WHO-EM/TFI/195/E

Regional strategy and action plan for TOBACCO CONTROL 2019–2023

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

Regional strategy and action plan for

TOBACCO CONTROL

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1. Introduction

Tobacco kills more than 7 million people globally each year, as a result of direct tobacco use and from exposure second-hand smoke. A significant proportion of these deaths are due to noncommunicable diseases – heart disease, cancer, stroke, and chronic lung disease – that are caused and exacerbated by tobacco use. In the World Health Organization (WHO) Eastern Mediterranean Region, more than 57% of all deaths are due to noncommunicable diseases; more than half of these deaths occur in persons under 70 years of age.[1] Tobacco is imposing a substantial health and economic burden and contributing to the rising noncommunicable disease-related premature mortality in the Region.

Member States recognize the gravity of the Region's tobacco epidemic, and must further intensify their commitment to curb tobacco consumption by seeking to reach the highest level of policy achievement and stability to create real and lasting change. This document seeks to provide a strategy towards halting the tobacco epidemic in the Region for the next 5 years.

Global and regional commitments

In September 2011, the United Nations (UN) General Assembly adopted the UN Political Declaration on the Prevention and Control of Non-communicable Diseases.[2] This landmark document identified the critical role of tobacco control in mitigating the noncommunicable disease epidemic and committed Member States to accelerate implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC). The Political Declaration also stipulated the establishment of measureable global noncommunicable disease targets by 2012. In May 2013, the Sixty-sixth World Health Assembly endorsed the Global monitoring framework for noncommunicable disease prevention and control, including a specific target of a 30% relative reduction in the prevalence of tobacco consumption among persons aged 15 years or above by 2025.

The UN General Assembly formally adopted the 2030 Agenda for Sustainable Development in September 2015. Target 3.4 under the overall health goal (SDG 3) is a one-third reduction of noncommunicable disease-related premature mortality by 2030.

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[1] Noncommunicable diseases: what is the regional burden? Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (http://www.emro.who.int/entity/ncds/index.html).

[2] UN Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. 66th Session of the UN General Assembly, September 2011 (A/66/L.1).

Target 3.A of the goal is to strengthen the implementation of the WHO FCTC in all countries, as appropriate, as means of reaching SDG 3 by 2030.[3]

The WHO FCTC is the most powerful evidence-based tool available to assist governments in meeting the targets of a 30% reduction in tobacco use and one-third reduction in noncommunicable disease-related premature mortality by 2030. Its Articles delineate both demand reduction and supply restriction measures to curb tobacco use; the major FCTC provisions, but not all, are addressed by the MPOWER measures. (Note: MPOWER is an acronym for the key tobacco control interventions, and is fully subordinate to the WHO FCTC.)

In 2016, WHO FCTC Parties at the Seventh session of the Conference of the Parties affirmed their commitment to achieving SDG targets 3.4 and 3.a. The Conference of the Parties called upon Parties to report at its next session on efforts to set national tobacco use reduction targets in line with the voluntary global targets of WHO's *Global monitoring framework on noncommunicable diseases*, and to report on progress towards reducing tobacco use.[4] This was followed in 2017 by the Montevideo roadmap 2018–2030, which was drafted and endorsed by world leaders to reinforce global support for noncommunicable disease prevention and control, with tobacco control as a cornerstone for action against noncommunicable diseases.[5]

To date, 19 of the 22 Member States of the Region are Parties to the WHO FCTC (Morocco and Somalia have yet to ratify the Convention; Palestine is officially a non-member observer state in the UN, and therefore is currently not eligible to ratify the Convention). Parties are legally bound to fully implement its articles according to the timeline set by the Conference of the Parties.[6] However, implementation of the WHO FCTC remains suboptimal in the Region; those that are Parties to the Convention face challenges to the full implementation of the Treaty's provisions.

Overview and methodology

At the 64th session of the Regional Committee for the Eastern Mediterranean in October 2017, the Committee requested the Regional Director to engage with Member States, relevant stakeholders and partners to develop a regional strategy and action plan for

[3] Sustainable Development Goal 3: ensure healthy lives and promote well-being for all at all ages. In: Sustainable development knowledge platform [website]. New York: United Nations; 2017 (https://sustainabledevelopment.un.org/sdg3, accessed 25 June 2017).

[4] Decision: contribution of the Conference of the Parties to achieving the noncommunicable disease global target on the reduction of tobacco use. Geneva: Conference of the Parties to the WHO Framework Convention on Tobacco Control, Seventh Session; 2016 (FCTC/COP7(27); (http://www.who.int/fctc/cop/cop7/FCTC_COP7(27)_EN.pdf, accessed 25 June 2017).

[5] Montevideo roadmap 2018–2030 on NCDs as a sustainable development priority. Montevideo: World Health Organization; 2017 (http://www.who.int/conferences/global-ncd-conference/Roadmap.pdf, accessed 15 January 2018).

[6] WHO's Framework Convention on Tobacco Control: a response to the global epidemic. Cairo: WHO Regional Office for the Eastern Mediterranean; 2010 (http://applications.emro.who.int/dsaf/emropub_2010_1246.pdf).

tobacco control reflecting the commitments of the WHO FCTC, to be presented for endorsement by the Regional Committee at its 65th session in 2018.[7]

This regional strategy and action plan for tobacco control 2019–2023 reflects the heightened awareness of the urgency of implementing the Articles of the WHO FCTC to substantially reduce the burden of tobacco-related noncommunicable diseases. The action plan provides the vision and strategy to effectively address the tobacco epidemic in the Region over the next 5 years. It acknowledges and builds upon the previous regional action plan and incorporates new evidence to highlight "best buys" for tobacco control – the core of the demand reduction and supply interventions contained in the WHO FCTC.

The 2018 launch of the regional strategy and action plan for tobacco control coincides with the Third UN High-level Meeting on Non-communicable Diseases, in which the WHO FCTC and tobacco control are envisioned to be major subjects of discussion. Thus, the regional strategy is positioned to further mobilize political will and country commitment to tobacco control as a fundamental public health priority to counter the escalating burden from noncommunicable diseases.

Based on the recommendations of various regional meetings on tobacco control and noncommunicable disease prevention and control, this document underscores the importance of collaborative efforts to increase country capacity and to accelerate the momentum for effective tobacco control by:

- mobilizing political support for 100% ratification and full implementation of the WHO FCTC by Member States of the Eastern Mediterranean Region, and protecting tobacco control policy from tobacco industry interference;
- enhancing the capacity of Member States to successfully implement and enforce the provisions of the Convention to reduce the demand for tobacco, while restricting its supply, at the country and subnational levels;
- ensuring that surveillance and monitoring result in coordinated and sustainable regional tobacco control efforts, and keeping track of legislation enforcement to promote compliance with established tobacco control policies.

This document is the result of a systematic effort to collaboratively develop a regional strategy and action plan for tobacco control that outlines key objectives, actions, expected results and indicators for Member States of the Region, consistent with the WHO FCTC. The Tobacco Free Initiative team at the Regional Office reviewed existing documents, meeting reports and data to develop a strategy and action plan, including inputs from Member States. The strategy underwent an initial round of peer review coordinated through the Regional Office, and further technical review by national tobacco focal points, regional tobacco control experts and selected relevant stakeholders. The revised document was discussed and finalized with national focal

[7]Annual report of the Regional Director for 2016. Regional Committee for the Eastern Mediterranean Sixty-fourth Session Agenda item 2. EM/RC64/R.1. Cairo: Regional Office for the Eastern Mediterranean; 2017 (http://applications.emro.who.int/docs/RC64_Resolutions_2017_R1_20124_EN.pdf?ua=1).

points using teleconferences and video conferences. The final strategy was presented to the Regional Committee at its 65th session in October 2018, for review and endorsement by Member States.

