GSTHR

# FIGHTING THE LAST WAR:

## THE WHO AND INTERNATIONAL TOBACCO CONTROL

GLOBAL STATE OF TOBACCO
HARM REDUCTION

# FIGHTING THE LAST WAR:

## THE WHO AND INTERNATIONAL TOBACCO CONTROL

GLOBAL STATE OF TOBACCO
HARM REDUCTION

***Fighting the Last War: The WHO and International Tobacco Control***



Fighting the Last War: The WHO and International Tobacco Control



Author: Harry Shapiro

Editor: Ruth Goldsmith

Data compilation: Tomasz Jerzyński

Production coordinator: Grzegorz Król

Report design and layout: WEDA sc: Urszula Biskupska

Project management: Professor Gerry Stimson, David MacKintosh and Paddy Costall

Cover image: 'Platinum' on vectorhq.com

The report is available at: https://gsthr.org

Knowledge•Action•Change, 8 Northumberland Avenue, London WC2 5BY



ISBN: 978-1-7398231-0-8

Citation:
*Fighting the Last War: The WHO and International Tobacco Control*. London: Knowledge•Action•Change, 2021.



The conception, design, analysis and writing of this report was undertaken independently and exclusively by Knowledge•Action•Change. This work was funded with a grant from the Foundation for a Smoke-Free World, Inc. (FSFW), a US nonprofit 501(c)(3) private foundation. FSFW had no role in the planning, execution or publication of this report.

# About the Global State of Tobacco Harm Reduction (GSTHR) project

Harm reduction is a range of pragmatic policies, regulations, and actions which either reduce health risks by providing safer forms of products or substances or encourage less risky behaviours. Tobacco harm reduction (THR), using safer nicotine products (SNP), offers new choices to millions of people worldwide who want to switch away from smoking or other dangerous forms of tobacco use, but have been unable to with the other options available.

Since 2018, the UK-based public health agency Knowledge•Action•Change (K•A•C) has produced two biennial reports examining progress in and barriers to tobacco harm reduction around the world:

*No Fire, No Smoke: The Global State of Tobacco Harm Reduction 2018* and *Burning Issues: The Global State of Tobacco Harm Reduction 2020*. Executive summaries of both reports are available in multiple languages as well as Chinese translations of the full 2018 and 2020 editions.

In addition, K•A•C publishes shorter reports such as this, driven by the key principles of the GSTHR project. The first, *Tobacco Harm Reduction and the Right to Health*, was published in January 2020 and can be read in 13 languages. The second, *Tobacco Harm Reduction: a Burning Issue for Asia* was published in April 2021. All GSTHR publications and translations can be downloaded at the GSTHR website, https://gsthr.org.

The GSTHR website offers a significant resource for researchers of tobacco harm reduction and smoking. The site allows users to search, compare and build bespoke data visualisations using regularly updated tobacco harm reduction and smoking statistics for more than 200 countries and territories. There is also a wealth of downloadable charts and infographics free to use in presentations.

Visit https://gsthr.org to find out more.

## Terminology

A number of terms are used for THR products, including ‘reduced risk products’ and ‘electronic nicotine delivery systems’ and ‘electronic non-nicotine delivery systems (ENDS and ENNDS – terms favoured by WHO). This report uses the term **safer nicotine products** (SNP) as a collective expression for nicotine vaping devices, heated tobacco products (HTP) and safer oral nicotine products such as Swedish-style pasteurised snus and non-tobacco nicotine pouches.

Unless quoting from documents, we do not use the term ‘e-cigarettes’ to describe nicotine vaping devices. The term is misleading for health professionals, politicians and the wider public, as it closely associates these new products with cigarettes. However, vaping devices do not burn tobacco and do not emit toxic smoke which harms bystanders. Many modern vaping devices bear no physical resemblance to traditional cigarettes.

# Contents

# Key messages

1. Despite all the efforts of tobacco control, **there are still 1.1 billion smokers worldwide** and many hundreds of thousands of people who use other dangerous tobacco products. **Smoking causes eight million deaths a year** with a projected billion lives lost by 2021. **Eighty per cent of smokers live in low and middle-income countries** (LMIC). They bear the brunt of deaths and disease.
2. The WHO claims that its monitoring and evaluation tobacco control strategy MPOWER 'protects' or 'covers' 5.3 billion people from deaths and diseases caused by smoking. In reality, **the bureaucratic and political processes of passing tobacco control legislation protect nobody** unless there are the necessary financial resources to implement legislation, a particular problem in LMIC where resources are stretched.
3. There is a substantial body of global independent evidence that **safer nicotine products (SNP) are significantly safer** than any combustible and many types of oral tobacco products.
4. Many smokers will successfully quit smoking using cessation support or nicotine replacement therapies. For those who do not want to quit nicotine, **switching to safer nicotine products offers a substantial potential public health benefit** for adult smokers, their families, and bystanders, at little cost to governments.
5. The WHO and its NGO allies are still engaged in an historic battle against the tobacco industry despite the emergence of new technologies. The evidence shows **these products are significantly less risky than combustible tobacco and have a role to play in harm reduction**.
6. For the WHO and its NGO allies, **the goal of tobacco control has shifted from protection against tobacco and smoking to protection against nicotine itself**. Innovative non-combustible nicotine technology and supporting evidence has moved forwards; **tobacco control policy is frozen in time**.
7. **Public health is not served by discouraging adult smokers from switching to SNP**, nor by implementing overly restrictive regulations that stop existing consumers accessing safer nicotine products. **The traditional tobacco industry is the only winner**, as the endgame for combustible cigarettes will disappear yet further into the future.
8. The 'mission creep' of international tobacco control from protection against tobacco smoke to a war on nicotine in all its forms is particularly egregious; the global campaign against SNP is funded by neo-colonial western philanthropic interests pursuing their own agenda. **LMIC, whose populations are most significantly impacted by smoking-related harms, stand to lose the most**.
9. The **Framework Convention on Tobacco Control (FCTC) Secretariat and its WHO accredited NGOs have undue and unhealthy influence over the deliberations before and during the FCTC Conference of the Parties (COP)** meetings on international tobacco and nicotine policy, as well as on post-COP implementation and interpretations of the meeting's decisions.
10. **It is unacceptable that the COP, as an international meeting of government officials ultimately funded by citizens' taxes, should be shrouded in a secrecy comparable to the UN Security Council**.
11. The Guidelines to Article 5.3 of the FCTC are over-interpreted. Article 5.3 itself reasonably states that governments need to be open and transparent in their

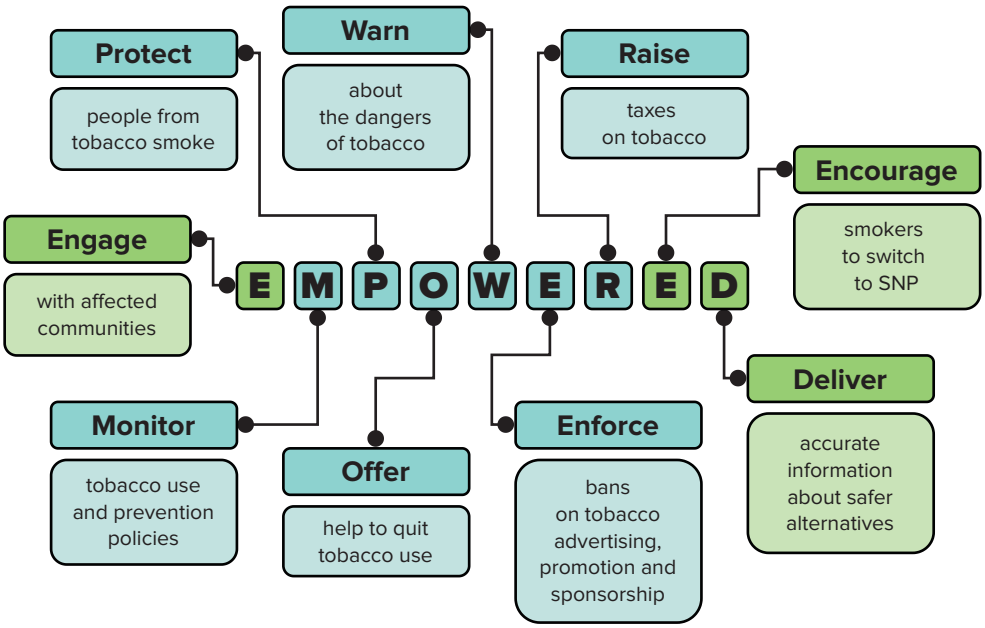
dealings with the tobacco industry. The Guidelines add detail to this. **The intention** of the FCTC was never to entirely close dialogue between public health and industry, let alone be the justification for the growing range of attacks and no-platforming experienced by tobacco harm reduction advocates.

12. **The refusal of the WHO and other agencies to endorse SNP despite significant international evidence in favour of their role in smoking cessation suggests little concern for current adult smokers**. Efforts are entirely focused on the acceptable political ground of prevention aimed at young people.

13. **International tobacco control must refocus on delivering tangible outcomes that reduce death and disease from smoking among adult smokers**. A radical overhaul of the FCTC is unlikely, nor is it required. Much can be achieved through recalibration and shifts in how the Convention is implemented at a national level.

14. **Parties need to exercise their control of the FCTC**, rather than leave it to the Secretariat to take leadership, and examine all options for widening the off-ramp from smoking. A Working Group on Tobacco Harm Reduction should be established. A primary aim would be to make a clear distinction between combustible and non-combustible safer nicotine products. The FCTC entered into force before SNP became widely available and it follows that **there needs to be a greater focus on the harm reduction element contained in the FCTC**.

15. **The MPOWER implementation strategy should be reconfigured to rectify the current deficits in international tobacco control policy**. MPOWER should become EMPOWERED:




16. **THR has a complementary role to play in tobacco control and reducing cigarette consumption**. Its potential can come to fruition if the international tobacco control community, led by the WHO, can disaggregate combustible from non-combustible tobacco products in its policy and legislative deliberations.

# 1: Still too many left behind: the context for the report

## The ambition

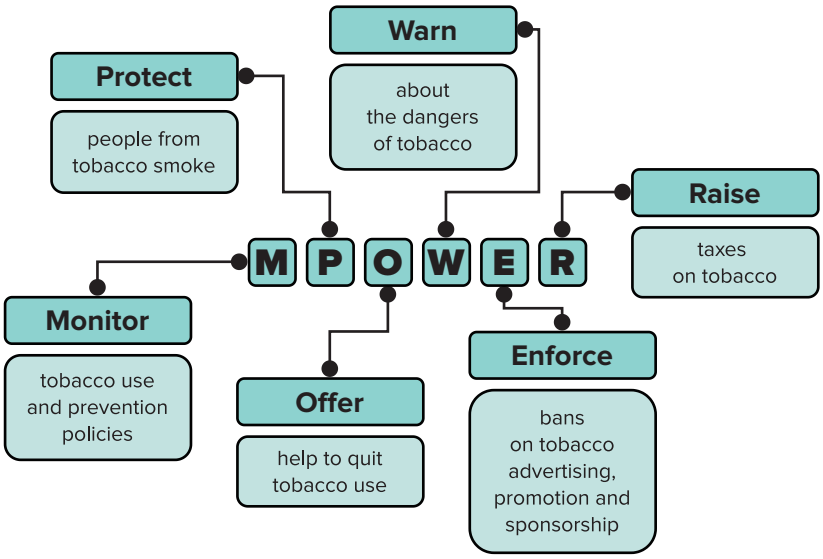
The main policy engine driving the international effort to combat the smoking epidemic is the WHO Framework Convention on Tobacco Control (FCTC), which entered into force in 2005. This enabled the creation of the Conference of the Parties (COP), regular meetings which bring together delegations of government representatives who discuss the implementation of FCTC measures.

'Tobacco control' is defined in Article 1d:

> *'Tobacco control' means a range of supply, demand and **harm reduction** strategies that aim to improve the health of a population by eliminating or **reducing** their consumption of tobacco products and **exposure to tobacco smoke**."* [1]

In terms of how tobacco control has been implemented since 2005, it is important to note that one of the stated objectives as agreed by all the Parties to the FCTC was to protect populations by reducing the harms caused by exposure to tobacco smoke. Whatever the intention, there is no differentiation made in the Articles in terms of risks of exposure to tobacco smoke between smokers or bystanders, so by the letter of the Convention, smokers are not excluded from this definition.

In 2007, the WHO launched a process and monitoring mechanism to implement the FCTC, known as MPOWER:




Smoking is the single greatest preventable cause of non-communicable disease (NCD). It is also the one risk factor common to the four main groups of NCD: cardiovascular disease, cancer, chronic lung disease and diabetes. Reducing tobacco smoking is therefore key to driving down the global incidence of deaths from NCD – an ambition both reflected in and quantified by the UN 2030 Agenda for Sustainable Development. Goal 3 of the Agenda is to "ensure healthy lives and promote well-being for all at all ages", with a specific goal (3.4) of "reducing premature deaths from non-communicable diseases by one third by 2030".[2]

[1] The Framework Convention on Tobacco Control (2005): https://www.who.int/fctc/text_download/en/

[2] United Nations. *Transforming our World: The 2030 Agenda for Sustainable Development*. UN, 2015, p.20. https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf

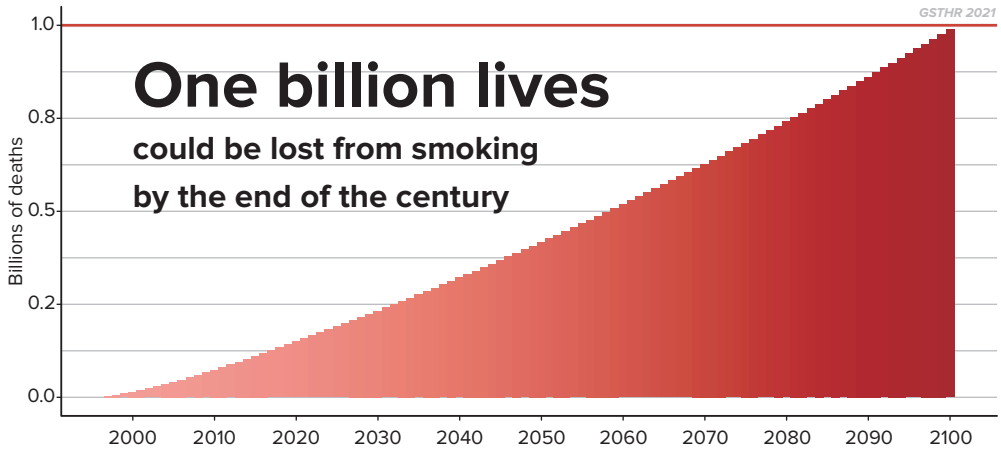
smoking is the single greatest preventable cause of non-communicable diseases

Discarded cigarette butts.
Credit: Pawel Czerwinski on Unsplash

## The reality

In 1997, the Global Burden of Disease (GBD) report estimated that around three million people were dying annually from tobacco use and projected a sharp increase in the decades to come. This analysis was sadly correct. The figure had risen to five million by 2002 with a WHO projection of eight million by 2030.[3] By 2021, the annual death toll already exceeded eight million, including those who died from exposure to secondhand smoke. In 2001, Professor Richard Peto, a leading expert on tobacco mortality, estimated a billion lives would be lost by the end of the century – a forecast which remains unchanged.[4] And while there are many thousands of deaths from oral tobacco products, the Institute for Health Metrics and Evaluation (IHME) estimates that 99.9 per cent of all tobacco-related deaths are caused by smoking.[5]

**Cumulative sums of deaths from smoking**
**Projection assuming the trend does not change**




Reference: compilation of data from Institute for Health Metrics and Evaluation (IHME). (2019). Global Burden of Disease (GBD 2019). IHME, University of Washington. http://www.healthdata.org/gbd/2019 and estimation by Peto, R., & Lopez, A. D. (2001). Future worldwide health effects of current smoking patterns. (pp. 154–161). Jossey-Bass. https://espace.library.uq.edu.au/view/UQ:114032

