Challenges in Implementing the Framework Convention on Tobacco Control (FCTC)

By

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Introduction

Tobacco is leading cause of preventable fatalities across the globe and its use among the global populace has been steady. Stakeholders in the global health sector have attempted to formulate some health policies to control tobacco with minimal success. 1992 marked the year when the first legislation dealing with tobacco control came into effect. The subsequent momentous events have included increased global awareness of the tobacco harmfulness as well as the World Health Organization (WHO FCTC). The latter treaty forms the most significant milestone in the tobacco control journey as it was the first to be negotiated under the umbrella of the WHO (WHO and Research for International Tobacco Control 6). The global tobacco epidemic compelled the world organization to oversee the formation of the Convention on Tobacco Control in 2005 to avert the adverse and alarming impacts of tobacco on the global populace. The rapid embracement of the treaty depicted the reaffirmation of the rights of the global populace to the highest standards of health. While WHO FCTC has made commendable strides in tackling the global tobacco epidemic, there have been serious challenges in the implementation of the treaty globally, an issue that this paper discusses in-depth.

The global populace has witnessed a series of significant events characterizing the process of tobacco control since 1992. The two remarkable milestones in the tobacco control include the increase in awareness of the harmfulness of the drug among the global The WHO FCTC formed in 2005 supported by WHO. The stakeholders in the global public health

fraternity, with the support of WHO adopted the FCTC in 2003 before its subsequent implementation in February 2005 to address the increase in tobacco prevalence rate (Wipfli and Samet 273). It is notable that more than 165 countries ratified the convention as of August 2012, including India which is the second most tobacco growing nation globally (Agrawal 1111). The adoption of FCTC by the WHO represented a paradigm shift in the process of developing a policy strategy to tackle addictive substances.

Contrary to the previous regulatory initiatives, the FCTC put much focus on the policies of reducing demand for, and supply of tobacco, thereby establishing a model for a cohesive multi-sectoral response to the critical public health concern (Fong iii3). Despite the numerous achievements of the framework mentioned above, the initiative has experienced enormous challenges, particularly revolving around its implementation. In this respect, the subsequent chapters in this article delve deep into the challenges in implementing the FCTC.

As noted above, there have been challenges in implementing the WHO FCTC, including resistance by the tobacco industry, ineffective enforcement of tobacco control, limited resources for the implementation of the framework and high prevalence and consumption of tobacco. Despite the successes witnessed in the last two decades on tobacco control, particularly emanating from the tobacco industry.

According to Bhardwaj and Prasad, the epidemiological projections on the prevalence of tobacco predict an alarming growth rate of the global tobacco epidemic if the stakeholders fail to intensify the tobacco control interventions (328). Several studies have argued that the tobacco industry can impede and thwart the attempts of the global health initiatives and tobacco control policies to protect its interests (Ruger 2). The tobacco industry, being the primary vector of the tobacco epidemic, can go to any legislative length to resist attempts to limit its scope.

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Resistance to Tobacco Control legislation by the Tobacco Industry

The challenges in the implementation of the WHO FCTC have been witnessed world over in the recent past. According to a study carried out by Bhardwaj and Prasad in India in 2017, the resistance by the tobacco industry on tobacco legislation has caused dilution and delay in the implementation of provisions stipulated under the WHO FCTC (330). The authors argue that the tobacco industry has adversely influenced the implementation of the WHO FCTC through impeding multi-sectoral coordination. Besides, the authors assert that the industry has also influenced legislation and policy-making initiatives by compromising the Indian Health Ministry among other government institutions and ministries (330). According to the authors named above, the industry has perfected its interference against the implementation of WHO FCTC in India through numerous litigation. Such litigations have been the biggest threats to the achievement of tobacco control, culminating in the dilution and delay of the legislation of tobacco control in India (330).

India's Ministry of Health and Family Welfare further echoes the findings of the above research by reaffirming that the tobacco industry has taken advantage of the numerous court cases to challenge the tobacco control provisions, thereby curtailing the effective implementation of the Framework (60). Furthermore, the Ministry laments that civil society or individual citizens have not initiated any action against the tobacco industry players, including legal pursuit for compensation (60). The tobacco industry has perfected the art of exploiting loopholes in the domestic legal framework to resist any attempts by the authorities to limit their scope.

