

# Strengthening tobacco control in the wake of COVID-19

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Discussion paper

## Strengthening tobacco control in the wake of COVID-19: Discussion paper

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## Audience, scope and summary

This paper is intended for governments, policymakers, United Nations agencies and development partners. It discusses the importance of tobacco control in reducing impacts from coronavirus disease (COVID-19), accelerating recovery toward achieving the Sustainable Development Goals (SDGs) and building resilience to pandemics. The paper provides recommendations for national and global action within and beyond the health sector. It was prepared jointly by the United Nations Development Programme (UNDP) and the Secretariat of the WHO Framework Convention on Tobacco Control (WHO FCTC).

In the wake of the COVID-19 pandemic and polycrisis, the United Nations, along with international financial institutions and others, is supporting countries to build resilience and recover towards achieving the *2030 Agenda for Sustainable Development*.<sup>1</sup> The Secretariat of the WHO FCTC, in partnership with the World Health Organization (WHO), UNDP and others, continues to support WHO FCTC Parties to accelerate tobacco control. This support is in line with the *Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025* [1], the *United Nations Development Programme Strategic Plan 2022–2025* [2] and the *UNDP HIV and Health Strategy 2022–2025* [3] include commitments to scale up work with WHO, the United Nations Children’s Fund and other partners to strengthen systems for health, including to address noncommunicable diseases (NCDs) and pandemics.

**Tobacco use prevalence remains alarmingly high.** There are 1.3 billion tobacco users worldwide, with over 80 percent living in low- and middle-income countries (LMICs). In 2020, 22.3 percent of the global population used tobacco (36.7 percent of men and 7.8 percent of women).

**Tobacco use is linked to worse COVID-19 outcomes.** According to WHO, “evidence indicates that smokers are more likely to suffer more severe outcomes of COVID-19, such as admission into intensive care units and death, than never smokers. Furthermore, severe forms of COVID-19 or deaths due to COVID-19 are more frequent in people with comorbidities that are related to tobacco use, including COPD [chronic obstructive pulmonary disease], lung cancer and cardiovascular diseases”[4].

**The interactions between tobacco use and COVID-19 compound the significant role that tobacco already plays in causing premature death, disease and disability.** In 2019, tobacco killed 8.7 million people, accounting for 15.4 percent of all deaths globally. In addition to being a major contributor to NCDs, tobacco use increases risks from many infectious disease threats. Examples include HIV/AIDS, tuberculosis, influenza, respiratory syncytial virus (RSV), pneumonia, severe acute respiratory syndrome and Middle East respiratory syndrome.

1 The 2030 Agenda for Sustainable Development is a plan of action for people, the planet and prosperity. It features Sustainable Development Goals and targets to stimulate action over the years 2015–2030 in areas of critical importance for humanity and the planet. For more information from the United Nations, visit <https://sdgs.un.org/2030agenda>.

**Tobacco's toll on health and development threatens to grow.** In many regions, the total number of tobacco users has risen significantly over the past two decades. Tobacco use trends among youth and women are troubling. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, is expected to continue to circulate in the future, and new variants of concern remain an ongoing possibility. Moreover, large burdens of post-COVID-19 health conditions could also combine negatively with tobacco-related harms. And the climate crisis is exacerbating risks from both NCDs and infectious diseases.

**The WHO FCTC is a global, evidence-based treaty with the objective of addressing the global tobacco epidemic by protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.** Strengthened implementation of this treaty in all countries as appropriate (SDG Target 3.a) can bolster defences against COVID-19 and other health threats while accelerating progress towards the SDGs. WHO FCTC implementation would improve population health, make health systems and economies more resilient, and help to protect the environment.

**There are important steps countries can take to accelerate WHO FCTC implementation and reap the full benefits of tobacco control for health and development.** It is recommended that countries:

- comprehensively implement the tobacco control measures set out in the WHO FCTC;
- include tobacco control in planning and financing for tackling COVID-19, addressing pandemics and achieving the SDGs;
- strengthen tobacco taxation to improve health, avoid the costs of poor health and raise domestic revenue;
- embed tobacco control in revamped national systems for health which address comorbidities and advance universal health coverage; and
- reinforce multisectoral governance for tobacco control, including by ending tobacco industry interference in policymaking.