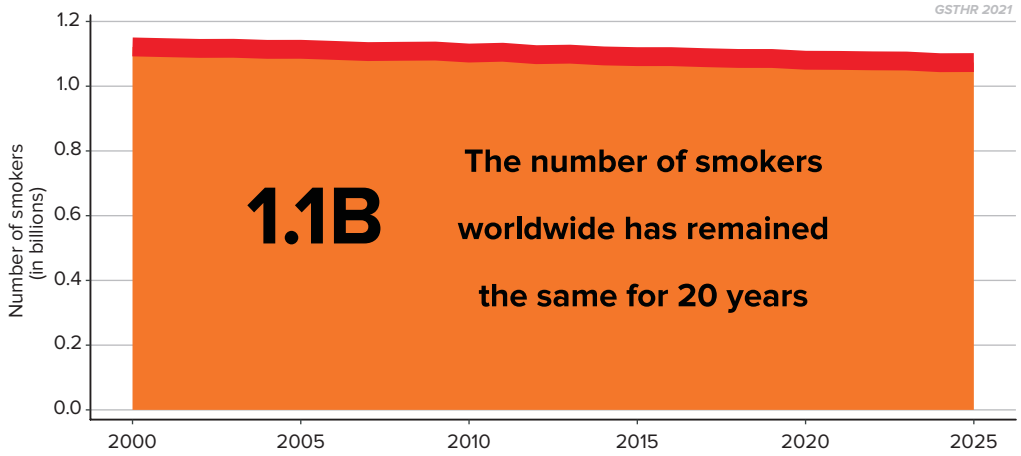
[3] Mathers, C and Loncar, D. *Updated projections of global mortality and burden of disease 2002-2030: sources, methods and results*. WHO, 2005
[4] Peto R and Lopez AD. *Future worldwide health effects of current smoking patterns*. In: Koop CE, et al. eds. Critical issues in global health. San Francisco: Wiley (Jossey-Bass), 2001: 154-61.
[5] Ritchie, Hannah and Roser, Max. 'Smoking'. Our World In Data (updated 2021). https://ourworldindata.org/smoking

A man smokes on the street in Karnakata, India.
Credit: Vaisakh MV on Unsplash

Smoking prevalence and therefore smoking-related deaths have been falling in high-income countries (HIC) for several decades, but population growth means that there are still 1.1 billion smokers worldwide. LMIC carry the burden of death and disease of smoking, amounting to around 50 per cent of all global smoking-related deaths.[6] However, data for LMIC may underestimate the scale of the losses. As the WHO states, "High-income countries have systems in place for collecting information on causes of death in the population. Many low- and middle-income countries do not have such systems, and the numbers of deaths from specific causes have to be estimated from incomplete data".[7]

It is LMIC that also bear the brunt of NCD. Three-quarters of NCD deaths occur in LMIC, where health systems are often not resourced to offer timely and appropriate treatments.[8]

**99.9 per cent**
**of all tobacco-related deaths are caused by smoking**




Data source: WHO. (2019). WHO global report on trends in prevalence of tobacco use 2000–2025, third edition. World Health Organization. https://www.who.int/publications/i/item/who-global-report-on-trends-in-prevalence-of-tobacco--use-2000-2025-third-edition

[6] *Tobacco Harm Reduction: A Burning Issue for Asia*. London: Knowledge Action Change (2021), p.9. https://gsthr.org/report/2021/burning-issue-for-asia/chapter-1
[7] The Global Health Observatory, WHO. *Total NCD deaths (in thousands)*. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-ncd-deaths-in-thousands
[8] *Factsheet: Noncommunicable diseases*, WHO. (2021). https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

## The failure of ambition

The WHO often lauds the success of MPOWER; the most recent report (2021) on its progress stated that 5.3 billion people were 'covered' by at least one MPOWER element to the 'highest level of achievement'[9]. But the accolade of 'coverage' by 'at least one MPOWER measure' begins to look less impressive given that MPOWER was launched in 2007. This is further compounded when it is revealed that nearly 30 per cent of countries who have signed up to the FCTC have not enacted a single MPOWER element. And closer analysis shows that, of the 49 countries with no element in place, 41 are LMIC.[10] It should also be noted that 'covered' often means little more than the enactment of frequently unenforceable laws, especially in LMIC where resources are stretched.

The WHO flag.
Source: Flickr

most of the elements of MPOWER do not directly alleviate the death and disease caused by smoking

Critically, most of the elements of MPOWER do not directly alleviate the death and disease caused by smoking. They are mainly legislative measures which, as it happens, are relatively cheap and easy to enact. What is much more expensive, especially for LMIC with fragile health systems and a need to focus on communicable diseases, is 'O – Offering help to smokers to quit'. And by its own admission, the WHO concedes that delivery on this element is the weakest, with 70 per cent of the global population having no access to comprehensive smoking cessation services.

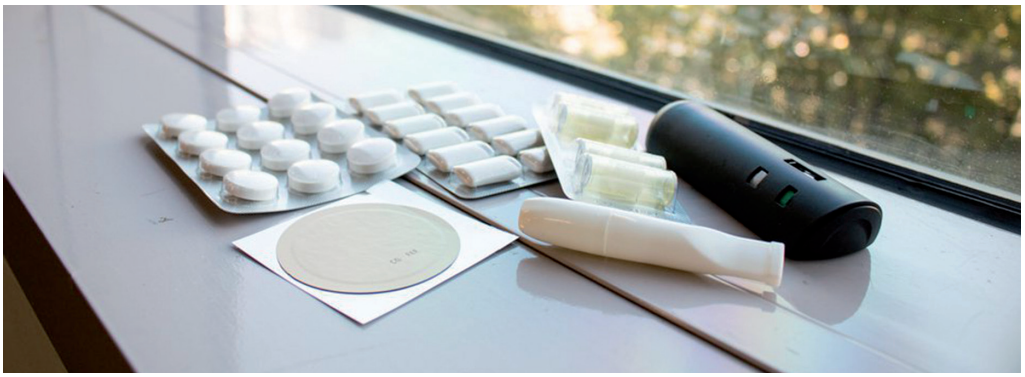
Even where countries' policies are cited as 'best practice', the truth on the ground can be very different. India is the only LMIC listed by the WHO as being a best practice country in providing support services. Yet a study of the availability and affordability of nicotine replacement therapy and cessation medicines in the Indian state of Kerala revealed that no products were available in public health care facilities and were only available in some private pharmacies.[11] The situation would be even more acute for the millions of tobacco consumers living in rural areas.

The WHO asserts that the slow progress towards reducing smoking levels in poorer countries is because the introduction of strong tobacco control policies has been

[9] WHO. *WHO report on global tobacco epidemic: addressing new and emerging products 2021.* WHO, 2021. https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2021
[10] ibid.
[11] Sarma Smitha et al. (2017). Availability, Sales, and Affordability of Tobacco Cessation Medicines in Kerala, India. *Circulation: Cardiovascular Quality and Outcomes*, 10(11), e004108. https://doi.org/10.1161/CIRCOUTCOMES.117.004108

impeded by lobbying from the tobacco industry. Lobbying may well be an issue, but this explanation alone fails to acknowledge the significant problems that accrue from the unwillingness of countries to fund internationally recognised tobacco control measures, at least since the financial crash of 2007-08 and even more so in an era of COVID.

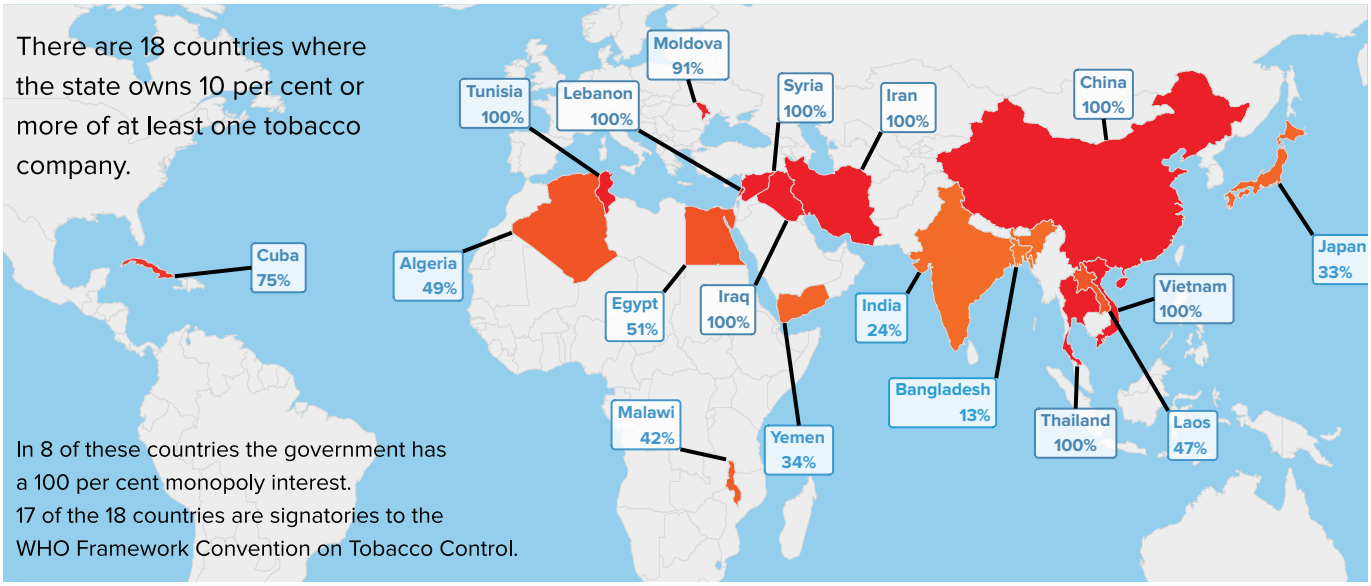
there are **18** countries where the state owns **10 per cent** or more of at least one tobacco company



A range of nicotine replacement products.
Source: Google

There also remain the enduring conflicts of interest of many countries with a seat at the COP table that have substantial if not monopoly stakes in their domestic tobacco industries. There are 18 countries where the state owns 10 per cent or more of at least one tobacco company. The governments of China, Iraq, Iran, Lebanon, Syria, Thailand, Tunisia and Vietnam have a 100 per cent monopoly interest. All but two are signatories to the FCTC. The Chinese National Tobacco Corporation (CNTC) outperforms all other multinational tobacco companies with 44 per cent of the global cigarette market. India's state-owned tobacco company ITC is in the top five behind CNTC, British American Tobacco (BAT), Philip Morris International (PMI) and the Japan Tobacco International (JTI) – and the Japanese government owns one-third of that business.[12]

**8** countries have a **100 per cent** monopoly interest in their domestic tobacco company




On the wider issue of dealing with NCD, the picture is equally bleak. A WHO NCD report noted, "Country actions against NCDs are uneven at best. National investments remain woefully small and not enough funds are being mobilized internationally...There is no excuse for inaction as we have evidence-based solutions". [13]

[12] Malan, D and Hamilton, B. *Contradictions and conflicts: state ownership of tobacco companies and the WHO Framework Convention on Tobacco Control.* Just Managing Consulting, 2020.
[13] WHO. *Time to deliver: report of the WHO independent high-level commission on non-communicable diseases.* WHO, 2018, p.4 https://apps.who.int/iris/handle/10665/272710

## Fighting the last war?

What is going wrong? In essence, the WHO, compliant governments and medical agencies, NGO allies and funders are fighting the last war against the tobacco industry. There are many historical examples, from the 19th century through to the Vietnam War, where generals assumed the political and technological environment of the current conflict remained unchanged from the last. Invariably this played out with deadly results for those on the frontline – while the generals watched from a distance.

Photograph showing British troops using a trench periscope and trench mirror to view no man's land.
Source: National Library of Scotland

**the WHO, compliant governments and medical agencies, NGO allies and funders are fighting the last war against the tobacco industry**

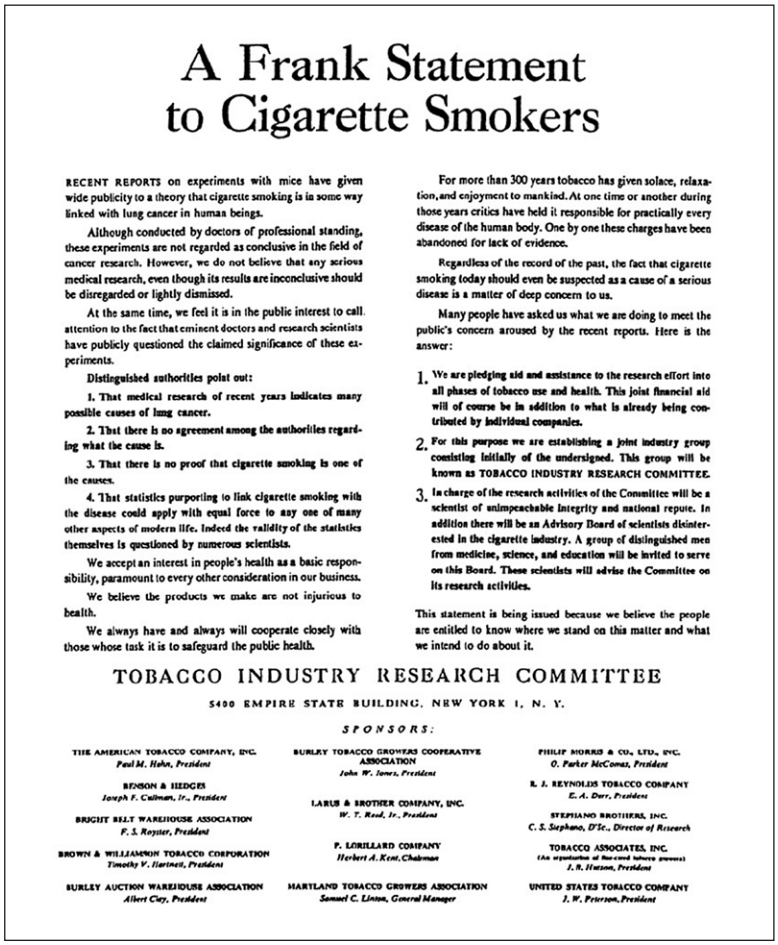
It is clear from the statistics that coming up with the same old strategies and tactics for reducing global smoking are not nearly enough to deliver on the public health imperative. To repeat the words of the WHO, "there is no excuse for inaction as we have evidence-based solutions".

The new approaches for the 21st century are grounded in the principle of tobacco harm reduction (THR), based on encouraging current smokers to switch to safer nicotine products (SNP). Delivery requires new strategies and new thinking. Instead, and for a variety of reasons, those with the responsibility to show global leadership in fighting the smoking problem are digging ever deeper trenches.

# 2: Hitting back against Big Tobacco: the background to the Framework Convention on Tobacco Control

## The truth will out

In 1954, following early research suggesting a link between smoking and cancer, the major US tobacco companies issued 'A Frank Statement to Cigarette Smokers' denying that their products were dangerous and claiming they only had the best interests of their customers at heart.[14]



A Frank Statement to Cigarette Smokers

RECENT REPORTS on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings.

Although conducted by doctors of professional standing, these experiments are not regarded as conclusive in the field of cancer research. However, we do not believe that any serious medical research, even though its results are inconclusive should be disregarded or lightly dismissed.

At the same time, we feel it is in the public interest to call attention to the fact that eminent doctors and research scientists have publicly questioned the claimed significance of these experiments.

