pack of cigarettes;

S_{av} = Share of ad valorem excise taxes (or equivalent) in the price of a pack of cigarettes;

S_{id} = Share of import duties in the price of a pack of cigarettes (if the most popular brand is imported);

S_{vat} = Share of the value added tax in the price of a pack of cigarettes.

Calculating S_{as} is fairly straightforward and involves dividing the specific tax amount for a 20-cigarette pack by the total price. Unlike S_{as} , the share of ad valorem taxes, S_{av} is much more difficult to calculate and involves making some assumptions described below. Import duties are sometimes amount-specific, sometimes value-based. S_{id} is therefore calculated the same way as S_{as} if it is amount-specific and the same way as S_{av} if it is value-based. VAT rates reported for countries are usually applied on the VAT-exclusive retail sale price but are also sometimes reported on VAT-inclusive prices. S_{vat} is calculated to consistently reflect the share of the VAT in VAT-inclusive retail sale price.

The price of a pack of cigarettes can be expressed as the following:¹

$$P = [(M + M \times ID) + (M + M \times ID) \times T_{av}\% + T_{as} + \pi] \times (1 + VAT\%)$$

or

$$P = [M \times (1 \times ID) \times (1 + T_{av}\%) + T_{as} + \pi] \times (1 + VAT\%) \quad \textcircled{2}$$

Where:

P = Price per pack of 20 cigarettes of the most popular brand consumed locally;

M = Manufacturer’s/distributor’s price, or import price if the brand is imported;

ID = Import duty rate (where applicable) on a pack of 20 cigarettes;²

T_{av} = Statutory rate of ad valorem tax;

1. Amount-specific excise taxes	An amount-specific excise tax is a tax <i>on a selected good</i> produced for sale within a country, or imported and sold in that country. In general, the tax is collected from the manufacturer/ wholesaler or at the point of entry into the country by the importer, in addition to import duties. These taxes come in the form of an amount per stick, pack, per 1000 sticks, or per kilogram. Example: US\$ 1.50 per pack of 20 cigarettes.
2. Ad valorem excise taxes	An ad valorem excise tax is a tax <i>on a selected good</i> produced for sale within a country, or imported and sold in that country. In general, the tax is collected from the manufacturer/wholesaler or at the point of entry into the country by the importer, in addition to import duties. These taxes come in the form of a percentage of the value of a transaction between two independent entities at some point of the production/distribution chain; ad valorem taxes are generally applied to the value of the transactions between the manufacturer and the retailer/wholesaler. Example: 60% of the manufacturer’s price.
3. Import duties	An import duty is a tax <i>on a selected good</i> imported into a country to be consumed in that country (i.e. the goods are not in transit to another country). In general, import duties are collected from the importer at the point of entry into the country. These taxes can be either amount-specific or ad valorem. Amount-specific import duties are applied in the same way as amount-specific excise taxes. Ad valorem import duties are generally applied to the CIF (cost, insurance, freight) value, i.e. the value of the unloaded consignment that includes the cost of the product itself, insurance and transport and unloading. Example: 50% import duty levied on CIF.
4. Value added taxes and sales taxes	The value added tax (VAT) is a “multi-stage” tax <i>on all consumer goods and services</i> applied proportionally to the price the consumer pays for a product. Although manufacturers and wholesalers also participate in the administration and payment of the tax all along the manufacturing/distribution chain, they are all reimbursed through a tax credit system, so that the only entity who pays in the end is the final consumer. Most countries that impose a VAT do so on a base that includes any excise tax and customs duty. Example: VAT representing 10% of the retail price. Some countries, however, impose sales taxes instead. Unlike VAT, sales taxes are levied at the point of retail on the total value of goods and services purchased. For the purposes of the report, care was taken to ensure the VAT and/or sales tax shares were computed in accordance with country-specific rules.
5. Other taxes	Information was also collected on any other tax that is not called an excise tax, import duty, VAT or sales tax, but that applies to either the quantity of tobacco or to the value of a transaction of a tobacco product, with as much detail as possible regarding what is taxed and how the base is defined.

T_{as} = Amount-specific excise tax on a pack of 20 cigarettes;

π = Retailer's, wholesaler's and importer's profit per pack of 20 cigarettes (sometimes expressed as a mark-up);

VAT = Statutory rate of value added tax on VAT-exclusive price.

Changes to this formula were made based on country-specific considerations such as the base for the ad valorem tax and excise tax, the existence – or not – of ad valorem and specific excise taxes, and whether the most popular brand was locally produced or imported. In many cases (particularly in low- and middle-income countries) the base for ad valorem excise tax was the manufacturer's/distributor's price.

Given knowledge of price (P) and amount-specific excise tax (T_{as}), the share S_{as} is easy to recover ($=T_{as}/P$). The case of ad valorem taxes (and, where applicable, S_{id}) is fairly straightforward when, by law, the base is retail price (as is the case in several European Union countries). The calculation is more complicated when the base isn't retail price, because the base (M) needs to be recovered in order to calculate the amount of ad valorem tax. In most of the cases M was not known (unless specifically reported by the country), and therefore had to be estimated.

Using equation (2), it is possible to recover M:

$$M = \frac{\frac{P}{1 + VAT\%} - \pi - T_{as}}{(1 + T_{av}\%) \times (1 + ID)} \quad ③$$

π , or wholesalers' and retailers' profit margins, are rarely publicly disclosed and will vary from country to country. For domestically produced most popular brands, we considered π to be nil (i.e. =0) in the calculation of M because the retailer's and wholesaler's margins are assumed to be small. Setting the margin to 0, however, would result in an overestimation of M and therefore of the base for the ad valorem tax. This will in turn result in an overestimation of the amount of ad valorem tax. Since the goal of this exercise is to measure how high the share of tobacco taxes is in the price of a typical pack of cigarettes,

assuming that the retailer's/wholesaler's profit (π) is nil, therefore, does not penalize countries by underestimating their ad valorem taxes. In light of this it was decided that unless and until country-specific information was made available to WHO, the retailer's or wholesaler's margin would be assumed to be nil for domestically produced brands.

For countries where the most popular brand is imported, the import duty is applied on CIF values, and the consequent excise taxes are typically applied on a base that includes the CIF value and the import duty, but not the importer's profit. For domestically produced cigarettes, the producer's price includes its own profit so it is automatically included in M. In practice, however, the importer's profit can be relatively significant and setting it to zero (as in the case of domestically manufactured cigarettes) would substantially overestimate M, and thereby overestimate the share of ad valorem tax in final price. For this reason, M had to be estimated differently for imported products: M^* (or the CIF value) was calculated either based on information reported by countries or using secondary sources (data from the United Nations Comtrade database). M^* was normally calculated as the import price of cigarettes in a country (value of cigarette imports divided by the quantity of cigarette imports for the importing country). However, in exceptional cases where no such data were available (Iraq and Namibia), the export price was considered instead (in the case of Iraq the FOB³ was considered too low so the CIF value was approximated as the export price plus US 10 cents). The ad valorem and other taxes were then calculated in the same way as for local cigarettes, using M^* rather than M as the base, where applicable.

In the case of VAT, in most of the cases the base was P excluding the VAT (or, similarly, the manufacturer's/distributor's price plus all excise taxes). In other words:

$$S_{VAT} = VAT\% \times (1 - S_{VAT}), \text{ equivalent to } \quad ④$$

$$S_{VAT} = VAT\% \div (1 + VAT\%)$$

So in sum, the tax rates are calculated this way:

$$S_{ts} = S_{id} + S_{as} + S_{av} + S_{VAT} \quad ⑤$$

$$S_{as} = T_{as} \div P$$

$$S_{av} = (T_{av}\% \times M) \div P$$

or

$$(T_{av}\% \times M^* \times (1 + S_{id})) \div P^4$$

if the most popular brand was imported

$$S_{id} = (T_{id}\% \times M^*) \div P$$

(if the import duty is value-based)

or

$$ID \div P$$

(if import duty is a specific amount per pack)

$$S_{VAT} = VAT\% \div (1 + VAT\%)$$

4. Prices

Primary collection of price data in this and previous reports involved surveying retail outlets. In order to improve the quality of the prices collected this year, similar to 2012, price data was collected in the following manner:

- In addition to the most sold brand reported in previous years, prices of two additional popular brands were requested.⁵
- For each brand, prices were required from three different types of retail outlets.

Questionnaires sent to data collectors were pre-populated with the names of the three highest selling brands in each country. The three popular brands were identified using data collected from the 2012 questionnaires, from secondary data (Euromonitor⁶) and through WHO's close collaboration with ministries of finance. For the countries where such data were not available, data collectors were asked to indicate the names of the popular brands and provide their prices.

Where brand market shares were available, calculations of average prices and taxes were also done (details in Section 7 below).

The three types of retail outlets were defined as follows:

1. Supermarket/hypermarket: chain or independent retail outlets with a selling space of over 2500 square metres and a primary focus on selling food/beverages/tobacco and

other groceries. Hypermarkets also sell a range of non-grocery merchandise.

2. Kiosk/newsagent/tobacconist/independent food store: small convenience stores, retail outlets selling predominantly food, beverages and tobacco or a combination of these (e.g. kiosk, newsagent or tobacconist) or a wide range of predominantly grocery products (independent food stores or independent small grocers).
3. Street vendors: sell goods in small amounts to consumers but not from a fixed location (not applicable to all countries).

Most sold brands have been used consistently over time to gain a better reflection of the change in prices. However, in some cases where the market share of the brand initially used was considered to have changed substantially, a change was made to the new, more prevalent brand. In 2014,

changes in the brand were made for Bahrain, Kiribati, Marshall Islands, Mongolia, Saint Lucia, Saint Vincent and the Grenadines and Tuvalu.

In all those countries the price of the new brand was lower, except for Mongolia where the shift was made to a more expensive brand. In the case of China, the most sold brand reported changed between 2010 and 2012 to a higher priced brand; this new brand continued to be reported as the most sold brand in 2014.

As in 2012, the price used for each of the 28 countries of the European Union (EU) was the most sold brand collected by WHO. Prior to 2012, price and tax information were taken entirely from the EU's Taxation and Customs Union website for the current report.⁷ The price used by the EU in the past to calculate tax rates was the most popular price category (MPPC), which was assumed to be similar to the most sold brand price category

collected in this report. However, since 2011, the EU calculates and reports tax rates based on the Weighted Average Price (WAP) and therefore information on the MPPC is no longer readily available for EU countries. Consequently, in order to be consistent with past years' estimates and to ensure comparability with other countries, WHO decided in 2012 to collect first hand prices of the most sold brand (the brand was determined based on brand market shares reported from secondary sources) to calculate tax rates. Excise and VAT rates are still collected from the EU published tables. This means, however, that tax shares as computed and reported in this report will not necessarily be similar to the rates published by the EU. This is mainly due to the calculation of the specific excise tax rates as a percentage of the retail price, which will vary depending on the price used.

See details of the difference in price and tax share for the EU countries in the table below.

Comparisons of prices and total tax shares are computed from WHO's most sold brand (MSB) survey and EU weighted average price (WAP).

Country	Total tax share (% of retail price)		Retail price (20 cigarettes)		Currency
	WHO estimates	EU reported rates	WHO reported MSB	EU reported WAP	
Austria	74.00%	76.83%	4.90	4.18	EUR
Belgium	75.92%	77.43%	5.79	4.88	EUR
Bulgaria	82.65%	83.11%	4.70	4.65	BGN
Croatia	75.26%	77.43%	23.00	20.56	HRK
Cyprus	77.47%	76.93%	4.00	4.08	EUR
Czech Republic	77.42%	76.64%	72.00	73.74	CZK
Denmark	74.75%	79.32%	44.00	40.55	DKK
Estonia	77.24%	83.65%	3.50	2.82	EUR
Finland	81.53%	82.54%	5.50	5.01	EUR
France	80.30%	81.37%	7.00	6.50	EUR
Germany	72.90%	75.55%	5.47	5.09	EUR
Greece	79.95%	85.80%	4.00	3.50	EUR
Hungary	77.26%	77.01%	1 000.00	1 010.22	HUF
Ireland	77.80%	80.63%	9.60	9.09	EUR
Italy	75.68%	76.16%	5.00	4.58	EUR
Latvia	76.89%	82.24%	3.00	2.60	EUR
Lithuania	77.64%	79.21%	8.90	8.52	LTL
Luxembourg	70.24%	69.69%	5.00	4.17	EUR
Malta	74.63%	80.81%	4.80	4.07	EUR
Netherlands	73.40%	77.91%	6.32	5.84	EUR
Poland	80.29%	85.01%	13.70	11.85	PLN
Portugal	74.51%	80.51%	4.50	3.90	EUR
Romania	75.41%	81.33%	14.50	12.50	RON
Slovakia	81.54%	79.30%	2.84	3.00	EUR
Slovenia	80.41%	82.08%	3.45	3.31	EUR
Spain	78.09%	79.17%	4.95	4.30	EUR
Sweden	68.84%	77.92%	58.95	49.55	SEK
UK	82.16%	85.69%	7.52	7.01	GBP

Note: WHO estimates pertain to most sold brand prices collected in July 2014. EU reported rates and weighted average prices pertain to data collected by the EU, and are also reported for July 2014.

5. Considerations in interpreting tax share changes

It is important to note that changes in tax as a share of price are not only dependent on tax changes but also on price changes. Therefore, despite an increase in tax, the tax share could remain the same or go down; similarly, sometimes a tax share can increase even if there is no change/increase in the tax.

In the current database, there are cases where taxes increased between 2012 and 2014 but the share of tax as a percentage of the price went down. This is mainly due to the fact that, in absolute terms, the price increase was larger than the tax increase (particularly in the case of specific excise tax increases). For example, in Cook Islands, the specific excise tax increased from 372 NZD per 1000 cigarettes in 2012 to 494 NZD per 1000 cigarettes in 2014 (a 33% increase) while the price of the most sold brand increased from 12 to 19 NZD per pack (a 58% increase). In terms of tax share the excise represented 62% of the price

in 2012 while it represented 52% of the price in 2014. This is because prices rose more than taxes.

On the other hand, there are cases where increases (decreases) in tax as a share of price were mitigated by factors not directly related to tax rates. In the current database, this was attributable to one or more of the following reasons:

- In some instances, the price increased without a tax change, leading to a decrease in the tax share for a specific or mixed excise structure (e.g. Argentina, Ethiopia, Nigeria, Tunisia, Turkmenistan and Viet Nam). In other cases, prices increased above tax increases, leading to a decrease in tax share (e.g. Cook Islands, Costa Rica, Latvia, Montenegro, Nepal and Serbia).
- In the case of imported products, the CIF value is an external variable that also influences the calculation of tax share. This has implications in countries where ad valorem is based on the CIF value, when import duties are applicable on the CIF value or when the VAT is calculated on the base of CIF value + excise rather than VAT exclusive retail price. For example, if the CIF value increases, the base for the application of the tax is higher, leading to a higher tax percentage if nothing else changes. Additionally, as indicated above, for some countries CIF values had to be estimated using secondary data. Those values are provided in US\$ and converted to the local currency, making the exchange rate an additional factor indirectly influencing tax shares. Some examples of countries where these factors influence tax share include: Malawi (increase in CIF value combined with increase in tax but increase in price is larger, leading to a reduction in overall tax share); Cameroon (decrease in exchange rate leading to decrease in tax share); or Liberia (increase in exchange rate but larger increase in price, leading to overall reduction in tax share).

Additionally, care should be taken in relation to countries where the most sold brand changed between 2012 and 2014. This has also had an impact on the tax proportion of the affected countries. In the case of Bahrain, Marshall Islands and St Vincent and the Grenadines, the tax proportion increased despite no tax change,

because of the apparent reduction in prices due to the new, cheaper brand reported as the most sold brand. In the case of Kiribati and St Lucia, while taxes have increased, the tax proportion increased even more because the new brand reported was cheaper. In the case of Mongolia, the tax increased but the tax proportion went down because the new price reported was much higher. Finally, in the case of Tuvalu, the CIF relevant to the new, cheaper price reported was much lower than before, leading to a reduction in the tax proportion.

Finally, when new, improved information was provided in terms of taxation and prices for some countries, corrections were made in the calculations of tax rates for 2008, 2010 and 2012 estimates, as needed.

6. Supplementary tax information (see table 2.3, Appendix II)

An important consideration highlighted in this report is that many aspects of tobacco taxation need to be taken into account in order to assess if a tax policy is well designed. Tax as a proportion of price does not tell the whole story about the effectiveness of a tax policy. To explore other dimensions of tax policy, the current report collected additional information in relation to tobacco taxation and compiled it into data that can inform researchers and policy-makers further on tax policy in different countries. The information was compiled and classified according to three main themes: tax structure/level; affordability and price dispersion; and tax administration. Information was also collected in relation to countries that earmark tobacco taxes to fund health programmes and/or tobacco control activities. The different sets of data/indicators reported under each of the themes were developed and are justified based on evidence provided in the background chapter on tax structure and tax administration.

- Tax structure/level
 - Excise tax proportion of price: higher tax rates and greater reliance on excise is better, particularly when the excise tax is $\geq 70\%$ of retail price.

b. Uniform vs. tiered excise tax system: a uniform excise is easier to administer than a tiered system where variable rates apply based on selected criteria within one tobacco product (not applicable in countries where no excise tax is implemented).

c. Whether a country applies a specific excise or a mixed system relying more on the specific tax component ($>50\%$ of total excise is specific): specific excises typically lead to higher prices and a smaller price gap between different brands, so it is better (not applicable in countries where only ad valorem excise is applicable or where no excise tax is implemented).

d. Base of the ad valorem tax in countries that apply an ad valorem or a mixed excise system. Ad valorem taxes applied to the retail price or the retail price excluding VAT are administratively simpler. The retail price is easier to determine than producer price or CIF value, and therefore there is less risk of undervaluation (not applicable in countries where only specific excise is applicable, or where no excise tax is implemented).

e. If the excise applied is ad valorem or if it is mixed, and whether there is a minimum specific tax. A minimum tax provides protection against products being undervalued. It also forces prices up since the price will not be lower than the tax paid (this category does not apply to countries where only specific excise tax is applicable or where no excise tax is implemented).