According to the 2014 WHO progress report, tobacco industry players in the domestic courts have challenged many governments about the implementation of WHO FCTC (WHO

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In India, the tobacco industry's interference through litigation has been one of the biggest threats to effective implementation of the framework convention, resulting in delay and dilution of the tobacco control legislation in the country (WHO, n.d (a); MOHFW, 2004; Arora et al., 2012 (a); Reddy et al., 2008; Oswal et al., 2010)

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9). The tobacco industry incorporated claims revolving around the relationship between domestic and international disputes as well as international trade laws. The measures implemented are guided by the domestic disputes and the relevant articles of the FCTC convention. For instance, Philippines and Brazil reported legal challenges in 2014 concerning the litigations on tobacco control as envisaged in Articles 9 and 10 of the convention.

Additionally, on the same note, Oswal and others have reiterated the unfortunate and continuous interference by the tobacco industry in the health sector, particularly in policy-making process (3). According to the authors, such interference poses the greatest threats to the effective implementation and enforcement of the treaty in India. The smoke-free policies, tobacco promotion of tobacco as well as deterring use and consumption of the products through warning have been some of the initiatives whose enforcements have failed due to the interference from the tobacco industry (Liberman 436). ~~According to Kaur and Jain, the government of India has spent much of its time fighting legal battles on tobacco control in courts, thus, weakening or slowing the enforcement of WHO FCTC (220).~~

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Previous studies have confirmed that the tobacco industry has employed multiple deceitful strategies and practices to suppress tobacco control and compromise public health, including curtailing the implementation the WHO FCTC (WHO 9). According to the WHO, the methods adopted by the tobacco industry to derail the control of this addictive substance is well documented (9). It is notable that the tobacco control community is well aware of the strategies and persistence of the industry in pursuing their interests, particularly in countries with nascent regulations on tobacco. Among the numerous strategies and practices used by the tobacco industry to undermine tobacco control across the globe include the leveraging of political influence and passionate opposition to the enactment and enforcement of effective tobacco control regulations and laws (Mohan, Mini, and Thankappan 178). Besides, the industry also engages in the introduction of dishonest corporate social responsibility

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practices, as well as suppressing scientific evidence against tobacco use. Kaur, Jagdish, and Jain explain that the practices stated above are just but a fraction of the several strategies adopted by the tobacco industry to pursue their business interests and jeopardize public health, particularly in countries with legislation and laws that are prone to industry exploitations (220).

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Increased Global Tobacco Consumption

The heightened rate of consumption of tobacco by the global populace is also a challenge to the implementation of WHO FCTC. According to the report by the World Health Organization, the number of individuals consuming tobacco across the globe has surged steadily, and this includes people of different ages and gender.

Unless policy-makers enforce and implement the regulations on tobacco control, the trend will remain unchanged. The number of people over 15 years is estimated to increase to 21,733, 000 by 2025 (WHO 2). The global tobacco survey conducted between 2009 and 2010 to examine utilization and consumption of tobacco drug revealed that 35% of India's adult population, translating to about 275 million people use any form of tobacco. The study also showed that 21% of the population mentioned above using smokeless tobacco, 9% using only smoke, while the remaining 5.3% using both smoke and smokeless forms of the drug (Bhardwaj and Prasad 331).

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As per the Global adult tobacco survey (GATS) 2009-10, standardized survey (international) to track tobacco use and consumption, around 35% (274.9 million) of adults use any form of tobacco in India with 21% (163.7 million) using only smokeless tobacco, 9% (68.9 million) using only smoke and 5.3% (42.3 million) using smoke and smokeless form of tobacco (IIPS, and MOHFW, 2010). Further, 5.3% tobacco users (9.3% of males and 1.3% of

Bhawna argues that 5.3% of individuals using both smoke and smokeless forms of tobacco products encounter serious challenges, including higher doses and duration of smoking. The issue not only poses a challenge to individuals who want to quit tobacco uses but also increases the likelihood of acquiring tobacco-related diseases (WHO India 9). The WHO India emphasize that the affordability, availability, and easy access to the locally-made and low-cost tobacco products are some of the factors that contribute to the challenges in tobacco control in the country. The array of marketing, consumption, and production avenues

also contribute to the heightened number of the persons using and consuming tobacco in India, and in other developing countries (WHO India 9). There has been increased number of deaths attributed to tobacco products. Notably, WHO estimates the number of fatalities emanating from smoking and smokeless tobacco use at six million globally, including 600,000 people dying from second-hand smoke.