Distinguished authorities point out:

1. That medical research of recent years indicates many possible causes of lung cancer.

2. That there is no agreement among the authorities regarding what the cause is.

3. That there is no proof that cigarette smoking is one of the causes.

4. That statistics purporting to link cigarette smoking with the disease could apply with equal force to any one of many other aspects of modern life. Indeed the validity of the statistics themselves is questioned by numerous scientists.

We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business.

We believe the products we make are not injurious to health.

We always have and always will cooperate closely with those whose task it is to safeguard the public health.

For more than 300 years tobacco has given solace, relaxation, and enjoyment to mankind. At one time or another during those years critics have held it responsible for practically every disease of the human body. One by one these charges have been abandoned for lack of evidence.

Regardless of the record of the past, the fact that cigarette smoking today should even be suspected as a cause of a serious disease is a matter of deep concern to us.

Many people have asked us what we are doing to meet the public's concern aroused by the recent reports. Here is the answer:

1. We are pledging aid and assistance to the research effort into all phases of tobacco use and health. This joint financial aid will of course be in addition to what is already being contributed by individual companies.

2. For this purpose we are establishing a joint industry group consisting initially of the undersigned. This group will be known as TOBACCO INDUSTRY RESEARCH COMMITTEE.

3. In charge of the research activities of the Committee will be a scientist of unimpeachable integrity and national repute. In addition there will be an Advisory Board of scientists disinterested in the cigarette industry. A group of distinguished men from medicine, science, and education will be invited to serve on this Board. These scientists will advise the Committee on its research activities.

This statement is being issued because we believe the people are entitled to know where we stand on this matter and what we intend to do about it.

TOBACCO INDUSTRY RESEARCH COMMITTEE

5400 EMPIRE STATE BUILDING, NEW YORK 1, N. Y.

SPONSORS:

THE AMERICAN TOBACCO COMPANY, INC. — Paul M. Hahn, President
BENSON & HEDGES — Joseph F. Cullman, Jr., President
BRIGHT BELT WAREHOUSE ASSOCIATION — F. S. Royster, President
BROWN & WILLIAMSON TOBACCO CORPORATION — Timothy V. Hartnett, President
BURLEY AUCTION WAREHOUSE ASSOCIATION — Albert Clay, President
BURLEY TOBACCO GROWERS COOPERATIVE ASSOCIATION — John W. Jones, President
LARUS & BROTHER COMPANY, INC. — W. T. Reed, Jr., President
P. LORILLARD COMPANY — Herbert A. Kent, Chairman
MARYLAND TOBACCO GROWERS ASSOCIATION — Samuel C. Linton, General Manager
PHILIP MORRIS & CO., LTD., INC. — O. Parker McComas, President
R. J. REYNOLDS TOBACCO COMPANY — E. A. Darr, President
STEPHANO BROTHERS, INC. — C. S. Stephano, D.Sc., Director of Research
TOBACCO ASSOCIATES, INC. — J. B. Hutson, President
UNITED STATES TOBACCO COMPANY — J. W. Peterson, President

Source: Wikimedia

This assertion was not seriously challenged until the early 1960s, when the UK Royal College of Physicians[15] (1962) and the US Surgeon General[16] (1964) both published

[14] Yach, D (2014). The origins, development, effects, and future of the WHO Framework Convention on Tobacco Control: a personal perspective. *Lancet*: 383, 1771-79. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62155-8/fulltext

[15] The Royal College of Physicians. *Smoking and health: a report of the Royal College of Physicians on smoking in relation to cancer of the lung and other diseases* (1962). Available at: https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-1962

[16] The US Surgeon General. *Smoking and health: report of the advisory committee to the Surgeon General of the public health service* (1964). Available at: https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X202-doc

reports on the harmful effects of smoking. The WHO adopted its first resolution on smoking in 1970. Over the next three decades, 154 countries introduced some domestic tobacco control measures.

For most of the 20th century, smoking-related death and disease was largely an issue for HIC. The WHO regarded this as a problem for those countries to deal with domestically – not least because the WHO was focused on the range of deadly communicable diseases ravaging LMIC. But a changing global economic climate, as much as a growing public health imperative, highlighted the need for more concerted action at an international level.

## International action against a transnational industry

From 1970 to the late 1990s, the major US tobacco companies became more transnational in outlook. The globalisation of the tobacco industry was greatly assisted by the opening up of Eastern European markets following the collapse of communism, pressure on countries from the World Bank and International Monetary Fund to liberalise foreign investment laws and privatise state companies, and the expansion of free trade areas in Asia and Latin America.[17]


The World Bank Headquarters in Washington, D.C.
Credit: Victor Grigas on Wikimedia Commons

**the growth of a transnational tobacco industry needed to be countered by a transnational agreement on tobacco control**

Over a near-thirty-year period, rather than exporting cigarettes to LMIC, the industry was therefore gradually establishing footholds outside the US. While the land devoted to tobacco growing in the US reduced by 50 per cent, it doubled in Malawi, Tanzania and also China, where the industry was and remains a state monopoly.[18] Momentum began to build within public health circles, recognising that the growth of a transnational tobacco industry needed to be countered by a transnational agreement on tobacco control.

From its inception in 1948, the WHO (under Article 19 of the WHO Constitution) had the constitutional authority to develop a legal instrument aimed at improving population health. The WHO had never acted on this. There was resistance within the WHO, whose officials – totally lacking in any experience of international treaty negotiations –

[17] Ibid p.19
[18] Wipfli, H. *The Global War on Tobacco: Mapping the world's first public health treaty*. John Hopkins Press, 2015, p.18.

were of the view that an international treaty on tobacco control was too ambitious and would struggle to get agreement.[19]

Even so, in 1994, at the Ninth World Conference on Tobacco and Health, a resolution was passed to take international legal action to combat the global smoking epidemic. By then, it was recognised that smoking was not just an issue for HIC. Two years later, the World Health Assembly formally agreed that the WHO should begin the process of formulating a Framework Convention on Tobacco Control (FCTC).

## Public health over economic interests

Three circumstances drove the process forward. First was the appointment of Dr Gro Brundtland as Director General of the WHO. She was a medical doctor who had been involved in tobacco control in her native Norway, where she had served three terms as Prime Minister. Brundtland had also held high office in the UN within the realm of sustainable development. She had the political experience lacking in the WHO which had suffered "years of dysfunction [and] desperately needed strong, clear, innovative leadership".[20] Brundtland appointed a transition team including Derek Yach, who had been Chair of the All-Africa Tobacco Control Conference and would go on to become the founding Director of the WHO's Tobacco Free Initiative (TFI).

the disclosure of reams of industry documentation revealed the depth of deceit and corruption in the service of profit

Second, the 1998 Tobacco Master Settlement Agreement in the USA demonstrated that, as powerful as it was, the tobacco industry could be legally held to account. The Settlement saw the industry forced to pay millions of dollars in 'reparations' to individual US states to head off huge quantities of time-consuming litigation. Moreover, the disclosure of reams of industry documentation revealed the depth of deceit and corruption in the service of profit.


Cover of Time magazine © after the Master Settlement Agreement, 1998.
Credit: Roberto Brosan

[19] Ibid, p.26
[20] Ibid, p.27

Thirdly, the World Bank, whose pressure on countries to open up trading channels had indirectly assisted the development of a globalised tobacco industry, published a report in 1999. Entitled *Curbing the Epidemic* it "provided perhaps the single most important tool in preparation for the FCTC negotiations."[21] The report majored on using demand reduction strategies such as tax increases, promotion bans, warning labels, restrictions on public smoking and the introduction of cessation services. This conveniently helped to assuage concerns by tobacco-producing countries that the emphasis might be on supply reduction.

However, while the appetite was growing for the development of an international tobacco control agreement, the negotiations themselves were far from straightforward. An International Negotiating Body was established. It met for six sessions, each lasting for between one and two weeks to negotiate the text, between October 2000 and February 2003. While ostensibly a public health negotiation, there were many competing interests within the government delegations - particularly between representatives of ministries of finance, commerce, trade and foreign affairs. The USA, China, Japan and Germany were the major bulwarks, attempting to water down provisions because of their tobacco interests. The USA was also traditionally not in favour of being bound by any international treaties.

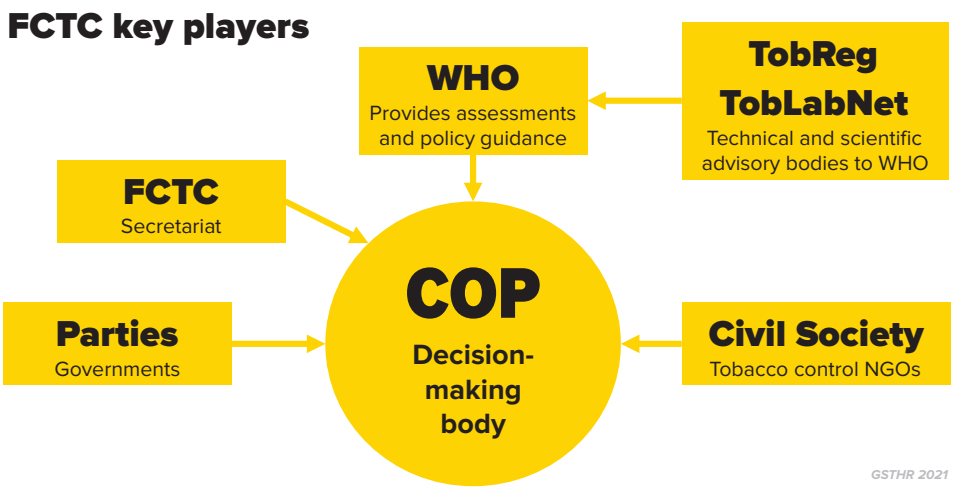
**the FCTC presented a political multilateral challenge to the multinational tobacco industry**

Despite a process described as "tedious, contentious and often confusing",[22] consensus on the text was eventually reached. The FCTC entered into force in February 2005 and was signed by 168 countries during its 12-month open period. To date, 181 countries have both signed and ratified the FCTC, which means it has been approved by domestic parliaments. Six countries, including the USA, have signed but not ratified, while nine countries have done neither.

The FCTC put tobacco control on the international health agenda and presented a political multilateral challenge to the multinational tobacco industry.

[21] Ibid, p.31
[22] Ibid p.43

# 3: International tobacco control: structure and functions




A framework convention is a legally binding treaty. A government that ratifies a framework convention is then required to adopt implementing legislation. A framework convention establishes broader commitments for Parties and leaves the setting of specific targets either to subsequent more detailed agreements (usually called Protocols) or to national legislation. In essence, a framework agreement is an umbrella document which lays down principles, objectives and the rules of governance.

A framework convention is used where the issue is not confined to specific interests, but has global implications, where there is no consensus for strong substantive measures and where both the scientific understanding and the issue being addressed are both evolving. There are only two framework conventions: the most well-known example is the Framework Convention on Climate Change (see also page 23).

Framework conventions tend not to have time-bound obligations (although the FCTC has two). This is usually left to detailed provisions in Protocols (or sub-treaties) which drill down into detail on a specific aspect within a framework convention, such as the Kyoto Protocol and the Montreal Protocol of the FCCC, and the Elimination of Illicit Trade Protocol to the FCTC. Protocols are stand-alone treaties and have their own administrative requirements for entry into force.

A framework convention is said to be 'legally binding', but this is not the same as a legally binding contract as most people understand the term. It is legally binding on the state or government to implement the obligations into domestic law according to national interpretation. In truth, it is an agreement between nations that they will act in good faith in pursuit of the goals of the convention. That said, the Framework Convention on Climate Change is taken very seriously – all nations are interdependent on this issue. The cross-border implications for the environment are huge where a country might renege on its commitments. There are also significant political pressures to tackle climate change on the domestic front, such as setting targets and goals for reducing carbon emissions, investing in alternative sources of energy, reducing pollution and so on.

**a convention is an agreement between nations that they will act in good faith in pursuit of the convention's goals**

Notwithstanding the obligation to act in good faith and keep promises, the 1969 Vienna Convention on the Law of Treaties[23] (which governs the laws of treaties and interpretation) has an interesting provision which could easily be applied to the current disruption caused by newly developed safer nicotine products. Article 62 allows for an individual nation to set aside treaty obligations where there is a "fundamental change of circumstances" which could not have been predicted at the time the treaty was being negotiated. The Preamble to the FCTC itself notes potential changes and a determination "to promote measures of tobacco control based on current and relevant scientific, technical and economic considerations."[24]

A 'no smoking' sign amid city office blocks.
Credit: Possessed Photography on Unsplash

## The Framework Convention on Tobacco Control (FCTC)[25]

The FCTC comprises 38 Articles and non-binding Guidelines to some of the Articles to assist Parties to deliver national obligations. There are Guidelines covering Article 5.3 (protecting health policies from commercial interests); Articles 8. 9 and 10 (protection from tobacco smoke; tobacco product content and testing); and Articles 11-14 (product packaging; public awareness; advertising; and demand reduction including cessation services).

There is currently one Protocol – the Protocol to Eliminate the Illegal Trade in Tobacco Products, which complements Article 15, Illicit Trade in Tobacco Products.

The Preamble to the FCTC has several recitals which are unambiguous in recognising the need to reduce death and disease from the use of tobacco. These recitals are given within the context of the universal right to health with nobody left behind and include;

> *"Determined to give priority to protect public health."*
>
> *"Reflecting…the devastating worldwide… consequences of…exposure to tobacco smoke."*

[23] Vienna Convention on the Law of Treaties (1969) https://legal.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf
[24] Op cit, ref 4, p.3
[25] The Framework Convention on Tobacco Control (2005): https://www.who.int/fctc/text_download/en/

*"Seriously concerned about increase in worldwide consumption…particularly in developing countries…and the burden this places on families, on the poor and on national health systems".*

*"Recalling Article 12 of the International Covenant on Economic, Social and Cultural Rights…which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*

*"Recalling…the Constitution of the [WHO] which states that [the right stated above] is a 'fundamental right of every human being'.*

*"Determined to promote measures of tobacco control based on current and relevant scientific, technical and economic considerations."*

## The Conference of the Parties (COP)

At the centre of the FCTC decision-making process is the biennial meeting of the nations who are Parties to the FCTC, known as the Conference of the Parties (COP). Party (or nation) representatives might sign the FCTC as an indication of intent, but the signing will not be ratified unless it is agreed by the Parliament of the country. This indicates that the Party has formally agreed to comply with the FCTC – although there are no 'sanctions' for non-compliance.

Parties who have both signed and ratified the FCTC or who have acceded to the FCTC can take an active role in discussions and decisions at COP. Those who have only signed (like the USA) have observer status and can intervene only when all other Parties have spoken. The views of those who have only signed do not have to be formally considered.

The WHO Executive Board Room.
Source: Wikimedia Commons

Since the first COP in 2006, there have been eight meetings in different locations around the world with the ninth set for November 2021, postponed from 2020 due to COVID.[26]

[26] Information about COP 9, held virtually in November 2021, can be accessed here: https://fctc.who.int/who-fctc/governance/conference-of-the-parties/ninth-session-of-the-conference-of-the-parties

Delegations will primarily consist of health officials, although other domestic departmental interests concerning, for example, business and trade might also attend. Delegations might also include NGO representatives and subject specialists.

At COP meetings, decisions are taken by consensus; voting is a very rare occurrence. If only one country opposes a provision, either the country concedes, or there is a text amendment that all must agree on. Every Party carries equal weight.