**Greater support from development partners is vital.** It is recommended that development partners:

- increase multilateral support for WHO FCTC implementation in LMICs;
- ensure coherent global support for effective tobacco taxation, including as a means of strengthening domestic financing for addressing COVID-19 and other pandemics; and
- further explore how WHO FCTC implementation can reinforce pandemic prevention, preparedness, response and recovery, including in relation to any future global accord.

## Introduction

The coronavirus disease (COVID-19) pandemic has revealed the world to be dangerously unprepared for health emergencies. A contributing deficiency has been inadequate progress in addressing noncommunicable diseases (NCDs) and their risk factors, including tobacco use. NCDs and their risk factors have played a major role in shaping countries' experiences during the pandemic. They have contributed to severe disease, hospitalization and death from COVID-19, thereby impacting health systems, economies and societies at large [5].

When the World Health Organization (WHO) declared COVID-19 a pandemic in March 2020, there were approximately 1.3 billion tobacco users worldwide. Evidence has since emerged, and continues to emerge, linking tobacco use with worse COVID-19 outcomes. According to WHO, "evidence indicates that smokers are more likely to suffer more severe outcomes of COVID-19, such as admission into intensive care units and death, than never smokers. Furthermore, severe forms of COVID-19 or deaths due to COVID-19 are more frequent in people with comorbidities that are related to tobacco use, including COPD (chronic obstructive pulmonary disease), lung cancer and cardiovascular diseases" [4]. As over 80 percent of the world's tobacco users live in low- and middle-income countries (LMICs) [6], continued COVID-19 vaccine inequity may be reinforcing these risks.

Evidence that tobacco use exacerbates disease burdens is neither new nor surprising. Before COVID-19, tobacco use, including second-hand smoke exposure, was already among the world's leading causes of preventable death, disease and disability. In 2019, tobacco killed nearly 9 million people, predominantly from NCDs, accounting for over 15 percent of all deaths globally [7]. Moreover, tobacco use has a long track record of interacting harmfully with infectious disease threats. Examples beyond COVID-19 include but are not limited to HIV/AIDS, tuberculosis (TB), influenza, respiratory syncytial virus (RSV), pneumonia, severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) [8].

The consequences of tobacco extend far beyond the health sector, and the broader social, economic and environmental impacts of tobacco consumption and production merit increased attention. In 2017, an analysis by the Secretariat of the WHO Framework Convention on Tobacco Control (WHO FCTC) and the United Nations Development Programme (UNDP) found negative impacts from tobacco across 67 social, economic and environmental targets for the Sustainable Development Goals (SDGs) – representing nearly 40 percent of the *2030 Agenda for Sustainable Development* [9]. For example, smoking by itself cost the global economy over US\$ 1.4 trillion in 2012 in health expenditures and productivity losses [10], and including the costs relating to the use of non-smoked tobacco products would only add to that figure. Moreover, the tobacco industry inflicts enormous and growing environmental harms on the planet. Examples include deforestation and soil degradation from tobacco growing, as well as water and soil pollution from pesticide use and littering – especially of cigarette butts that are made of plastic fibres that do not readily decompose [11], [12].



Strengthened implementation of the WHO FCTC [13] in all countries, as appropriate, is SDG Target 3.a of the *2030 Agenda for Sustainable Development* [14]. The WHO FCTC is a global, evidence-based treaty created to address the global tobacco epidemic. It has 182 Parties covering over 90 percent of the global population. Since entering into force in 2005, millions of lives have been saved by the tobacco control measures set out in the WHO FCTC [15]. A review of the impact of the WHO FCTC published in 2019 found that the Convention has increased the implementation of approaches that have reduced tobacco consumption, prevalence and associated harms. However, the review cautioned that WHO FCTC implementation must be accelerated, and Parties need to meet all their treaty obligations and consider measures that exceed minimum requirements [16]. Support for WHO FCTC implementation continues to be mobilized, including the FCTC 2030 project administered by the Secretariat of the WHO FCTC [17].