In light of the above findings, there is a need for the authorities and policymakers to focus on reducing both the smoking and smokeless forms of tobacco products because of the latter's harmful and more prevalent. Tobacco consumers in countries such as India and other developing nations are also unaware of the consequences of smoking (Agarwal et al., 2013). The cultural, sociological, and religious differences have also complicated the tobacco control landscape as well as jeopardized the effective implementation of WHO FCTC not only in India but across the world (MOHFW 61). In India, for instance, the implementation of WHO FCTC has encountered challenges, particularly from the high prevalence and tobacco consumption patterns in the country for the past seven years (MOHFW 61). 2012 WHO FCTC report places India in the second position among the largest consumers and producers of tobacco products globally. Similarly, the existence of a plethora of tobacco products, including both the smokeless and the smoking tobacco products have impeded the implementation of tobacco control legislation (MOHFW 61).

Ineffective Tobacco Control Implementation and Limited Resources for Enforcement of the WHO FCTC Provisions

The state and central governments of India hold the instrumental role of ensuring adequate legislation and enforcement of tobacco control initiatives (Fidler 843). In this respect, the coordination and collaboration between these authorities are central to the achievement of the objective mentioned above (Mehrotra et al., 2010). Many countries, especially in the developing world grapple with public health issues including reducing

mortality rates among children and women among other health concerns. As a result, prioritizing tobacco control varies from one nation to the other based on its resources (Jagdish and Mohan 675). While the role of the central government often revolves around providing financial and technical resources and capacity building, the state government engages in the enforcement of legislation. Lack of coordination and collaboration between the two government enforcement agencies as well as lack of awareness among policymakers, healthcare experts have undermined the effective implementation of WHO FCTC in many countries such as India (Kaur and Jain, 2011). Moreover, the weak presence of non-governmental organizations has also contributed to the ineffective and delay in the implementation of WHO FCTC (Lin 77).

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A lack of resources in the developing world has impeded the effective enforcement of the WHO FCTC in many countries (Gostin 2057). For instance, lack or inadequate resources compromise the ability of government to train officials from various departments involved in the enforcement of the WHO FCTC. In a study by Owusu-Dabo and others, lack of awareness among the policy makers played out as one of the major factors inhibiting the effective implementation of WHO FCTC in Ghana among other developing countries (1).

Ghana became the 39th nation to ratify the tobacco control treaty in 2004 as well as adopted practices and policies aimed at the consumption of tobacco products in the country (Wellington ET AL. 36). A notable example is the formation of the national steering committee in 2003 under the auspices of the Ghana Health Services. The West African nation has engaged in various conferences of parties intended to negotiate procedures for the implementation of FCTC. Some of the challenges that stood out in the study mentioned above included the lack of legal framework to implement deterrent measures to control tobacco in Ghana, limited resources, failure to prioritize tobacco policy, as well as the slow implementation of the policy. Owusu-Dabo and others cite the slow pace of the

implementation of the FCTC policies in the country (6). The respondents in the above-stated study noted that the tobacco control bill proposed in Ghana is yet to be signed into law, Owusu-Doho was written in 2010- it is six years. Unless it is not yet in law, which makes it 13. Besides, Owusu-Dabo et al. argue that there is uncertainty in the level to which tobacco control is a priority in Ghana, despite the fact that policymakers should be aware of the FCTC and subsequent obligations. Despite making the tobacco control policy priority in Ghana, the government and other stakeholders in the public health have failed to prioritize the efforts towards controlling tobacco products (18).

The relationship between international trade and investments and WHO FCTC has drawn much attention in the recent years as the stakeholders in the public health attempt to uncover the implications of such relationship on the implementation of the convention (Martin and De Leeuw 6). The increasing attention of the global populace mentioned above follows similar legal complications witnessed in the implementation of tobacco control initiatives in WTO dispute litigation and domestic forums as well as international investment treaties. In 2014, for instance, there was ongoing litigation on the implementation of tobacco control initiatives in Uruguay and Australia (WHO 9).