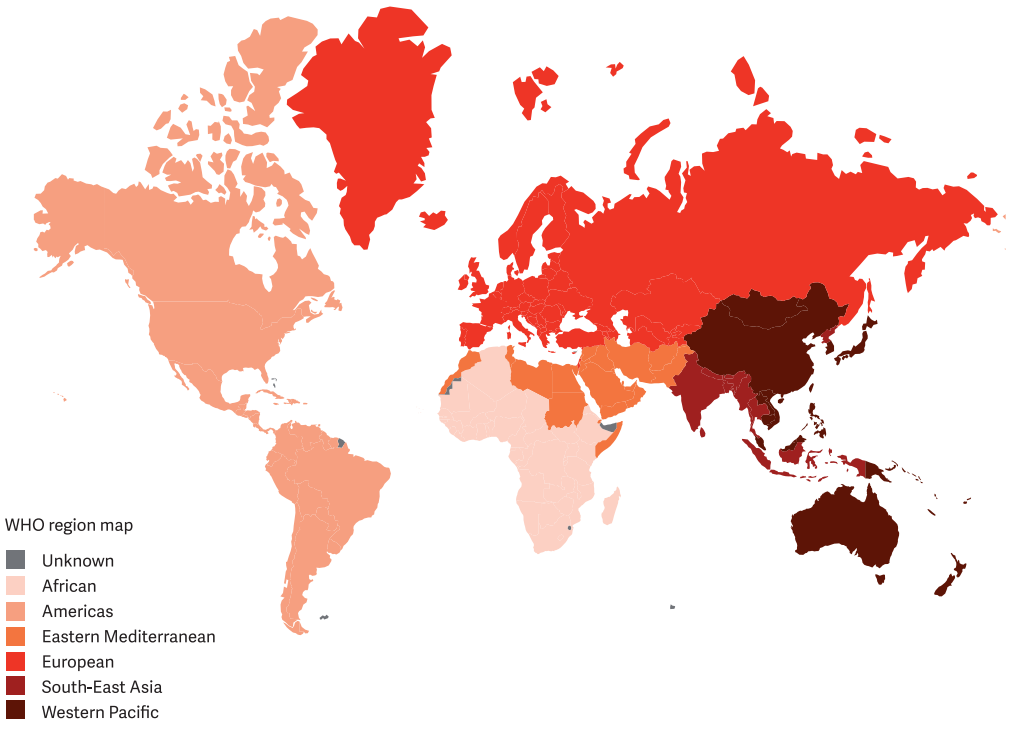
## Structure of the meetings

Apart from the main plenary sessions that involve all Parties, the COP breaks into two committees – Committee A and Committee B. Committee A deals with policy matters and Committee B deals with matters such as funding. The Committees are there to discuss agenda items such as proposals put forward by Parties, and sometimes to draft decisions to enable consensus to be reached in the plenary sessions. Sub-drafting groups may be convened if consensus cannot be reached in Committee.

## A world of pre-meetings

Parties that wish to make proposals for inclusion on the COP agenda will do so some months before the agenda is circulated. The positions that governments will take are usually decided well before the meeting. This means that the COP sessions are largely an exercise in rubber stamping. However, a degree of horse trading may take place in the Committee meetings.

Much of the pre-meeting discussion and positioning goes on in the WHO Regional Meetings in advance of a COP. There are six WHO regions; Africa (AFRO); the Americas (AMRO); South-East Asia (SEARO); Western Pacific (WPRO); Europe (EURO) and Eastern Mediterranean (EMRO). Parties can speak for themselves at the COP, but are encouraged to allow the elected country for the region to do the talking, to save time and consolidate issues.




Credit: Atlas of MS toolkit

## Informing decision-making

One COP may decide that it needs to explore specific issues for a report to the next COP. This can happen through two channels:

1. Working Groups

These comprise COP delegates (up to around 40 in number) with equal representation from the six WHO regions who might, for example, work on developing guidelines for specific FCTC Articles.

2. Expert Groups

These are convened by the FCTC Secretariat (see below) acting on a request of the COP to report on specific technical issues such as legal.

There are also standing expert groups including the Tobacco Laboratory Network (TobLabNet), which develops standard testing and measurement methods for tobacco products, and the WHO Study Group on Tobacco Product Regulations (TobReg), which focuses on tobacco and nicotine science and policy.

## The COP support network

1. The WHO

The COP meetings are hosted by the WHO. However, the WHO does not have an official voice in the negotiations. It cannot propose amendments to the text. Nevertheless, the WHO can intervene to assist negotiations and encourage governments to endorse WHO views on tobacco control. It has considerable influence, since most countries are passive and say and initiate nothing. Most will go with the flow, which is different to other substantive global issues such as trade and climate, where national governments fight strongly for national positions and leadership.

2. The FCTC Secretariat

This is the administrative body that supports the COP. It is funded by Parties, both in the form of assessed contributions for mainstream Secretariat work, and voluntary contributions for specific projects. Although housed within the WHO HQ in Geneva, the WHO has no direct line management of the Secretariat nor does the WHO have direct input into COP discussions and decisions.

**the head of the Secretariat reports to the COP, but the relationship is not one of supervision nor line management**

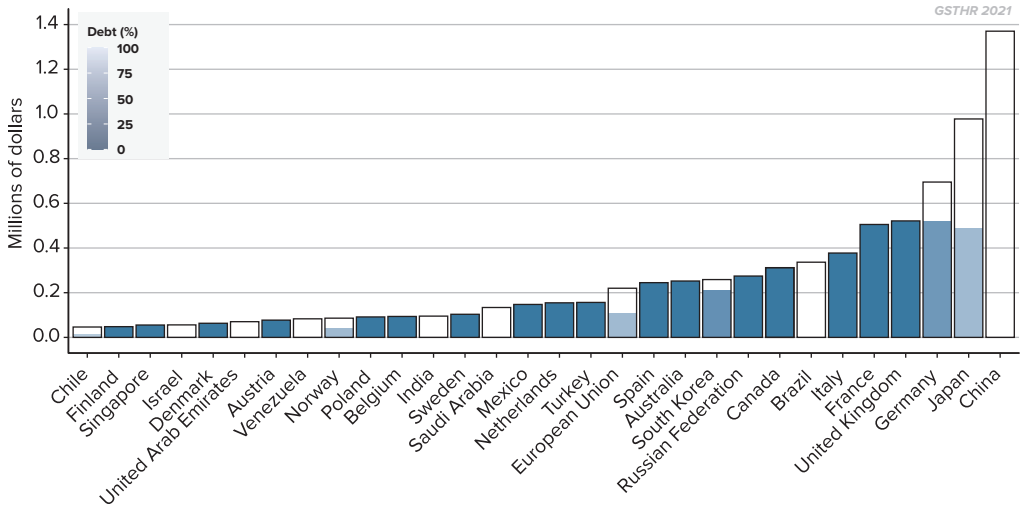
Geneva, the home of the WHO.
Credit: Lukas Blaskevicius on Unsplash

**few countries pay the amount they owe**

The Secretariat coordinates all the work that goes on in and between the COP meetings and produces all the necessary documentation including proposals for the COP agenda. The FCTC is required to act in accordance with the Parties' wishes and proposals. As well as appointed officials, there is an inner group of advisers within the Secretariat known as 'The Bureau', composed of a president, five vice-presidents and six regional coordinators. They are elected at the end of each COP and finish their term at the conclusion of the next.

It would appear that the WHO Director-General appoints the head of the Secretariat, usually from within the WHO 'family'. The head of the Secretariat reports to the COP, but the relationship is not one of supervision nor line management.

The FCTC is funded by a combination of assessed and voluntary contributions from the Parties. The assessment is made on the basis of a formula related to gross domestic product (GDP). Few countries pay the amount they owe, including several of the Parties with the highest assessed contributions.




Assessed and paid contributions to the FCTC.
Data source: FCTC/COP/9/14. (2021). Payment of the assessed contributions and measures to reduce Parties in arrears. Provisional agenda item 6.3. https://untobaccocontrol.org/downloads/cop9/main-documents/FCTC_COP9_14_EN.pdf

3. The WHO Tobacco Free Initiative (TFI)

This is the WHO's tobacco control arm, providing policy and legal advice to Parties, preparing draft provisions and brokering negotiating compromises. It is also the public face of WHO tobacco control policies and programmes. The TFI used to be a department in its own right, with its own Director. It has since been subsumed into the WHO department working to tackle NCD.

## The role of COP non-state observers

So far, we have outlined a hinterland network of meetings, information and technical support provided to Parties and organised by WHO officials and appointed experts. But the influence on the deliberations of the COP does not end there.

The preamble to the FCTC recognises the "special contribution of non-governmental organizations and other members of civil society…to tobacco control efforts nationally and internationally…" NGOs are allowed a presence at the COP, but only those specifically accredited by the WHO. International non-governmental organisations can apply for WHO accreditation. Smaller NGOs can participate as members of the NGO tobacco control umbrella body known as the Framework Convention Alliance (FCA), but membership is dependent on FCA acceptance.

Accredited FCTC NGOs can participate in negotiations and make interventions when invited by the session Chair once Parties have concluded. They might also be allowed to attend the Committee A or B meetings but not small working groups. These are where all the serious work is carried out, if there are still matters of conflict which have not been resolved in all the meetings which have taken place in the period since the previous COP.

FCA accreditation is only open to those with no connections to the tobacco industry, however tangential or historical. Also excluded are advocacy NGOs representing people directly affected by tobacco control regimes, who include smokers and, now, users of safer nicotine products.


Unfortunately many influential stakeholders believe that anyone who advocates for tobacco harm reduction using SNP must be linked to, in the pay of or apologists for the tobacco industry. This is due to the involvement of the tobacco industry in the production of some (but by no means all) of the safer nicotine products on the market. Advocacy organisations in favour of tobacco harm reduction, including numerous vaping or snus consumer advocacy organisations, are therefore excluded de facto and get no seat at the table.

**advocacy NGOs representing people directly affected by tobacco control regimes, who include smokers and, now, users of safer nicotine products, are excluded**

## A breath of fresh air?

The FCTC COP, an international meeting of government ministers and officials ultimately funded by citizens' taxes, is shrouded in a secrecy comparable to the UN Security Council.

This is in stark contrast to the Framework Convention on Climate Change (FCCC) COP meeting. The FCCC COP 26 is due to take place in November 2021, the same month as the FCTC COP 9. The world's media is already very engaged with the FCCC COP 26 meeting and its potential to affect change. Mainstream media has barely picked up on the FCTC COP 9.

At the FCCC COP, observers representing a broad range of interests are admitted; environmental, agriculture, indigenous communities, women's issues, gender issues and youth groups - along with research and academic interests, labour unions and representatives from business. Applicants need only demonstrate that they represent a national or international body and have relevant knowledge and experience.[27]

[27] For more details on the difference between the attendance criteria of the FCTC and Climate Control COPs, see https://www.clivebates.com/documents/APPGVapingFeb2021.pdf, p.12-13


A protest against political inactivity on climate change.
Credit: Marcus Spiske on Unsplash

**decisions at COP have the potential to affect the lives of millions of people worldwide, including the approximately 100 million people who have already switched from smoking to use safer nicotine products**

The type, number and impact of business representation at the Climate Change COP is not without controversy. Delegates from heavily-polluting legacy industries, including coal, oil, gas, automobile and mining, attend. Under the convention's own rules, it is permitted for trade bodies representing oil and gas to attend annual talks and inter-sessional meetings as observers. At some previous COPs, major polluters have even been allowed to sponsor the meetings, with car manufacturers, energy companies and coal producers paying millions to get their brands front and centre. At COP 26, the UK government has stated that sponsors must "have a credible plan to cut their emissions to net zero by 2050".[28]

Sponsorship deals aside, there may be an interesting point to be made about these industries being 'in the room' at COP meetings. Tackling the climate emergency requires engagement with the very industries that have contributed so significantly to the crisis. Failure to transform these companies and the way they operate will only hinder progress towards the ultimate goals of the Framework Convention on Climate Change. The meetings and the attendant media and political focus puts the spotlight on the progress or lack of progress in transitioning to greener technologies, processes and products. Yet the car manufacturers present at the COP26 to demonstrate their new electric vehicles are still actively selling vehicles with combustion engines.

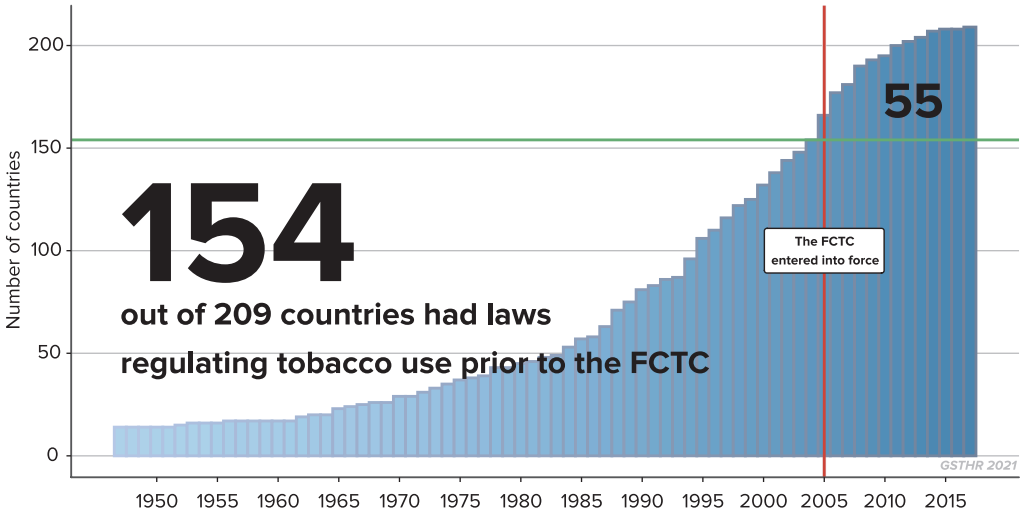
The contrast with the FCTC COP could not be more stark. Decisions at COP have the potential to affect the lives of millions of people worldwide, including the approximately 100 million people[29] who have already switched from smoking to use safer nicotine products, the 1.1 billion people who continue to smoke, their families and others at risk from inhaling secondhand smoke.  There are a huge number of organisations that need to be onside to implement the significant changes that are required to bring about an end to the death and disease caused by smoking – and pragmatically, that includes manufacturers.

[28] *Climate Change News* (18/08/20) 'Big oil need not apply'. Accessed August 2021.  https://www.climatechangenews.com/2020/08/18/big-oil-need-not-apply-uk-raises-bar-un-climate-summit-sponsorship/
[29] *Burning Issues: The Global State of Tobacco Harm Reduction 2020.* Knowledge-Action-Change, 2020, p.54 https://gsthr.org/report/2020/burning-issues/chapter-2#unrialisedpublichealth

# 4: Tobacco harm reduction

## Beyond ‘quit or die’

The way international tobacco control plays out leaves the adult smoker two options – crudely put ‘quit or die’. Many of the gains in reducing smoking death and disease in HIC were achieved before the FCTC was enacted. Moreover, 154 countries had implemented some tobacco control measures before 2005. It would be wrong to suggest that, for example, public smoking bans or price rises have had no impact on prevalence and so, therefore, on death and disease. But since the 1970s, there has been a move away from smoking in HIC, as part of a gradual move towards ‘healthier lifestyles’, largely among people from higher socioeconomic groups (with high smoking rates still present among many marginalised and poorer communities in HIC).[30]




Data source: Tobacco Control Laws. (2021). Retrieved September 2, 2021, from https://www.tobaccocontrollaws.org/

As we pointed out above, the reality is that the current international tobacco control efforts are simply not enough. As of 2021, even in HIC, smoking prevalence graphs are levelling out while population growth is predicted to result in a rise in smoking prevalence in LMIC.

There is, however, a complementary and potentially life-saving intervention which can be delivered at little cost to governments. It offers a third and more palatable option for current adult smokers. It is tobacco harm reduction using safer nicotine products.