II. Affordability and price dispersion

a. Affordability index (% of GDP per capita to buy 100 packs of cigarettes of the most sold brand): across countries, a higher value indicates cigarettes are relatively more expensive in relation to income.

b. Whether cigarettes have become relatively more affordable between 2008 and 2014 (change in the affordability index as measured above, between 2008 and 2014): as affordability decreases, consumption is discouraged.

c. If the excise tax applied is specific or if it is mixed, and whether the specific tax component is automatically adjusted for

inflation. If the specific tax is not adjusted for inflation over time, its impact will be eroded. It is good to have it adjusted automatically (this category does not apply to countries where only ad valorem excise tax is applicable or where no excise tax is implemented).

d. Price dispersion: share of cheapest brand price in premium brand price (cheapest brand price \div premium brand price $\times 100$). The higher the proportion, the smaller the gap and the fewer are the opportunities for substitution to cheaper brands.

III. Tax administration

a. Requirement of tax stamps on tobacco products: tax stamps help administrators ensure that producers and importers comply with tax payment requirements, and help detect illicit tobacco products. A note was made of countries requiring tax stamps to bear special features beyond those found on traditional paper stamps. Specifically, these are encrypted tax stamps that include unique, machine-readable identification markings and can be used to track production in the country through monitoring devices installed in manufacturing facilities that scan the digital stamp, and are also used to detect the presence of illicit products. The devices register a wealth of information that is automatically sent to tax administrators and is useful for tracking and tracing and enforcement work. Similar stamps are also applied on imported products. This is considered best practice for monitoring the market.

b. Duty free imports: banning duty-free imports for personal consumption reduces the chance that these products end up in the illicit market. Additionally, there is no justification for selling a deadly product duty-free; those foregone taxes are a revenue loss for the government. While a few countries ban duty free imports outright, many countries permit them, but limit the quantity that travellers are allowed to bring in. These restrictions can vary by tobacco products; the data reported only refers to limits on cigarette quantities.

Earmarking (portion of taxes or revenues from taxes dedicated to health and/or tobacco control). Taxes can generate substantial revenues. One

way of correcting for the negative externality of tobacco use would be to increase taxes to reduce consumption and fund health care, which is put under strain because of tobacco use and often underfunded (see table 2.4 in Appendix II).

7. Average price and tax estimates (see table 9.7, online Appendix IX)

Data on the most sold brand prices tend to be more readily available across countries; this underlies the decision to use the most sold brand in successive editions of this report. However, an estimation of tax share that best reflects the tax burden within a market would ideally be based on the average price and taxes levied on *all* brands sold in that market.

As in 2012, in addition to collecting and reporting most sold brand prices and tax shares, WHO attempted to estimate country-level average estimates of the tax share based on an estimate of the average price of a pack of cigarettes. This exercise was more complex because of the additional data required on brands, prices and market shares.

Data sources

- For each country, the three most popular brands were identified, and wherever possible, questionnaires were pre-populated using secondary sources or data reported in 2012. The sources were Euromonitor, feedback from the questionnaires and WHO's internal data.
- Brand market share weights used to calculate the average were taken from the same sources.
- The prices of the three brands from the three different types of retail outlets were collected by WHO through regional and country data collectors (nine prices in total for each country).
- Euromonitor provides information on the distribution of cigarettes in 26 different types of outlets. For countries that had Euromonitor data, we selected 10 of these types of outlet, and consolidated them into three groups of retail outlets as defined in Section 4 of this Technical Note. In the few countries where

brand market shares were available but the shares of cigarette sales by type of retail outlet were not available, an approximation was made using the retail distribution of a country with similar attributes (e.g. region, types of products consumed, belonging to the same economic bloc etc.).

Calculation

I. Average price:

First, averages were calculated for each brand weighted by the outlet distribution. In many cases, the outlet share data collected and categorized in the three broad groups did not add up to 100%, reflecting the fact that there are other retail outlet types. So, based on their proportional weight, they were first re-normalized to total 100%. When prices were the same across different stores for any brand in any particular country, equal weights (33.33%) were inputted to all three types of stores. The retail outlet distribution weights were then used to calculate the average price for each brand.

Or:

$$SS_j = \frac{SS_j}{\sum_{j=1}^3 SS_j} * 100\% \quad \textcircled{6}$$

$$AP_i = \sum_{j=1}^3 P_i * SS_j \quad \textcircled{7}$$

Where,

SS_j = Estimated outlet share of all brands in store

type (j) where $\forall j = 1, 2, 3$

ss_j = Reported or estimated outlet share of store type j where $\forall j = 1, 2, 3$

P_i = Reported price of brand (i)

AP_i = Estimated average price of brand (i) where $\forall i = 1, 2, 3$

Once the average prices were obtained for each brand they were multiplied by the brand-specific market share to get the overall average price of cigarettes in the country. It is understood that in most countries more than three brands are consumed, but because of difficulty in collecting prices for all brands, the three most sold brands were identified to calculate the average price. In some countries, two to three brands can capture 80 to 90% of market consumption but in countries

such as China, the three most popular brands represent about 25% of market share. In all cases, the brand market shares of the three most popular brands were re-normalized in order to add up to 100% based on their proportional weight.

$$BS_i = \frac{bs_i}{\sum_{i=1}^3 bs_i} * 100\% \quad \textcircled{8}$$

$$AP = \sum_{i=1}^3 AP_i * BS_i \quad \textcircled{9}$$

Where,

BS_i = Estimated market share of brand (i)

bs_i = Reported or estimated market share of brand (i) where $\forall i=1,2,3$

AP = Estimated average price of a cigarette pack in the country

II. Average tax share

The average tax share was calculated in two steps.

First, the tax share of each brand was calculated separately. This helps account for specificities of each brand (e.g. if a different tax rate applies to different brands or if the brand is imported or not). The price used for each brand was the price weighted by the retail outlet distribution. The method used to calculate the tax share of each brand was the same as for the most sold brand. Then, the overall tax share in any country was obtained by taking the average of the three brands' tax shares. The average tax share was weighted by each brand's market share.

$$etax_{i,n} = \phi (tax_{i,n}, AP_i) \quad \textcircled{10}$$

$$AT_i = \sum_{n=1}^5 etax_{i,n} \quad \textcircled{11}$$

$$AT = \sum_{i=1}^3 AT_i * BS_i \quad \textcircled{12}$$

Where,

$tax_{i,n}$ = Reported tax data by type of tax (n) for brand (i), where $\forall n = 1, \dots, 5$ and $\forall i = 1,2,3$.

The 5 types of tax (n=1,..., 5) are: specific excise, ad valorem excise, import duty, value added or sales tax, and other taxes.

$etax_{i,n}$ = Estimated total rate of type n for brand (i); a function of average price APi

ATi = Estimated average total share of brand (i)

AT = Overall average tax share estimated for any particular country.

APi and BSi defined in formulas (7) and (8) above.

¹ This formula applies when the ad valorem tax is applied on the manufacturer's/distributor's price, the import duty is applied on the manufacturer's/distributor's price of the CIF value and the VAT is applied on the VAT-exclusive retail price. Other scenarios exist (e.g. ad valorem rate applies on the retail price) but they are not described here because they are usually more straightforward to calculate.

² Import duties may vary depending on the country of origin in cases of preferential trade agreements. WHO tried to determine the origin of the pack and relevance of using such rates where possible.

³ "Free On Board" or "Freight On Board": value of a product at export.

⁴ Or $(Tax \% \times M^*) \div P$, if the ad valorem tax was applied only on the CIF value, not the CIF value + the import duty.

⁵ The brands are used for internal purposes for data validation and are not published in the report.

⁶ Euromonitor International's Passport, 2012.

⁷ See http://ec.europa.eu/taxation_customs/taxation/excise_duties/tobacco_products/rates/index_en.htm



APPENDIX I: REGIONAL SUMMARY OF MPOWER MEASURES

Appendix I provides an overview of selected tobacco control policies. For each WHO region an overview table is presented that includes information on monitoring and prevalence, smoke-free environments, treatment of tobacco dependence, health warnings and packaging, advertising, promotion and sponsorship bans, and taxation levels, based on the methodology outlined in Technical Note I.

Country-level data were often but not always provided with supporting documents such as laws, regulations, policy documents, etc. Available documents were assessed by WHO and this appendix provides summary measures or indicators of country achievements for each of the six MPOWER measures. It is important to note that data for the report are based on existing legislation and reflect the status of adopted but not necessarily implemented legislation, as long as the law clearly indicates a date of entry into force and is not undergoing a legal challenge. The summary measures

developed for the *WHO report on the global tobacco epidemic, 2015* are the same as those used for the 2013 report. The methodology used to calculate each indicator is described in Technical Note I. This review, however, does not constitute a thorough and complete legal analysis of each country's legislation. Except for smoke-free environments and bans on tobacco advertising, promotion and sponsorship, data were collected at the national/federal level only and, therefore, provide incomplete policy coverage for Member States where subnational governments play an active role in tobacco control.

Daily smoking prevalence for the population aged 15 and over in 2013 is an indicator modelled by WHO from tobacco use surveys published by Member States. Tobacco smoking is one of the most widely reported indicators in country surveys. The calculation of WHO estimates to allow international comparison is described in Technical Note II.

South-East Asia

Table 1.3
Summary of
MPOWER measures

... Data not reported/not available.
- Data not required/not applicable.

2014 INDICATOR AND COMPLIANCE

COUNTRY	ADULT DAILY SMOKING PREVALENCE (2013)	M MONITORING	P SMOKE-FREE POLICIES <small>LINES REPRESENT LEVEL OF COMPLIANCE</small>	O CESSATION PROGRAMMES	W WARNINGS		E ADVERTISING BANS <small>LINES REPRESENT LEVEL OF COMPLIANCE</small>	R TAXATION
					HEALTH WARNINGS	MASS MEDIA		
Bangladesh	20%		||||				|||||||	76%
Bhutan	...		|||||||				|||||||	—
Democratic People's Republic of Korea	...		||||				—	0%
India	11%		|||| ☆				|||||	60%
Indonesia	33%		|				—	53%
Maldives	...		||||				|||||	66%
Myanmar	16%		||||				|||||	50%
Nepal	18%		|||||||				|||||||	28%
Sri Lanka	11%		||||				|||||	74%
Thailand	18%		||||				|||||||	73%
Timor-Leste	...						—	34%

CHANGE SINCE 2012

P SMOKE-FREE POLICIES	O CESSATION PROGRAMMES	W HEALTH WARNINGS	E ADVERTISING BANS	R TAXATION
CHANGE IN POWER INDICATOR GROUP, UP OR DOWN, SINCE 2012				
		▲		▲
	▲			
		▲		▲
▲	▲			
			▲	

ADULT DAILY SMOKING PREVALENCE*: AGE-STANDARDIZED PREVALENCE RATES FOR ADULT DAILY SMOKERS OF TOBACCO (BOTH SEXES COMBINED), 2013

...	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 July 2012 and June 2014 with duration of at least three weeks
	National campaign conducted with 1–4 appropriate characteristics
	National campaign conducted with 5–6 appropriate characteristics, or with 7 characteristics excluding airing on television and/or radio
	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 in at least one of the assessed public places if they are separately ventilated to the outside and/or kept under negative air pressure in relation to the surrounding areas.
- ▲▼ Change in POWER indicator group, up or down, between 2012 and 2014. Some 2012 data were revised in 2014. 2014 grouping rules were applied to both years.

Refer to Technical Note 1 for definitions of categories



2014 INDICATOR AND COMPLIANCE

Table 1.6
Summary of MPOWER measures

... Data not reported/not available.
 - Data not required/not applicable.

COUNTRY	ADULT DAILY SMOKING PREVALENCE (2013)	M MONITORING	P SMOKE-FREE POLICIES <small>LINES REPRESENT LEVEL OF COMPLIANCE</small>	O CESSATION PROGRAMMES	W WARNINGS		E ADVERTISING BANS <small>LINES REPRESENT LEVEL OF COMPLIANCE</small>	R TAXATION
					HEALTH WARNINGS	MASS MEDIA		
Australia	14%		|||||				...	57%
Brunei Darussalam	13%		|||||				|||||	62%
Cambodia	20%		—				||||	22%
China	22%		||||				||||	44%
Cook Islands	...		||||				|||||	61%
Fiji	18%		||||				|||||	44%
Japan	18%		—				—	64%
Kiribati	46%		|||||				|||||	89%
Lao People's Democratic Republic	29%		||||				|||||	17%
Malaysia	18%		—				|||||	55%
Marshall Islands	...		|||||				|||||	59%
Micronesia (Federated States of)	...		|||||				—	63%
Mongolia	23%		|||||				|||||	42%
Nauru	40%		||||				|||||	...
New Zealand	16%		...				...	77%
Niue	12%		—				—	70%
Palau	...		|||||				|||||	67%
Papua New Guinea	...		||||				||||	36%
Philippines	21%		||||		⊙		|||||	74%
Republic of Korea	26%		|||||				...	62%
Samoa	24%		|||||				|||||	55%
Singapore	13%		... ☆				...	66%
Solomon Islands	...		||		⊙		|||||	29%
Tonga	26%		|||||				|||||	72%
Tuvalu	...		|||||				|||||	3%
Vanuatu	...		—				||||	52%
Viet Nam	19%		||||				|||||	42%

CHANGE SINCE 2012

P SMOKE-FREE POLICIES	O CESSATION PROGRAMMES	W HEALTH WARNINGS	E ADVERTISING BANS	R TAXATION
CHANGE IN POWER INDICATOR GROUP, UP OR DOWN SINCE 2012				
▲	▲			
	▲			
		▲		
			▲	
▲	▲	▲	▲	▲
	▼			
				▲
	▲			
				▲
	▲	▲		
		▲		
		▲		

ADULT DAILY SMOKING PREVALENCE*: AGE-STANDARDIZED PREVALENCE RATES FOR ADULT DAILY SMOKERS OF TOBACCO (BOTH SEXES COMBINED), 2013

...	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 July 2012 and June 2014 with duration of at least three weeks
	National campaign conducted with 1–4 appropriate characteristics
	National campaign conducted with 5–6 appropriate characteristics, or with 7 characteristics excluding airing on television and/or radio
	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 in at least one of the assessed public places if they are separately ventilated to the outside and/or kept under negative air pressure in relation to the surrounding areas.
- ⊙ Policy adopted but not implemented by 31 December 2014.
- ▲▼ Change in POWER indicator group, up or down, between 2012 and 2014. Some 2012 data were revised in 2014. 2014 grouping rules were applied to both years.

Refer to Technical Note I for definitions of categories





APPENDIX II: TOBACCO TAXES AND PRICES

Appendix II provides detailed information on tobacco taxes and prices in WHO Member States for each WHO region. Data in this appendix were primarily provided by Member States and were reviewed by WHO; calculations of comparable tax rates were performed by WHO. The following data are reported in this appendix:

- The share of total and excise taxes in the price of the most sold brand of cigarettes, based on tax policy information collected at country level. Figures published in this appendix were calculated by WHO based on data submitted by countries. Because of the calculations and assumptions made in some cases, the figures in the report and those submitted by countries as statutory tax rates are not identical.

- The price of Marlboro or equivalent premium brand as well as the cheapest brand price found in countries.
- Supplementary information on tobacco taxation are compiled in three main themes: tax structure/level; affordability and price dispersion; and tax administration.
- Information in relation to countries that earmark tobacco taxes or tax revenues to fund health programmes and/or tobacco control activities.

Please refer to Technical Note III for detailed description of the methodology used by WHO to produce the data in this appendix.

Africa

Table 2.1.1
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in Africa, 2014

+ Total tax includes excise taxes, import duties, VAT and other taxes as applicable.

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.

... Data not reported /not available.