2. Situation in the Region

Situation analysis

Tobacco use is a significant contributor to mortality and disease burden in the Region. Estimates indicate that tobacco use is responsible for 7% of all adult deaths, accounting for 12% of all adult male deaths and 2% of all adult female deaths. Smoking is estimated to cause about 67% of all lung cancer deaths, 34% of chronic respiratory disease deaths and 8% of cardiovascular disease deaths in the Region. Tobacco use accounted for 9% of all lower respiratory infection deaths and 5% of all tuberculosis deaths.[8] As tobacco consumption rises, the proportion of tobacco-related deaths borne by the Region can be expected to increase accordingly.

In addition to premature death and disability, the tobacco epidemic imposes a serious economic burden on countries. Health care costs from tobacco-related diseases can drain national health resources and shift funds from other needed health care priorities. In Egypt, for example, the direct cost estimate of smoking during the period 2003–2008 exceeded 11% of the country's total health care expenditure.[9]

Tobacco use also causes significant preventable disability, comprising approximately 2% of all disability-adjusted life years (DALYs) in the Region.[10] The majority of individuals affected are of working age; the costs of lost labour productivity compound the economic losses due to tobacco use. Moreover, within the Region, over 98% of DALYs are borne by low- and middle-income countries.

On average, close to 1 in 5 adults in the Region currently smokes tobacco. Smoking prevalence varies widely across countries, and consumption is generally lower among adult females than males.[11] However, tobacco consumption among women is likely to be underreported, and the official prevalence rates may underestimate actual use. Smoking prevalence among youth aged 13–15 years mirrors adult prevalence, except the difference between the genders is reduced. The difference between the genders in smoking prevalence is more noticeably reduced among users of smokeless tobacco.[12]

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[8] WHO global report: mortality attributable to tobacco. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/handle/10665/44815/9789241564434_eng.pdf?sequence=1).

[9] Tobacco taxation in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2010 (http://applications.emro.who.int/dsaf/emropub_2010_1247.pdf?ua=1&ua=1).

[10] Global health risks: mortality and burden of disease attributable to selected major risks. Geneva: World Health Organization; 2009 (http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf).

[11] WHO report on the global tobacco epidemic, 2017: monitoring tobacco use and prevention policies. Geneva: World Health Organization; 2017.

[12] WHO global youth tobacco surveys, 2010–2016.

Smokeless tobacco use in the Region is increasing rapidly, especially among young people and women. The Region has some of the highest rates in the world with overall rates of use of tobacco products other than cigarettes (including smokeless tobacco) of 14% among boys aged 13–15 (compared to 7% cigarette use) and 9% among girls aged 13–15 (compared to 2% cigarette use). In many countries, more women and young people use other tobacco products rather than smoke cigarettes.[13]

This raises the potential for poorer reproductive outcomes due to tobacco use if consumption rates among young females are not reduced in the near future. Over the longer term, the trend foreshadows rising tobacco-related morbidity and mortality among women in the Eastern Mediterranean Region.

The *WHO global report on trends in prevalence of tobacco smoking 2015* noted that the Eastern Mediterranean Region is one of two WHO regions that did not demonstrate a decline in smoking prevalence between 2000 and 2012. Prevalence projections indicate that, at the current level of implementation of tobacco control efforts, the Region can expect to see an increase in current tobacco smoking from an average of 19.5% in 2010 to 24.6% in 2025.[29]

Several country-specific projections are of particular concern. For instance, Bahrain is projected to experience a dramatic increase in adult smoking from 25% in 2010 to about 60% in 2025 if tobacco control efforts remain at the current level. Oman's adult smoking prevalence is estimated to more than double, from 11% in 2010 to around 23% in 2025.[14]

Waterpipe smoking

Waterpipe smoking is a traditional method of tobacco consumption that is customary in the Middle East. Tobacco smoke in a waterpipe passes through water before being inhaled by the consumer.[15] This has led to the wrong belief that water filters the smoke and eliminates its toxic chemicals, and that waterpipe smoking is less harmful than other forms of tobacco and is associated with lower degrees of nicotine dependence.[16] However, numerous studies have shown that waterpipe smoke contains several carcinogens, heavy metals and other toxins, and is associated with smoking-related diseases.[17] Evidence suggests that a single use of waterpipe is equal to smoking 100

[13] The truth about smokeless tobacco use. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (http://www.emro.who.int/tfi/know-the-truth/smokeless-tobacco-use.html#tobacco, accessed 20 August 2017).

[14] WHO global report on trends in prevalence of tobacco smoking 2015. Geneva: World Health Organization; 2015 (http://www.who.int/tobacco/publications/surveillance/reportontrendstobaccosmoking/en/index4.html, accessed 20 August 2017).

[15] Shihadeh A. Investigation of mainstream smoke aerosol of the argileh water pipe. Food Chem Toxicol. 2003;41(1):143–52.

[16] Smith-Simone S, Maziak W, Ward KD, Eissenberg T. Waterpipe tobacco smoking: knowledge, attitudes, beliefs, and behavior in two U.S. samples. Nicotine Tob Res. 2008;10(2):393–8.

[17] Akl EA, Gaddam S, Gunukula SK, Honeine R, Jaoude PA, Irani J. The effects of waterpipe tobacco smoking on health outcomes: a systematic review. Int J Epidemiol 2010;39(3):834–57.

cigarettes in terms of the amount of toxins entering the body.[18] Nonetheless, the prevalence of waterpipe smoking is increasing worldwide, including in Europe and North America.[19] A study in the Islamic Republic of Iran found that 30% of participants reported using waterpipes.[20]

A study in Mediterranean countries showed that waterpipes had replaced cigarettes as the most common form of tobacco consumption.[21] Some young adult users of waterpipes have never smoked cigarettes. This finding suggests that millions of young adults are exposed to tobacco smoke via waterpipes and become addicted to nicotine.[22] A significant association between cigarette and waterpipe smoking has been previously documented. However, sufficient evidence does not exist to support the role of cigarette smoking as a predictor of waterpipe smoking in young adults. Most young individuals initially experience tobacco by smoking waterpipes, which may lead on to cigarette smoking.[23]

Countries in emergencies

As of 2016, the Eastern Mediterranean Region is home to more than 76 million people affected by political conflict, natural disasters and the health issues that accompany large-scale emergencies. Three countries (Somalia, Syrian Arab Republic and Yemen) are in grade 3 emergencies, four countries (Iraq, Libya, Palestine and Sudan) are in grade 2, and one country (Afghanistan) is at grade 1. The disruption in normal governance processes, weakening of the health care infrastructure, displaced populations and refugees, and heightened priority for human security and survival pose serious challenges to effective tobacco control.