### **Box 1. Tobacco use prevalence: encouraging global progress but worrying trends**

The *WHO Global Report on Trends in Prevalence of Tobacco Use 2000–2025, Fourth Edition* shows encouraging declines in tobacco use globally. Between 2000 and 2020, tobacco use prevalence among those aged 15 and older declined from 32.7 percent to 22.3 percent, a testament to the positive impact of tobacco control policies. As of 2020, sixty countries are on track to achieve the voluntary global target of a 30 percent reduction in tobacco use between 2010 and 2025, up from 32 countries in 2018. However, the total number of tobacco users aged 15 or older remains high at 1.3 billion (2020) and is rising in three WHO regions: Africa, the Eastern Mediterranean and the Western Pacific. This is fuelled by population growth, income growth, increasing affordability of tobacco products and aggressive tobacco industry marketing. Moreover, boys and girls continue to be able to acquire tobacco and other nicotine products for their own use, including from shops. Globally, around 10 percent of adolescents aged 13–15 years use tobacco [18]. Tobacco use prevalence among both male and female youth increased in 32 countries from 1999 to 2019. In several countries, tobacco use among adolescent females is now more common than among adult females, heralding future levels of adult tobacco addiction and associated harms [18], [19].

Several factors are now converging to make the need for tobacco control even more urgent. These include worrying tobacco use trends, particularly in certain regions and among youth and women (**Box 1**); the prediction that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) will continue circulating in the future, bringing the possibility of new variants of concern [20] and larger burdens of post-COVID health conditions; recent surges in other non-COVID respiratory viruses such as influenza and RSV; and projected increases in NCD burdens and infectious disease threats due to climate change [21], [22]. Considering such intersecting risks, accelerated WHO FCTC implementation would improve health, advance resilient health systems and economies, and help protect the environment. Realizing the multidimensional benefits of tobacco control requires the scale up of specific tobacco control measures and greater integration of WHO FCTC implementation in broader health and development efforts.





## Box 2. A call to action at the Ninth session of the Conference of the Parties (COP9)

The theme of COP9 (8–13 November 2021) was “Tobacco control during a global health emergency.” At COP9, the *Declaration on WHO FCTC and recovery from the COVID-19 pandemic* [23] was adopted, which sets out that the Conference of the Parties, inter alia:

- was *mindful* that both tobacco consumption and NCDs contribute to developing severe COVID-19-related illness, placing an additional burden on health systems;
- *acknowledged* that the WHO FCTC is an accelerator for the achievement of the SDGs, and that comprehensive implementation of the WHO FCTC will play a crucial role in recovery from the global COVID-19 pandemic;
- *resolved* to accelerate implementation of the WHO FCTC, including through tobacco taxation and elimination of illicit trade in tobacco products, as these reduce the severity of the pandemic and increase resources for economic recovery;
- *declared* a commitment to demand-reduction measures for tobacco dependence and to increase the availability of cessation measures; and
- *reaffirmed* determination to prevent tobacco industry interference in policymaking.

Through the Declaration, Parties were called on:

- to prevent tobacco industry interference and involvement in COVID-19-related public health policies and actions;
- to include actions to achieve SDG targets 3.a (WHO FCTC implementation) and 3.4 (NCDs) as an integral component of national recovery from the COVID-19 pandemic, including in national SDG plans; and
- to explore health system adaptations (for example, e-health and telemedicine) to support tobacco dependence and cessation services.



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## I. Tobacco, COVID-19 and the SDGs

The interaction of tobacco with NCDs, COVID-19, and other health and development threats has led to tobacco being described as a “slow-motion pandemic” [24] and a “crisis within a crisis” [25].