COUNTRY
Algeria
Angola
Benin
Botswana **
Burkina Faso
Burundi
Cabo Verde
Cameroon
Central African Republic
Chad **
Comoros
Congo **
Côte d'Ivoire **
Democratic Republic of the Congo
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia **
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho **
Liberia
Madagascar **
Malawi **
Mali
Mauritania **
Mauritius **
Mozambique **
Namibia **
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal **
Seychelles
Sierra Leone **
South Africa **
South Sudan
Swaziland **
Togo **
Uganda **
United Republic of Tanzania **
Zambia
Zimbabwe **

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED *	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX +
85.00	DZD	1.43	1.08	38.14%	0.00%	12.65%	0.00%	0.00%	50.79%
200.00	AOA	2.18	2.06	0.00%	0.00%	22.90%	0.00%	0.76%	23.66%
500.00	XOF	2.04	1.02	0.00%	5.38%	2.42%	0.00%	0.94%	8.74%
27.33	BWP	7.10	3.08	42.44%	9.53%	10.71%	0.00%	0.00%	62.68%
500.00	XOF	2.21	1.02	0.00%	16.95%	15.25%	0.00%	0.00%	32.20%
1 600.00	BIF	2.05	1.03	27.50%	0.00%	15.25%	0.00%	0.00%	42.75%
180.00	CVE	2.45	2.18	0.00%	12.32%	9.24%	0.00%	0.31%	21.87%
500.00	XAF	1.92	1.02	0.00%	6.69%	6.44%	6.18%	1.34%	20.65%
500.00	XOF	1.59	1.02	0.00%	16.81%	15.97%	0.00%	0.00%	32.77%
700.00	XAF	2.87	1.43	0.00%	20.00%	11.88%	0.00%	2.09%	33.97%
500.00	KMF	1.84	1.36	0.00%	37.73%	9.09%	3.14%	1.41%	51.38%
600.00	XAF	1.87	1.22	6.67%	14.19%	15.25%	0.00%	4.76%	40.87%
700.00	XOF	2.17	1.43	0.00%	15.18%	10.93%	0.00%	0.00%	26.11%
750.00	CDF	1.34	0.81	13.55%	10.21%	13.79%	10.21%	0.00%	47.76%
500.00	XOF	1.18	1.02	0.00%	22.06%	8.60%	13.24%	0.44%	44.35%
60.00	ERN	4.67	3.90	0.00%	44.64%	10.71%	0.00%	0.00%	55.36%
15.00	ETB	1.91	0.76	0.00%	13.90%	4.87%	0.00%	0.00%	18.77%
1 000.00	XAF	3.21	2.04	0.00%	19.56%	15.25%	0.00%	0.00%	34.81%
30.00	GMD	3.26	0.71	30.00%	0.00%	6.56%	2.29%	6.90%	45.75%
2.50	GHS	2.29	0.82	0.00%	13.20%	14.89%	0.00%	0.22%	28.31%
...
300.00	XOF	1.40	0.61	0.00%	3.28%	13.04%	2.07%	0.72%	19.11%
100.00	KES	1.95	1.14	0.00%	35.00%	13.79%	0.00%	0.00%	48.79%
34.99	LSL	6.47	3.27	33.15%	0.00%	13.04%	0.00%	0.00%	46.20%
79.12	LRD	...	0.90	0.00%	10.86%	6.54%	1.48%	0.15%	19.03%
2 500.00	MGA	2.26	1.01	0.00%	63.78%	16.67%	0.00%	0.00%	80.45%
800.00	MWK	7.43	2.01	14.53%	0.00%	4.09%	2.06%	0.00%	20.68%
1 000.00	XOF	3.37	2.04	0.00%	6.70%	6.80%	5.07%	0.63%	19.20%
500.00	MRO	3.31	1.74	0.00%	8.26%	12.28%	3.58%	0.55%	24.67%
125.00	MUR	6.98	4.10	59.47%	0.00%	13.04%	0.00%	0.00%	72.52%
30.00	MZN	1.76	0.98	16.33%	0.00%	14.53%	0.00%	0.00%	30.86%
40.00	NAD	5.74	3.74	29.00%	0.00%	3.80%	0.00%	0.00%	32.80%
500.00	XOF	1.86	1.02	0.00%	11.11%	15.97%	0.00%	0.83%	27.91%
265.00	NGN	2.74	1.71	0.00%	15.87%	4.76%	0.00%	0.00%	20.63%
650.00	RWF	2.12	0.95	0.00%	17.42%	5.23%	0.00%	0.00%	22.64%
20 000.00	STD	1.39	1.09	0.00%	18.33%	0.00%	6.67%	0.00%	25.00%
400.00	XOF	1.47	0.82	0.00%	25.00%	15.25%	0.00%	0.00%	40.25%
75.00	SCR	10.64	6.09	66.67%	0.00%	13.04%	0.00%	0.00%	79.71%
3 500.00	SLL	1.51	0.78	0.00%	6.76%	13.04%	0.00%	0.11%	19.91%
31.76	ZAR	5.36	2.97	36.52%	0.00%	12.28%	0.00%	0.00%	48.80%
...
35.00	SZL	6.54	3.27	33.14%	0.00%	20.00%	0.00%	0.00%	53.14%
400.00	XOF	1.36	0.82	0.00%	8.26%	4.79%	0.00%	0.36%	13.41%
2 000.00	UGX	1.73	0.76	35.00%	0.00%	10.08%	0.00%	0.00%	45.08%
3 700.00	TZS	5.41	2.24	14.43%	0.00%	15.25%	0.00%	0.00%	29.69%
9.00	ZMW	1.80	1.47	0.00%	20.00%	1.36%	0.00%	0.00%	21.36%
1.30	USD	1.05	1.30	23.08%	23.95%	13.04%	0.00%	0.00%	60.08%



The Americas

Table 2.1.2
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in the Americas, 2014

* Total tax includes excise taxes, import duties, VAT and other taxes as applicable.
* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).
** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.
... Data not reported /not available.

COUNTRY
Antigua and Barbuda
Argentina
Bahamas**
Barbados
Belize
Bolivia
Brazil**
Canada ^{1**}
Chile**
Colombia**
Costa Rica**
Cuba
Dominica
Dominican Republic**
Ecuador**
El Salvador
Grenada
Guatemala
Guyana
Haiti
Honduras**
Jamaica
Mexico
Nicaragua**
Panama
Paraguay
Peru
Saint Kitts and Nevis
Saint Lucia**
Saint Vincent and the Grenadines
Suriname
Trinidad and Tobago
United States of America ^{2,3**}
Uruguay**
Venezuela (Bolivarian Republic of)

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED*	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX*
8.00	XCD	3.99	2.96	0.00%	0.00%	13.04%	5.56%	1.59%	20.19%
14.50	ARS	3.42	1.77	0.00%	64.33%	5.51%	0.00%	0.00%	69.84%
7.00	BSD	9.41	7.00	42.86%	0.00%	0.00%	0.00%	0.00%	42.86%
13.85	BBD	11.30	6.93	27.15%	0.00%	14.89%	0.00%	0.00%	42.04%
5.00	BZD	4.78	2.50	0.00%	0.00%	11.11%	0.00%	26.00%	37.11%
10.00	BOB	2.74	1.45	0.00%	27.31%	13.04%	0.00%	0.00%	40.35%
5.75	BRL	2.75	2.54	20.87%	8.10%	25.00%	0.00%	10.97%	64.94%
9.25	CAD	7.50	8.49	60.93%	0.00%	8.87%	0.00%	0.00%	69.80%
2 500.00	CLP	5.98	4.38	4.35%	60.50%	15.97%	0.00%	0.00%	80.81%
2 479.00	COP	1.82	1.32	25.65%	10.00%	13.79%	0.00%	0.00%	49.44%
1 600.00	CRC	3.85	2.97	27.38%	30.88%	11.50%	0.00%	0.00%	69.76%
...
4.25	XCD	3.19	1.57	10.35%	0.00%	13.04%	0.00%	0.00%	23.40%
150.00	DOP	5.93	3.43	26.67%	16.95%	15.25%	0.00%	0.00%	58.87%
3.10	USD	5.14	3.10	59.68%	0.00%	10.71%	0.00%	0.00%	70.39%
2.00	USD	3.85	0.23	22.50%	18.52%	11.50%	0.00%	0.00%	52.52%
7.50	XCD	4.93	2.78	0.00%	32.76%	13.04%	0.00%	1.95%	47.76%
16.00	GTQ	2.98	2.05	0.00%	38.27%	10.71%	0.00%	0.00%	48.98%
300.00	GYD	3.11	1.45	0.00%	11.40%	13.79%	0.00%	0.00%	25.19%
...
36.00	HNL	3.56	1.72	21.51%	0.00%	15.25%	0.00%	0.00%	36.76%
800.00	JMD	13.00	7.10	26.25%	0.00%	14.16%	0.00%	2.52%	42.94%
45.00	MXN	5.08	3.45	15.56%	36.52%	13.79%	0.00%	0.00%	65.87%
39.00	NIO	3.70	1.50	19.23%	0.00%	13.04%	0.00%	0.00%	32.27%
4.25	PAB	6.40	4.25	0.00%	43.48%	13.04%	0.00%	0.00%	56.52%
1 500.00	PYG	0.54	0.35	0.00%	6.91%	9.09%	0.00%	0.00%	16.00%
6.20	PEN	3.81	2.22	22.58%	0.00%	15.25%	0.00%	0.00%	37.83%
8.00	XCD	3.55	2.96	0.00%	4.03%	14.53%	0.00%	1.21%	19.76%
7.25	XCD	4.40	2.69	48.55%	0.00%	13.04%	0.00%	1.29%	62.88%
5.00	XCD	3.44	1.85	2.20%	0.00%	13.04%	0.00%	1.52%	16.76%
9.00	SRD	3.88	2.73	48.40%	0.00%	6.97%	0.00%	0.42%	55.79%
23.00	TTD	3.51	3.60	16.57%	0.00%	13.04%	0.00%	0.00%	29.61%
6.23	USD	6.23	6.23	37.38%	0.00%	5.16%	0.00%	0.00%	42.54%
78.00	UYU	3.62	3.35	48.72%	0.00%	18.03%	0.00%	0.00%	66.75%
90.00	VEF	15.13	14.32	0.00%	67.57%	3.47%	0.00%	0.00%	71.04%

NOTES

¹ Subnational rates and national excise taxation rates have been used by WHO to reflect an average Canadian taxation rate. Consequently, the reported taxation rates will be different to the posted tax rates. The price is a sales-weighted average of the price in Canada for the most sold brand.
² The price is a sales-weighted average of state prices, the taxes include the federal taxes and a state tax sales-weighted average.
³ Data not approved by national authorities.



South-East Asia

Table 2.1.3
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in South-East Asia, 2014

+ Total tax includes excise taxes, import duties, VAT and other taxes as applicable.

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.

... Data not reported /not available.

— Data not required/not applicable.

COUNTRY
Bangladesh **
Bhutan ¹
Democratic People's Republic of Korea
India **
Indonesia**
Maldives
Myanmar
Nepal **
Sri Lanka **
Thailand **
Timor-Leste

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED *	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX +
70.00	BDT	1.93	0.90	0.00%	61.00%	15.00%	0.00%	0.00%	76.00%
—	—	—	—	—	—	—	—	—	—
246.38	KPW	...	2.51	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
106.00	INR	4.50	1.76	42.45%	1.27%	16.67%	0.00%	0.00%	60.39%
18 333.33	IDR	2.51	1.58	40.91%	4.09%	8.40%	0.00%	0.00%	53.40%
38.00	MVR	3.18	2.47	0.00%	0.00%	0.00%	65.79%	0.00%	65.79%
650.00	MMK	1.28	0.67	0.00%	50.00%	0.00%	0.00%	0.00%	50.00%
132.00	NPR	3.02	1.37	16.29%	0.00%	11.50%	0.00%	0.00%	27.79%
600.00	LKR	9.24	4.61	59.15%	3.91%	10.71%	0.00%	0.00%	73.78%
65.00	THB	3.66	2.03	2.86%	63.72%	6.54%	0.00%	0.00%	73.13%
1.25	USD	6.25	1.25	30.40%	0.00%	2.44%	0.67%	0.00%	33.51%

NOTES

¹ It is illegal to sell cigarettes in Bhutan.



Europe

Table 2.1.4
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in Europe, 2014

* Total tax includes excise taxes, import duties, VAT and other taxes as applicable.
* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).
** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.
... Data not reported /not available.

COUNTRY
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 of Great Britain and Northern Ireland **
Uzbekistan **

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED *	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX *
200.00	ALL	3.87	1.93	45.00%	0.00%	16.67%	2.42%	0.00%	64.08%
3.50	EUR	...	4.68	63.88%	0.00%	4.31%	0.00%	0.00%	68.18%
600.00	AMD	2.74	1.48	16.67%	0.00%	16.67%	0.00%	0.00%	33.33%
4.90	EUR	5.63	6.56	16.33%	41.00%	16.67%	0.00%	0.00%	74.00%
1.40	AZN	2.49	1.79	2.02%	0.00%	15.25%	0.03%	0.00%	17.30%
14 500.00	BYR	2.80	1.41	34.48%	0.00%	16.67%	0.00%	0.00%	51.15%
5.79	EUR	6.44	7.75	8.15%	50.41%	17.36%	0.00%	0.00%	75.92%
3.70	BAM	4.50	2.53	24.32%	42.00%	14.53%	1.48%	0.00%	82.33%
4.70	BGN	6.44	3.21	42.98%	23.00%	16.67%	0.00%	0.00%	82.65%
23.00	HRK	5.50	4.04	18.26%	37.00%	20.00%	0.00%	0.00%	75.26%
4.00	EUR	5.47	5.35	27.50%	34.00%	15.97%	0.00%	0.00%	77.47%
72.00	CZK	5.32	3.49	33.06%	27.00%	17.36%	0.00%	0.00%	77.42%
44.00	DKK	5.06	7.89	53.75%	1.00%	20.00%	0.00%	0.00%	74.75%
3.50	EUR	5.51	4.68	26.57%	34.00%	16.67%	0.00%	0.00%	77.24%
5.50	EUR	5.49	7.36	10.18%	52.00%	19.35%	0.00%	0.00%	81.53%
7.00	EUR	7.76	9.37	13.93%	49.70%	16.67%	0.00%	0.00%	80.30%
2.20	GEL	2.22	1.26	34.09%	0.00%	15.25%	0.00%	0.00%	49.35%
5.47	EUR	6.45	7.32	35.19%	21.74%	15.97%	0.00%	0.00%	72.90%
4.00	EUR	5.95	5.35	41.25%	20.00%	18.70%	0.00%	0.00%	79.95%
1 000.00	HUF	6.78	4.29	25.00%	31.00%	21.26%	0.00%	0.00%	77.26%
1 219.00	ISK	8.89	10.59	36.08%	0.00%	20.32%	0.00%	0.00%	56.40%
9.60	EUR	11.16	12.84	50.38%	8.72%	18.70%	0.00%	0.00%	77.80%
30.00	ILS	7.78	8.75	26.60%	42.43%	15.25%	0.00%	0.00%	84.28%
5.00	EUR	5.82	6.69	5.24%	52.41%	18.03%	0.00%	0.00%	75.68%
210.00	KZT	1.42	1.15	28.57%	0.00%	10.71%	0.00%	0.00%	39.29%
35.00	KGS	1.42	0.68	16.00%	8.00%	10.71%	3.83%	0.00%	38.54%
3.00	EUR	7.14	4.01	34.53%	25.00%	17.36%	0.00%	0.00%	76.89%
9.40	LTL	5.34	3.65	33.40%	25.00%	17.36%	0.00%	0.00%	75.76%
5.00	EUR	4.71	6.69	7.10%	48.14%	15.00%	0.00%	0.00%	70.24%
4.80	EUR	7.77	6.42	34.38%	25.00%	15.25%	0.00%	0.00%	74.63%
...
1.30	EUR	2.96	1.74	26.92%	35.00%	15.97%	0.00%	0.00%	77.89%
6.32	EUR	7.40	8.46	55.09%	0.95%	17.36%	0.00%	0.00%	73.40%
97.90	NOK	8.99	15.59	48.83%	0.00%	20.00%	0.00%	0.00%	68.83%
13.70	PLN	6.87	4.41	30.18%	31.41%	18.70%	0.00%	0.00%	80.29%
4.50	EUR	6.70	6.02	38.81%	17.00%	18.70%	0.00%	0.00%	74.51%
15.00	MDL	1.91	1.08	10.00%	24.00%	16.67%	0.00%	0.00%	50.67%
14.50	RON	6.46	4.39	37.06%	19.00%	19.35%	0.00%	0.00%	75.41%
67.00	RUB	2.42	1.88	23.88%	8.50%	15.25%	0.00%	0.00%	47.63%
4.50	EUR	4.68	6.02	0.00%	74.17%	0.00%	0.00%	0.00%	74.17%
170.00	RSD	3.72	1.95	28.25%	33.00%	16.67%	0.00%	0.00%	77.92%
2.84	EUR	5.28	3.80	41.87%	23.00%	16.67%	0.00%	0.00%	81.54%
3.45	EUR	5.66	4.62	39.37%	23.01%	18.03%	0.00%	0.00%	80.41%
4.95	EUR	6.82	6.62	9.74%	51.00%	17.36%	0.00%	0.00%	78.09%
58.95	SEK	6.50	8.55	47.84%	1.00%	20.00%	0.00%	0.00%	68.84%
8.40	CHF	5.21	9.24	28.79%	25.00%	7.41%	0.00%	0.00%	61.20%
5.00	TJS	2.26	1.01	2.66%	0.00%	15.25%	7.97%	0.00%	25.88%
60.00	MKD	2.85	1.31	48.33%	9.00%	15.25%	0.00%	0.00%	72.59%
8.00	TRY	5.61	3.82	1.63%	65.25%	15.25%	0.00%	0.00%	82.13%
11.65	TMT	5.25	4.09	0.00%	12.23%	13.04%	0.83%	0.00%	26.11%
9.00	UAH	2.09	0.74	48.11%	10.00%	16.67%	0.00%	0.00%	74.78%
7.52	GBP	11.00	12.69	48.99%	16.50%	16.67%	0.00%	0.00%	82.16%
2 200.00	UZS	1.92	0.94	15.86%	0.00%	16.67%	0.00%	0.00%	32.53%



Eastern Mediterranean

Table 2.1.5
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in the Eastern Mediterranean, 2014

* Total tax includes excise taxes, import duties, VAT and other taxes as applicable.

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.

... Data not reported /not available.

< Refers to a territory.