The current evidence base on tobacco control in countries in emergencies is extremely limited and significant gaps exist. However, research has shown the following:

- conditions surrounding the emergency may increase the likelihood or increase the frequency of tobacco use; in addition, exposure to secondhand smoke is high;[24]

[18] Cobb CO, Shihadeh A, Weaver MF, Eissenberg T. Waterpipe tobacco smoking and cigarette smoking: a direct comparison of toxicant exposure and subjective effects. Nicotine Tob Res. 2011;13(2):78–87.

[19] Maziak W, Ward KD, Eissenberg T. Interventions for waterpipe smoking cessation. Cochrane Database Syst Rev. 2007;(4):CD005549.

[20] Sadr M, Abdolahinia A, Masjedi M. Prevalence of hookah consumption in Tehran. Eur Res J. 2012;40(56):P4068.

[21] Maziak W. The waterpipe: an emerging global risk for cancer. Cancer Epidemiol. 2013;37(1):1–4.

[22] Amin TT, Amr MA, Zaza BO, Suleman W. Harm perception, attitudes and predictors of waterpipe (shisha) smoking among secondary school adolescents in Al-Hassa, Saudi Arabia. Asian Pac J Cancer Prev. 2010;11(2):293–301.

[23] McKelvey KL, Wilcox ML, Madhivanan P, Mzayek F, Khader YS, Maziak W. Time trends of cigarette and waterpipe smoking among a cohort of school children in Irbid, Jordan, 2008–11. Eur J Public Health. 2013;23(5):862–7.

[24] Jawad M, Khader A and Millett C. Differences in tobacco smoking prevalence and frequency between adolescent Palestine refugee and non-refugee populations in Jordan, Lebanon, Syria and the West Bank: cross sectional analysis of the Global Youth Tobacco Survey. Confl Health. (2016) 10:20.

- the increase in tobacco consumption extends beyond the civilian population to members of military;[25]
- breakdown in governance structures can impede enactment of strong tobacco control legislation and weaken existing policies;
- the tobacco industry can take advantage of political disruption to maximize sales, through illicit trade and other tactics.[26]

Persistent tobacco consumption adds to the health burden evoked by humanitarian emergencies. It aggravates the adverse health impact accompanying crisis conditions, and depletes family resources at a time of financial need. With illicit trade in tobacco products, governments are also losing tax revenues at a time when they have higher health care costs.[27]

While some may argue that tobacco control is not a priority during times of crisis, the existing evidence indicates that objectively, tobacco control is even more urgent during political turmoil and natural disasters. Acknowledging this, the United Nations for Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) has made tobacco control a priority, incorporating tobacco control into its efforts to strengthen primary health care services to refugees.[28] Where appropriate, this regional strategy indicates suggested tobacco control actions for countries in crisis. The Eighth session of the Conference of the Parties to the WHO FCTC in October 2018 will address tobacco control implementation in countries in emergencies.

Challenges to tobacco control

Much of the disease burden and premature mortality attributable to tobacco use disproportionately affect the poor. Tobacco use can also compound poverty. Several studies have shown that in the poorest households in low-income countries, as much as 10–17% of total household expenditure is on tobacco. This means that impoverished families have less money to spend on essential items such as food, health care and education.

Raising tobacco taxes to increase tobacco product prices is likely the most powerful strategy to quickly reduce tobacco use, especially among the poor and youth. The Eastern Mediterranean Region has the lowest average tobacco prices and the second-

[25] Smith B, Ryan M, Wingard D, Patterson TL, Slymen DJ, Macera CA. Cigarette smoking and military deployment: a prospective evaluation. Am J Prev Med. 2006;35(6):539–46. doi: 10.1016/j.amepre.2008.07.009.

[26] Titeca K, Joossens L, Raw M. Blood cigarettes: cigarette smuggling and war economies in central and eastern Africa. Tob Control. 2011;20:226–32. doi: 10.1136/tc.2010.041574.

[27] Prasad V, Schwerdtfeger U, El-awa F, Bettcher D, da Costa e Silva V. Closing the door on illicit tobacco trade, opens the way to better tobacco control. East Mediterr Health J. 2015;21:6.

[28] UNRWA's efforts in tobacco control. 2014. https://www.globalbridges.org/spotlight/unrwas-efforts-in-tobacco-control/#.WlxUMCOB2jg

lowest average excise tax per pack compared to other WHO regions.[29] However, in 2017, the Gulf Cooperation Council (GCC) Unified Treaties for VAT and Excise Tax provided for increases in excise taxes on tobacco (100%), soft drinks (50%) and energy drinks (100%). Once fully implemented, GCC countries may see significant declines in tobacco and unhealthy drinks consumption.

Tobacco advertising bans remain incomplete in the majority of countries, providing the tobacco industry with multiple loopholes to promote their products. In addition, non-traditional advertising has been observed to be rising across the Region. Data indicate that tobacco advertising and promotion in drama is associated with increased prevalence of tobacco consumption, especially among young people. Often, tobacco use in drama is much higher than in real life, creating a false norm that promotes the acceptability of tobacco use, particularly among women.[30]

The addictive properties of nicotine make cessation difficult, even for those tobacco users who are highly motivated to quit. This is coupled with a paucity of systematic cessation guidelines and programmes in many countries, particularly addressing the use of smokeless tobacco and waterpipes, and the high cost of pharmacologic treatment for nicotine addiction.

Illicit trade in tobacco is rampant in several countries within the Region,[31] involving both smoked and smokeless tobacco products.[32]

All these factors make tobacco control an urgent public health priority, especially among the low- and middle-income countries of the Eastern Mediterranean Region. Overall, tobacco control experts have identified two main reasons for the inconsistent progress in tobacco control within the Region:

- willingness to accept a "comfort zone" level of policy implementation instead of striving for the highest possible level of achievement;
- absence of policy stability over time.[33]

[29] Tobacco taxation in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2010 (http://applications.emro.who.int/dsaf/emropub_2010_1247.pdf?ua=1&ua=1).

[30] Titeca K, Joossens L, Raw M. Blood cigarettes: cigarette smuggling and war economies in central and eastern Africa. Tob Control. 2011;20:226–32. doi: 10.1136/tc.2010.041574.

[31] Heydari G, Tafti SF, Telischi F, Joossens L, Hosseini M, Masjedi M, et al. Prevalence of smuggled and foreign cigarette use in Tehran, 2009. Tob Control. 2010;19:380–2.

[32] Illicit Trade Report 2013. Brussels: World Customs Organization; 2014.

[33] El-awa F, Vinayak P and Bettcher D. Moving away from the comfort zone of tobacco control policies to the highest level if implementation. East Mediterr Health J. 2016;22:3(85–6).

Opportunities for progress

While the WHO FCTC provides guidelines to reduce the harm from tobacco use, definitive action to control tobacco use must take place at the national level. This requires good governance and long-term political commitment to developing and sustaining country capacity, identifying and appropriating the resources needed for comprehensive tobacco control, and protecting tobacco control initiatives from tobacco industry interference. It also necessitates proactive efforts to identify and nurture tobacco control leaders and champions at all levels of society.