## What is harm reduction?

Harm reduction is a range of pragmatic policies, regulations and actions that either reduce health risks by providing safer forms of products or substances or encourage less risky behaviours with an important role in championing social justice and human rights for people who are often among the most marginalised in society. Proponents of harm reduction argue that people should not forfeit their right to health if they are undertaking potentially risky activities, like drug or alcohol use, sexual activity or smoking.

harm reduction is a range of pragmatic policies, regulations and actions that either reduce health risks by providing safer forms of products or substances or encourage less risky behaviours

[30] Ibid, p. 140–146. Chapter 7: The right to health and the people left behind https://gsthr.org/report/2020/burning-issues/chapter-7

people who use nicotine have the same fundamental right to enjoy the highest attainable standard of health as those who do not

While harm reduction as a social movement is relatively new, what affected communities have always been fighting for – the right to health, with nobody left behind – has long been enshrined in international conventions and continues to be so. The WHO is signed up to harm reduction across many of its activities.

People who use nicotine have the same fundamental right to enjoy the highest attainable standard of health as those who do not. People who smoke to obtain nicotine therefore have the right to access accurate information and products that help them achieve this.

## Tobacco harm reduction: from conception to reality

While specifically referenced in the FCTC under Article 1d, harm reduction per se is not defined. It was included because the FCTC transition team sat down with the industry to hear what its plans were to produce safer products.

On 13 October 2000, the WHO Director-General Dr Gro Brundtland made a statement in which she acknowledged the clear differences which existed between the priorities of public health and the industry, but even so, that "we are committed to hearing how the tobacco companies do propose to reduce the harm their products cause".[31]

the possibility of new developments was recognised in Recital 21 of the FCTC Preamble

It would be years before safer products became available, but the possibility of new developments was recognised in *Recital 21* of the FCTC Preamble that Parties are, "*Determined* to promote measures of tobacco control based on current and relevant scientific, technical and economic considerations". Even as recently as 2014, in a paper on new nicotine products prepared for COP 6, the WHO stated, "the greater responsibility to prove claims about ENDS scientifically should remain with the industry".[32]

Fifteen years after vaping products emerged onto the market, what is the evidence that safer nicotine products are exactly that? There is one simple scientific fact which underpins the relative safety of SNP – there is no combustion of tobacco.

Combustion of tobacco is the key difference.
Credit: Gary Ellis on Unsplash

[31] WHO Director-General's response to the tobacco hearings. 13 October 2000, p.3.
[32] WHO. *Electronic nicotine delivery systems: report by the WHO*. WHO, 2014, FCTC/COP6/10-21 July 2014, para 35, p.10

When a cigarette is lit, some 7,000 chemicals are released which are responsible for all the harms of smoking; cancer, heart and respiratory diseases. Smokers smoke tobacco because they are looking to experience the effects of nicotine, but suffer disease and might die because of the toxins in the smoke that is released when tobacco is burned.

Safer nicotine products deliver nicotine to the user without combustion of tobacco. But what about nicotine itself? Issues of 'nicotine illiteracy' among health professionals and the public persist. Many mistakenly believe that nicotine itself is carcinogenic[33,34,35]; in fact, as the UK Royal College of Physicians has stated, "it is widely accepted that any long-term hazards of nicotine are likely to be of minimal consequence in relation to those associated with continued tobacco use."[36]

'Nicotine addiction' is also often cited as a concern. However, 'addiction' is a loaded term, which can bring to mind the damage to individuals, families and wider society caused by serious illicit drug problems. Nicotine itself is a relatively benign substance, used in pharmaceutical nicotine replacement therapies, which does not cause any of the illnesses associated with smoking. Using nicotine is arguably not the physical or psychological problem usually conveyed by the public image of the word 'addiction'.[37]

**there is one simple scientific fact which underpins the relative safety of safer nicotine products. There is no combustion of tobacco**

The harm reduction potential for non-combustible nicotine products was realised by British tobacco researcher Professor Michael Russell as far back as 1976, but the products to deliver on the promise were not available in a form acceptable to smokers. Now they are and the evidence is growing substantially.

Vaping device showing heated coils.
Credit: Boukaih on Unsplash

[33] Moysidou, A. et al. (2016). Knowledge and Perceptions about Nicotine, Nicotine Replacement Therapies and Electronic Cigarettes among Healthcare Professionals in Greece. *International Journal of Environmental Research and Public Health*, 13(5). https://doi.org/10.3390/ijerph13050514

[34] Ratschen, E. et al. (2009). Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. *General Hospital Psychiatry*, 31(6), 576–582. https://doi.org/10.1016/j.genhosppsych.2009.08.003

[35] Ramesh Patwardhan, S., & Murphy, M. A. (2013). Survey of GPs' understanding of tobacco and nicotine products. *Drugs and Alcohol Today*, 13(2), 119–150. https://doi.org/10.1108/DAT-02-2013-0010

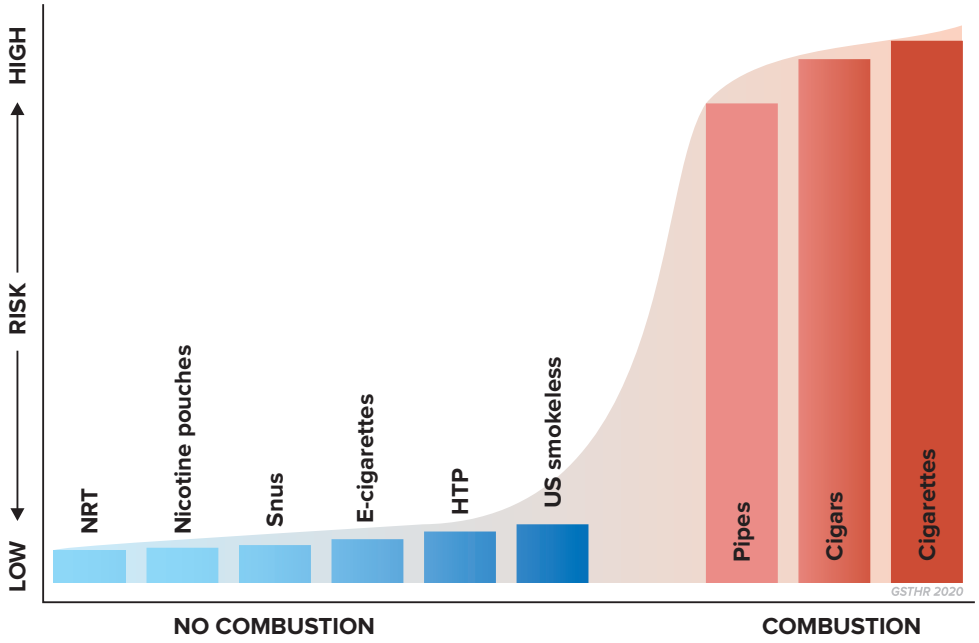
[36] Royal College of Physicians (RCP) (2016). *Nicotine without smoke; tobacco harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians*. https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction

[37] *Tobacco Harm Reduction: A Burning Issue for Asia*. London: Knowledge Action Change (2021), p.18. https://gsthr.org/report/2021/burning-issue-for-asia/chapter-3

Tobacco harm reduction was advocated by the UK Royal College of Physicians (RCP) in the 2007 report *Harm reduction in nicotine addiction*.[38] The report argued that "harm reduction in smoking can be achieved by providing smokers with safer sources of nicotine that are acceptable and effective cigarette substitutes" and suggested the potential for rebalancing the market in favour of the safest nicotine products.[39]

In 2017, in a position statement on vaping products, the UK Royal College of General Practitioners said, "The evidence so far shows that e-cigarettes have significantly reduced levels of key toxicants compared to cigarettes, with average levels of exposure falling well below the thresholds for concern."[40]

In 2020, Public Health England reaffirmed its earlier conclusion that "vaping is at least 95 per cent less harmful than smoking".[41]




**by 2020, the Global State of Tobacco Harm Reduction calculated that there were nearly 100 million users of safer nicotine products**

Not only is the evidence base growing, so is the global market demonstrating that if smokers are given the option of safer nicotine products which are available, affordable, accessible and appropriate, they will switch. By 2020, the Global State of Tobacco Harm Reduction calculated that there were nearly 100 million users of safer nicotine products, primarily vaping products, but also heated tobacco products and oral products like Swedish-style snus.[42]

## Tobacco harm reduction works

In *Burning Issues: The Global State of Tobacco Harm Reduction 2020* report, we offer strong epidemiological evidence of a substitution effect, where smokers are switching to safer nicotine, in four countries.

[38] Tobacco Advisory Group, Royal College of Physicians. *Harm reduction in nicotine addiction: helping people who can't quit.* London, RCP, 2007.
[39] Ibid.
[40] Royal College of General Practitioners *Position Statement on the use of electronic nicotine vapour products* (September 2017). https://www.rcgp.org.uk/-/media/Files/Policy/2017/RCGP-E-cig-position-statement-sept-2017.ashx?la=en
[41] Public Health England (2020) *Vaping in England – 2020 evidence update summary.* https://www.gov.uk/government/publications/vaping-in-england-evidence-update-march-2020/vaping-in-england-2020-evidence-update-summary
[42] *Burning Issues: The Global State of Tobacco Harm Reduction 2020.* Knowledge-Action-Change, 2020, p.51–53. https://gsthr.org/report/2020/burning-issues/chapter-2#windowsofopportunity

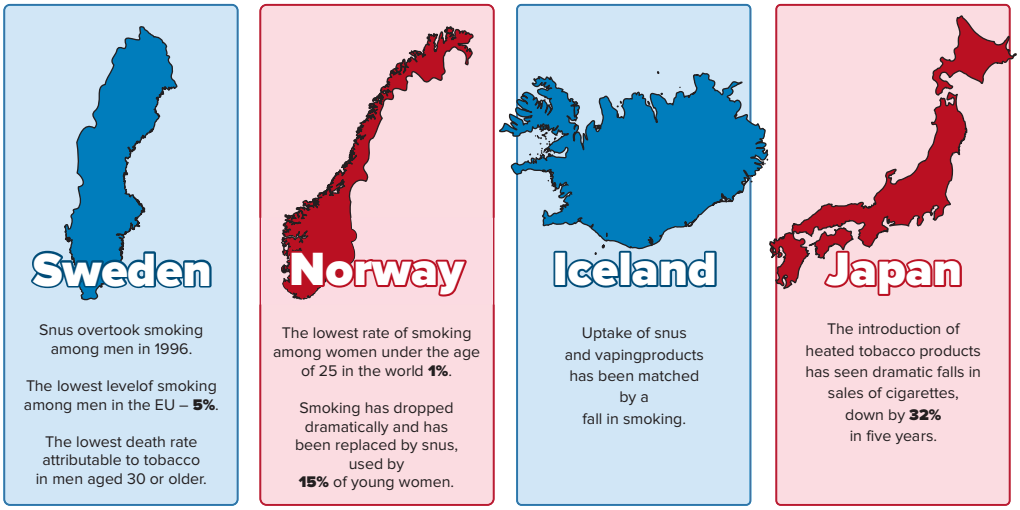
In Sweden, a tradition of using snus, an oral tobacco, had been present for centuries. It was in the 20th century however that snus manufacturing processes became significantly more safety-focused. By 1996, the use of this new, safer, pasteurised snus overtook smoking among men. Sweden now has the lowest level of smoking among men in the EU – 5 per cent against the EU average of 24 per cent. Sweden also boasts the lowest death rate per 100,000 attributable to tobacco in men aged 30 or older. If the EU ban on snus was revoked, it is calculated that around 320,000 tobacco-related premature deaths among men aged 30 years or older could be prevented in the EU every year.[43]

At a mere 1 per cent, Norway has the lowest rate of smoking among women under the age of 25 in the world; this has been driven by the substitution of snus for cigarettes – 15 per cent of young women use snus. Generally, use of snus is replacing cigarette smoking in the country.

A similar picture can be seen in Iceland, where the uptake of snus and vaping products has been matched by a fall in smoking.

In Japan, the introduction of heated tobacco products has seen dramatic falls in sales of cigarettes, down by 32 per cent in five years. Heated tobacco products now account for a third of all tobacco sales.[44]

## Tobacco harm reduction at work




Data source: European Commission. (2021). Special Eurobarometer 506: Attitudes of Europeans towards tobacco and electronic cigarettes (S2240_506_ENG). European Commission. http://data.europa.eu/88u/dataset/S2240_506_ENG; Statistics Norway. (2021). Tobacco, alcohol and other drugs. SSB. https://www.ssb.no/en/helse/helseforhold-og-levevaner/statistikk/royk-alkohol-og-andre-rusmidler; Japanese domestic cigarette monthly sales results (Information by Business Segment). (2020). Japan Tobacco Inc. https://www.jt.com/investors/results/S_information/domestic_cigarette/index.html

So how have the WHO, its NGO and funding allies responded to these disruptive technologies and the opportunities they present to make more tangible inroads into reducing death and disease from smoking?

[43] Lars Ramström, Institute for Tobacco Studies, Sweden. Poster for the Global Forum on Nicotine 2017, quoted in *No Fire, No Smoke: Global State of Tobacco Harm Reduction 2018*. KAC: 2018, p.50 https://gsthr.org/resources/item/no-fire-no-smoke-global-state-tobacco-harm-reduction-2018

[44] For more detail and full references, please see: Knowledge-Action-Change. *No Fire, No Smoke: Global State of Tobacco Harm Reduction 2018*. KAC: 2018, pp.45-50 https://gsthr.org/resources/item/no-fire-no-smoke-global-state-tobacco-harm-reduction-2018, Knowledge-Action-Change. *Burning Issues: Global State of Tobacco Harm Reduction, 2020*. KAC: 2020, pp.51-53 https://gsthr.org/report/2020/burning-issues/chapter-2#windowsofopportunity

# 5: Trench warfare: the WHO, allies and funders

## A new front opens up

The history of domestic and international tobacco control has been dominated by attempts to curb the power of the tobacco industry and expose its manifold strategies for undermining laws and regulations. Cigarette consumption has been falling in HIC in recent decades. Yet the global value of the cigarette market is predicted to continue rising substantially, mainly through sales in LMIC. The battle against combustible products is far from over and nobody would suggest stepping back from that. But there are alternate strategies to be deployed now.

**THR can come to fruition if the international tobacco control community, led by the WHO, can disaggregate combustible from non-combustible tobacco products in its policy and legislative deliberations**

THR has a complementary role to play in tobacco control and reducing cigarette consumption. Its potential can come to fruition if the international tobacco control community, led by the WHO, can disaggregate combustible from non-combustible tobacco products in its policy and legislative deliberations.

As it stands, all nicotine products are regarded by many of the powerful forces of international tobacco control as being equally dangerous, warranting either total bans or to be heavily regulated as if they were combustible tobacco products. This approach saves tobacco control from having to disrupt a deeply entrenched policy mindset. It also enables a new front to open up in the war against the tobacco industry, serving certain moral and financial vested interests.