COUNTRY
Afghanistan
Bahrain
Djibouti
Egypt **
Iran (Islamic Republic of)
Iraq
Jordan **
Kuwait
Lebanon
Libya
Morocco **
Oman
Pakistan **
Qatar
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
West Bank and Gaza Strip ¹ <**
Yemen **

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED *	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX *
20.00	AFN	0.59	0.35	0.00%	0.00%	0.00%	2.78%	0.00%	2.78%
0.50	BHD	1.71	1.33	0.00%	0.00%	0.00%	40.00%	0.00%	40.00%
200.00	DJF	1.92	1.13	0.00%	26.34%	2.31%	0.00%	0.00%	28.65%
8.00	EGP	2.31	1.12	23.13%	50.00%	0.00%	0.00%	0.00%	73.13%
22 000.00	IRR	1.94	0.84	0.00%	0.00%	2.41%	0.00%	2.42%	4.83%
500.00	IQD	0.48	0.43	0.00%	0.00%	0.00%	19.24%	0.00%	19.24%
1.20	JOD	1.95	1.69	69.50%	0.00%	13.79%	0.00%	0.00%	83.29%
0.75	KWD	2.34	2.65	0.00%	0.00%	0.00%	34.72%	0.00%	34.72%
3 250.00	LBP	3.22	2.16	0.00%	32.61%	9.09%	1.51%	0.00%	43.21%
3.00	LYD	2.69	2.38	0.00%	0.00%	1.04%	0.00%	7.33%	8.37%
19.50	MAD	3.92	2.34	34.56%	20.63%	15.26%	0.00%	0.00%	70.46%
0.90	OMR	2.84	2.34	0.00%	0.00%	0.00%	22.22%	0.00%	22.22%
47.00	PKR	1.10	0.48	46.17%	0.00%	14.53%	0.00%	0.00%	60.70%
10.00	QAR	2.76	2.75	0.00%	0.00%	0.00%	20.00%	0.00%	20.00%
10.00	SAR	3.42	2.67	0.00%	0.00%	0.00%	20.00%	0.00%	20.00%
...
14.00	SDG	3.35	2.46	0.00%	57.90%	14.53%	0.00%	0.00%	72.43%
...
2.55	TND	3.47	1.48	40.20%	26.19%	8.21%	0.00%	0.00%	74.60%
10.00	AED	1.90	2.72	0.00%	0.00%	0.00%	20.00%	0.00%	20.00%
22.00	ILS	...	6.42	36.27%	33.26%	13.10%	0.00%	0.00%	82.63%
280.00	YER	1.91	1.30	6.43%	0.00%	47.37%	0.00%	0.00%	53.80%

NOTES

¹ Data apply only to West Bank.



Western Pacific

Table 2.1.6
National taxes and retail price for a pack of 20 cigarettes of the most sold brand in the Western Pacific, 2014

+ Total tax includes excise taxes, import duties, VAT and other taxes as applicable.
* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).
** The country has increased tobacco excises since 2012; however, due to price variability the effect is not necessarily apparent in the tax indicators.
... Data not reported /not available.

COUNTRY
Australia **
Brunei Darussalam
Cambodia**
China
Cook Islands
Fiji**
Japan **
Kiribati **
Lao People's Democratic Republic
Malaysia **
Marshall Islands
Micronesia (Federated States of)
Mongolia **
Nauru
New Zealand **
Niue
Palau **
Papua New Guinea
Philippines **
Republic of Korea
Samoa
Singapore **
Solomon Islands **
Tonga **
Tuvalu
Vanuatu
Viet Nam

PRICE OF A 20-CIGARETTE PACK OF THE MOST SOLD BRAND				TAXES AS A % OF PRICE OF THE MOST SOLD BRAND					
IN REPORTED CURRENCY	CURRENCY REPORTED *	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	SPECIFIC EXCISE	AD VALOREM EXCISE	VALUE ADDED TAX/SALES TAX	IMPORT DUTIES	OTHER TAXES	TOTAL TAX +
17.05	AUD	10.99	15.90	47.67%	0.00%	9.09%	0.00%	0.00%	56.76%
8.10	BND	8.79	6.52	61.73%	0.00%	0.00%	0.00%	0.00%	61.73%
1 800.00	KHR	1.12	0.44	0.00%	13.15%	9.09%	0.00%	0.00%	22.24%
10.00	CNY	2.33	1.62	0.60%	29.30%	14.53%	0.00%	0.00%	44.43%
19.00	NZD	...	16.12	52.00%	0.00%	8.81%	0.00%	0.00%	60.81%
7.80	FJD	4.56	4.21	31.05%	0.00%	13.04%	0.00%	0.00%	44.09%
430.00	JPY	4.22	4.18	56.95%	0.00%	7.41%	0.00%	0.00%	64.36%
2.70	AUD	10.55	2.52	77.78%	0.00%	11.11%	0.00%	0.00%	88.89%
8 000.00	LAK	1.93	0.99	6.25%	1.43%	9.09%	0.00%	0.48%	17.25%
12.00	MYR	6.22	3.76	41.67%	8.93%	4.76%	0.00%	0.00%	55.36%
2.14	USD	5.98	2.14	0.00%	0.00%	11.93%	46.73%	0.00%	58.66%
2.12	USD	4.83	2.12	0.00%	0.00%	25.00%	37.74%	0.00%	62.74%
2 700.00	MNT	2.50	1.44	33.26%	0.00%	9.09%	0.00%	0.00%	42.35%
...
17.00	NZD	10.22	14.43	64.16%	0.00%	13.04%	0.13%	0.00%	77.34%
12.00	NZD	...	10.18	0.00%	0.00%	11.11%	50.35%	8.34%	69.80%
5.25	USD	8.69	5.25	66.67%	0.00%	0.00%	0.00%	0.00%	66.67%
16.00	PGK	8.63	6.54	26.42%	0.00%	9.09%	0.00%	0.00%	35.51%
26.75	PHP	1.03	0.62	63.55%	0.00%	10.71%	0.00%	0.00%	74.27%
2 500.00	KRW	3.14	2.43	52.90%	0.00%	9.09%	0.00%	0.00%	61.99%
9.50	WST	7.05	4.13	42.32%	0.00%	13.04%	0.00%	0.00%	55.36%
13.00	SGD	12.31	10.44	59.69%	0.00%	6.54%	0.00%	0.00%	66.23%
30.08	SBD	7.01	4.13	19.15%	0.00%	10.00%	0.00%	0.00%	29.15%
8.50	TOP	8.30	4.68	58.82%	0.00%	13.04%	0.00%	0.00%	71.87%
2.50	AUD	2.50	2.33	0.00%	2.26%	0.11%	0.31%	0.01%	2.68%
720.00	VUV	11.90	7.56	44.44%	0.00%	6.12%	1.60%	0.00%	52.17%
18 730.00	VND	1.80	0.88	0.00%	32.50%	9.09%	0.00%	0.00%	41.59%



Africa

Table 2.2.1
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in Africa, 2014

* According to International Organization for Standardization, ISO 4217
currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

COUNTRY
Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cabo Verde
Cameroon
Central African Republic
Chad
Comoros
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
South Africa
South Sudan
Swaziland
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
DZD	150.00	2.53	1.91	50.00	0.84	0.64
AOA	200.00	2.18	2.06	150.00	1.63	1.54
XOF	...	...	...	200.00	0.81	0.41
BWP	27.33	7.10	3.08	...	...	...
XOF	600.00	2.65	1.22	300.00	1.33	0.61
BIF	6 000.00	7.69	3.88	1 600.00	2.05	1.03
CVE	250.00	3.40	3.03	...	...	...
XAF	1 100.00	4.21	2.24	300.00	1.15	0.61
XAF	2 000.00	6.37	4.08	300.00	0.95	0.61
XAF	1 000.00	4.11	2.04	500.00	2.05	1.02
KMF	1 250.00	4.61	3.40	225.00	0.83	0.61
XAF	1 150.00	3.59	2.35	400.00	...	0.82
XOF	800.00	2.48	1.63	475.00	1.48	0.97
CDF	2 600.00	4.64	2.81	550.00	0.98	0.60
...
ERN	200.00	15.58	13.01	40.00	3.12	2.60
ETB	40.00	5.10	2.04	5.00	0.64	0.25
...
GMD	40.00	4.35	0.95	10.00	1.09	0.24
GHS	6.00	5.50	1.98	1.00	0.92	0.33
...
XOF	600.00	2.79	1.22	...	...	...
KES	200.00	3.89	2.28	60.00	1.17	0.68
LSL	...	...	...	30.00	5.55	2.80
LRD	79.12	...	0.90	26.68	...	0.30
MGA	10 000.00	9.04	4.06	1 550.00	1.40	0.63
MWK	1 200.00	11.14	3.01	400.00	3.71	1.00
XOF	700.00	2.36	1.43	250.00	0.84	0.51
MRO	500.00	3.31	1.74	200.00	1.33	0.70
MUR	155.00	8.66	5.09	90.00	5.03	2.96
MZN	80.00	4.70	2.62	30.00	1.76	0.98
NAD	38.00	5.46	3.55	17.00	2.44	1.59
XOF	1 500.00	5.57	3.06	250.00	0.93	0.51
...
RWF	1 000.00	3.26	1.46	350.00	1.14	0.51
STD	60 000.00	4.16	3.28	20 000.00	1.39	1.09
XOF	700.00	2.57	1.43	400.00	1.47	0.82
SCR	93.00	13.19	7.56	75.00	10.64	6.09
SLL	6 500.00	2.80	1.44	1 500.00	0.65	0.33
ZAR	33.60	5.67	3.14	18.03	3.04	1.68
...
SZL	48.00	8.97	4.48	...	...	...
XOF	1 000.00	3.40	2.04	250.00	0.85	0.51
UGX	6 000.00	5.20	2.29	2 000.00	1.73	0.76
TZS	5 000.00	7.30	3.02	...	...	...
ZMW	30.00	6.00	4.89	6.00	1.20	0.98
USD	2.00	1.61	2.00	1.00	0.80	1.00



The Americas

Table 2.2.2
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in the Americas,
2014

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

— Data not required/not applicable.

COUNTRY
Antigua and Barbuda
Argentina
Bahamas
Barbados
Belize
Bolivia
Brazil
Canada
Chile
Colombia
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
Grenada
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Panama
Paraguay
Peru
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines
Suriname
Trinidad and Tobago
United States of America
Uruguay
Venezuela (Bolivarian Republic of)

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
XCD	8.00	3.99	2.96	6.00	3.00	2.22
ARS	15.50	3.65	1.90	6.50	1.53	0.80
BSD	8.20	11.02	8.20	3.99	5.36	3.99
BBD	15.19	12.39	7.60	12.05	9.83	6.03
BZD	12.00	11.48	6.00	5.00	4.78	2.50
BOB	14.00	3.83	2.03	5.00	1.37	0.72
BRL	6.75	3.23	2.98	4.00	1.92	1.76
—	—	—	—	—	—	—
CLP	2 800.00	6.69	4.91	1 300.00	3.11	2.28
COP	3 407.00	2.50	1.82	1 444.00	1.06	0.77
CRC	1 700.00	4.09	3.16	1 300.00	3.13	2.41
...
XCD	12.00	9.00	4.44	4.50	3.38	1.67
DOP	180.00	7.11	4.11	112.00	4.43	2.56
USD	3.50	5.80	3.50	2.80	4.64	2.80
USD	2.75	5.29	0.31	1.75	3.37	0.20
XCD	13.29	8.74	4.92	6.45	4.24	2.39
GTQ	18.00	3.35	2.31	13.00	2.42	1.67
GYD	500.00	5.19	2.42	300.00	3.11	1.45
...
HNL	38.00	3.76	1.81	32.00	3.16	1.53
JMD	820.00	13.32	7.28	400.00	6.50	3.55
MXN	45.00	5.08	3.45	37.00	4.18	2.83
...
PAB	4.50	6.78	4.50	3.50	5.27	3.50
PYG	8 500.00	3.06	1.98	1 500.00	0.54	0.35
PEN	7.50	4.60	2.68	4.20	2.58	1.50
XCD	7.50	3.33	2.78	6.50	2.88	2.41
XCD	16.68	10.12	6.18	7.25	4.40	2.69
XCD	6.75	4.64	2.50	5.00	3.44	1.85
SRD	13.00	5.61	3.94	2.00	0.86	0.61
TTD	25.00	3.82	3.91	15.00	2.29	2.35
—	—	—	—	—	—	—
UYU	85.00	3.95	3.65	73.00	3.39	3.13
VEF	95.00	15.97	15.12	...	...	...



South-East Asia

Table 2.2.3
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in South-East Asia,
2014

* According to International Organization for Standardization, ISO 4217
 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

— Data not required/not applicable.

COUNTRY
Bangladesh
Bhutan ¹
Democratic People's Republic of Korea
India
Indonesia
Maldives
Myanmar
Nepal
Sri Lanka
Thailand
Timor-Leste

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
BDT	190.00	5.23	2.45	30.00	0.83	0.39
—	—	—	—	—	—	—
KPW	...	...	...	7.47	...	0.08
INR	190.00	8.06	3.15	38.00	1.61	0.63
IDR	15 500.00	2.12	1.34	6 666.67	0.91	0.58
MVR	40.00	3.35	2.60	32.00	2.68	2.08
MMK	2 300.00	4.54	2.37	320.00	0.63	0.33
NPR	170.00	3.89	1.77	25.00	0.57	0.26
LKR	700.00	10.78	5.38	200.00	3.08	1.54
THB	90.00	5.07	2.81	32.00	1.80	1.00
USD	2.00	10.00	2.00	...	...	...

NOTES

¹ It is illegal to sell cigarettes in Bhutan.



Europe

Table 2.2.4
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in Europe, 2014

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

COUNTRY
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 of Great Britain and Northern Ireland
Uzbekistan

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
ALL	270.00	5.23	2.60	120.00	2.32	1.16
EUR	3.50	...	4.68	2.55	...	3.41
AMD	600.00	2.74	1.48	180.00	0.82	0.44
EUR	4.90	5.63	6.56	3.95	4.54	5.28
AZN	2.50	4.44	3.21	0.60	1.07	0.77
BYR	16 000.00	3.10	1.55	5 700.00	1.10	0.55
EUR	5.79	6.44	7.75	4.68	5.21	6.27
BAM	4.30	5.23	2.94	2.90	3.53	1.98
BGN	5.20	7.12	3.56	4.05	5.55	2.77
HRK	25.00	5.98	4.39	17.00	4.07	2.98
EUR	4.50	6.16	6.02	3.25	4.45	4.35
CZK	91.00	6.73	4.42	65.00	4.81	3.15
DKK	44.00	5.06	7.89	36.00	4.14	6.46
EUR	3.50	5.51	4.68	2.70	4.25	3.61
EUR	6.00	5.99	8.03	4.60	4.60	6.15
EUR	7.00	7.76	9.37	6.50	7.21	8.70
GEL	3.20	3.23	1.84	0.80	0.81	0.46
EUR	5.47	6.45	7.32	4.84	5.71	6.48
EUR	4.00	5.95	5.35	3.30	4.91	4.42
HUF	1 084.21	7.35	4.65	789.47	5.35	3.39
ISK	1 219.00	8.89	10.59	1 049.00	7.65	9.11
EUR	9.60	11.16	12.84	7.95	9.24	10.64
ILS	30.00	7.78	8.75	24.00	6.22	7.00
EUR	5.00	5.82	6.69	4.00	4.66	5.35
KZT	265.00	1.79	1.45	180.00	1.21	0.98
KGS	50.00	2.03	0.97	12.00	0.49	0.23
EUR	3.30	7.86	4.42	2.55	6.07	3.41
LTL	10.20	5.79	3.96	6.29	3.57	2.44
EUR	5.00	4.71	6.69	4.00	3.77	5.35
EUR	4.80	7.77	6.42	4.10	6.63	5.49
...
EUR	2.40	5.47	3.21	0.80	1.82	1.07
EUR	6.32	7.40	8.45	4.58	5.36	6.13
NOK	97.90	8.99	15.59	79.90	7.34	12.72
PLN	14.70	7.37	4.73	9.95	4.99	3.20
EUR	4.50	6.70	6.02	3.80	5.65	5.08
MDL	22.00	2.80	1.58	5.50	0.70	0.39
RON	14.80	6.60	4.48	12.70	5.66	3.85
RUB	87.00	3.15	2.44	35.00	1.27	0.98
EUR	4.50	4.68	6.02	3.80	3.95	5.08
RSD	260.00	5.69	2.98	125.00	2.74	1.43
EUR	3.37	6.26	4.51	2.21	4.11	2.96
EUR	3.90	6.39	5.22	2.89	4.74	3.87
EUR	4.95	6.82	6.62	3.95	5.44	5.28
SEK	58.95	6.50	8.55	43.00	4.74	6.24
CHF	8.40	5.21	9.24	5.80	3.60	6.38
TJS	12.00	5.42	2.42	2.00	0.90	0.40
...
TRY	10.00	7.02	4.78	5.50	3.86	2.63
TMT	13.00	5.86	4.56	11.13	5.02	3.91
UAH	18.00	4.18	1.49	5.00	1.16	0.41
GBP	9.00	13.18	15.19	6.31	9.23	10.65
UZS	5 000.00	4.36	2.14	1 300.00	1.13	0.56



Eastern Mediterranean

Table 2.2.5
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in the Eastern
Mediterranean, 2014

* According to International Organization for Standardization, ISO 4217 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

< Refers to a territory.

COUNTRY
Afghanistan
Bahrain
Djibouti
Egypt
Iran (Islamic Republic of)
Iraq
Jordan
Kuwait
Lebanon
Libya
Morocco
Oman
Pakistan
Qatar
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
West Bank and Gaza Strip ¹ <
Yemen

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
AFN	100.00	2.95	1.73	15.00	0.44	0.26
BHD	1.00	3.42	2.66	0.50	1.71	1.33
DJF	200.00	1.92	1.13	130.00	1.25	0.73
EGP	20.00	5.79	2.80	8.00	2.31	1.12
IRR	100 000.00	8.81	3.80	15 000.00	1.32	0.57
IQD	3 500.00	3.34	3.00	350.00	0.33	0.30
JOD	1.80	2.92	2.54	1.10	1.79	1.55
KWD	0.75	2.34	2.65	0.27	0.84	0.96
LBP	3 250.00	3.22	2.16	750.00	0.74	0.50
LYD	4.00	3.58	3.17	0.50	0.45	0.40
MAD	32.00	6.43	3.83	10.00	2.01	1.20
OMR	0.90	2.84	2.34	0.50	1.58	1.30
PKR	111.00	2.60	1.12	43.00	1.01	0.44
QAR	10.00	2.76	2.75	3.00	0.83	0.82
SAR	10.00	3.42	2.67	...	...	...
...
SDG	24.00	5.74	4.21	4.00	0.96	0.70
...
TND	5.45	7.43	3.17	0.40	0.54	0.23
AED	10.00	1.90	2.72	3.00	0.57	0.82
ILS	25.00	...	7.29	20.00	...	5.83
YER	300.00	2.05	1.40	100.00	0.68	0.47

NOTES

¹ Data apply to West Bank only.