### Box 3. Tobacco and COVID-19

#### *Epidemiology*

- A review of 109 articles covering 517,020 COVID-19 patients found a history of smoking to increase the risk for severe disease, intensive-care hospitalization and death [26]. Associations between smoking and worse COVID-19 outcomes have been shown to be independent of other factors and stronger among younger smokers [27], [28]. Active smoking has been associated with higher risk of developing post-COVID health conditions, or “long COVID” [29].
- Generally, smoking weakens the immune system, increasing susceptibility to viral and bacterial infections, and compromising efforts to fight them [30], [31].
- Tobacco use is a main risk factor for NCDs, which have contributed strongly to higher COVID-19 death rates in many countries [5]. Of the estimated 15 million excess deaths over 2020–2021 due to the pandemic [32], it has been estimated that 70–90 percent were among people with NCDs, who have faced major disruptions in health service access [33].
- Tobacco use poses theoretical risks for contracting COVID-19 through frequent hand-to-mouth contact, sharing of mouthpieces, and exhaled smoke or vape carrying SARS-CoV-2. Although exposure to second-hand tobacco smoke has not been established as an independent risk factor for severe COVID-19 – potentially due to lack of surveillance [34] – it leads to health conditions that contribute to worse COVID-19 outcomes [35].

#### *Governance*

- The pandemic and certain response measures, such as lockdowns, may have contributed to increased tobacco use in some countries by exacerbating factors that can lead to use, such as stress and isolation [36]–[40].
- The pandemic has severely disrupted diagnostic, treatment and other health services, including for NCDs and other tobacco-attributable illnesses [41], [42].
- For children and young people whose family members smoke, more time at home due to social restrictions can increase exposure to second-hand smoke. This population can be particularly vulnerable to illness from second-hand smoke [43].
- While attention to the pandemic has interrupted momentum for tobacco control in some places, potentially due to funding shortages and a diversion of tobacco control resources [23], it has propelled it in others. For example, several countries enhanced public health communications by including COVID-19-related warnings on tobacco products, fighting misinformation around tobacco use and COVID-19 through media, and promoting cessation services [44].
- Some countries have increased tobacco taxes and/or strengthened tobacco tax administration to help finance response and recovery efforts. Others have weakened or maintained suboptimal tobacco taxation in misguided attempts to revitalize economies and due to tobacco industry pressures [45]–[47].

More broadly, the COVID-19 pandemic has driven greater attention to how diseases and social conditions interact. For example, it has been suggested that COVID-19 is not a pandemic but rather a “syndemic” wherein SARS-CoV-2 and NCDs are “clustering within social groups according to patterns of inequalities deeply embedded in our societies” [48]. Tobacco use also plays a harmful role in other syndemics. The Secretariat of the WHO FCTC and UNDP have laid out interactions between tobacco, HIV, TB and their common determinants, and the need for an integrated response [49]. This need remains urgent. For example, tobacco was associated with around 730,000 new TB cases in 2020 [50]. And there are many other important links between tobacco and infectious diseases [8], including respiratory illnesses (**Box 4**). These include influenza and RSV, both of which have surged alongside SARS-CoV-2 in many places to comprise what some have called a “triple-demic” [51]. The many interactions between tobacco and infectious diseases merit increased attention as part of tackling syndemics, pandemics and epidemics.

#### **Box 4. Tobacco and selected respiratory illnesses**

- **Influenza.** An analysis of randomized controlled trial, cohort and case control studies found that current smokers are over five times more likely to develop laboratory-confirmed influenza than non-smokers. Smokers were found to be 34 percent more likely to develop influenza-like illness [52]. Another systematic review found that “ever-active” smokers had higher odds of hospital admissions after influenza infection [53].
- **Childhood respiratory illness.** Maternal smoking and second-hand smoke exposure are risk factors for both acute and chronic respiratory illness among children. Examples include upper- and lower-respiratory tract infections and asthma [54]. Second-hand smoke exposure increases the risk of severe RSV among infants and children [55]. Maternal smoking is also associated with increased RSV risks [56].
- **Pneumonia.** A systematic review of 27 studies found that current tobacco smokers are more than twice as likely to develop community acquired pneumonia (CAP) compared to never smokers, with ex-smokers also at higher risk (1.5 times). Exposure to second-hand smoke among adults aged 65 and over was found to increase the risk of CAP by 64 percent [57]. Parental smoking increases susceptibility to pneumonia among children [58].
- **SARS and MERS.** According to WHO, “Smoking tobacco is also a known risk factor for severe disease from many respiratory infections, including coronaviruses, SARS (first identified in 2003) and MERS-CoV (first documented in June 2012)” [4]. For example, smoking has been identified as a risk factor for MERS coronavirus (CoV) illness [59] and associated with higher risk of death from MERS-CoV [60], [61].