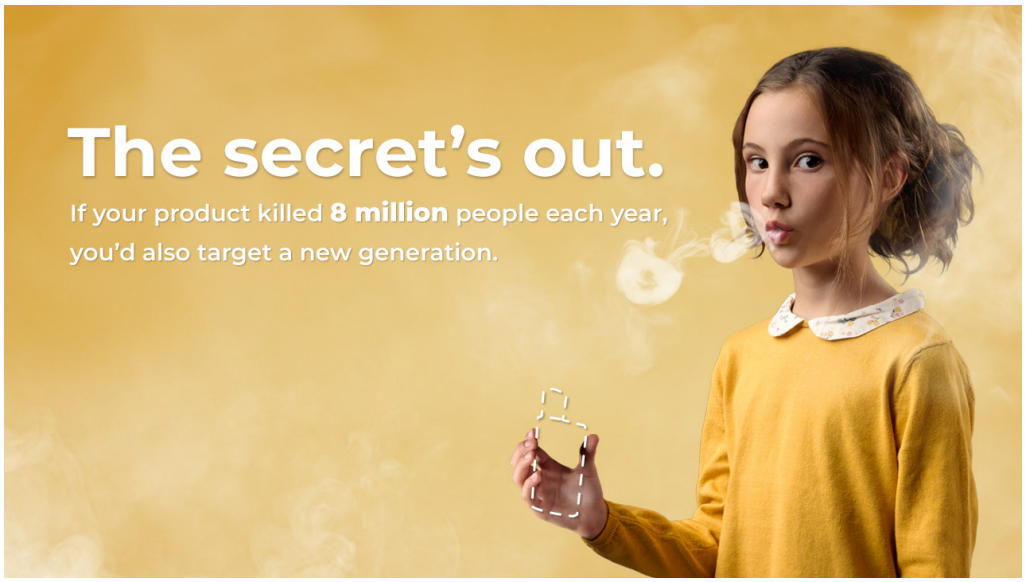



Image depicts a child purportedly vaping. See page 37 for more examples of the WHO using children in its campaigns.
Source: WHO World No Tobacco Day 2020

Despite the general failings of current strategies to curb smoking, especially in LMIC, and the scarcity of global smoking cessation services, it is becoming apparent that:

- The original wording and intention of the FCTC notwithstanding, the policy and legislative goalposts have shifted from tobacco and smoking – and now to an entirely prohibitionist stance targeting nicotine irrespective of the delivery mechanism.
- Anti-THR campaigning and funding is focused on preventing young people initiating nicotine use. This has the advantage of being beyond political criticism. At the same time, it is impossible to evaluate without long-term, expensive longitudinal studies.

Process and activity boxes can be ticked, while measurable health outcomes are conveniently forgotten.

» The prohibitionist agenda speaks to a moral conclusion that current adult smokers have only themselves to blame, leaving them with the stark choice to 'quit or die'.

» By sowing doubt and confusion in the minds of smokers, health professionals, the media and wider society about the relative safety of SNP and their potential for helping adult smokers switch away from smoking, the WHO and its allies have taken a leaf out of the old-style tobacco industry playbook.

How does this play out on the ground? There are four key actors: the FCTC Secretariat; the WHO TFI, anti-THR NGOs and Bloomberg Philanthropies. Although these are iterated individually below, they form a close interdependent and overlapping network of influence on Parties to the FCTC and their tobacco control policies.

## FCTC Secretariat – tobacco control out of control

For anyone with a knowledge of harm reduction and its implementation in other areas of health policy, the FCTC Secretariat's outright opposition to tobacco harm reduction is a source of considerable frustration. Harm reduction sits right at the heart of WHO policy to reduce the risk of death and disease caused by HIV and injecting drug use. WHO explicitly supports the implementation of harm reduction programmes, which include the distribution of condoms and clean needles, or the provision of opioid substitution therapy for people dependent on heroin or other opiates.[45]

A condom. Credit: Reproductive Health Supplies Coalition on Unsplash
Syringes. Credit: John Cameron on Unsplash
Opioid substitution therapy. Credit: Josh Estey, AusAID on Wikimedia Commons

The WHO estimates that there are 11 million people who inject drugs worldwide and that injecting drug use accounts for 10 per cent of all new HIV infections.[46] There are 1.1 billion people who smoke around the world, 8 million people a year who die from smoking-related diseases and an estimated 14 per cent of all NCD deaths among adults aged 30 years and over are tobacco-related.

Despite the huge potential to make significant public health gains in the fight to reduce the smoking-related death and disease affecting millions worldwide, it seems as though there are no connections made between the WHO's pragmatic and non-moralistic policy approach to harm reduction for HIV and injecting drug use and that for tobacco.

there are no connections made between the WHO's pragmatic and non-moralistic policy approach to harm reduction for HIV and injecting drug use and that for tobacco

[45] WHO Regional Office For Europe, Policy guidance by HIV intervention area: harm reduction https://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-areas-of-intervention/harm-reduction

[46] WHO, Global HIV, Hepatitis and STI Programmes: People who inject drugs https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-who-inject-drugs

How has this happened? Whatever the formal structures look like, in reality the Secretariat is very influential in the flow of information to the COP from outside sources. It guides which proposals find their way onto the agenda and how they are phrased.

**while the WHO hosts the FCTC Secretariat, it does not have any direct line management control – nor is it clear who does**

To reiterate, while the WHO hosts the FCTC Secretariat, it does not have any direct line management control – nor is it clear who does. Combined with a lessening of interest in tobacco control on the part of Parties and, more recently, the WHO's focus on COVID, this has allowed what one correspondent has called 'rogue elements' within the FCTC to thread a prohibitionist, anti-THR agenda through Convention deliberations. This is made manifest in the papers submitted to different COP meetings over the years.

## The COP and the history of SNP

The WHO first considered 'ENDS' in 2010 with a regulatory consultation exercise prior to COP 4. The report that went to the COP recommended extreme caution when it came to these new products.

Another report was ordered for COP 5 in 2012. This recommended the new products should not be regarded as safer alternatives to combustible tobacco products.

By the time the next paper was prepared for the COP meeting of 2014, it was clear that the report commissioned by the FCTC Secretariat saw no benefit in encouraging a switch to vaping products. It was deemed this would be entirely outside of both the spirit and the letter of the FCTC, to the extent that "while medicinal use of nicotine is a public health option under the treaty, recreational use is not".[47]

A range of vaping devices and liquids.
Credit: Antonin FELS on Unsplash

The 2016 COP meeting had more positive comments on THR and the potential for ENDS. Drawing heavily on a TobReg Report[48], the Decision at COP 7 was to 'welcome'

[47] WHO. *Electronic nicotine delivery systems: report by WHO*. Prepared for FCTC/COP 6, September 2014, p. 10. See also: https://www.who.int/publications/m/item/background-papers-to-the-who-report-on-electronic-nicotine-delivery-systems-and-electronic-non-nicotine-delivery-systems-(ends-ennds) (2016); https://www.who.int/fctc/cop/sessions/cop8/FCTC_COP8(22).pdf (2018)

[48] FCTC/COP/7/11 *Report: Electronic Nicotine Delivery Systems and Electronic Non-Nicotine Delivery Systems (ENDS/ENNDS): Report by WHO* https://www.who.int/fctc/cop/cop7/FCTC_COP_7_11_EN.pdf

the report which included the following statement: “If the great majority of tobacco smokers who are unable or unwilling to quit would switch without delay to using an alternative source of nicotine with lower health risks, and eventually stop using it, this would represent a significant contemporary public health achievement.”[49] The Decision went on to describe a number of options for regulating ENDS.

Unfortunately, these recommendations were preceded by a statement about banning products, with the implication that this was the preferred policy option. A very thin 2018 paper simply reiterated the points for Party consideration in the previous paper.

## Safer nicotine products at COP 9

Two new papers were tabled for COP 9 relating to safer nicotine products, which were published within days of each other in July 2021. The first, by the WHO, is titled a ‘*Comprehensive report on research and evidence on novel and emerging tobacco products, in particular heated tobacco products*’.[50] The second, by the Convention Secretariat, considers *‘Challenges posed by and classification of novel and emerging tobacco products’*.[51] Both reports focus on heated tobacco and ENDS (with no mention of snus or nicotine pouches).


A heated tobacco device.
Source: Wikimedia Commons

However, when the Provisional Agenda for COP 9 was published, it was revealed that “the Bureau [had] decided that [these two] reports [...] should be presented for information and that related substantive discussions should be deferred to COP 10.”[52] If a Party or Parties wish to discuss the papers they can decide to raise them – but discussion may well have to wait until COP 10 in 2023.

[49] FCTC/COP/7/9 *Decision: Electronic nicotine delivery systems and electronic non nicotine delivery systems* https://www.who.int/fctc/cop/cop7/FCTC_COP7_9_EN.pdf?ua=1
[50] FCTC/COP/9/9 *Comprehensive report on research and evidence on novel and emerging tobacco products, in particular heated tobacco products, in response to paragraphs 2(a)–(d) of decision FCTC/COP8(22): report by WHO.* https://untobaccocontrol.org/downloads/cop9/main-documents/FCTC_COP9_9_EN.pdf
[51] FCTC/COP/9/10 *Challenges posed by and classification of novel and emerging tobacco products: report by Convention Secretariat* https://untobaccocontrol.org/downloads/cop9/main-documents/FCTC_COP9_10_EN.pdf
[52] FCTC COP 9 *Provisional agenda annotated* https://untobaccocontrol.org/downloads/cop9/main-documents/FCTC_COP_9_1_annotated_EN.pdf

None of these papers concede at any point that any of the products discussed could have a role in reducing the burden of death and disease from smoking.

It is also worth highlighting here the WHO study group on tobacco product regulation, commonly known as TobReg. This is a long-standing scientific advisory committee, which has produced some useful reports. However, its latest report (2021)[53] contained a dozen recommendations which underpin general WHO intransigence to SNP and are hostile to the idea SNP offer public health benefits in tackling the smoking epidemic. The text puts harm reduction in quote marks. It refers to "claims" of less harm and "alleged belief" in less harm. The word 'may' is used frequently, for example when it states that young people "may" be attracted to e-liquid flavours or "may" go on to smoke combustible cigarettes, without offering any substantive evidence to support the assertions. There are also sneering references to "fancy" IQOS concept stores.[54]

## Guidelines

The most contentious and deliberate method of attack on supporters of THR is the over-interpretation of the Guidelines for Article 5.3. Given the time period in which the FCTC was drafted and the industry track record, the wording of the original article was perfectly reasonable:

> *"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."*

It is important to note that even in the context of a 'good faith' convention, FCTC Guidelines are non-binding proposals: they are merely guides to assist Parties to implement their obligations in various articles. They do not extend the obligations of the FCTC nor do they constitute a subsequent interpretation of the FCTC. This is the basis on which Parties agree to the adoption of Guidelines.

A COP Working Group on Article 5.3, comprising two representatives from each WHO region, was constituted as part of the process of providing non-binding guidance on how Parties may interpret Article 5.3. The Working Group was to present proposals to the 2008 COP 3 meeting in Durban. Like much of the FCTC, the Guidelines on 5.3 were primarily to assist LMIC. In the EU, for example, principles and guidelines were already in place.

**it was never intended that the Guidelines would be used to exclude the industry from discussions related to tobacco use and tobacco products at either a domestic or international level**

The main thrust was to set out in more detail the objective to limit as far as possible contact between governments and the industry, and to ensure that any dealings with the industry were as open and transparent as possible. While some Parties wanted tougher provisions and others pressured for a lighter touch, the Key Facilitator was aiming for a document that was balanced and proportionate. It was never intended that the Guidelines would be used to exclude the industry – or anyone else – from involvement in discussions related to tobacco use and tobacco products at either a domestic or international level.

Yet, while the provisions of the 5.3 Guidelines remain reasonable, the opening Guiding Principle is now out of date:

> *"There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests."*

[53] WHO. WHO study group on tobacco product regulation. WHO, 2021. https://www.who.int/publications/i/item/9789240022720

[54] Ibid. p54. See also a summary of the group's recommendations on SNP to the WHO Executive Board which are highly damaging to the progress of THR. https://www.clivebates.com/documents/APPGVapingFeb2021.pdf p.19

In the light of a new generation of demonstrably safer nicotine products being produced by both multinational companies and a significant contingent of middle and small manufacturers around the world, this principle is no longer sustainable.


Image of portion snus. Source: Wikimedia Commons

Traditional tobacco war thinking cannot be upheld in light of this disruption. How has international tobacco control responded? By deliberately over-interpreting and subverting Article 5.3 to extend the notion of 'the tobacco industry' so that any business, organisation, NGO, academic, consumer group or clinician who supports THR is included by default. The Guidelines have been invoked by state and non-state agencies across the world to engage in no-platforming and ad hominem attacks.

the Guidelines have been invoked by state and non-state agencies across the world to engage in no-platforming and ad hominem attacks against tobacco harm reduction and its advocates

## Article 5.3 – Guidelines fall-out

Ironically, while the Guidelines call for dealings with the industry to be accountable and transparent, the same cannot be said for the conduct of the COP meeting. Over time, the COP has become a self-referential echo chamber where dissenting voices are stifled by the over-interpretation of 5.3 Guidelines.

During the initial FCTC negotiating meetings in 2000-2003 the public gallery was open to anybody to witness the deliberations. The same applied to the first three COP meetings. Over time, the general public – including media – has been excluded from all but the opening day plenary by a decision of the Parties. This is completely at odds with the way other UN agency meetings are conducted, including the Commission on Human Rights, the Commission on Narcotic Drugs and, as referenced above, the COP meeting on Climate Change.


A uniformed security guard at the United Nations.
Credit: Manuel Elias, via UN Photo on flickr

any attempt to conduct UN meetings like this, outside of the UN Security Council, would not be tolerated by diplomats and government officials

Any attempt to conduct UN meetings like this, outside of the UN Security Council, would not be tolerated by diplomats and government officials. The funding for UN and WHO meetings relies on public money donated by the Parties. It follows that there needs to be public accountability and transparency. Lack of transparency at COP needs to be raised with government accountability departments.

The level of paranoia and insecurity enveloping the COP hit a high point of absurdity in 2014 when a representative from the International Crime Police Organisation (Interpol) was denied entry on the basis that Interpol had received money from a tobacco company to tackle the illicit market in cigarettes.[55]

There is a view that part of this demand for secrecy has come from health ministry delegations aiming to swerve around domestic opposition to tobacco control and anxious to avoid publicity. But it also plays to a patronising attitude towards LMIC – namely that their delegates need special 'protection' from industry influence.

Having established that the FCTC Secretariat wields unhealthy power within the FCTC/COP universe, there remains the question of how WHO is operating against THR in the wider world.

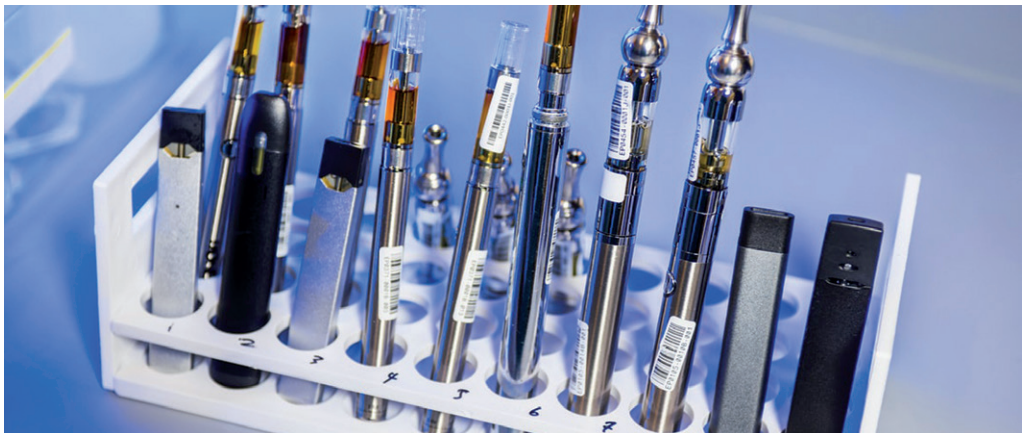
## WHO Tobacco Free Initiative (TFI)

the WHO is a trusted source of health information, so it is deeply troubling that it has been the purveyor of entirely fabricated information about safer nicotine products

The TFI is the public face of WHO tobacco control efforts. It drives the combined WHO and FCTC Secretariat anti-THR advocacy effort, which includes speeches, reports, social media channels, awards, events and online resources. The WHO is a trusted source of health information, so it is deeply troubling that via all these media, it has been the purveyor of entirely fabricated information about SNP, devoid of any robust evidence base. Several examples can be given, but three will suffice.