Western Pacific

Table 2.2.6
Retail price for a pack of 20
cigarettes – premium brand and
cheapest brand – in the Western
Pacific, 2014

* According to International Organization for Standardization, ISO 4217
 currency names and code elements (http://www.iso.org/iso/home/standards/currency_codes.htm).

... Data not reported/not available.

COUNTRY
Australia
Brunei Darussalam
Cambodia
China
Cook Islands
Fiji
Japan
Kiribati
Lao People's Democratic Republic
Malaysia
Marshall Islands
Micronesia (Federated States of)
Mongolia
Nauru
New Zealand
Niue
Palau
Papua New Guinea
Philippines
Republic of Korea
Samoa
Singapore
Solomon Islands
Tonga
Tuvalu
Vanuatu
Viet Nam

CURRENCY REPORTED*	PRICE OF A 20-CIGARETTE PACK OF MARLBORO OR OTHER PREMIUM BRAND			PRICE OF A 20-CIGARETTE PACK OF THE CHEAPEST BRAND		
	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES	IN REPORTED CURRENCY	INTERNATIONAL DOLLARS (AT PURCHASING POWER PARITY)	IN US\$ AT OFFICIAL EXCHANGE RATES
AUD	18.56	11.96	17.31	14.65	9.44	13.66
BND	8.10	8.79	6.52	6.20	6.72	4.99
KHR	5 400.00	3.37	1.33	620.00	0.39	0.15
CNY	16.00	3.73	2.59	2.50	0.58	0.41
...
FJD	14.90	8.72	8.03	6.80	3.98	3.67
JPY	460.00	4.52	4.48	210.00	2.06	2.04
AUD	5.00	19.53	4.66	2.70	10.55	2.52
LAK	15 000.00	3.62	1.86	6 000.00	1.45	0.75
MYR	12.00	6.22	3.76	7.00	3.63	2.20
USD	3.50	9.78	3.50	2.14	5.98	2.14
USD	3.50	7.97	3.50	2.12	4.83	2.12
MNT	3 000.00	2.77	1.60	1 300.00	1.20	0.69
...
NZD	18.80	11.30	15.95	17.00	10.22	14.43
NZD	...	...	...	12.00	...	10.18
USD	5.25	8.69	5.25	2.85	4.72	2.85
PGK	17.00	9.16	6.94	11.20	6.04	4.58
PHP	55.00	2.11	1.27	...	...	...
KRW	2 700.00	3.39	2.63	2 000.00	2.51	1.95
...
SGD	13.00	12.31	10.44	8.50	8.05	6.82
SBD	...	...	...	30.08	7.01	4.13
TOP	10.00	9.77	5.51	7.00	6.84	3.85
AUD	5.07	5.08	4.73	2.50	2.50	2.33
VUV	760.00	12.56	7.97	720.00	11.90	7.56
VND	22 750.00	2.18	1.07	5 630.00	0.54	0.26



Africa

Table 2.3.1
Supplementary information on
taxation in Africa, 2014

... Data not reported /not available.

— Data not required/not applicable.

* Indicates that the country implements a system of encrypted tax stamps which include unique identification markings that are machine-readable only and which are used to monitor legal and illegal products found in the market. These stamps are also used to monitor production in the country through monitoring devices installed in manufacturing facilities that scan the digital stamps. The devices register a wealth of information which is automatically sent to tax administrators and is useful for tracking and tracing, and enforcement work.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/VARYING RATES)
Algeria	38.14%	Specific excise	No
Angola	0.00%	No excise	—
Benin	5.38%	Ad valorem excise	Yes
Botswana	51.97%	Mixed excise	Yes
Burkina Faso	16.95%	Ad valorem excise	No
Burundi	27.50%	Specific excise	Yes
Cabo Verde	12.32%	Ad valorem excise	Yes
Cameroon	6.69%	Ad valorem excise	...
Central African Republic	16.81%	Ad valorem excise	Yes
Chad	20.00%	Ad valorem excise	Yes
Comoros	37.73%	Ad valorem excise	Yes
Congo	20.86%	Mixed excise	Yes
Côte d'Ivoire	15.18%	Ad valorem excise	No
Democratic Republic of the Congo	23.76%	Mixed excise	No
Equatorial Guinea	22.06%	Ad valorem excise	Yes
Eritrea	44.64%	Ad valorem excise	Yes
Ethiopia	13.90%	Ad valorem excise	Yes
Gabon	19.56%	Ad valorem excise	Yes
Gambia	30.00%	Specific excise	Yes
Ghana	13.20%	Ad valorem excise	Yes
Guinea	...	...	...
Guinea-Bissau	3.28%	Ad valorem excise	...
Kenya	35.00%	Ad valorem excise	Yes
Lesotho	33.15%	Specific excise	Yes
Liberia	10.86%	Ad valorem excise	...
Madagascar	63.78%	Ad valorem excise	Yes
Malawi	14.53%	Specific excise	Yes
Mali	6.70%	Ad valorem excise	No
Mauritania	8.26%	Ad valorem excise	Yes
Mauritius	59.47%	Specific excise	Yes
Mozambique	16.33%	Specific excise	No
Namibia	29.00%	Specific excise	Yes
Niger	11.11%	Ad valorem excise	Yes
Nigeria	15.87%	Ad valorem excise	Yes
Rwanda	17.42%	Ad valorem excise	Yes
Sao Tome and Principe	18.33%	Ad valorem excise	Yes
Senegal	25.00%	Ad valorem excise	No
Seychelles	66.67%	Specific excise	Yes
Sierra Leone	6.76%	Ad valorem excise	Yes
South Africa	36.52%	Specific excise	Yes
South Sudan	...	...	...
Swaziland	33.14%	Specific excise	...
Togo	8.26%	Ad valorem excise	Yes
Uganda	35.00%	Specific excise	No
United Republic of Tanzania	14.43%	Specific excise	No
Zambia	20.00%	Ad valorem excise	Yes
Zimbabwe	47.03%	Mixed excise	Yes

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT AUTOMATICALLY ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	—	—	1.84%	No	No	33.33%	No	Limited	200
—	—	—	...	...	—	75.00%	...	None	—
—	No	No	11.69%	No	—	...	No	Limited	...
Yes	No	No	3.98%	No	...	...	Yes	Banned	—
—	Yes	No	13.28%	No	—	50.00%	No	Limited	200
—	—	—	31.32%	Yes	No	26.67%	Yes	None	—
—	No	No	5.73%	No	—	...	Yes	Limited	200
—	No	No	7.15%	No	—	27.27%	Yes	Banned	—
—	No	No	...	...	—	15.00%	...	...	...
—	No	Yes	10.17%	Yes	—	50.00%	No	None	—
—	No	No	13.62%	No	—	18.00%	No	Limited	...
No	No	No	3.71%	Yes	No	...	No	None	—
—	No	No	10.42%	No	—	59.38%	Yes	None	—
Yes	No	No	19.71%	No	...	21.15%	Yes	...	...
—	No	No	0.52%	Yes	—	...	No	None	—
—	No	No	65.91%	Yes	—	20.00%	No	Limited	200
—	No	No	13.96%	Yes	—	12.50%	No	Banned	—
—	No	No	1.56%	No	—	...	Yes	Limited	...
—	—	—	15.01%	Yes	...	25.00%	No	None	—
—	No	No	6.09%	No	—	16.67%	No	Limited	...
...
—	...	No	10.22%	No	—	...	...	...	...
—	Yes	Yes	7.79%	No	—	30.00%	Yes*	Limited	250
—	—	—	25.41%	No	Yes	...	No	Banned	—
—	...	No	18.26%	No	—	...	...	...	...
—	No	No	21.34%	Yes	—	15.50%	No	None	—
—	—	—	...	...	...	33.33%	No	Limited	...
—	No	No	29.43%	Yes	—	35.71%	Yes	Banned	—
—	No	No	15.46%	No	—	40.00%	No	Banned	—
—	—	—	4.23%	Yes	...	58.06%	Yes	Limited	200
—	—	—	15.66%	Yes	No	37.50%	No	None	—
—	—	—	6.84%	Yes	...	44.74%	No	None	—
—	No	No	21.05%	No	—	16.67%	No	None	—
—	Yes	No	5.00%	No	—	...	No	Limited	...
—	No	No	13.18%	No	—	35.00%	Yes	Banned	—
—	No	No	5.90%	No	—	33.33%	No	None	—
—	No	No	7.47%	No	—	57.14%	No	Limited	...
—	—	—	3.89%	Yes	No	80.65%	No	Limited	200
—	No	No	8.96%	No	—	23.08%	No	Limited	...
—	—	—	4.67%	Yes	Yes	...	...	Limited	200
...
—	—	—
—	No	No	11.80%	No	—	25.00%	No	Banned	—
—	—	—	11.11%	Yes	No	33.33%	No	None	—
—	—	—	29.11%	Yes	No	...	Yes	Limited	...
—	Yes	No	8.61%	Yes	—	20.00%	No	Limited	...
No	No	No	12.55%	Yes	No	50.00%	No	Limited	...



The Americas

Table 2.3.2
Supplementary information on
taxation in the Americas, 2014

... Data not reported /not available.

— Data not required/not applicable.

* Indicates that the country implements a system of encrypted tax stamps which include unique identification markings that are machine-readable only and which are used to monitor legal and illegal products found in the market. These stamps are also used to monitor production in the country through monitoring devices installed in manufacturing facilities that scan the digital stamps. The devices register a wealth of information which is automatically sent to tax administrators and is useful for tracking and tracing, and enforcement work.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/VARYING RATES)
Antigua and Barbuda	0.00%	No excise	—
Argentina	64.33%	Ad valorem excise	Yes
Bahamas	42.86%	Specific excise	Yes
Barbados	27.15%	Specific excise	Yes
Belize	0.00%	No excise	—
Bolivia	27.31%	Ad valorem excise	Yes
Brazil	28.97%	Mixed excise	No
Canada	60.93%	Specific excise	Yes
Chile	64.85%	Mixed excise	Yes
Colombia	35.65%	Mixed excise	Yes
Costa Rica	58.26%	Mixed excise	Yes
Cuba	...	...	...
Dominica	10.35%	Specific excise	Yes
Dominican Republic	43.62%	Mixed excise	Yes
Ecuador	59.68%	Specific excise	Yes
El Salvador	41.02%	Mixed excise	Yes
Grenada	32.76%	Ad valorem excise	Yes
Guatemala	38.27%	Ad valorem excise	Yes
Guyana	11.40%	Ad valorem excise	Yes
Haiti	...	...	...
Honduras	21.51%	Specific excise	Yes
Jamaica	26.25%	Specific excise	Yes
Mexico	52.08%	Mixed excise	Yes
Nicaragua	19.23%	Specific excise	...
Panama	43.48%	Ad valorem excise	Yes
Paraguay	6.91%	Ad valorem excise	...
Peru	22.58%	Specific excise	Yes
Saint Kitts and Nevis	4.03%	Ad valorem excise	Yes
Saint Lucia	48.55%	Specific excise	Yes
Saint Vincent and the Grenadines	2.20%	Specific excise	Yes
Suriname	48.40%	Specific excise	Yes
Trinidad and Tobago	16.57%	Specific excise	Yes
United States of America ¹	37.38%	Specific excise	Yes
Uruguay	48.72%	Specific excise	Yes
Venezuela (Bolivarian Republic of)	67.57%	Ad valorem excise	...

NOTES

¹ Data not approved by national authorities.

² Applies to cigarettes entering by air. Cigarettes entering by land are limited to 60.

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT AUTOMATICALLY ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	—	—	2.12%	Yes	—	75.00%	...	Limited	200
—	No	No	1.39%	Yes	—	41.94%	Yes	...	...
—	—	—	2.91%	Yes	...	48.66%	Yes	Banned	—
—	—	—	4.52%	Yes	...	79.33%	No	Banned	—
—	—	—	5.35%	No	—	41.67%	...	Limited	200
—	No	No	4.78%	Yes	—	35.71%	Yes	Limited	400
Yes	No	Yes	2.29%	Yes	No	59.26%	Yes*	Limited	400
—	—	—	1.68%	Yes	Yes	...	Yes*	...	...
No	No	Yes	2.94%	Yes	...	46.43%	No	Banned	—
Yes	No	Yes	1.58%	Yes	Yes	42.38%	No	Banned	—
No	Yes	No	2.81%	Yes	Yes	76.47%	No	Limited	...
...
—	—	—	2.17%	Yes	...	37.50%	No	Limited	200
Yes	No	Yes	5.82%	Yes	...	62.22%	No	Limited	...
—	—	—	4.94%	Yes	Yes	80.00%	No	Limited	400 ²
Yes	No	No	0.58%	No	No	63.64%	No	Limited	200
—	No	No	...	...	—	48.53%	...	None	—
—	No	No	5.58%	Yes	—	72.22%	No	Limited	80
—	No	No	3.68%	No	—	60.00%	No	Banned	—
...
—	—	—	7.32%	Yes	Yes	84.21%	No	Banned	—
—	—	—	14.28%	Yes	No	48.78%	No	Limited	200
No	No	No	3.18%	Yes	...	82.22%	No	Limited	200
—	—	—	7.86%	Yes	...	...	...	...	...
—	Yes	No	3.60%	Yes	—	77.78%	No	Banned	—
—	...	No	0.77%	Yes	—	17.65%	...	...	...
—	—	—	3.35%	Yes	...	56.00%	No	Limited	400
—	Yes	No	2.18%	Yes	—	86.67%	No	...	...
—	—	—	3.39%	Yes	...	43.47%	No	Limited	...
—	—	—	2.73%	No	No	74.07%	No	Limited	...
—	—	—	2.86%	Yes	No	15.38%	Yes	Limited	200
—	—	—	1.64%	Yes	No	60.00%	No	Limited	200
—	—	—	1.14%	Yes	No	...	Yes	Limited	...
—	—	—	2.05%	Yes	...	85.88%	No	Limited	800
—	...	Yes	20.85%	Yes	—	...	...	...	...



South-East Asia

Table 2.3.3
Supplementary information on
taxation in South-East Asia, 2014

... Data not reported /not available.

— Data not required/not applicable.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/VARYING RATES)
Bangladesh	61.00%	Ad valorem excise	No
Bhutan ¹	—	—	—
Democratic People's Republic of Korea	0.00%	No excise	—
India	43.73%	Mixed excise	No
Indonesia	45.00%	Mixed excise	No
Maldives	0.00%	No excise	—
Myanmar	50.00%	Ad valorem excise	Yes
Nepal	16.29%	Specific excise	No
Sri Lanka	63.07%	Mixed excise	No
Thailand	66.59%	Mixed excise	Yes
Timor-Leste	30.40%	Specific excise	Yes

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT AUTOMATICALLY ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	No	Yes	7.66%	Yes	—	15.79%	Yes	Limited	200
—	—	—	—	—	—	—	...	Limited	200
—	—	—	—
Yes	No	No	10.82%	No	No	20.00%	Yes	Limited	...
Yes	No	No	4.65%	No	No	43.01%	Yes	Limited	200
—	—	—	3.51%	Yes	—	80.00%	...	...	...
—	No	No	...	...	—	13.91%	Yes	Limited	400
—	—	—	19.66%	Yes	...	14.71%	Yes	Banned	—
Yes	No	Yes	13.50%	No	No	28.57%	No	Limited	200
No	Yes	No	3.66%	Yes	...	35.56%	Yes	Limited	200
—	—	—	...	...	...	...	No	Banned	—

NOTES

¹ It is illegal to sell cigarettes in Bhutan.



Table 2.3.4
Supplementary information on
taxation in Europe, 2014

... Data not reported /not available.

— Data not required/not applicable.