The WHO FCTC, a recognized accelerator of sustainable development, can continue to make further contributions toward an equitable, resilient and sustainable recovery from the COVID-19 pandemic (**Box 5**). Indeed, there is an urgent need to deploy impactful tools to restore and accelerate progress. The *Sustainable Development Goals Report* for 2021 [62] and the report for 2022 [63] paint a devastating picture of health and development impacts due to the COVID-19 pandemic, as well as the climate crisis, humanitarian emergencies and other shocks. Addressing the interlinks among tobacco, COVID-19, health and development through strengthened WHO FCTC implementation can support an historic “SDG push” out of polycrisis, in line with the *Decade of Action to deliver the Global Goals* [64] and *Our Common Agenda* [65].

### **Box 5. Tobacco in the context of the COVID-19 recovery – key links**

#### **Poverty**

- Poorer people smoke more in comparison to other economic groups, explaining a substantial portion of socioeconomic and health disparities within many countries [66], [67].
- Out-of-pocket expenditures to treat tobacco-related illnesses can be significant and impoverishing [68], [69].
- Tobacco use diverts household spending from basic needs such as food and shelter. Lost human capital from tobacco-attributable death and disease results in economic disadvantage [6].

#### **Food security**

- Household spending on tobacco displaces spending on nutritious foods. Tobacco users are at increased risk of food insecurity [70], [71].
- Tobacco growing uses land that could help end food insecurity [72]. About 90 percent of commercial tobacco leaf is grown in the Global South, often in countries where undernourishment and child labour continue to pose challenges [11], [73]. Nicotine toxicity from handling tobacco leaves – known as “green tobacco sickness” – can harm the health of farm workers, including children and minority and migrant workers [74].

#### **Health**

- Tobacco use is a leading cause of premature death and is responsible for a significant amount of disease and disability. Smoking is a risk factor for at least 50 serious health conditions [75].
- Annual health care expenditures for smoking-attributable diseases are preventable and totalled US\$ 422 billion globally in 2012, nearly 6 percent of all health care spending [10]. This is more than seven times the estimated cost (around US\$ 55 billion) to vaccinate 70 percent of the population in low and low-middle income countries worldwide against COVID-19 [76].

#### **Education**

- Tobacco use can interrupt or end a child’s education if they are forced to care for sick relatives or work to make up for lost wages. Of the 17 million people working in tobacco cultivation worldwide, 90 percent live in LMICs; many children are pulled from school to work in tobacco fields [77]. More than one million children are estimated to be working in tobacco fields [78].
- Tobacco-using households spend substantially less on education and health care, impacting human capital accumulation [79].

### **Gender**

- As with COVID-19, gender-blind approaches to tobacco may miss key determinants of risk and effective interventions [80]. The targeted, manipulative marketing of tobacco to women and girls threatens to increase their consumption [81], and women account for more than half of all deaths from second-hand smoke [82]. Women have been called “silent sufferers” because they endure long-term disease and disability from NCDs, yet their health priorities are often neglected, including during humanitarian emergencies [83], [84]. Women and girls provide the bulk of unpaid care for NCDs and health. COVID-19 has worsened this burden, adding to stress, mental ill-health and gender inequalities [85], [86].

### **Economic growth**

- The total economic cost of smoking (combined health expenditures and productivity losses) totalled over US\$ 1.4 trillion in 2012, equivalent in magnitude to 1.8 percent of the world’s annual gross domestic product [10]. These are estimates only for smoking, and the costs will be even higher if all forms of tobacco use are considered.
- As with pandemic preparedness and vaccine equity, timely investments in tobacco control can prevent significant costs. Across a set of 24 tobacco control investment cases in official development assistance (ODA) eligible countries under the FCTC 2030 project, an average investment of US\$ 25.7 million per country in stronger WHO FCTC implementation would avert an average of US\$ 2.9 billion in economic losses while saving a total of 1.4 million lives over a 15-year period [87].