Ensuring the sustainability of tobacco control programmes remains a major challenge for many countries, and must be addressed. Attempts by the tobacco industry to oppose or circumvent national and regional tobacco control efforts will escalate as Member States expand implementation of the WHO FCTC. Strategic collaboration with other health programmes and diverse sectors within governments as well as with development partners, international agencies and nongovernmental organizations is needed to safeguard the WHO FCTC and strengthen national tobacco control efforts. Innovative means to finance tobacco control (i.e. tobacco taxes and/or the creation of a special fund) should be pursued by countries. Opportunities exist with the recent high profile given to noncommunicable diseases at the Third UN High-level Meeting on Noncommunicable Diseases in September 2018, and the growing interest in tobacco taxation structures that link tobacco tax revenues to health foundations.

In addition, Member States need to coordinate their efforts to address those aspects of the tobacco epidemic that transcend national borders. A major issue involves trade liberalization as it applies to tobacco products, and its impact on import duties. Other transnational issues include cross-borders illicit trade in tobacco products, global marketing and advertising.

Reliable surveillance and monitoring systems are essential to measure progress. A regional strategy to guide research and the generation of evidence to support policy and programme development is necessary throughout the entire process of tobacco control capacity-building.

3. Regional action plan for tobacco control 2019–2023

Vision

A healthy and tobacco-free Eastern Mediterranean Region, in which deaths and diseases caused by tobacco use are significantly reduced.

Mission

To empower Member States to fulfil their international obligations under the Convention, and enable countries to effectively address the tobacco epidemic and achieve the health–related SDG targets through full implementation of the WHO FCTC.

Goal and strategies

The goal of this action plan is to markedly reduce the health and socioeconomic burden from preventable tobacco-related deaths and diseases by reducing tobacco consumption and exposure to tobacco smoke through:

- strengthening political will and good governance to fully implement the WHO FCTC, and to protect tobacco control from tobacco industry interference;
- expanding the implementation of evidence-based strategies to reduce and eventually prevent the demand for tobacco;
- accelerating the implementation of evidence-based strategies to restrict and control the supply of tobacco and tobacco products;
- ensuring that surveillance and monitoring generate quality data to guide tobacco control actions, while keeping track of legislation enforcement to promote compliance with established tobacco control policies.

Areas of commitment

Four areas of commitment, which address various corresponding Articles of the WHO FCTC, have been identified.

- **Governance and political commitment** – 100% ratification of the WHO FCTC is a necessary prerequisite to drive national and regional tobacco control policies and interventions. Ratification needs to be followed with comprehensive

implementation, and support for national tobacco control programme infrastructure (Article 5). Strong leadership is necessary to protect against the tobacco industry's efforts to undermine tobacco control (Article 5.3).

- **Demand reduction** strategies for tobacco control through policy, legislation and needed health services consistent with the WHO FCTC (Articles 6–14) to prevent the demand for tobacco.
- **Supply restriction** strategies consistent with the WHO FCTC (Articles 15–17) to control the supply of tobacco and tobacco products.
- **Surveillance, monitoring and research** to provide the national and regional database that will guide future actions and track progress, particularly in policy enforcement, helping to ensure compliance at the highest achievable level (Article 20 and part of Article 5).

Guiding principles

In developing this action plan, six overarching principles have been recognized.

1. **Using evidence for action**. Sufficient evidence for effective action against the tobacco epidemic exists; the evidence is articulated in the WHO FCTC. The action plan further urges Member States to consider the experiences of other countries in the Region that have already implemented specific Articles of the WHO FCTC, and to apply the lessons learned when adapting interventions for their own populations.

2. **Emphasizing comprehensive approaches: demand reduction and supply restriction**. To be effective, tobacco control requires a complex mix of interventions that simultaneously address the need to: (1) reduce the demand for tobacco products; (2) restrict the supply; (3) counter tobacco industry interference; (4) ensure adequate national capacity and infrastructure; and (5) generate sound data to measure progress.

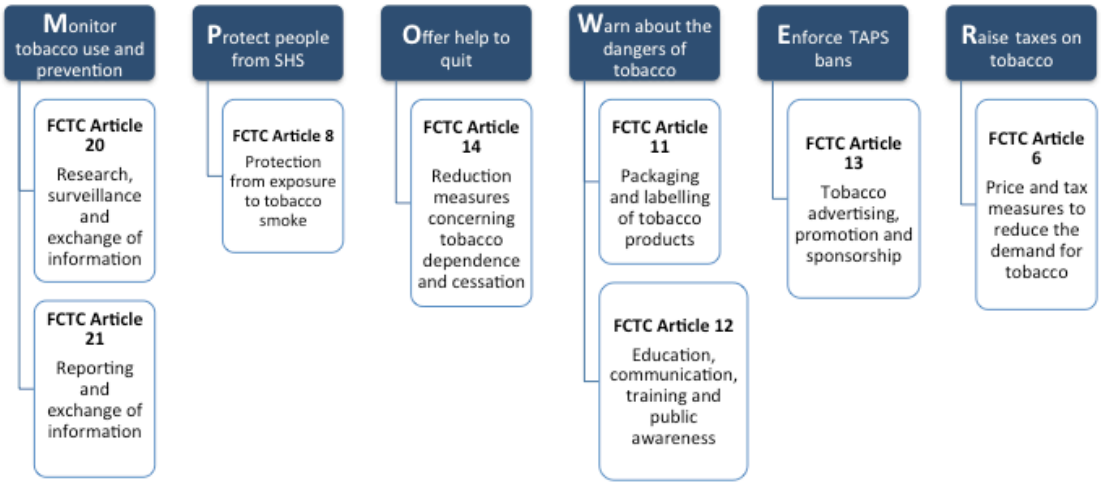

Fig.1. MPOWER measures to reduce demand for tobacco

Demand reduction interventions are covered by Articles 6–14 of the WHO FCTC. The most critical of these demand reduction strategies are highlighted by the WHO MPOWER package (see Fig. 1).[34]

The key supply restriction strategies include: (1) banning tobacco sales to and by minors; (2) controlling illicit trade in tobacco products; and (3) supporting economically viable alternatives to tobacco agriculture. Because tobacco agriculture continues to provide the means for livelihood in several countries, complementary measures are needed to ensure that tobacco farmers are assisted to transition to alternative crops. At the same time, it is essential to forestall any further expansion of tobacco agriculture in the Region.

Evidence shows that the tobacco industry has used a wide range of tactics to interfere with tobacco control at the global, regional, national and subnational levels in the past.[35] Measures to counter the tobacco industry will be critical to support the implementation of demand reduction and supply restriction strategies, given that effective tobacco control threatens the economic interests of the tobacco industry. Tobacco industry interference can be minimized by strict controls on interactions and by setting rules of engagement, as well as by demanding transparency and disclosure of tobacco industry conduct and finances.

3. **Fostering multisectoral collaboration, partnerships and networking at all levels.** Effective tobacco control necessitates multisectoral participation, strong partnerships and networking. At the national level, the health sector must engage with other government ministries to fully address the comprehensive nature of tobacco control. Within society in general, the public sector needs to work collaboratively with appropriate private sector counterparts for effective advocacy

[34] WHO report on the global tobacco epidemic, 2008: the MPOWER package. Geneva: World Health Organization; 2008 (http://apps.who.int/iris/bitstream/handle/10665/43818/9789241596282_eng.pdf?sequence=1).

[35] Tobacco industry interference with tobacco control. Geneva: World Health Organization; 2008 (http://apps.who.int/iris/bitstream/handle/10665/83128/9789241597340_eng.pdf?sequence=1).

and community mobilization to support tobacco control policies and programmes. A number of countries already have intersectoral mechanisms that facilitate the participation of relevant national stakeholders in tobacco control.