* Indicates that the country implements a system of encrypted tax stamps which include unique identification markings that are machine-readable only and which are used to monitor legal and illegal products found in the market. These stamps are also used to monitor production in the country through monitoring devices installed in manufacturing facilities that scan the digital stamps. The devices register a wealth of information which is automatically sent to tax administrators and is useful for tracking and tracing, and enforcement work.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/VARYING RATES)
Albania	45.00%	Specific excise	Yes
Andorra	63.88%	Specific excise	No
Armenia	16.67%	Specific excise	No
Austria	57.33%	Mixed excise	Yes
Azerbaijan	2.02%	Specific excise	No
Belarus	34.48%	Specific excise	No
Belgium	58.56%	Mixed excise	Yes
Bosnia and Herzegovina	66.32%	Mixed excise	Yes
Bulgaria	65.98%	Mixed excise	Yes
Croatia	55.26%	Mixed excise	Yes
Cyprus	61.50%	Mixed excise	Yes
Czech Republic	60.06%	Mixed excise	Yes
Denmark	54.75%	Mixed excise	Yes
Estonia	60.57%	Mixed excise	Yes
Finland	62.18%	Mixed excise	Yes
France	63.63%	Mixed excise	Yes
Georgia	34.09%	Specific excise	No
Germany	56.93%	Mixed excise	Yes
Greece	61.25%	Mixed excise	Yes
Hungary	56.00%	Mixed excise	Yes
Iceland	36.08%	Specific excise	Yes
Ireland	59.10%	Mixed excise	Yes
Israel	69.03%	Mixed excise	Yes
Italy	57.65%	Mixed excise	Yes
Kazakhstan	28.57%	Specific excise	Yes
Kyrgyzstan	24.00%	Mixed excise	No
Latvia	59.53%	Mixed excise	Yes
Lithuania	58.40%	Mixed excise	Yes
Luxembourg	55.24%	Mixed excise	Yes
Malta	59.38%	Mixed excise	Yes
Monaco	...	...	...
Montenegro	61.92%	Mixed excise	Yes
Netherlands	56.04%	Mixed excise	Yes
Norway	48.83%	Specific excise	Yes
Poland	61.59%	Mixed excise	Yes
Portugal	55.81%	Mixed excise	Yes
Republic of Moldova	34.00%	Mixed excise	No
Romania	56.06%	Mixed excise	Yes
Russian Federation	32.38%	Mixed excise	Yes
San Marino	74.17%	Ad valorem excise	...
Serbia	61.25%	Mixed excise	Yes
Slovakia	64.87%	Mixed excise	Yes
Slovenia	62.38%	Mixed excise	Yes
Spain	60.74%	Mixed excise	Yes
Sweden	48.84%	Mixed excise	Yes
Switzerland	53.79%	Mixed excise	Yes
Tajikistan	2.66%	Specific excise	No
The former Yugoslav Republic of Macedonia	57.33%	Mixed excise	Yes
Turkey	66.88%	Mixed excise	Yes
Turkmenistan	12.23%	Ad valorem excise	Yes
Ukraine	58.11%	Mixed excise	No
United Kingdom of Great Britain and Northern Ireland	65.49%	Mixed excise	Yes
Uzbekistan	15.86%	Specific excise	No

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT AUTOMATICALLY ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	—	—	3.93%	Yes	...	44.44%	Yes*	Limited	200
—	—	—	...	...	No	...	No	Limited	300
—	—	—	4.38%	No	No	30.00%	Yes	Limited	400
No	Yes	Yes	1.28%	Yes	...	80.61%	No	Limited	200
—	—	—	2.16%	Yes	...	24.00%	Yes	Limited	600
—	—	—	1.72%	Yes	No	35.63%	Yes	Limited	200
No	Yes	Yes	1.64%	Yes	...	80.91%	Yes	Limited	200
No	Yes	Yes	5.16%	Yes	No	67.44%	Yes	Limited	...
Yes	Yes	Yes	4.20%	Yes	...	77.88%	Yes	Limited	200
No	Yes	Yes	2.96%	Yes	...	68.00%	Yes	Limited	200
No	Yes	Yes	2.23%	Yes	...	72.22%	No	Limited	200
Yes	Yes	Yes	1.84%	Yes	No	71.43%	Yes	Limited	200
Yes	Yes	Yes	1.28%	Yes	No	81.82%	Yes	Limited	...
No	Yes	Yes	2.37%	Yes	No	77.14%	Yes	Limited	200
No	Yes	Yes	1.46%	Yes	...	76.67%	Yes	Limited	200
No	Yes	Yes	2.06%	Yes	...	92.86%	No	Limited	200
—	—	—	3.50%	No	No	25.00%	Yes	Limited	200
Yes	No	Yes	1.55%	Yes	...	88.46%	Yes	Limited	200
Yes	Yes	Yes	2.40%	Yes	...	82.50%	Yes	Limited	200
No	Yes	Yes	3.26%	Yes	No	72.82%	Yes	Limited	200
—	—	—	2.12%	Yes	No	86.05%	No	Limited	200
Yes	Yes	Yes	2.51%	Yes	...	82.81%	Yes	Limited	200
No	No	No	2.31%	Yes	...	80.00%	...	Limited	...
No	Yes	Yes	1.88%	Yes	No	80.00%	Yes	Limited	200
—	—	—	0.88%	Yes	No	67.92%	Yes	Limited	200
Yes	Yes	Yes	5.04%	No	No	24.00%	Yes	Limited	200
Yes	Yes	Yes	2.49%	Yes	...	77.27%	Yes	Limited	200
Yes	Yes	Yes	2.22%	Yes	...	61.67%	Yes	Limited	200
No	Yes	Yes	0.57%	Yes	...	80.00%	Yes	Limited	200
Yes	Yes	Yes	2.64%	Yes	...	85.42%	Yes	Limited	200
...
No	Yes	Yes	2.33%	Yes	No	33.33%	Yes	None	—
Yes	Yes	Yes	1.62%	Yes	Yes	72.50%	Yes	Limited	200
—	—	—	1.57%	Yes	No	81.61%	No	Limited	200
No	Yes	Yes	3.07%	Yes	No	67.69%	Yes	Limited	200
Yes	Yes	Yes	2.77%	Yes	No	84.44%	Yes	Limited	200
No	No	Yes	4.94%	Yes	No	25.00%	Yes	Limited	200
Yes	Yes	Yes	4.32%	Yes	...	85.81%	Yes	Limited	200
Yes	Yes	Yes	1.31%	Yes	No	40.23%	Yes	Limited	200
—	No	No	...	...	—	84.44%	No	Banned	—
No	Yes	Yes	3.29%	Yes	Yes	48.08%	Yes	Limited	200
Yes	Yes	Yes	2.06%	Yes	...	65.63%	Yes	Limited	200
Yes	Yes	Yes	1.91%	Yes	...	74.10%	Yes	Limited	200
No	Yes	Yes	2.20%	Yes	...	79.80%	Yes	Limited	200
Yes	Yes	Yes	1.49%	Yes	Yes	72.95%	No	Limited	200
Yes	Yes	Yes	1.10%	Yes	No	69.05%	No	Limited	250
—	—	—	...	...	...	16.67%	Yes	Limited	400
Yes	Yes	Yes	2.48%	No	No	...	...	...	...
No	Yes	Yes	3.63%	Yes	Yes	55.00%	Yes*	Limited	400
—	Yes	No	4.98%	No	—	85.62%	Yes	Limited	200
Yes	Yes	Yes	2.50%	Yes	No	27.78%	Yes	Limited	200
Yes	Yes	Yes	2.87%	Yes	...	70.06%	No	Limited	200
—	—	—	4.58%	No	No	26.00%	Yes	Limited	400



Eastern Mediterranean

Table 2.3.5
Supplementary information
on taxation in the Eastern
Mediterranean, 2014

... Data not reported /not available.

— Data not required/not applicable.

< Refers to a territory.

* Indicates that the country implements a system of encrypted tax stamps which include unique identification markings that are machine-readable only and which are used to monitor legal and illegal products found in the market. These stamps are also used to monitor production in the country through monitoring devices installed in manufacturing facilities that scan the digital stamps. The devices register a wealth of information which is automatically sent to tax administrators and is useful for tracking and tracing, and enforcement work.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/ VARYING RATES)
Afghanistan	0.00%	No excise	—
Bahrain	0.00%	No excise	—
Djibouti	26.34%	Ad valorem excise	...
Egypt	73.13%	Mixed excise	No
Iran (Islamic Republic of)	0.00%	No excise	—
Iraq	0.00%	No excise	—
Jordan	69.50%	Specific excise	No
Kuwait	0.00%	No excise	—
Lebanon	32.61%	Ad valorem excise	Yes
Libya	0.00%	No excise	—
Morocco	55.20%	Mixed excise	No
Oman	0.00%	No excise	—
Pakistan	46.17%	Specific excise	No
Qatar	0.00%	No excise	—
Saudi Arabia	0.00%	No excise	—
Somalia	...	...	...
Sudan	57.90%	Ad valorem excise	Yes
Syrian Arab Republic	...	...	...
Tunisia	66.39%	Mixed excise	Yes
United Arab Emirates	0.00%	No excise	—
West Bank and Gaza Strip ¹ <	69.53%	Mixed excise	Yes
Yemen	6.43%	Specific excise	Yes

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	—	—	4.99%	Yes	—	15.00%	...	Limited	...
—	—	—	0.47%	No	—	50.00%	...	Limited	400
—	...	No	6.68%	No	—	65.00%	...	...	...
No	No	Yes	3.35%	Yes	No	40.00%	Yes	Limited	200
—	—	—	1.62%	Yes	—	15.00%	...	Limited	200
—	—	—	0.66%	No	—	10.00%	...	None	—
—	—	—	3.10%	No	No	61.11%	No	Banned	—
—	—	—	0.59%	Yes	—	36.00%	...	Banned	—
—	No	No	2.05%	Yes	—	23.08%	No	Limited	400
—	—	—	3.00%	Yes	—	12.50%	...	Limited	400
Yes	Yes	No	6.89%	No	No	31.25%	Yes*	Banned	—
—	—	—	1.08%	Yes	—	55.56%	...	Limited	400
—	—	—	3.73%	Yes	No	38.74%	No	Limited	...
—	—	—	0.29%	Yes	—	30.00%	...	Limited	...
—	—	—	1.05%	Yes	—	...	...	...	...
...
—	No	No	12.38%	No	—	16.67%	No	Banned	—
...
Yes	No	No	3.32%	Yes	...	7.34%	No	Limited	200
—	—	—	0.61%	Yes	—	30.00%	...	Limited	200
Yes	Yes	No	23.05%	Yes	No	...	Yes	Banned	—
—	—	—	7.87%	Yes	...	33.33%	Yes	Limited	600

NOTES

¹ Data refer to West Bank only.



Western Pacific

Table 2.3.6
Supplementary information on
taxation in the Western Pacific, 2014

... Data not reported /not available.

— Data not required/not applicable.

§ Tobacco products are allowed for sale at border exit-entry tax free shops, but not any other tax free shops.

COUNTRY			
	EXCISE TAX PROPORTION OF PRICE	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED YES (UNIFORM), NO (TIERED/VARYING RATES)
Australia	47.67%	Specific excise	Yes
Brunei Darussalam	61.73%	Specific excise	Yes
Cambodia	13.15%	Ad valorem excise	Yes
China	29.90%	Mixed excise	No
Cook Islands	52.00%	Specific excise	Yes
Fiji	31.05%	Specific excise	No
Japan	56.95%	Specific excise	No
Kiribati	77.78%	Specific excise	Yes
Lao People's Democratic Republic	7.68%	Mixed excise	No
Malaysia	50.60%	Mixed excise	Yes
Marshall Islands	0.00%	No excise	—
Micronesia (Federated States of)	0.00%	No excise	—
Mongolia	33.26%	Specific excise	Yes
Nauru	...	...	...
New Zealand	64.16%	Specific excise	Yes
Niue	0.00%	No excise	—
Palau	66.67%	Specific excise	...
Papua New Guinea	26.42%	Specific excise	No
Philippines	63.55%	Specific excise	No
Republic of Korea	52.90%	Specific excise	Yes
Samoa	42.32%	Specific excise	Yes
Singapore	59.69%	Specific excise	Yes
Solomon Islands	19.15%	Specific excise	No
Tonga	58.82%	Specific excise	No
Tuvalu	2.26%	Ad valorem excise	Yes
Vanuatu	44.44%	Specific excise	...
Viet Nam	32.50%	Ad valorem excise	Yes

TAX STRUCTURE/LEVEL			AFFORDABILITY AND PRICE DISPERSION				TAX ADMINISTRATION		
GREATER RELIANCE ON SPECIFIC TAX IN MIXED EXCISE REGIME	MINIMUM SPECIFIC TAX APPLIED IN AD VALOREM OR MIXED EXCISE REGIME	RETAIL PRICE USED AS BASE OF AD VALOREM COMPONENT IN AD VALOREM OR MIXED EXCISE REGIME (OR RETAIL PRICE EXCLUSIVE OF VAT)	% OF GDP PER CAPITA REQUIRED TO PURCHASE 100 PACKS OF MOST SOLD BRAND (THE HIGHER THE %, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE IN 2014 COMPARED TO 2008	SPECIFIC TAX COMPONENT AUTOMATICALLY ADJUSTED FOR INFLATION (OR OTHER)	PRICE DISPERSION: SHARE OF CHEAPEST BRAND PRICE IN PREMIUM BRAND PRICE (THE HIGHER THE %, THE SMALLER THE GAP)	TAX STAMPS APPLIED ON TOBACCO PRODUCTS	BANS OR LIMITS ON DUTY FREE IMPORTS BY TRAVELLERS	IF DUTY FREE IMPORTS ARE LIMITED, DUTY FREE ALLOWANCE (NUMBER OF CIGARETTE STICKS)
—	—	—	2.53%	Yes	Yes	78.96%	No	Limited	50
—	—	—	1.54%	Yes	No	76.54%	No	Banned	—
—	No	No	4.03%	No	—	11.48%	Yes	Limited	400
No	No	No	2.14%	Yes	No	15.63%	No	Restricted [§]	...
—	—	—	...	...	...	...	No	Limited	200
—	—	—	...	...	...	45.64%	No	Limited	200
—	—	—	1.11%	Yes	No	45.65%	No	None	—
—	—	—	17.19%	No	No	54.00%	No	Limited	200
Yes	No	No	5.86%	No	No	40.00%	No	Limited	200
Yes	No	No	3.40%	Yes	No	58.33%	...	Limited	200
—	—	—	6.45%	No	—	61.14%	...	Limited	200
—	—	—	6.47%	Yes	—	60.57%	...	Limited	600
—	—	—	3.60%	Yes	...	43.33%	Yes	Limited	400
...
—	—	—	3.26%	Yes	Yes	90.43%	No	Limited	200
—	—	—	...	...	—	...	...	Limited	200
—	—	—	3.59%	Yes	...	54.29%	...	...	...
—	—	—	...	...	...	65.88%	No	Limited	250
—	—	—	2.11%	Yes	Yes	...	Yes	Limited	...
—	—	—	0.85%	No	No	74.07%	No	Limited	200
—	—	—	9.61%	Yes	No	...	...	...	...
—	—	—	1.86%	No	No	65.38%	No	Banned	—
—	—	—	...	...	...	...	No	Limited	25
—	—	—	9.83%	No	No	70.00%	No	Limited	250
—	No	No	6.52%	No	—	49.31%	No	Limited	200
—	—	—	25.24%	Yes	...	94.74%	No	Limited	250
—	No	No	4.25%	No	—	24.75%	Yes	Limited	400



Table 2.4
Use of earmarked tobacco taxes in countries* that reported earmarking parts of their excise taxes or excise tax revenues for health purposes

* Only countries that have reported earmarking tobacco taxes or tobacco tax revenues for a specific health purpose are listed in this table. Some other countries may be applying a similar policy but no data were provided for the purposes of this report. Additionally, some countries did report earmarking tobacco taxes but for purposes other than health, therefore, they are not included in this table.

COUNTRY
Algeria
Argentina
Bangladesh
Cabo Verde
Colombia
Comoros
Congo
Costa Rica
Côte d'Ivoire
Egypt
El Salvador
Guatemala
Iceland
India
Indonesia
Iran (Islamic Republic of)
Jamaica
Madagascar
Mongolia
Nepal
Panama
Philippines
Poland
Republic of Korea
Romania
Switzerland
Thailand
The former Yugoslav Republic of Macedonia
United States of America

REPORTED USE OF EARMARKED TOBACCO TAXES
6 dinars per pack of cigarettes go to the emergency fund and medical care activities, 2 dinars per pack go to cancer control
Additional emergency tax of 7% of retail price to finance social and/or health programmes of the Rural Change Program and the Social-Agricultural Programmes
Additional excise of 1% of the retail price goes to the Ministry of Health
All excise tax revenues are used for sports and health
16% of the specific excise tax on tobacco products is used for sports while all revenues from ad valorem excise go to health
Part of the 5% of tax on tobacco goes to Ministry of Sports and the hospital emergencies section
Specific excise tax per pack (40 XOF): half goes to health insurance and half to sports
All revenues from the specific excise tax are used to fund programmes for the prevention and treatment of diseases related to tobacco use, cancer treatment, harmful use of alcohol, and sports
An extra tax of 5% goes to the AIDS solidarity fund and another 2% extra tax goes to sports
An extra tax of 10 piasters per pack is used to fund student health insurance
35% of revenues from taxes on tobacco, alcohol and firearms, ammunition and explosives (or a minimum of US\$ 20 million per year) fund the FOSALUD (solidarity fund for health)
All revenues from the ad valorem excise tax on tobacco are used for health programmes
At least 0.9% of gross tobacco sales is allocated to tobacco control
Specific amount for all tobacco products (varies by product), except bidis, goes to the Health Cessation Fund and an amount levied on bidis goes to the Bidi Workers' Welfare Fund, which also includes medical care to workers involved in the bidi industry
10% surcharge imposed on tobacco excise; at least 50% of its proceeds are allocated for health programmes and law enforcement at the regional level. 2% of tobacco tax revenues are allocated to regional governments of which a proportion should be used for health
Up to 2% of taxes collected on tobacco products are used to support tobacco control activities
20% of the Special Consumption Tax (SCT) on tobacco and another 5% of the SCT on all products including tobacco go to the National Health Fund
6 ariary per pack to fund the National Fund for the Promotion and Development of Youth, Sports and Recreation
A proportion of tobacco (2%) and alcohol (1%) excise tax revenues is allocated to the Health Promotion Foundation
All tobacco tax revenues go to the Health Tax Fund, financing mainly prevention and treatment of noncommunicable diseases
50% of tobacco tax revenues collected go to National Institute of Oncology, the Ministry of Health for cessation services and Customs to fight illicit trade in tobacco products. The Ministry of Health also funds regional activities on tobacco control through the money received
Following the tax increase in 2012, about 80% of incremental revenues will be allocated for universal health care while 20% will be allocated nationwide for medical assistance and health facility enhancement programmes
0.5% of the excise duty levied funds a programme to reduce tobacco product consumption
An amount of 354 won per pack goes to the Health Promotion Fund which finances health promotion research and projects
10 euros per 1,000 cigarettes and 13 euros per kilogram of loose tobacco are dedicated for health. Additionally, 1% of the budget from the excise on cigarettes is used to finance sports
0.26 francs per pack of cigarettes goes to the Tobacco Prevention Fund
Surcharge of 2% on tobacco and alcohol excise goes to ThaiHealth Fund
Amount of 0.053 denars per piece (cigarette) allocated to fund drugs for rare diseases
Varies by state. Amount per pack funds different types of activities, mainly health activities





APPENDIX III: YEAR OF HIGHEST LEVEL OF ACHIEVEMENT IN SELECTED TOBACCO CONTROL MEASURES

Appendix III provides information on the year in which respective countries attained the highest level of achievement for five of the MPOWER measures. Data are shown separately for each WHO region.