Lack of Capacity Building

As noted earlier in this article, capacity building is an instrumental aspect of the effective implementation of WHO FCTC. In a qualitative study of the WHO FCTC on four small islands of the Pacific by Martin and De Leeuw, the lack of capacity found in the Vanuatu and Cook Islands was a concern, particularly in the enforcement of tobacco control initiatives. The sector-wide absence of capacity in the three actions under this study is also replicated in other developing countries across the world, an issue that has since compromised the effective implementation of the convention. In the current global environment, the Bill and Melinda, as well as Bloomberg initiative, engage in the financing

of tobacco control measures in the developing world (6). The health initiatives by these two institutions give preferences to countries that have reported prevalence rates in tobacco epidemic, and not nations with smaller population sizes. The criteria mentioned above implies that these three pacific countries are not eligible to receive funding from these two institutions. In one instance during the study, the Cook Islands acknowledged the lack of capacity as the most outstanding challenges to the effective and comprehensive implementation of WHO FCTC in the country. Martin and De Leeuw aver that global funding initiative is one of the many ways of flagging the implementation of FCTC as a means of addressing the capacity issue (5).

The study further highlights the most significant challenges witnessed in Palau particularly on the enforcement and implementation of WHO FCTC provisions. According to Martin and De Leeuw, the informants from Palau pointed out lack of commitment as the primary barrier to the effective application of the convention. Particularly, the informants cited the senior government levels as well as various non-health departments in the country, where the Congress weakened the tobacco control bill, thereby jeopardizing the enforcement of WHO FCTC (Martin and De Leeuw 4). In comparison to the other countries investigated in this study, Palau reported less restrictive resource capacity to enforce the WHO FCTC. The US-based CDC has involved in funding the country through its Ministry of Health, an issue that has helped Palau in implementing the provisions of the convention (Martin and De Leeuw 4). Besides, it is worth noting that the aggressiveness and active nature of the ’’coalition for a Tobacco-Free Palau’’ were also instrumental in helping the government to achieve its objective of controlling the use and consumption of tobacco products in the country.

It is also noteworthy that the recent tobacco control legislation in Palau that is not in full compliance with the provisions of WHO FCTC, numerous provisions such as smoke-free

restaurants and bars. In addition, packaging and labeling have not been prominent in the public realm (Martin and De Leeuw 4). Nevertheless, the Palau government has made commendable strides towards the implementation of tobacco control legislation. For instance, Martin and De Leeuw affirm that the government has affected the ban on TAPS as well as expressed efforts towards scaling up the effective enforcement of WHO FCTC in the country (4).

In addition to the lack of capacity, some of the provisions of the WHO FCTC proved to be challenging, particularly their enactment and subsequent implementation (Joossens and Martin 249). According to Kaur, Jagdish, and Jain, various policy initiatives were difficult to enact, including product testing and regulation, bans on sponsorship, control of illicit trade, point-of-sale interventions, as well as pursuing alternative livelihoods to tobacco crops (220). Developing countries, for instance, often experience myriad challenges in the implementation of the WHO FCTC. These challenges may include acquiring the necessary and comprehensive technical and scientific infrastructures to ensure effective implementation of the convention. The infrastructure mentioned above include, but is not limited to, the establishment of a surveillance system of tobacco use and consumption (Lin 77).

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Capacity building is a fundamental aspect of the implementation of tobacco control initiatives, including the WHO FCTC. According to Lin, issues of capabilities have dogged all nations and sectors across the globe, and countries with successful tobacco control measures have had several years to handle the issue as well as certainly specified capabilities (77). The UK and the US are some of the countries that have succeeded in implementing tobacco control initiatives because of the existing capabilities and several years of addressing the tobacco menace. The challenges witnessed in many other nations, particularly those that are yet to achieve success in the implementation of tobacco control measures, include the inexistence of active non-governmental organizations. According to Lin, such organizations

play a critical role in pushing the government to enact and ensure implementation of tobacco control initiatives through a variety of means (77). First, they adopt the broad-based advocacy tactics and coalitions and move the government into action, thereby changing social norms (MacLean and Sherri 11). For instance, the 1988 California Tobacco Tax and Health Promotion Act provided an avenue for the use of social mobilization strategy with the intention of altering public opinion. The subsequent governments have made commendable strides in implementing various initiatives, including the principles of Ottawa Charter. On the contrary, many countries in the developing world without such non-governmental organizations often lack the aggressiveness and enthusiasm in pursuing various control initiatives, including WHO FCTC (Tumwine 4312).