4. **Utilizing a pragmatic and iterative process that builds on existing work and facilitates ongoing quality improvement.** The process that underpins this action plan is an iterative one; that is, it should ideally incorporate an ongoing system for assessment, capacity-building, prioritization, implementation and evaluation that will provide continuous feedback to improve and revise strategies and interventions. The action plan also recognizes that countries are at different stages of capacity for tobacco control, and supports a phased or graduated approach that allows Member States to tailor their priorities and actions depending upon their local situation, capacity and resources.

5. **Tailoring interventions to address Region-specific needs: cultural competence.** While the evidence for effective action against tobacco is prescribed by the WHO FCTC, the implementation process should be adapted to address regional and country-specific needs. Local culture, language preferences and other unique characteristics of specific populations should be taken into consideration when designing the approaches and formats for implementation.

6. **Recognizing and reducing social inequity and the social determinants of tobacco use.** Finally, this action plan requires Member States to systematically address social inequities that directly or indirectly impact on tobacco consumption and exposure to tobacco smoke. Incorporating a perspective that considers gender, ethnicity, religion and other socioeconomic determinants is critical if Member States are to build capacity to resolve the fundamental causes of poor health and elevated risks among vulnerable populations.

4. Objectives, actions and indicators

Governance and political commitment

Objective 1: By 2023, attain ratification of the WHO FCTC in all Member States and ensure that infrastructure is in place for its implementation

Objective 1.1: By 2023, all Member States are Parties to the WHO FCTC.

(Note: Palestine is officially a non-member observer state in the UN, and is currently not eligible to ratify the WHO FCTC.)

Indicator: WHO FCTC ratification/accession rate
Baseline, as of April 2018: 19 out of 21 Member States are Parties to the WHO FCTC
Expected result, by 2023: All Member States (100%) are Parties to the WHO FCTC

Suggested actions for Member States

For non-Party Member States:

- Examine the country-specific reasons for non-ratification/accession and develop strategies to address the barriers.
- Collaborate with partners in the private sector to strategically advocate for ratification/accession of the WHO FCTC among pivotal government leaders and agencies.
- Explore and utilize strategic opportunities for national leaders to meet and interact with champions from other Member States in the Region who have ratified/acceded to the WHO FCTC.

For Member States that are already Parties to the WHO FCTC:

- Proactively engage in documenting the experience of tobacco control following becoming a Party to the WHO FCTC, and highlight best practices to share with other countries.

For Palestine:

- Enact national legislation and policies to mirror the Articles of the WHO FCTC to enable regional policy harmonization.

Suggested actions for WHO

- Provide technical assistance and training on implementation of the regional strategy and action plan and on how to calculate indicators and monitor progress.
- Provide technical assistance to non-Party Member States on the WHO FCTC and its opportunities and implications for countries.
- Facilitate networking opportunities between key health decision-makers from Party Member States and non-Party Member States.
- Facilitate networking opportunities and exchange of ideas between civil society partners of Party and non-Party Member States.
- Assist Palestine to develop tobacco control policies and legislation that are consistent with the WHO FCTC.

Suggested actions for civil society partners

In non-Party Member States:

- Identify and target key decision-makers to mobilize political support for ratification/accession to the WHO FCTC.
- Expand and sustain grassroots advocacy efforts for tobacco control to mobilize community support for ratification/accession to the WHO FCTC.

In Member States that are already Party to the WHO FCTC:

- Share experiences, lessons learned, strategies and tactics, and resources with civil society counterparts in non-Party Member States.

Objective 1.2: By 2023, all Member States will have developed comprehensive, multisectoral national tobacco control strategies, plans and programmes, in accordance with the WHO FCTC, and infrastructure for tobacco control implementation

Indicators:

1. Number of Member States with comprehensive, multisectoral national tobacco control strategies, plans and programmes, consistent with the WHO FCTC
2. Number of Member States with designated national tobacco control focal point
3. Number of Member States with national tobacco control unit
4. Number of Member States with designated national coordinating mechanism for tobacco control

Baseline, as of 2017:

1. Parties to the WHO FCTC with comprehensive, multisectoral national tobacco control strategies, plans and programmes = 5
2. Member States with designated national tobacco control focal point = 21
3. Member States with national tobacco control unit = 22
4. Member States with national coordinating mechanism for tobacco control = 10

Expected results, by 2023:

1. All Parties to the WHO FCTC (100%) have established comprehensive, multisectoral national tobacco control strategies, plans and programmes
2. All Member States (100%) have a designated national tobacco control focal point
3. All Member States (100%) continue to maintain a national tobacco control unit
4. All Member States (100%) have a designated national coordinating mechanism for tobacco control

Suggested actions for Member States

- Review and amend existing national tobacco control policies and legislation to reflect the Articles of the WHO FCTC, as a minimum standard for a comprehensive approach to tobacco control.
- If no policies or legislation exist, or if they are more than 5 years old, develop new policies that are consistent with the WHO FCTC.
- Establish and incorporate a multisectoral legislative and policy development agenda that addresses both demand- and supply-side interventions into the national strategic plan for tobacco control.
- Secure a designated national focal person for tobacco control, and establish a national tobacco control unit.
- Strengthen national coordinating mechanism for tobacco control to include representation by youth, women's and religious organizations, and other legitimate tobacco control stakeholders.
- Conduct stakeholder analysis among key decision-makers in institutional entities involved in policy adoption to identify potential legislative champions and advocacy targets.
- Facilitate provision of technical support and tools to legislative champions and key technical staff/units involved in drafting national tobacco control policies.
- Channel advocacy efforts from civil society and regional/international partners towards critical audiences to mobilize political support for WHO FCTC-consistent policies and legislation, and tobacco control personnel and programme support.
- Formulate targeted strategies to cover high-risk and hard-to-reach populations, especially the poor and underserved, whose tobacco use rates are significant, and incorporate these into the national plan of action. For countries in emergencies, consider interventions for refugees and displaced populations, military personnel and humanitarian workers.

Suggested actions for WHO

- Support Member States to comply with legislative requirements addressing the WHO FCTC guidelines and protocols through expanded technical assistance and resources including the Convention Secretariat.
- Identify Member States with no existing national action plans for tobacco control and provide technical support for the establishment of plans, ensuring consistency with the WHO FCTC requirements.
- For Member States with insufficient tobacco control programme infrastructure, advocate with the national health leadership to channel resources for augmenting tobacco control staffing.
- Support technical training and assistance to selected countries (particularly those with demonstrated need and political and programmatic readiness/commitment) for tobacco control policy development, consistent with the WHO FCTC.

- Develop models and best practices for dissemination that address tobacco control issues including gender, high-risk and hard-to-reach populations and poverty as they relate to tobacco control policies.

Suggested actions for civil society partners

- Scale up advocacy and community mobilization efforts to motivate political leaders to support national tobacco control policy adoption.
- Provide support to the national tobacco control programme in updating/expanding the national tobacco control action plan.
- Participate in multisectoral working groups for coordinating WHO FCTC compliance.
- Collaborate with public sector partners to develop effective tobacco control messages and communication networks capable of reaching a critical mass of political decision-makers.
- Shadowing the implementation unit: monitor progress in implementation of national action plans and stimulate government authorities to implement planned actions.