For *Monitoring tobacco use* the earliest year assessed is 2007. However, it is possible that while 2007 is reported as the year of highest achievement for some countries, they actually may have reached this level earlier.

Years of highest level achievement of the MPOWER measure *Raise taxes on tobacco* are not included in this appendix. The share of taxes in product price depends both on tax policy and on demand and supply factors that affect manufacturing and retail prices. Countries with tax increases might have seen the share of tax remain unchanged or even decline if the non-tax share of price rose at the same, or a higher rate, complicating the interpretation of the year of highest level of achievement. See Technical Note III for details on the construction of tax shares.

The Americas

Table 3.2
Year of highest level of achievement in selected tobacco control measures in the Americas

Note: Refer to Technical Note I for definitions of highest level of achievement. An empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* Or earlier year.

⊙ Policy adopted but not implemented by 31 December 2014.

COUNTRY
Antigua and Barbuda
Argentina
Bahamas
Barbados
Belize
Bolivia (Plurinational State of)
Brazil
Canada
Chile
Colombia
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
Grenada
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Panama
Paraguay
Peru
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines
Suriname
Trinidad and Tobago
United States of America
Uruguay
Venezuela (Bolivarian Republic of)

MONITOR TOBACCO USE	YEAR THE HIGHEST LEVEL OF ACHIEVEMENT WAS ATTAINED			
	PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
2010	2011	2014	2012	
	2010			
			2009	
	2011	2002	2003	2011
2007*	2007	2008	2011	
2007*	2013		2006	
2012	2008			2009
2007*	2012		2013	
	2011		2012	
		2012	2011	
	2008			
	2010			
	2013		2013	
		2014	2009	
2012	2008	2010	2005	2008
2010	2010		2010	
2014	2013			2013
	2009		2013 ⊙	
2007*		2008		
2007*	2005	2012	2005	2014
	2011		2004	

South-East Asia

Table 3.3
Year of highest level of achievement in selected tobacco control measures in South-East Asia

Note: Refer to Technical Note I for definitions of highest level of achievement. An empty cell indicates that the population is not covered by the measure at the highest level of achievement.

COUNTRY
Bangladesh
Bhutan
Democratic People's Republic of Korea
India
Indonesia
Maldives
Myanmar
Nepal
Sri Lanka
Thailand
Timor-Leste

YEAR THE HIGHEST LEVEL OF ACHIEVEMENT WAS ATTAINED				
MONITOR TOBACCO USE	PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
			2013	
	2010			
				2010
2012	2011		2011	2014
			2014	
2008	2010		2005	

Europe

Table 3.4
Year of highest level of achievement in selected tobacco control measures in Europe

Note: Refer to Technical Note I for definitions of highest level of achievement. An empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* Or earlier year.

⊙ Policy adopted but not implemented by 31 December 2014.

COUNTRY
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 of Great Britain and Northern Ireland
Uzbekistan

MONITOR TOBACCO USE	YEAR THE HIGHEST LEVEL OF ACHIEVEMENT WAS ATTAINED			
	PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
	2006			2006
2010				
2007*				
2007*		2014		
2008	2012			
2007*				
2007*		2012		
2007*				
2007*				
2008				
2007*				
2007*	2010			
2007*				
2007*				
2007*	2004	2003		
		2008		
2007*				
2010				
2007*				
2007*				
2010				
	2010	2014		
2007*		2014		
2007*				
2010				
2007*				
2014				
2007*				
2010	2013			2013
2010				
2007*				
2007*				
2007*	2010			2010
2007*				
2007*				
2012	2008	2010	2012	2012
	2000		2014 ⊙	
2007*			2009	
2007*	2006	2001		

Eastern Mediterranean

Table 3.5
Year of highest level of achievement
in selected tobacco control measures
in the Eastern Mediterranean

Note: Refer to Technical Note I for definitions of highest level of achievement. An empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* Or earlier year.
 < Refers to a territory.

COUNTRY
Afghanistan
Bahrain
Djibouti
Egypt
Iran (Islamic Republic of)
Iraq
Jordan
Kuwait
Lebanon
Libya
Morocco
Oman
Pakistan
Qatar
Saudi Arabia
Somalia
South Sudan
Sudan
Syrian Arab Republic
Tunisia
United Arab Emirates
West Bank and Gaza Strip <
Yemen

YEAR THE HIGHEST LEVEL OF ACHIEVEMENT WAS ATTAINED				
MONITOR TOBACCO USE	PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
				2011
			2008	2007
2010			2008	
2007*	2007	2008	2008	2007
2010		2012		
	2011			
	2009			2009
2014	2009			
2014				
	2012			
		2008		2014
2012	2011			
				2013

Western Pacific

Table 3.6
Year of highest level of achievement
in selected tobacco control measures
in the Western Pacific

Note: Refer to Technical Note I for definitions of highest level of achievement. An empty cell indicates that the population is not covered by the measure at the highest level of achievement.

* Or earlier year.

⊙ Policy adopted but not implemented by 31 December 2014.

COUNTRY
Australia
Brunei Darussalam
Cambodia
China
Cook Islands
Fiji
Japan
Kiribati
Lao People's Democratic Republic
Malaysia
Marshall Islands
Micronesia (Federated States of)
Mongolia
Nauru
New Zealand
Niue
Palau
Papua New Guinea
Philippines
Republic of Korea
Samoa
Singapore
Solomon Islands
Tonga
Tuvalu
Vanuatu
Viet Nam

MONITOR TOBACCO USE	YEAR THE HIGHEST LEVEL OF ACHIEVEMENT WAS ATTAINED			
	PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
2007*	2005	2011	2004	
	2012	2014	2007	
			2013	
2007*				2013
2012			2008	
	2006			
2010	2012		2012	
	2009			
2008	2003	2000	2007	
2012				
	2012			
2007*			2014 ⊙	
2007*		2006		
			2013	
2012		1999	2012	
			2013 ⊙	
				2008
			2013	2008
			2013	



APPENDIX IV: HIGHEST LEVEL OF ACHIEVEMENT IN SELECTED TOBACCO CONTROL MEASURES IN THE 100 BIGGEST CITIES IN THE WORLD

Appendix IV provides information on whether the populations of the 100 biggest cities in the world are covered by selected tobacco control measures at the highest level of achievement.

Cities are listed by population size in descending order. There are many ways to define geographically and measure the size of "a city". For the purposes of this report, we focused on the jurisdictional boundaries of cities, since subnational laws will apply to populations within jurisdictions. Where a large "city"

includes several jurisdictions or parts of jurisdictions, it is possible that not everyone in the entire "city" is covered by the same laws. We therefore use the list of cities and their populations published in the UNSD Demographic Yearbook, since these are defined jurisdictionally. Please refer to Table 8 at <http://unstats.un.org/unsd/demographic/products/dyb/dyb2012.htm> to access the source data.

Refer to Technical Note I for definitions of highest level of achievement.

Table 4.1
Highest level of achievement in
selected tobacco control measures in
the 100 biggest cities in the world

N	City's population covered by national legislation or policy at the highest level of achievement
S	City's population covered by state-level legislation or policy at the highest level of achievement
C	City's population covered by city-level legislation or policy at the highest level of achievement

Notes: An empty cell indicates that the population in the respective city is not covered by the measure at the highest level of achievement.

Refer to Technical Note I for definitions of highest level of achievement of the respective measure.

* Only cities which appear among the top 100 cities sorted by population size, according to the United Nations Statistics Division Demographic Yearbook 2011-2012 (available at: <http://unstats.un.org/UNSD/demographic/products/dyb/dyb2012/Table08.xls>).

CITY	POPULATION (2012)
Beijing	19 610 000
Shanghai	14 348 535
Mumbai	11 978 450
Moscow	11 577 022
São Paulo	11 152 344
Seoul	10 038 905
Delhi	9 879 172
Chongqing	9 691 901
Jakarta	9 607 787
Lima	9 437 493
Karachi	9 339 023
Tokyo	8 945 695
Mexico City	8 851 080
Guangzhou	8 524 826
Wuhan	8 312 700
New York	8 175 133
Tianjin	7 499 181
Cairo	7 248 671
Hong Kong SAR	7 154 600
Tehran	7 088 287
Shenzhen	7 008 831
Dongguan	6 445 777
Rio de Janeiro	6 320 446
Santiago	6 148 754
Singapore	5 312 400
Shenyang	5 303 053
Lagos	5 195 247
Lahore	5 143 495
Saint Petersburg	4 926 282
Kolkata	4 572 876
Xi'an	4 481 508
Aleppo	4 450 000
Alexandria	4 358 439
Chennai	4 343 645
Chengdu	4 333 541
Bangalore	4 301 326
Riyadh	4 087 152
Sydney	4 028 524
Melbourne	3 847 570
Los Angeles	3 792 621
Yokohama	3 688 773
Hyderabad	3 637 483
Nanjing	3 624 234
Ahmedabad	3 520 085
Berlin	3 501 872
Haerbin	3 481 504
Busan	3 420 679
Kabul	3 289 000
Dalian	3 245 191
Changchun	3 225 557
Madrid	3 198 645

COVERAGE AT THE HIGHEST LEVEL OF ACHIEVEMENT					COUNTRY
PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP	RAISE TAXES ON TOBACCO	
C					China
					China
					India
N			N		Russian Federation
N	N	N	N		Brazil
	N				Republic of Korea
					India
					China
S					Indonesia
N		N			Peru
N					Pakistan
					Japan
S	N	N			Mexico
					China
					China
S	N				United States of America
					China
		N			Egypt
C	C	C			China, Hong Kong SAR
N	N	N	N		Iran (Islamic Republic of)
			C		China
					China
N	N	N	N		Brazil
N		N		N	Chile
	N	N			Singapore
					China
					Nigeria
N					Pakistan
N				N	Russian Federation
					India
					China
				...	Syrian Arab Republic
		N			Egypt
					India
					China
					India
N					Saudi Arabia
S	N	N			Australia
S	N	N			Australia
	N				United States of America
					Japan
					India
					China
					India
					Germany
					China
	N				Republic of Korea
					Afghanistan
					China
					China
N			N	N	Spain

Table 4.1
Highest level of achievement in selected tobacco control measures in the 100 biggest cities in the world (continued)

N	City's population covered by national legislation or policy at the highest level of achievement
S	City's population covered by state-level legislation or policy at the highest level of achievement
C	City's population covered by city-level legislation or policy at the highest level of achievement

Notes: An empty cell indicates that the population in the respective city is not covered by the measure at the highest level of achievement.

Refer to Technical Note I for definitions of highest level of achievement of the respective measure.

* Only cities which appear among the top 100 cities sorted by population size, according to the United Nations Statistics Division Demographic Yearbook 2011-2012 (available at: <http://unstats.un.org/UNSD/demographic/products/dyb/dyb2012/Table08.xls>).

SYMBOLS LEGEND

☆	Separate, completely enclosed smoking rooms in at least five of the assessed public places are allowed if they are separately ventilated to the outside and kept under negative air pressure in relation to the surrounding areas.
⊙	Policy adopted but not implemented by 31 December 2014
...	Data not reported

CITY	POPULATION (2012)
Pyongyang	3 144 470
Nairobi	3 133 518
Giza	3 122 041
Casablanca	3 083 000
Kunming	3 035 406
Ho Chi Minh	3 015 743
Jinan	2 999 934
Guiyang	2 985 105
Zibo	2 817 479
Jiddah	2 801 481
Kiev	2 772 951
Rome	2 771 585
Surabaya	2 765 487
Quezon City	2 761 720
Qingdao	2 720 972
Chicago	2 695 598
Incheon	2 675 476
Salvador	2 674 923
Osaka	2 665 314
Addis Ababa	2 646 000
Zhengzhou	2 589 387
Taiyuan	2 558 382
Kanpur	2 551 337
Pune	2 538 473
Damascus Rural (Rif Dimashq)	2 529 000
Brasília	2 481 272
Chaoyang	2 470 812
Fortaleza	2 452 185
Hangzhou	2 451 319
Surat	2 433 835
Mashhad	2 427 316
Daegu	2 417 943
Bandung	2 394 873
Belo Horizonte	2 375 151
Zhongshan	2 363 322
Jaipur	2 322 575
Guayaquil	2 278 691
Nagoya	2 263 894
Amman	2 248 799
Paris	2 234 105
Lucknow	2 185 927
Kano	2 166 554
Tashkent	2 137 218
Nanghai	2 133 741
La Habana	2 129 013
Fuzhou	2 124 435
Changsha	2 122 873
Caracas	2 104 423
Houston	2 099 451

COVERAGE AT THE HIGHEST LEVEL OF ACHIEVEMENT					COUNTRIES
PROTECT PEOPLE FROM TOBACCO SMOKE	OFFER HELP TO QUIT TOBACCO USE	WARN ABOUT THE DANGERS OF TOBACCO	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP	RAISE TAXES ON TOBACCO	
					Democratic People's Republic of Korea
			N		Kenya
		N			Egypt
					Morocco
					China
		N			Viet Nam
					China
					China
N					China
		N			Saudi Arabia
☆				N	Ukraine
					Italy
					Indonesia
		N ⊙			Philippines
					China
S	N				United States of America
	N				Republic of Korea
N	N	N	N		Brazil
					Japan
					Ethiopia
					China
					China
					India
					India
				...	Syrian Arab Republic
N	N	N	N		Brazil
					China
N	N	N	N		Brazil
					China
					India
N	N	N	N		Iran (Islamic Republic of)
	N				Republic of Korea
					Indonesia
N	N	N	N		Brazil
					China
					India
N and C		N			Ecuador
					Japan
				N	Jordan
	N			N	France
					India
					Nigeria
					Uzbekistan
					China
				...	Cuba
					China
					China
N		N			Venezuela (Bolivarian Republic of)
C	N				United States of America



APPENDIX V: **STATUS OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL**

Appendix V shows the status of the WHO Framework Convention on Tobacco Control (WHO FCTC). Ratification is the international act by which countries that have already signed a convention formally state their consent to be bound by it. Accession is the international act by which countries that have not signed a treaty/convention formally state their consent to be bound by it. Acceptance and approval are the legal equivalent of ratification. Signature of a convention indicates that a country is not legally bound by the treaty but is committed not to undermine its provisions.

The WHO FCTC entered into force on 27 February 2005, on the 90th day after the deposit of the 40th instrument of ratification in the United Nations headquarters in New York, the depository of the treaty. The treaty remains open for ratification, acceptance, approval, formal confirmation and accession indefinitely for States and eligible regional economic integration organizations wishing to become Parties to it.

Table 5.1
**Status of the WHO
 Framework Convention
 on Tobacco Control, as
 of 22 May 2015**

- * Ratification is the international act by which countries that have already signed a treaty or convention formally state their consent to be bound by it.
- ^a Accession is the international act by which countries that have not signed a treaty/convention formally state their consent to be bound by it.
- ^A Acceptance is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- ^{AA} Approval is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- ^c Formal confirmation is the international act corresponding to ratification by a State, whereby an international organization (in the case of the WHO FCTC, competent regional economic integration organizations) formally state their consent to be bound by a treaty/convention.
- ^d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered into by their predecessor State.