In 2019, the *Lancet* published an article under the name of the WHO Director-General, full of misinformation based on cherry-picked flawed studies relating to 'toxic emissions' from vaping devices, risks of heart attack and lung damage, fetal abnormalities and impaired brain development, making the overall assertion that "ENDS are undoubtedly harmful" and should be regulated to the nth degree.[56]

On 20 January 2020, the WHO published a Q+A page on ENDS. The answers to the nine questions were severely criticised on social media. About ten days later, the Q+A was marginally updated, without any notification of changes or acknowledgement of errors. Even the updated version was full of false or misleading information, errors of



Test tube rack with a range of vaping devices. Credit: CDC on Unsplash

[55] WHO (2014). *Report of the sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control*. Section 2.20, page 7. https://www.who.int/fctc/cop/sessions/COP6_report_FINAL_04122014.pdf

[56] Tedros Adhanom Ghebreyesus (2019) Progress in beating the tobacco epidemic. *Lancet* July 26, 2019 http://dx.doi.org/10.1016/S0140-6736(19)31730-1

fact, exaggerations and over-simplifications covering general risks, addiction, lung damage, second-hand dangers and aids to cessation.[57]

Perhaps the most egregious example was the latest in the WHO series *Report on the Global Tobacco Epidemic* published in July 2021. This report was subtitled *Addressing new and emerging products* and for the first time devoted a whole chapter to SNP. There were large banner quotes at the beginning of the document declaring "ENDS should be strictly regulated for maximum protection of public health" and the equally bogus claim that "Children and adolescents who used ENDS can double their risk of smoking". It is the visual portrayal of 'children' which is particularly disturbing. Every colour photo in the 200-page report bar one depicted a young child. Worse still, screenshots taken from the WHO report launch depicted two young people purportedly vaping while a third appears to show a baby reaching for a vaping device.

**screenshots depict two young people vaping while a third appears to show a baby reaching for a vaping device**


Screenshots taken from the public online launch of the *WHO Report on the Global Tobacco Epidemic 2021*.

In relation to child labour and tobacco farming, the WHO regularly references the UN Convention on the Rights of the Child. It would do well to get its own house in order with reference to Article 36 which states that "Governments must protect children from all…forms of exploitation, for example the exploitation of children for political activities, by the media or for medical research".[58]

This emphasis on children and young people is the most obvious example of the influence of a third set of actors: NGOs, and in particular, the US-based Campaign for Tobacco Free Kids (CTFK).

## Non-governmental organisations (NGOs)

Historically, anti-tobacco campaigners in the USA have scored considerable success against the tobacco industry. They have teamed up with state governments to bring about the Master Settlement Agreement, and campaigned for all the elements we see in tobacco control policies across the world – advertising, promotion and public smoking bans, warning labels and so on.

Anti-tobacco campaigners were also highly influential during the FCTC negotiating process. This caused disquiet for at least one member of the US delegation, Greg Jacob, who later described the FCTC negotiating process as "deeply flawed".[59]

The FCTC negotiation was the first time the WHO had been involved in drafting an international health treaty. Many of the delegates were health ministers, including several doctors. Collectively, however, they knew little or nothing about international law and the process of treaty negotiations. Into the breach, wrote Jacob, came CTFK

[57] To read the full account and the resulting trenchant criticism, see: https://www.clivebates.com/world-health-organisation-fails-at-science-and-fails-at-propaganda-the-sad-case-of-whos-anti-vaping-qa/

[58] The United Nations Convention on the Rights of the Child (1989), p.10, accessed at UNICEF website: https://www.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf,

[59] Jacob, G. (2018). *Administering the mark of Cain: secrecy and exclusion in the FCTC implementation process*. Fordham International Law Journal: 41 (3), p.669-696

and US Action on Smoking and Health (ASH). They banded together with other NGOs to form the Framework Convention Alliance (FCA). Jacob contended,

> *"...the NGO advisers did not act as disinterested legal advisers and along the way more than one delegation was hoodwinked into believing the NGOs' all-too-frequently distorted version of the truth."*

In a harbinger of the 5.3 scandals to come, Jacob reported on the discussions around the definition of "tobacco advertising and promotion". It was clear to Jacob and most of the delegates in the meetings that the definition was ridiculously broad:

> *"It took a minor miracle just to get the word 'commercial' inserted in the definition... as many members of the [WHO regional groups] wanted the definition to cover non-commercial speech by actors outside the tobacco industry."*

**representatives followed him around trying to eavesdrop on his phone conversations**

It was during these negotiations that NGOs indulged in what can only be described as the politics of the playground. Jacob alleges that representatives followed him around trying to eavesdrop on his phone conversations. They continued these antics in subsequent COP meetings doing 'click and run' sorties to photograph any industry representative in the building and putting these photos on a poster. One industry observer was literally followed into the toilet. There was public naming and shaming and the issuing of 'Dirty Ashtray awards' to delegations deemed to be obstructing progress.

But gesture politics aside, since the advent of SNP, the influence of western-based NGOs more broadly in international tobacco control has become increasingly inimical to the best interests of global public health.

**since the advent of SNP, the influence of western-based NGOs more broadly in international tobacco control has become increasingly inimical to the best interests of global public health**

At least in America, NGOs like CTFK were becoming victims of their own success. Legal victories over the tobacco industry, increasing rules and regulations about smoking and a decline in the number of both adult and teen smokers left the CTFK in danger of being an NGO without a mission.

The arrival of vaping devices in 2006-07 was manna from heaven for those who wanted to carry on the fight against the old enemy. To keep the agency alive, it was imperative that the new situation was entirely framed through the prism of past battles. The best way of doing that? Claim that the new products were no safer than cigarettes - and maybe even more dangerous. Big Tobacco was up to its old tricks trying to hook kids, but now it was doing it to compensate for falling cigarette sales. It could be argued that, in terms of its mission, the CTFK did not need to concern itself with adult smokers. But its activities were not only imparting false information to young people. Its powerful lobbying capacity was bending the ears of politicians to take action - to the detriment of the existing at-risk community of adult smokers.

A pile of $100 dollar bills.
Credit: Giorgio Trovato on Unsplash

Even so, an entirely US-based campaign risked running out of steam. But then, with a massive injection of funding from Bloomberg Philanthropies (see below), CTFK suddenly found itself in a position to obtain global reach. The organisation could take on the world, advocating bans and strict regulations and utilising its well-honed 'kiddification' programme to undermine the evidence base for SNP as a harm reduction option for adult smokers.

**with a massive injection of funding from Bloomberg Philanthropies, the Campaign for Tobacco-Free Kids suddenly found itself in a position to obtain global reach**

Many HIC like those in the EU (tied to the EU Tobacco Products Directive), the USA, Australia, New Zealand, Japan, Canada and elsewhere already had regulations in place. Western-based NGOs like CTFK and the International Union Against Tuberculosis and Lung Disease (The Union) were aiming at LMIC. The central message delivered through webinars, press releases and other media was 'Don't bother to try and come to your own decisions about these products. The WHO says there is no merit in any of them. They are all bad, so just ban them.' This was a 'get out of jail free' card for many health ministries to enact some laws with few resources for enforcement and consider the issue dealt with.


Union Position Paper on E-cigarettes and HTP sales in LMICs. (n.d.). The Union. Retrieved 20 July 2020, from https://theunion.org/technical-publications/union-position-paper-on-e-cigarettes-and-htp-sales-in-lmics (accessed November 2020)

This approach is problematic on at least two levels.

**parachuting in 'oven-ready' tobacco control policies takes no account of the best public health interests of the population**

1. Parachuting in 'oven-ready' tobacco control policies takes no account of the best public health interests of the population (and could be compared to neo-con US foreign policies aiming to 'build democracy'). This particularly applies in LMIC, where most smokers live and die. These people could clearly benefit from access to accessible, affordable, appropriate and acceptable SNP.
2. Winning policy battles and pushing for law changes appeared to become the focus – irrespective of whether or not these would make any material difference to death and disease from smoking in those countries. The chances are they will not. The only element which appears to impact on use is taxation – but that drives those with the least income and most risk from smoking to the illicit market.

Leaked CTFK documents revealed a whole global strategy to include political advocacy, campaigning, legal assistance, public health and media training. The strategy appears to set out the goal of commandeering the tobacco control policies of many LMIC, rather than simply supporting them.[60]

[60] Minton, M. (2021), *Exposed: Bloomberg's anti-tobacco meddling in developing countries*. https://cei.org/blog/exposed-bloombergs-anti-tobacco-meddling-in-developing-countries/. However, the full extent of CTFK involvement was revealed by documents leaked to Minton.

a US-based NGO, with a brief to prevent smoking among US teens, has managed to undertake wide-ranging tobacco control activity across vast swathes of Latin America, Asia, and Africa

Thus a US-based NGO, with a brief to prevent smoking among US teens, has managed to undertake wide-ranging tobacco control activity across vast swathes of Latin America, Asia, and Africa. How? And how has the WHO TFI continued to operate on reduced donor contributions following the 2007-08 financial crash and now the global pandemic?

This leads us to our fourth actor – Bloomberg Philanthropies.

## Bloomberg Philanthropies

Since the turn of the 20th century, rich US-based private foundations like Rockefeller, Carnegie and Ford gave millions of dollars to fund activities across society including scientific and medical research, technical innovation, education and arts and culture endowments.

Nowadays, the richest and most famous of these foundations is that established by Bill and Melinda Gates (BMGF). BMGF has donated to US domestic education programs but is best known for work overseas to tackle communicable diseases such as malaria.

What is different about BMGF is that unlike its predecessors, it has been in the foreground of what economists Matthew Bishop and Michael Green call 'philanthro-capitalism'.[61] This has two elements. The first is that the organisation is run more along the lines of a for-profit corporate enterprise with, for example, programme target-setting and often micro-management of process. The second is, to put it crudely, "if we pull people out of poverty and make them healthy, they will buy more of our stuff". Bill Gates said as much in an article for *Time* magazine in 2008.[62]

if we pull people out of poverty and make them healthy, they will buy more of our stuff

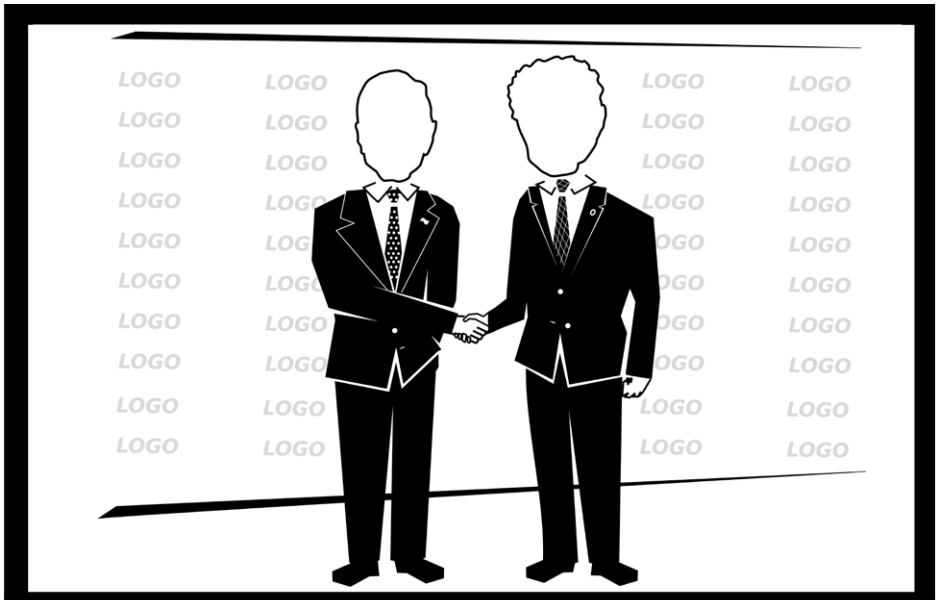
Whatever the business model, concerns have been expressed generally about the nature of these American private foundations. The first revolves around issues of accountability and transparency. They are obliged to submit tax forms containing basic information but are answerable to nobody apart from a handful of trustees. There are some details on websites about sums of money handed out, but the process of decision-making around grants remains hidden from public view. The second concern is the degree to which funds are eroding government support for public welfare and education. Thirdly are concerns about the provenance of foundation money. For example, Microsoft was the subject of several anti-trust lawsuits in the 1980s and 1990s.

Some of these concerns are mirrored in the case of Bloomberg Philanthropies (BP), but not all. As Mayor of New York, Bloomberg, an ex-smoker, oversaw some radical tobacco control policies in the city. Combined with a hatred of the tobacco industry, he was persuaded by his tobacco control adviser Tom Frieden to put his considerable wealth behind the global effort to reduce death and disease from smoking.

Once the FCTC entered into force in 2005, Parties began implementation, but there was no money for the sort of data collection and monitoring required to determine progress in delivering the ambitions of the FCTC.

Bloomberg made no secret of the fact that he had little belief in the UN and its agencies to deliver anything within any reasonable time frame. In a parallel exercise to the FCTC Secretariat, which was collecting its own data from Parties, the now-renamed Bloomberg Initiative produced the MPOWER monitoring strategy.

[61] Knowledge-Action-Change. *Burning Issues: Global State of Tobacco Harm Reduction 2020*. KAC, 2020, p.100.
[62] Ibid.

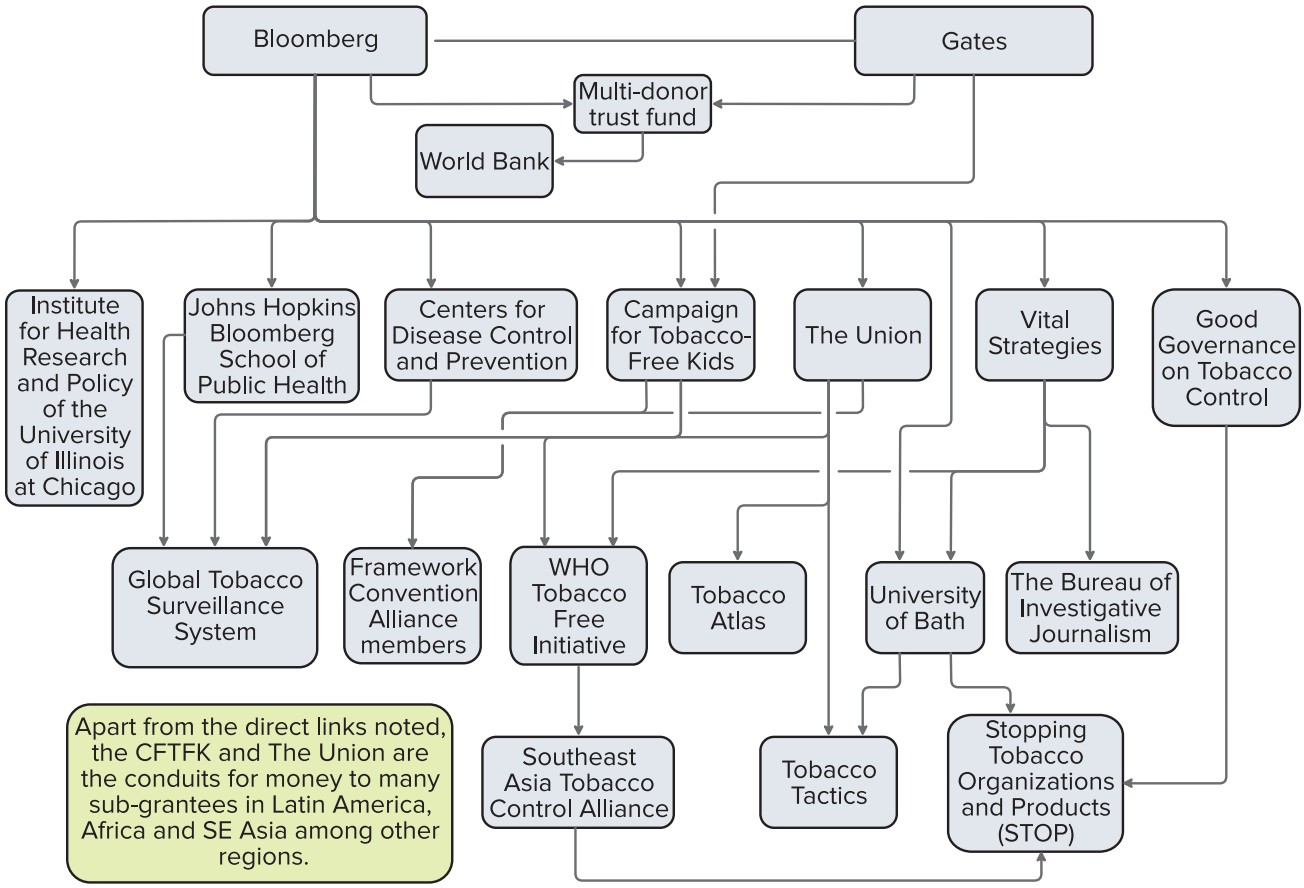



Michael Bloomberg of Bloomberg Philanthropies and Dr. Tedros Adhanom Ghebreyesus, WHO Director-General, against a backdrop of Bloomberg Philanthropies and World Health Organization logos.