Objective 1.3: By 2023, establish regional and subregional mechanisms to address transnational tobacco control issues.

Indicators:

1. Number of regional and subregional networks and alliances that address transnational tobacco control issues
2. % of Member States covered by subregional and regional networks and alliances

Baseline: 0

Expected result, by 2023: The number of bilateral and multilateral partnerships addressing transnational tobacco control issues (such as illicit trade, cross-border/internet advertising) has increased.

Suggested actions for Member States

- Expand existing intercountry alliances that address tobacco control to include a greater number of Member States.
- Advocate for the inclusion of transnational tobacco control issues on the agenda of subregional and regional bodies such as the Arab League and GCC (noting that the GCC tobacco control committee is a well-established body dedicated to tobacco control issues at GCC level).
- Develop collaborative interventions with neighbouring countries to regulate tobacco products and advertising, and reduce cross-border illicit trade.

Suggested actions for WHO

- Continue to convene regional and subregional meetings to tackle cross-border issues, particularly on controlling illicit trade in tobacco products and harmonizing tobacco product regulation and advertising.
- Support Member States to coordinate their response to cross-border tobacco control issues.

Suggested actions for civil society partners

- Contribute to regional and subregional efforts to develop coordinated interventions that address the transnational dimension of tobacco control.
- Raise public awareness on the importance of intercountry collaboration to address cross-border tobacco control issues.

Objective 2: By 2023, strengthen national capacity and leadership for tobacco control to counter tobacco industry interference in at least 50% of Member States

Indicators:

1. % of Member States incorporating measures to protect tobacco control policies from commercial and other vested interests of the tobacco industry into their national tobacco control plan
2. % of Member States implementing systematic capacity-building and leadership training workshops addressing Article 5.3 of the WHO FCTC and its guidelines

Baseline: 3

Expected results, by 2023:

1. At least 50% of Member States have included measures to address Article 5.3 of the WHO FCTC into their national tobacco control plan
2. All Member States have expanded their national pool of technical experts and champions who advocate for protecting tobacco control policies and initiatives from tobacco industry interference

Suggested actions for Member States

- Ensure that the national tobacco control plan includes measures to protect public health policies from the influence of the tobacco industry.
- Adopt measures and institutional policies to limit interaction with the tobacco industry, and ensure the transparency of any interactions.
- Provide opportunities for capacity-building/leadership workshops for public sector officials in key government agencies that are involved in multisectoral tobacco control issues.
- Identify and nurture prospective tobacco control champions within each of the ministries involved in tobacco control policy development, as well as among critical stakeholder groups such as faith-based organizations, and women's and youth groups.

- Advocate for integration of tobacco control training, including WHO FCTC Article 5.3 guidelines, in the curricula for all health professionals.
- Establish mechanisms to monitor the tobacco industry and publicize findings to key audiences and the general population.

Suggested actions for WHO

- Support Member States in monitoring regional and country-level tobacco industry activity and communicate the results regularly to Member States.
- Provide technical assistance in developing legislative and policy measures that address Article 5.3 of the WHO FCTC.
- Engage with relevant partner agencies (e.g. Johns Hopkins Bloomberg School of Public Health) to adapt and conduct leadership training on tobacco control within the Region.
- Provide regional training opportunities to Member States, with special attention to building capacity for implementing WHO FCTC Article 5.3 guidelines.
- Identify and collate existing tobacco control training tools and training curricula, or develop new ones, and assist Member States in adapting these for local use.
- Provide technical and logistic support to Member States that request enquiries into tobacco industry activities.

Suggested actions for civil society partners

- Utilize existing opportunities to build capacity within civil society to monitor and act upon tobacco industry interference in public health policies.
- Search for and disseminate information on tobacco control capacity-building and leadership training opportunities to relevant community stakeholders, including religious organizations and women's and youth groups.
- Explore the feasibility of joint tobacco control training workshops with government partners to leverage and extend capacity-building resources and increase training efficiency.
- Prioritize media and advocacy initiatives that target normative change and expose tobacco industry tactics to derail tobacco control efforts.
- Undertake tobacco control advocacy efforts for which public sector counterparts may be constrained or limited in overseeing (e.g. using social media for advocacy, or serving as "whistle blowers,")

Objective 3: By 2023, establish measures to ensure sustainability of tobacco control programmes in all Member States

Indicators:

1. % of Member States with fiscal mechanisms to fund tobacco control programmes
2. % of Member States that integrate tobacco control policies and interventions into related health and non-health programmes
3. % of Member States with tobacco control as a priority in their national noncommunicable disease plans

Baseline, **as of 2017**:

1. 50% of Member States have funding mechanism dedicated to national tobacco control activities
2. 50% of Member States have tobacco control policies and interventions integrated into related health and non-health programmes
3. 50% of Member States have identified tobacco control as a priority in their national noncommunicable disease plans

Expected results, by 2023:

1. All Member States (100%) have fiscal mechanisms in place to ensure sustainable funding for tobacco control
2. All Member States (100%) have integrated tobacco control into critical programme areas
3. All Member States (100%) have identified tobacco control as a priority in their national noncommunicable disease plans

Suggested actions for Member States

- Engage with the finance and trade sectors to pursue mechanisms for sustainable funding for tobacco control (e.g. earmarking budgets for tobacco control, funding tobacco control measures from "sin tax" revenues, etc.). Ideally, pass national legislation to endorse earmarking of funds to safeguard tobacco control programmes from political fluctuation and changing personnel.
- If appropriate fiscal mechanisms are in place, advocate for raising allocations to tobacco control to meet programme needs.
- Identify and utilize existing opportunities to merge tobacco control policies and interventions into related health and non-health programmes such as noncommunicable disease prevention and control, poverty alleviation and sustainable development programmes. For countries in emergencies, explore the integration of tobacco control policies into refugee health, settlement areas and military health.
- Advocate for tobacco control as a priority in national noncommunicable disease plans, given the high profile of noncommunicable disease prevention and control resulting from the UN Summit on noncommunicable diseases and the SDGs.

Suggested actions for WHO

- Identify, collate, systematically review, adapt and disseminate models for ensuring financial sustainability of national tobacco control programmes.
- Provide technical support to countries who want to legislate measures that will ensure sustained funding for tobacco control.

- Develop and disseminate guidelines for integrating tobacco control into other health programmes such as noncommunicable diseases, healthy settings, tuberculosis control, occupational health and health promotion, as well as other relevant non-health programmes including those that address development and poverty alleviation.

Suggested actions for civil society partners

- Advocate for budgetary allocations to tobacco control that are commensurate to programme needs.
- Engage with nongovernmental organizations and other civil society partners in related health and non-health areas and advocate for integration of tobacco control policies and interventions.
- Proactively position tobacco control issues within the radar of noncommunicable disease organizations and stakeholders, to capitalize on the growing political importance of noncommunicable disease prevention and control.