The aspect of poverty in the low and middle-income countries has also impeded the implementation of effective WHO FCTC in the developing world. It is obvious that these nations will put much emphasis on pertinent issues such as curbing poverty levels among their citizens, thereby ignoring other equally vital issues in the health sector, including tobacco control. Of more importance and priority to the governments in these countries are the achievement of the UN Millennium Development Goals (MDGs) and improving access to health services (Lin 78). In the process of emphasizing on poverty alleviation, the authorities and policymakers in the developing world have sidelined tobacco control initiatives. According to Lin, this idea emanates from the fact that the stakeholders in the health sector in these countries have failed to effectively articulate the connection between social health determinants, poverty, and tobacco (78).

In this respect, the developed world has made attempts to harmonize the disparity in the control of tobacco. For instance, the USA has engaged in identifying and eliminating the inequities existing between groups while Australia emphasizes indigenous tobacco control by investing strongly in the process (Brown 898). According to Lin, the challenges in the low

and middle-income countries affect other sectors within the public health other than tobacco control, including physical activities and nutrition among others. The challenges for tobacco control, particularly the implementation of WHO FCTC in the low and middle-income countries mentioned above emanates from the disparities in income equity as well as capacity for enforcement (Kevany 788). Kevany notes that it is often challenging to separate the global health programs with an economic and political sphere (788). Nevertheless, it is important to point out that equity and capacity are likely to provide the desired avenue for reinforcing the link between health promotion and FCTC to achieve the required benefits.

Tobacco Taxation

Contrary to the expectations of many people across the globe and the momentum around smoke-free initiatives and policies, taxation and price control on tobacco products remains one of the FCTC policy sectors where the implementation rate has been slow (Gneiting 82). According to Gneiting, Article 6 of the FCTC provides for the implementation of tax policies by the member states, including duty-free tobacco products and tax levies. However, there has been slower progress in the enforcement of Article 6 as a result of the reluctance of the members of the domestic network. Such reluctance in the implementation of Article 6 of the FCTC may be visible in the low level of assistance requested by the civil society groups from the international funders, including tobacco control organizations and the Bill and Melinda Gates Foundation among others (Mamudu and Stanton 151; Nagler and Kasisomayajula 834).

While taxation has been one of the most effective means of curbing tobacco demands, the sluggish progress witnessed in the taxation of tobacco products remains puzzling. The advocates in the global public health sector have encountered enormous challenges while

translating the commitment of member countries towards tobacco taxation. A notable example of such challenges is the absence of effective enforcement guidelines for the FCTC provision at the global level (Nagler and Kasisomayajula 834). The variations in domestic tobacco taxation policies between member states have heightened the complication witnessed in the enforcement of WHO FCTC across the world (Mamudu and Stanton 151). For instance, it has become challenging to harmonize the global tobacco control policy with the domestic taxation policies on tobacco control due to variations in evaluative criteria such as pricing and level of taxation among other barriers. In so doing, implementing the provisions of Article 6 of the FCTC has become challenging.

Conclusion

Advocates for tobacco control have been instrumental in the spirited efforts to curb the use and consumption of tobacco products amidst the global tobacco epidemic. Several initiatives and policies have been enacted since the establishment of the first tobacco policy initiative in 1992. The formation of WHO FCTC in 2005 was a landmark treaty that came into force following the global tobacco epidemic. The convention mentioned above has been fundamental in the control of the use and consumption of tobacco products across the globe. The swift adoption of the treaty reaffirmed the commitment by the global health advocates to uphold the rights of the global populace to the highest standards of health. While WHO FCTC has made commendable strides in tackling the global tobacco epidemic, it is not devoid of challenges in the global public health sector. These challenges have compromised the effective enforcement and implementation of the tobacco control initiatives as stipulated in the WHO FCTC. For instance, the resistance by the tobacco industry has been the dominant challenge in the implementation of effective FCTC. Several studies have cited myriad tactics used by the tobacco industry to derail the implementation process, including

several litigations as well as compromising stakeholders in the health sector, particularly in vulnerable countries. Other challenges including lack of capacity building and capabilities, tobacco taxation challenges, limited resources, failure in prioritizing tobacco control, particularly in the developing world, as well as ineffective measures in the implementation of tobacco control initiatives among other challenges.

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