COUNTRY	DATE OF SIGNATURE	DATE OF RATIFICATION* (OR LEGAL EQUIVALENT)
Afghanistan	29 June 2004	13 August 2010
Albania	29 June 2004	26 April 2006
Algeria	20 June 2003	30 June 2006
Andorra		
Angola	29 June 2004	20 September 2007
Antigua and Barbuda	28 June 2004	5 June 2006
Argentina	25 September 2003	
Armenia		29 November 2004 ^a
Australia	5 December 2003	27 October 2004
Austria	28 August 2003	15 September 2005
Azerbaijan		1 November 2005 ^a
Bahamas	29 June 2004	3 November 2009
Bahrain		20 March 2007 ^a
Bangladesh	16 June 2003	14 June 2004
Barbados	28 June 2004	3 November 2005
Belarus	17 June 2004	8 September 2005
Belgium	22 January 2004	1 November 2005
Belize	26 September 2003	15 December 2005
Benin	18 June 2004	3 November 2005
Bhutan	9 December 2003	23 August 2004
Bolivia (Plurinational State of)	27 February 2004	15 September 2005
Bosnia and Herzegovina		10 July 2009 ^a
Botswana	16 June 2003	31 January 2005
Brazil	16 June 2003	3 November 2005
Brunei Darussalam	3 June 2004	3 June 2004
Bulgaria	22 December 2003	7 November 2005
Burkina Faso	22 December 2003	31 July 2006
Burundi	16 June 2003	22 November 2005
Cabo Verde	17 February 2004	4 October 2005
Cambodia	25 May 2004	15 November 2005
Cameroon	13 May 2004	3 February 2006
Canada	15 July 2003	26 November 2004
Central African Republic	29 December 2003	7 November 2005
Chad	22 June 2004	30 January 2006
Chile	25 September 2003	13 June 2005
China	10 November 2003	11 October 2005
Colombia		10 April 2008 ^a
Comoros	27 February 2004	24 January 2006
Congo	23 March 2004	6 February 2007
Cook Islands	14 May 2004	14 May 2004
Costa Rica	3 July 2003	21 August 2008
Côte d'Ivoire	24 July 2003	13 August 2010
Croatia	2 June 2004	14 July 2008
Cuba	29 June 2004	
Cyprus	24 May 2004	26 October 2005
Czech Republic	16 June 2003	1 June 2012
Democratic People's Republic of Korea	17 June 2003	27 April 2005
Democratic Republic of the Congo	28 June 2004	28 October 2005
Denmark	16 June 2003	16 December 2004
Djibouti	13 May 2004	31 July 2005
Dominica	29 June 2004	24 July 2006

COUNTRY	DATE OF SIGNATURE	DATE OF RATIFICATION* (OR LEGAL EQUIVALENT)
Dominican Republic		
Ecuador	22 March 2004	25 July 2006
Egypt	17 June 2003	25 February 2005
El Salvador	18 March 2004	21 July 2014
Equatorial Guinea		17 September 2005 ^a
Eritrea		
Estonia	8 June 2004	27 July 2005
Ethiopia	25 February 2004	25 March 2014
European Union	16 June 2003	30 June 2005 ^c
Fiji	3 October 2003	3 October 2003
Finland	16 June 2003	24 January 2005
France	16 June 2003	19 October 2004 ^{AA}
Gabon	22 August 2003	20 February 2009
Gambia	16 June 2003	18 September 2007
Georgia	20 February 2004	14 February 2006
Germany	24 October 2003	16 December 2004
Ghana	20 June 2003	29 November 2004
Greece	16 June 2003	27 January 2006
Grenada	29 June 2004	14 August 2007
Guatemala	25 September 2003	16 November 2005
Guinea	1 April 2004	7 November 2007
Guinea-Bissau		7 November 2008 ^a
Guyana		15 September 2005 ^a
Haiti	23 July 2003	
Honduras	18 June 2004	16 February 2005
Hungary	16 June 2003	7 April 2004
Iceland	16 June 2003	14 June 2004
India	10 September 2003	5 February 2004
Indonesia		
Iran (Islamic Republic of)	16 June 2003	6 November 2005
Iraq	29 June 2004	17 March 2008
Ireland	16 September 2003	7 November 2005
Israel	20 June 2003	24 August 2005
Italy	16 June 2003	2 July 2008
Jamaica	24 September 2003	7 July 2005
Japan	9 March 2004	8 June 2004 ^A
Jordan	28 May 2004	19 August 2004
Kazakhstan	21 June 2004	22 January 2007
Kenya	25 June 2004	25 June 2004
Kiribati	27 April 2004	15 September 2005
Kuwait	16 June 2003	12 May 2006
Kyrgyzstan	18 February 2004	25 May 2006
Lao People's Democratic Republic	29 June 2004	6 September 2006
Latvia	10 May 2004	10 February 2005
Lebanon	4 March 2004	7 December 2005
Lesotho	23 June 2004	14 January 2005
Liberia	25 June 2004	15 September 2009
Libya	18 June 2004	7 June 2005
Lithuania	22 September 2003	16 December 2004
Luxembourg	16 June 2003	30 June 2005
Madagascar	24 September 2003	22 September 2004

Table 5.1
**Status of the WHO
 Framework Convention
 on Tobacco Control,
 as at 22 May 2015
 (continued)**

- * Ratification is the international act by which countries that have already signed a treaty or convention formally state their consent to be bound by it.
- ^a Accession is the international act by which countries that have not signed a treaty/convention formally state their consent to be bound by it.
- ^A Acceptance is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- ^{AA} Approval is the international act, similar to ratification, by which countries that have already signed a treaty/convention formally state their consent to be bound by it.
- ^c Formal confirmation is the international act corresponding to ratification by a State, whereby an international organization (in the case of the WHO FCTC, competent regional economic integration organizations) formally state their consent to be bound by a treaty/convention.
- ^d Succession is the international act, however phrased or named, by which successor States formally state their consent to be bound by treaties/conventions originally entered into by their predecessor State.

COUNTRY	DATE OF SIGNATURE	DATE OF RATIFICATION* (OR LEGAL EQUIVALENT)
Malawi		
Malaysia	23 September 2003	16 September 2005
Maldives	17 May 2004	20 May 2004
Mali	23 September 2003	19 October 2005
Malta	16 June 2003	24 September 2003
Marshall Islands	16 June 2003	8 December 2004
Mauritania	24 June 2004	28 October 2005
Mauritius	17 June 2003	17 May 2004
Mexico	12 August 2003	28 May 2004
Micronesia (Federated States of)	28 June 2004	18 March 2005
Monaco		
Mongolia	16 June 2003	27 January 2004
Montenegro		23 October 2006 ^d
Morocco	16 April 2004	
Mozambique	18 June 2003	
Myanmar	23 October 2003	21 April 2004
Namibia	29 January 2004	7 November 2005
Nauru		29 June 2004 ^a
Nepal	3 December 2003	7 November 2006
Netherlands	16 June 2003	27 January 2005 ^A
New Zealand	16 June 2003	27 January 2004
Nicaragua	7 June 2004	9 April 2008
Niger	28 June 2004	25 August 2005
Nigeria	28 June 2004	20 October 2005
Niue	18 June 2004	3 June 2005
Norway	16 June 2003	16 June 2003 ^{AA}
Oman		9 March 2005 ^a
Pakistan	18 May 2004	3 November 2004
Palau	16 June 2003	12 February 2004
Panama	26 September 2003	16 August 2004
Papua New Guinea	22 June 2004	25 May 2006
Paraguay	16 June 2003	26 September 2006
Peru	21 April 2004	30 November 2004
Philippines	23 September 2003	6 June 2005
Poland	14 June 2004	15 September 2006
Portugal	9 January 2004	8 November 2005 ^{AA}
Qatar	17 June 2003	23 July 2004
Republic of Korea	21 July 2003	16 May 2005
Republic of Moldova	29 June 2004	3 February 2009
Romania	25 June 2004	27 January 2006
Russian Federation		3 June 2008 ^a
Rwanda	2 June 2004	19 October 2005
Saint Kitts and Nevis	29 June 2004	21 June 2011
Saint Lucia	29 June 2004	7 November 2005
Saint Vincent and the Grenadines	14 June 2004	29 October 2010
Samoa	25 September 2003	3 November 2005
San Marino	26 September 2003	7 July 2004
Sao Tome and Principe	18 June 2004	12 April 2006
Saudi Arabia	24 June 2004	9 May 2005
Senegal	19 June 2003	27 January 2005
Serbia	28 June 2004	8 February 2006

COUNTRY	DATE OF SIGNATURE	DATE OF RATIFICATION* (OR LEGAL EQUIVALENT)
Seychelles	11 September 2003	12 November 2003
Sierra Leone		22 May 2009 ^a
Singapore	29 December 2003	14 May 2004
Slovakia	19 December 2003	4 May 2004
Slovenia	25 September 2003	15 March 2005
Solomon Islands	18 June 2004	10 August 2004
Somalia		
South Africa	16 June 2003	19 April 2005
South Sudan		
Spain	16 June 2003	11 January 2005
Sri Lanka	23 September 2003	11 November 2003
Sudan	10 June 2004	31 October 2005
Suriname	24 June 2004	16 December 2008
Swaziland	29 June 2004	13 January 2006
Sweden	16 June 2003	7 July 2005
Switzerland	25 June 2004	
Syrian Arab Republic	11 July 2003	22 November 2004
Tajikistan		21 June 2013 ^a
Thailand	20 June 2003	8 November 2004
The former Yugoslav Republic of Macedonia		30 June 2006 ^a
Timor-Leste	25 May 2004	22 December 2004
Togo	12 May 2004	15 November 2005
Tonga	25 September 2003	8 April 2005
Trinidad and Tobago	27 August 2003	19 August 2004
Tunisia	22 August 2003	7 June 2010
Turkey	28 April 2004	31 December 2004
Turkmenistan		13 May 2011 ^a
Tuvalu	10 June 2004	26 September 2005
Uganda	5 March 2004	20 June 2007
Ukraine	25 June 2004	6 June 2006
United Arab Emirates	24 June 2004	7 November 2005
United Kingdom of Great Britain and Northern Ireland	16 June 2003	16 December 2004
United Republic of Tanzania	27 January 2004	30 April 2007
United States of America	10 May 2004	
Uruguay	19 June 2003	9 September 2004
Uzbekistan		15 May 2012 ^a
Vanuatu	22 April 2004	16 September 2005
Venezuela (Bolivarian Republic of)	22 September 2003	27 June 2006
Viet Nam	3 September 2003	17 December 2004
Yemen	20 June 2003	22 February 2007
Zambia		23 May 2008 ^a
Zimbabwe		4 December 2014 ^a

Source: United Nations Treaty Collection web site https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IX-4&chapter=9&lang=en, accessed 22 May 2015).

Though not a Member State of WHO, as a Member State of the United Nations, Liechtenstein is also eligible to become Party to the WHO FCTC, though it has taken no action to do so.

On submitting instruments to become Party to the WHO FCTC, some Parties have included notes and/or declarations. All notes can be viewed at https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IX-4&chapter=9&lang=en



Acknowledgements

The World Health Organization gratefully acknowledges the contributions made to this report by the following individuals:

WHO African Region:

Gracia Mabaya, Ezra Ogwel Ouma, Nivo Ramanandraibe.

WHO Region of the Americas:

Adriana Blanco, Roberta Caixeta, Leticia Martinez Lopez, Rosa Sandoval.

WHO South-East Asia Region:

Naveen Agarwal, Mahfuzul Huq (Bangladesh), Dina Kania (Indonesia), Nyo Nyo Kyaing, Vineet Munish (India), Farrukh Qureshi (Indonesia), Dharendra N Sinha.

WHO European Region:

Toker Ergüder (Turkey), Matheus Guerra, Josephine Jackisch, Elizaveta Lebedeva, Kristina Mauer-Stender, Nataliia Toropova (Russian Federation), Trudy Wijnhoven.

WHO Eastern Mediterranean Region:

Fatimah El-Awa, Heba Fouad, Aya Mostafa Kamal Eldin.

WHO Western Pacific Region:

Mina Kashiwabara, Kelvin Khow, Angela Pratt (China), Pham Thi Quynh Nga (Viet Nam), Susy Mercado, Ada Moadsiri, Lam Nguyen Tuan (Viet Nam), James Rarick, Florante Trinidad.

WHO Headquarters Geneva:

Virginia Arnold, Lubna Bhatti, Benn McGrady, Titus Molkenbur, Vinayak Prasad, Luminita Sanda, Lina Sovani, Emily Wymer.

Special thanks to Vera Luiza da Costa e Silva, Guangyuan Liu, and Tibor Szilagyi from the World Health Organization Framework Convention on Tobacco Control Secretariat for their contributions to several chapters of this report as well as for their overall comments on the draft.

Kerstin Schotte coordinated the production of this report.

Administrative support was provided by: Zahra Ali Piazza, Miriamjoy Aryee-Quansah, Emmanuel Blavo, Gareth Burns, Gloria Haselmann, Luis Madge, Carolyn Patten, Rosane Serrao and Elizabeth Tecson.

Armando Peruga was responsible for the country legislation assessment and analysis

performed by Marine Perraudin with support from Maren Langhorst, Euan O'Neill and KyungHyun Park.

Data management, data analysis and creation of tables, graphs and appendices were performed by Alison Commar. The prevalence estimates were calculated by Alison Commar and Edouard Tursan d'Espaignet, with a statistical model developed by Ver Luanni Feliciano Bilano. Sameer Pujari and Amulya Reddy provided support for this work.

Data on tobacco cessation were updated by Dongbo Fu.

Financial and economic review and analysis, including tobacco taxation and prices, were provided by Anne-Marie Perucic with the support of Rajeev Cherukupalli, Jami Husain, Avdyl Ramaj and Alejandro Ramos. Tax and price data were collected with support from officials from ministries of finance and ministries of health, and by Luk Joossens, Konstantin Krasovsky and Ada Moadsiri.

The "Raise taxes on tobacco" chapter was prepared with invaluable input of Aftab Baloch, Abdoul Azizou Barmou Batoure, Douglas Bettcher, Melanie Bertram, Jo Birckmayer, Evan Blecher, Mod Ceesay, Frank Chaloupka, Katherine Deland, Sofia Delipalla, Jennifer Ellis, Mark Goodchild, Kelly Henning, Mauricio Hernandez-Avila, Teh-Wei Hu, Ghulam Hussain, Paul Isenman, Konstantin Krasovsky, Montserrat Meiro-Lorenzo, Nigar Nargis, Jeremias Paul, Anne-Marie Perucic, Armando Peruga, Alejandro Ramos, Kerstin Schotte, Frank Van Driessche, Ken Warner and Ayda Yurekli.

Thanks also to Rajeev Cherukupalli who, among others, provided much-appreciated input and comments.

We thank Jennifer Ellis and Kelly Henning of the Bloomberg Initiative to Reduce Tobacco Use for their collaboration.

Our thanks also go to Colin Mathers and Gretchen Stevens from the WHO Mortality & Burden of Disease Department, to Florence Rusciano for providing the maps, and to

the team of the Office on Smoking and Health of the US Centers for Disease Control and Prevention, as well as to the Institute for Global Tobacco Control at the Johns Hopkins Bloomberg School of Public Health.

We would like to thank World Lung Foundation for their collaboration in collecting and reviewing the data on tobacco control mass media campaigns, specifically Christina Curell and Alexey Kotov. We would also like to thank Enrico Aditjondro, Tom Carroll, Claudia Cedillo, Winnie Chen, Stephen Hamill, Chun-Yu Huang, Mego Lien, Vaishakhi Mallik, Irina Morozova, Sandra Mullin, Nandita Murukulta and Rebecca Perl.

Special thanks also to the Campaign for Tobacco Free Kids, especially Jo Birckmayer, Liz Candler, Maria Carmona, Kaitlin Donley, Emma Green and Monique Muggli for their constructive exchange of tobacco control information and legislation. Thanks also to Rob Cunningham from the Canadian Cancer Society for exchanging information on health warning labels. Yul Dorotheo from SEATCA provided valuable input for the Philippines case study.

We thank the team from Alboum for the quality and speed with which we received the translations of legislation.

Drew Blakeman acted as principal drafter of this report. Douglas Bettcher, Vera Luiza da Costa e Silva and Armando Peruga reviewed the full report and provided final comments. Special thanks are due to our copyeditor and proofreader Angela Burton and our designer Jean-Claude Fattier for their efficiency in helping to get this report published on time.

Production of this WHO document has been supported by a grant from the World Lung Foundation with financial support from Bloomberg Philanthropies. The contents of this document are the sole responsibility of WHO and should not be regarded as necessarily reflecting the position of the World Lung Foundation.

Photographs and illustrations

© World Health Organization

Page 11
Page 13 – Photographer: Christopher Black
Page 20 – Photographer: Fernando G. Revilla
Page 26 – Photographer: Fernando G. Revilla
Page 28 – Photographer: Ashaluck Bhatiasavi
Page 42
Page 47
Page 55 – Photographer: Daruvath Yel
Page 61 – WHO Country Office China
Page 62
Page 70 – Photographer: Sergey Volkov
Page 74 – WHO Regional Office for the Eastern Mediterranean
Page 85
Page 91 – WHO Regional Office for Europe
Page 92 – Photographer: Christopher Black
Page 116 – Photographer: Ashaluck Bhatiasavi

© The World Bank

Page 15
Page 16 – Photographer: Curt Carnemark
Page 18 – Photographer: Graham Crouch
Page 32 – Photographer: Curt Carnemark
Page 36 – Photographer: Curt Carnemark
Page 41 – Photographer: Mariana Ceratti
Page 59 – Photographer: Curt Carnemark
Page 98 – Photographer: Curt Carnemark
Page 130
Page 170 – Photographer: Curt Carnemark
Page 184 – Photographer: Arne Hoel
Page 190 – Photographer: Curt Carnemark
Page 196 – Photographer: Aisha Faquir

Page 22 – © WHO/WHO FCTC Secretariat
Page 44 – © Kenya Revenue Authority and SICPA
Page 49 – © Ministry of Healthcare, Russian Federation
Page 56 – © World Lung Foundation, photographer: Aleksey Spasskiy
Page 60 – © Campaign for Tobacco-Free Kids (CTFK)
Page 61 – © Office National de Lutte Antitabac, Madagascar
Page 65 – © Smoke Free City Project of Melaka State Health Department, Malaysia
Page 66 – © WHO FCTC Secretariat
Page 66 – © Photocall Ireland, photographer: Mark Stedman
Page 69 – © Ministry of Public Health, Thailand
Page 70 – © Ministry of Health, Egypt
Page 73 – © World Lung Foundation
Page 77 – © Cooperativa 21 de Octubre, Uruguay
Page 86 – © Ministry of Finance, Brazil
Page 87 – © Malacanang Photo Bureau, Philippines
Page 87 – © Keystone/Magnum photos, photographer: Dominic Nahr
Page 91 – © Ministry of Health and Family Welfare, India

Design by **Estúdio infinito**

Layout by **Jean-Claude Fattier**

Printed by **Imprimerie Centrale**





**World Health
Organization**

**20 Avenue Appia
CH-1211 Geneva 27
Switzerland
www.who.int/tobacco**

ISBN 978 92 4 150912 1



9 789241 509121