Demand reduction

Objective 4: Initiate new and expand implementation of existing demand reduction measures for tobacco control, consistent with guidelines and protocols adopted by the Conference of the Parties to the WHO FCTC and with the MPOWER package, in all Member States

Objective 4.1: By 2023, enhance implementation of key demand reduction policies for tobacco control (tax increases; banning tobacco advertising, promotion and sponsorship (TAPS); smoke-free policies; and warning labels) identified by the WHO FCTC guidelines and the MPOWER package

Indicators:

1. Number of Member States at the highest level of achievement for implementation of the key demand reduction measures
2. Number of Member States at the lowest level of achievement for implementation of the four key demand reduction policies

Baseline, as of 2017:

1. Member States at the highest level of achievement for:
   a. raising taxes = 2
   b. banning TAPS = 6
   c. protecting people from secondhand smoke = 6
   d. warning about tobacco's dangers = 3
2. Member States at the lowest level of achievement for:
   a. raising taxes = 10
   b. banning TAPS = 3
   c. protecting people from secondhand smoke = 7
   d. warning about tobacco's dangers = 8

Expected results, by 2023:

1. Implementation of key WHO FCTC-related policies has been strengthened in Member States
2. All public places and workplaces are totally smoke-free with no designated smoking areas
3. All forms of tobacco advertising, promotion or sponsorship are banned
4. All tobacco products have graphic health warnings at least 50% of pack size

Suggested actions for Member States

Policy establishment and expansion:

- Work collaboratively with finance and trade ministries and tax authorities to further increase tobacco taxes to at least 75% of the retail price, and include all tobacco products in tax increases.
- Mobilize political and public support to expand current smoke-free policies to cover all public places and workplaces. For countries in emergencies, emulate the UNRWA smoke-free policies for resettlement camps and workplaces for military and humanitarian aid workers.
- Engage with relevant sectors to establish a complete ban on tobacco advertising, promotion and sponsorship, including a ban on tobacco promotion in drama. If partial bans exist, advocate for extending these to total bans.
- Enforce graphic health warnings at least 50% of the pack size on all tobacco products and packaging that are consistent with the WHO FCTC guidelines.
- Incorporate a communications and advocacy strategy into the national tobacco control plan to mobilize support for demand reduction policies.
- Actively search for and promote popular tobacco-free role models who can sway the public towards tobacco-free social norms, particularly in drama where tobacco promotion and indirect advertising is increasing.
- Identify and actively participate in media opportunities that call attention to the tobacco epidemic and effective solutions, including World No Tobacco Day.
- Tackle TAPS in entertainment media, based on decisions of the Conference of the Parties.

Policy enforcement:

- Partner with enforcement agencies to build up and strengthen enforcement and monitoring capacity for tobacco control policies and legislation.
- Explore complementary mechanisms for expanding enforcement capacity for smoke-free laws and advertising bans (e.g. settings-based enforcement, private sector involvement, use of media, community-based participatory monitoring).
- Assess mechanisms and approaches to ensure that implementation efforts are equitably distributed across the entire population.
- Support advocacy initiatives to garner population support for enforcement of tobacco control policies.

Suggested actions for WHO

- Sustain and expand technical support to Member States to increase/modify their tobacco taxes consistent with WHO FCTC recommendations.
- Advocate to influential governments in critical regional bodies, such as the GCC, to champion evidence-based tax increases on all tobacco products.
- Provide technical support to Member States in developing 100% smoke-free policy enforcement guidelines and training curricula. Address the need for policy and technical guidance in developing smoke-free policies for countries in emergencies.
- Review and collect best practice models/templates for enforcement of total advertising bans that are applicable to the Region, and disseminate these in an efficient and timely manner.
- Establish and maintain a regional database of pictorial health warnings and messages.
- Facilitate and promote the use of the new copyright-free pictorial health warnings database among Member States.
- Expedite information and resource dissemination from other WHO regions such as "good practice" examples of tobacco control policy enforcement strategies, including strategies to ensure equitable enforcement.

Suggested actions for civil society partners

- Support national counterparts by advocating on behalf of civil society for tobacco control policies and legislation that adhere to the WHO FCTC guidelines.
- Establish civil society counterparts to complement, assist and expand the reach of government enforcement agencies.
- Develop and sustain public information dissemination and advocacy campaigns to increase public awareness of tobacco control policy enforcement initiatives and penalties.
- Create a civil society monitoring system, using community-based participatory approaches, to validate enforcement compliance from the public's perspective.

Objective 4.2: By 2023, adopt population-based cessation approaches and incorporate brief cessation advice into primary health care delivery in all Member States

Indicators:

1. Number of Member States at the highest level of achievement for cessation services
2. Number of Member States where primary health care providers are trained in brief cessation advice
3. Number of Member States that integrate brief cessation advice into health promotion, risk reduction and disease control programmes

Baseline, as of 2017:

1. Member States at the highest level for cessation services = 3
2. Member States training primary health care providers in brief cessation advice = 15
3. Member States integrating brief cessation advice into health promotion, risk reduction and disease control programmes = 15

Expected results, by 2023:

1. All Member States have advanced by at least 1 level (or maintined highest level) for implementation of cessation services
2. Training for primary health care providers in cessation advice offered in all Member States
3. All Member States have incorporated brief cessation advice into health promotion, risk reduction and disease control programmes

Suggested actions for Member States

- Incorporate delivery of brief cessation advice into essential health service packages for primary health care. Ensure service delivery in countries in emergencies.
- Mandate training of all health professionals in brief cessation advice and link to continuing professional education (e.g. as a requirement for licensure). For countries in emergencies, consider extending the training to humanitarian aid workers.
- Integrate cessation interventions in relevant programmes e.g. noncommunicable diseases and tuberculosis control.
- Provide health financing for cessation interventions e.g. social health insurance coverage.
- Invest in population-based cessation approaches including quit lines.
- Create/provide cessation services for vulnerable populations such as the poor, youth, women, refugees and internally displaced persons, soldiers and humanitarian workers.

Suggested actions for WHO

- Collate and disseminate cessation best practice guidelines that are applicable to the Region, particularly for waterpipe use and smokeless tobacco.
- Develop tools and training modules to support countries to expand training in brief cessation advice to primary health care workers.
- Consider establishing a regional cessation clearinghouse with cessation materials that Member States can replicate and adapt for local use.
- Advocate for integration of population-based cessation approaches into relevant public health programmes at the regional and national levels.

Suggested actions for civil society partners

- Encourage private businesses to include cessation coverage in their employee health plans.
- Participate in cessation training and outreach for community stakeholders.
- Include cessation messages in tobacco control advocacy initiatives and link advocacy to cessation resources.
- Publicize community cessation resources through existing networks and communication channels (e.g. nongovernmental organization websites, mailing lists and newsletters)
- Advocate for covered cessation services, at a minimum to include brief cessation advice, in primary health care settings.
- Assist the health sector in reaching out to vulnerable populations.

Supply restriction

Objective 5: Establish and implement supply restriction measures consistent with the guidelines and protocols adopted by the Conference of the Parties to the WHO FCTC in at least 50% of Member States

Objective 5.1: By 2023, at least nine Member States have ratified/acceded to the Protocol to Eliminate Illicit Trade in Tobacco Products (ITP) and started implementation.

Objective 5.2: By 2023, all Member States have prohibited sales of tobacco products to and by minors.

Objective 5.3: By 2023, at least 50% of Member States involved in tobacco growing have started to implement measures to reduce tobacco agriculture.