Original image removed under threat of legal action from Bloomberg Philanthropies lawyers. View the original image here https://twitter.com/who/status/1356948447077814274

WHO TFI staff were unhappy with the high-handed approach taken by Bloomberg Philanthropies in trying to dictate to TFI staff on how to go about implementing MPOWER. But their appeals to the WHO Director-General fell on deaf ears. Staff were told just to take the money and get on with it – because there were no funds from anywhere else. Money that Bloomberg offered to the FCTC Secretariat was rejected, not on any ethical grounds, but more to underline the apparent animosity between the heads of the TFI and the FCTC Secretariat at the time.

**staff were told just to take the money and get on with it**



Since then, Bloomberg Philanthropies has funnelled around one billion dollars through a network of grantees headed up by CTFK and The Union. Because of the opacity of the funding streams, it is impossible to determine what percentage is devoted to anti-THR activities. But given the degree of coordination between the WHO TFI and all the other Bloomberg Philanthropies grantees around attacking THR in many and various ways, it is reasonable to assume that this is a prime directive of the funding. To show how closely the WHO is tied to Bloomberg Philanthropies, Michael Bloomberg is now the WHO Global Ambassador for Non-Communicable Diseases.

Several problems accrue from the money stream flowing from Bloomberg Philanthropies:

1. Bloomberg Philanthropies monies are being used to conduct a war against nicotine and THR which is diametrically opposed to the best interests of global public health.
2. Bloomberg Philanthropies monies are primarily targeted at LMIC. These countries are home to the most smokers and the highest rates of mortality and morbidity from smoking and are places where THR policies could be most effective.
3. There are no obvious material benefits accruing to Bloomberg business interests from successful tobacco control policies in LMIC. This makes it more a case of philanthro-colonialism. Millions of dollars are being siphoned through boots-on-the-ground grantees to interfere in the domestic tobacco control policies of sovereign nations.
4. The 'corporate style' expectations Bloomberg Philanthropies has of its grantees are where the philanthro-capitalism comes in. For-profit corporations operate on the basis of short-term planning cycles. The worlds of business, finance and consumerism move at pace. Bloomberg Philanthropies' audit culture expects quick wins; in the world of tobacco control, that means getting laws and regulations onto the statute book with no thought given to longer-term evaluation. There certainly seems to be no thought given to the much more expensive and complicated business of establishing effective and accessible cessation services.
5. All the smoke and mirrors of well-funded and highly organised global activity - primarily aimed at smoking prevention among young people - hides the unpalatable truth. Efforts to tackle the smoking epidemic are failing in LMIC and even stalling in HIC, as the falls in smoking prevalence begin to plateau.

**the unpalatable truth is that efforts to tackle the smoking epidemic are failing in low and middle-income countries and even stalling in high-income countries**

Apart from western NGOs exerting pressure in LMIC against THR, these NGOs and WHO officials are in lockstep in exerting undue influence over information streams to FCTC Parties. It is the duty of the Parties to the FCTC to exercise the control they have and move the tobacco control agenda forward, and to recognise the potential of SNP to realise the ambitions of the FCTC.

# 6: What can be done? New thinking for the 21st century

## A moral imperative to act

The evidence in favour of embracing THR and SNP as valid public health interventions can no longer be seriously denied. To add to the growing body of evidence from independent expert groups, no fewer than fifteen past presidents of the Society for Research on Nicotine and Tobacco wrote a paper for the American Journal of Public Health in August 2021 in which they said,

> *"Because evidence indicates that e-cigarette use can increase the odds of quitting smoking, many scientists, including this essay's authors, encourage the health community, media and policymakers to more carefully weigh vaping's potential to reduce adult smoking-attributable mortality."*[63]

It is now a moral imperative that the WHO and allies retrench from their current intransigent and obstructive position of not only refusing to accept any positive health benefits from SNP, but actively campaigning against their use.

The FCTC is failing to adapt to the new reality for SNP because it is anti-THR elements within WHO and elsewhere who are calling the shots. They are failing to recognise the growing demand for these products across the world by smokers who want to switch away from the deadliest way of consuming nicotine.

**it is anti-tobacco harm reduction elements within WHO who are calling the shots**

## Moving towards tobacco harm reduction

Parties should now be pressing for more evidence-based discussions on THR and SNP, calling upon the widest breadth of scientific, clinical and epidemiological expertise alongside those involved in the SNP industry, and taking into account the lived experience of consumers. Those Parties that have successfully introduced tobacco harm reduction policies alongside their tobacco control regimes – countries such as the United Kingdom and New Zealand – should be encouraged to lead the way, sharing evidence and best practice from their national perspectives. They need to prepare now so that THR is on the agenda for COP10 in 2023. It is up to Parties to propose this, as they determine the agenda, not the WHO or the Secretariat.

One pragmatic route forward could be the establishment of a Working Group on Tobacco Harm Reduction to take the FCTC forward into the 21st century in a world where SNP are now available. Modification of international conventions is difficult to achieve – and in reality, many of the problems with the FCTC are due to interpretation and implementation, including the neglect of harm reduction despite it being prominent in the FCTC text. A Working Group to elaborate on tobacco harm reduction could approach the FCTC with a new perspective, in which safer nicotine products have a role to play in bringing an end to smoking, and with a renewed focus on delivering tangible outcomes that reduce death and disease from smoking. The Working Group would need to develop interpretation and guidance which:

1. Disaggregates combustible and more dangerous oral tobacco products from safer non-combustible products as a key starting point. All FCTC Articles would need to

[63] Balfour, D et al. (2021) Balancing the risks and benefits of e-cigarettes. *American Journal of Public Health* https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2021.306416


'Nothing about us without us' is an important concept for tobacco harm reduction.
Image: Google

be examined against this criteria. The FCTC text was adopted before SNP became widely available, and therefore needs reassessing in light of their emergence onto the market. The FCTC itself is clear in the Preamble that tobacco control policies must be based on "current and relevant scientific, technical and economic considerations".

2. Ensures the FCTC retrenches from mission creep, and reiterates that alongside supply and demand reduction, one of the first principles of the FCTC is to 'reduce harm' from tobacco smoke.

3. Offers a clear definition of harm reduction within the FCTC, as the WHO sets out, for example, a definition as it relates to drugs and HIV: "Harm reduction is a set of policies, programmes, services and actions that aim to reduce the harm to individuals, communities and society related to drugs, including HIV infection. Harm reduction is key in the prevention of HIV infection among people who inject drugs (PWIDs) and their sexual partners."[65]

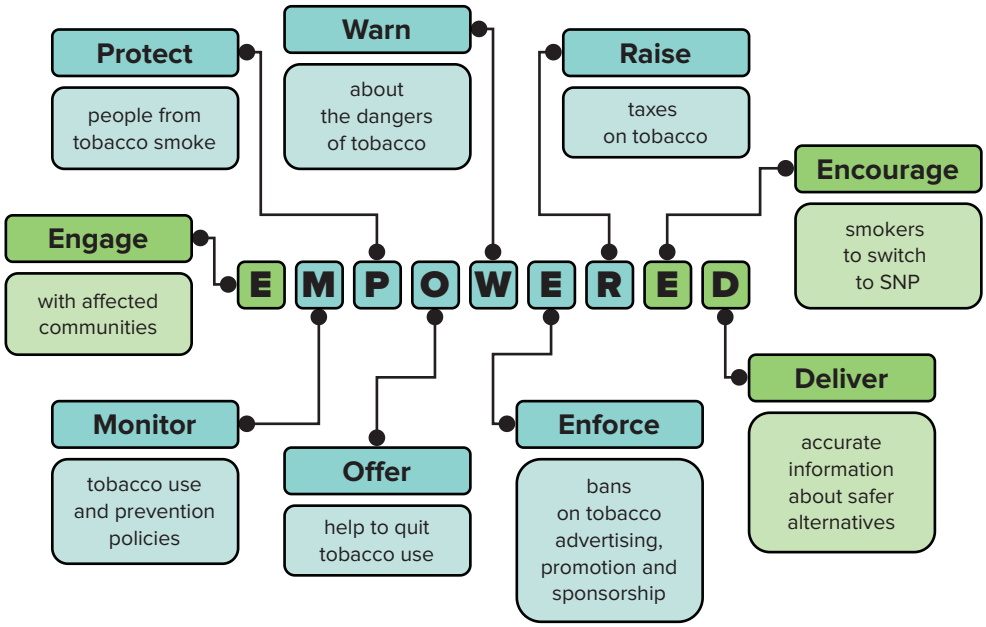
4. Ensures that, in line with long-standing international health and human rights treaties, representatives of all affected communities, including smokers and users of safer nicotine products, are recognised as legitimate stakeholders for the purposes of national and international policy deliberations.

5. Calls for an end to an over-interpretation of the Guidelines of Article 5.3 which is currently not only preventing alternate views on tobacco control to be heard, but also shutting down the COP from legitimate public scrutiny.

[64] WHO Regional Office For Europe, Policy guidance by HIV intervention area: harm reduction https://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-areas-of-intervention/harm-reduction

# From MPOWER to EMPOWERED

Further to this, the Working Group could also highlight that it is the duty of the WHO to ensure that all smokers can access accurate information about the potential benefits of SNP, to ensure they can make informed choices. The WHO TFI should reframe MPOWER to EMPOWERED:




A start with community engagement would be to involve a wider range of civil society representation at COP and other meetings – primarily those with lived experience of making the switch from smoking to the use of SNP. As the Global State of Tobacco Harm Reduction estimated in 2020, there are now 100 million SNP users globally[65] whose voices are unheard in the tobacco and nicotine policymaking which affects their lives.

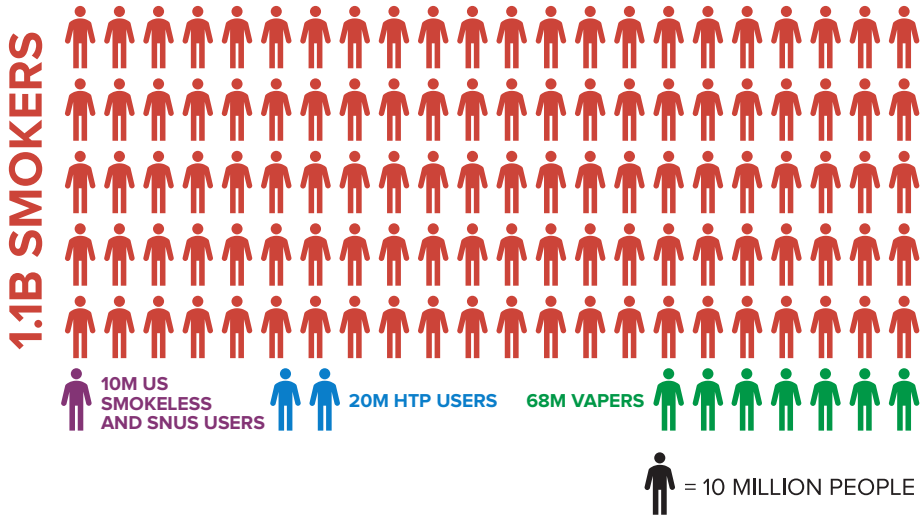
**the WHO Tobacco Free Initiative should reframe MPOWER to EMPOWERED**

[65] *Burning Issues: The Global State of Tobacco Harm Reduction 2020*. Knowledge-Action-Change, 2020, p.54 https://gsthr.org/report/2020/burning-issues/chapter-2#unrialisedpublichealth

# 7: Final thoughts

the strategy of WHO, its allies and key private funder is to continue to fight the old war against the tobacco industry

Despite the enactment of the FCTC and the accompanying MPOWER monitoring and evaluation tool, the projected death toll from smoking has remained unchanged for a decade. Over that period, new and disruptive technologies have produced demonstrably safer ways to consume nicotine while recent research has established the relative safety of an oral product called snus. Proof of concept has been established and the consumer market in safer nicotine products has grown to nearly 100 million people.




they stand accused of deploying the same tactics as the tobacco industry – sowing confusion and doubt through misinformation and interference

However, instead of embracing and adapting to the new reality, the strategy of the WHO, its allies and key private funder is to continue to fight the old war against the tobacco industry. In doing so, they stand accused of deploying the same tactics as their sworn enemy, the tobacco industry - of sowing confusion and doubt about the safety and efficacy of SNP through misinformation and interference. There is little evidence of any concern for the welfare of current adult smokers; instead, the emphasis is on politically acceptable youth prevention strategies.

Evidence in favour of THR and SNP as a complementary intervention to help drive down death and disease from smoking is robust. It is robust enough for the Parties to the FCTC to take back control of the Convention and examine alternative policies to those advocated by the WHO, that all products should be banned or heavily regulated. The most important aspect of this policy and legislative review is to disaggregate combustible from non-combustible products. To that end, all relevant stakeholders need to be involved, including both the industry (in all its forms) and those consumers with lived experience of switching to SNP. National governments need to engage more readily with consumers so that they can effectively represent them at the COP.

the imperative for international tobacco control policy in the 21st century is to preside over the dying embers of combustion

The imperative for international tobacco control policy in the 21st century is to preside over the dying embers of combustion. It must not use a new fight against nicotine to fan the flames of the last war on the tobacco industry.

# Fighting the Last War:
## The WHO and International Tobacco Control

You can watch videos of the presentations from the report launch, held on 27 October 2021, at https://gsthr.org/events/ftlw/

### SESSION 1 – FCTC Past, present and future

| Topic | Panellists |
|---|---|
| **Welcome to the day and introduction to the session** | **Will Godfrey** (Session host)<br>Editor-in-chief of the Filter Magazine, USA |
| **'From Hope to Despair – Tobacco control loses its way'** | **Harry Shapiro**<br>The author of the report K•A•C, UK |
| **'The origins and decline of the FCTC'** | **Derek Yach**<br>Executive Director of the Foundation for a Smoke-Free World, USA |
| **'Our Health – Consumers the often forgotten majority'** | **Tom Gleeson**<br>New Nicotine Alliance Ireland |
| **Q&A session** | |

### SESSION 2 – Challenges in making the FCTC an inclusive international framework convention

| Topic | Panellists |
|---|---|
| **Introduction to the session** | **Jeannie Cameron** (Session host)<br>JCIC International, UK |
| **'Under the influence: The politics of international drug control'** | **Ethan Nadelmann**<br>Founder and former-Executive Director of the Drug Policy Alliance, USA |
| **From Tobacco Control to HR advocacy: A Professional and Personal Journey** | **Nataliia Toropova**<br>Healthy Initiatives, Ukraine |
| **'What have we learnt and what next for tobacco harm reduction'** | **Gerry Stimson**<br>Director K•A•C, UK |
| **Q&A session and concluding remarks** | |

GSTHR.ORG