Indicator 5.1.a: Number of Parties to the WHO FCTC that have ratified/acceded to the ITP **Baseline, as of August 2018:** 4 **Expected result 5.1.a, by 2023:** At least 9 Member States have become Parties to the ITP by 2023 **Indicator 5.1.b, by 2023:** Number of Member States with national legislation or policies that address the illicit trade in tobacco products **Baseline:** 4 **Expected result 5.1.b, by 2023:** At least 50% of Member States have established national legislation or policies addressing the illicit trade in tobacco products
Indicator 5.2: Number of Member States with legislation banning sales of tobacco products to and by minors, with clear penalties for violations of the law **Baseline:** 15 **Expected result 5.2, by 2023:** All Member States (100%) have enacted legislation banning sales of tobacco products to and by minors
Indicator 5.3: 1. Number of Member States with crop diversification programmes 2. Number of States involved in domestic tobacco growing with national policies to limit land use for tobacco agriculture **Baseline:** 0 **Expected result 5.3, by 2023:** At least 50% of Member States involved in tobacco growing have created policies and programmes to reduce tobacco agriculture

Suggested actions for Member States

- Adopt measures to minimize the illicit trade in tobacco products, consistent with Article 15 of the WHO FCTC.
- For Member States that are Parties to the WHO FCTC, pursue ratification of the ITP.
- Initiate, if none exists, a ban on tobacco sales to and by minors in line with Article 16 of the WHO FCTC.
- Implement policy options and recommendations on economically sustainable alternatives to tobacco growing, in relation to Article 17 of the WHO FCTC, including development of pilot projects and other initiatives (Decision FCTC COP6(11)).
- Explore establishment of an crop diversification programme to transition tobacco farmers towards other crops, in line with Article 17 of the WHO FCTC.
- Prohibit expansion of land designated for tobacco cultivation and advocate to eliminate incentives for tobacco agriculture.

Suggested actions for WHO

- Support, in collaboration with the Convention Secretariat, interested Parties to develop pilot projects and other initiatives that aim to implement policy options and recommendations adopted by the Conference of the Parties as outlined in the annex of Decision FCTC/COP6(11).
- Provide tools, guidelines, best-practice examples and technical support to Member States to address supply-side interventions for tobacco control.
- Partner with institutional and individual experts to provide capacity-building opportunities to Member States for the development, strengthening and enforcement of supply-side interventions for tobacco control.

Suggested actions for civil society partners

- Support national counterparts in disseminating information on, advocating for and enforcing supply-side interventions for tobacco control.

Surveillance, monitoring and research

Objective 6: By 2023, enhance surveillance, monitoring, research and information dissemination across the Region so that recent, representative and periodic data for youth and adults are available in at least 50% of Member States.

Indicators:

1. Number of Member States at the highest level of achievement for monitoring
2. Number of Member States participating in the Global Youth Tobacco Survey (GYTS)
3. Number of Member States participating in the Global Adult Tobacco Survey (GATS) or Tobacco Questions for Surveys (TQS)
4. Number of Member States initiating activities to monitor the tobacco industry
5. Number of Member States tracking tobacco control policy enforcement

Baseline, as of 2017:

1. Member States at the highest level of achievement for monitoring = 6
2. Member States with at least 2 cycles of the GYTS completed = 21
3. Member States with at least 2 cycles of the GATS/TQS completed = 1
4. Member States undertaking initiatives to monitor the tobacco industry = 0
5. Member States with a mechanism to track progress in tobacco control policy enforcement = 0

Expected results, by 2023:

1. All Member States have advanced by at least 1 level (or maintined highest level) for monitoring
2. At least 50% of Member States have completed a minimum of 3 cycles of the GYTS
3. At least 50% of Member States have completed a minimum of 2 cycles of the GATS/TQS
4. At least 25% of Member States have initiated a mechanism to track tobacco industry activities
5. At least 25% of Member States are periodically tracking the level of tobacco control policy enforcement

Suggested actions for Member States

- Regularly implement standard global/regional surveys (as part of the Global Tobacco Surveillance System) and evaluation on tobacco control activities, and promptly report results to the Regional Office.
- Create, if none exists, or update if existing, a national tobacco control database including information taken from sources such as school surveys and national household surveys.
- Develop and implement a research agenda that addresses country needs and data gaps, including:
  - tracking tobacco industry efforts to circumvent tobacco control in the country and in the Region;
  - initiating an analysis of the relationship between tobacco use and poverty;
  - evaluating interventions to help reduce other forms of tobacco use popular in the Region, such as waterpipes.
- Disseminate relevant information to local policy-makers, stakeholders and other key partners in a timely manner.

- Explore global examples of good practice for tobacco industry monitoring (such as the Tobacco Industry Interference Index by the Southeast Asia Tobacco Control Alliance) and adapt for use in the Region.
- Incorporate indicators and surveillance questions to gauge progress in tobacco control policy enforcement, to ensure that the highest achievable level of policy implementation is sustained over time.

Suggested actions for WHO

- Engage with relevant partner agencies (e.g. US Centers for Disease Control and Prevention) to:
  - disseminate standard global/regional surveillance and evaluation instruments and methods;
  - train Member States to utilize such methods to build an effective surveillance infrastructure;
  - collect all data from Member States.
- Provide regional training and tools for data collection, data analysis and effective data translation, as well as for tobacco industry monitoring and enforcement tracking.
- Assist Member States to develop relevant and practical research agendas to support tobacco control data needs.
- Collate data from other related surveys, such as WHO STEPS, and make data accessible to Member States.
- Facilitate the use of existing data resources such as the Global Information System on Tobacco Control.

Suggested actions for civil society partners

- Complement national tobacco control surveillance with qualitative data from community-based participatory research.
- Supplement national tobacco control database by providing data collected through civil society mechanisms.
- Help disseminate local data by incorporating these into advocacy and outreach materials and activities.
- Explore innovative means for data dissemination (e.g. use of interactive websites, social media, text messaging) and share these with government partners.

5. Conclusion

With the growing health and socioeconomic burden from the tobacco epidemic, tobacco control efforts must be accelerated in the Eastern Mediterranean Region. The WHO FCTC provides a global template for a comprehensive, evidence-based approach to reducing tobacco consumption and exposure to tobacco smoke, but its effectiveness is dependent on political commitment, multisectoral coordination and the ability of every Member State to translate policy into action.

In recent years, several Member States have demonstrated remarkable progress in their national efforts to mitigate the adverse impact of tobacco use. However, moving to the next stage in the fight against tobacco requires regional synergy, innovation and engagement with critical partners in government and civil society.

This regional strategy and action plan is intended as a crucial element to guide Member States in their efforts to curb the tobacco epidemic, and implement obligations as outlined in the WHO FCTC and agreed on by Heads of States during the development of the SDGs. Through the objectives and strategic actions outlined in this plan, it is hoped that Member States will be able to join forces and empower each other to effectively counter the tobacco epidemic in a coordinated and robust manner. So empowered, Member States of the Eastern Mediterranean Region can progress towards the vision of a healthy and tobacco-free Region, in which deaths and diseases caused by tobacco use are prevented.

Tobacco kills millions of people every year through direct use or exposure to second-hand smoke. Because of it, people are dying too young from heart and lung diseases, cancers and strokes. More than half of all deaths in the Eastern Mediterranean Region are due to these conditions. The resulting health and economic burden is substantial. Halting the tobacco epidemic is the only way to save the lives being lost. But real and lasting change cannot happen overnight. This document provides a strategy to direct countries for the next five years, to curb tobacco consumption and end this deadly epidemic.