### **Inequalities and inequities**

- Tobacco use widens inequalities and poses human rights considerations [88], [89]. Tobacco use is far more common in disadvantaged and socially deprived populations, which also face difficulties in accessing health services and information.
- Effective price and tax measures on tobacco drive equity. High tax rates reduce tobacco consumption and associated costs, deliver the biggest benefits to lower-income populations and youth, and raise government revenue [90]. These measures are specified in the *Addis Ababa Action Agenda* of the Third International Conference on Financing for Development [91]. Low income countries are not taking advantage of fiscal policies such as high tobacco taxes that will help shape more equitable societies and support recovery from COVID-19 [62].

### **Climate and environment**

- Exposure to second-hand smoke is harmful to health. There are more than 5,000 chemicals in cigarette smoke, including hundreds of chemicals that are toxic and about 70 that can cause cancer [92]. The WHO FCTC recognizes that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability, and obliges Parties to protect people from exposure in indoor work and public places.
- The tobacco industry inflicts enormous and growing environmental harm on the planet. The entire tobacco supply chain – growing, curing, manufacturing, consumption and disposal – impacts climate change, adding to climate-related food insecurity and health issues. Cigarette butts are toxic, contribute to plastic waste pollution and are compromising efforts to ensure the protection of marine areas [11]. Some 4.5 trillion cigarette butts are littered each year [93]. These are made of plastic fibres that do not readily decompose [12].



## II. Tobacco control and a better future for all - priorities for Parties

Parties can improve health and drive sustainable development gains by taking the following priority tobacco control actions, in line with the *Global Strategy to Accelerate Tobacco Control: Advancing sustainable development through the implementation of the WHO FCTC 2019–2025* [1]. A range of implementation guidelines specific to WHO FCTC articles, as well as other resources to assist Parties in implementing the WHO FCTC, are available [13]. This includes advice for strengthening tobacco control that was developed by WHO and public health stakeholders during the COVID-19 pandemic [94], [95].

**Parties should comprehensively implement the tobacco control measures set out in the WHO FCTC. That includes the following demand reduction measures:**

**Increasing tobacco taxation to reduce the affordability of tobacco products (WHO FCTC Article 6).** Increasing the cost of tobacco products through tobacco taxation is one of the most cost-effective policies to reduce tobacco use and can help raise domestic revenue. Lower-income populations and youth are most sensitive to tobacco price changes and thus reduce consumption most in high-price settings [96]. However, as of 2020, only 13 percent of the global population were living in countries where the tax share of the retail price of the most-sold brand of cigarettes met or exceeded 75 percent – considered in the *WHO Report on the Global Tobacco Epidemic, 2021* [97] as the highest level of achievement. The *Tobacconomics Cigarette Tax Scorecard 2nd edition* reveals little progress globally on increasing tobacco taxes since 2014 [98]. The tobacco industry is known to lobby governments not to increase tobacco taxes, including by intimidating them with misleading or false claims about equity, revenue, job loss and illicit tobacco trade.

**Creating smoke-free public places and workplaces to protect people from the harms of tobacco smoke (WHO FCTC Article 8).** There is no safe level of exposure to second-hand smoke and even brief exposure can cause harm [97], [99]. Tobacco smoke is a danger to all exposed and poses specific risks for children and infants, as well as pregnant women and fetal development [97]. As of 2020, just 32 percent of Parties have implemented comprehensive bans on smoking in all indoor public places, workplaces and public transport, while 26 percent of Parties have prohibited smoking in most of these areas [100]. Now is the time to accelerate implementation and enforcement of smoke-free laws in public places. Governments are encouraged to raise awareness about the risks to health from second-hand smoke, especially for children, and to urge people to also make their private spaces such as homes smoke free.

**Requiring graphic health warnings on tobacco product packaging that describes the harms of tobacco use (WHO FCTC Article 11).** In 2020 almost 4.7 billion people in 101 countries were protected by strong graphic health warnings on tobacco packages [97]. Nevertheless, there are still many countries that have not implemented measures for health warnings on tobacco packs that meet relevant WHO FCTC implementation guidelines [101]. Graphic health warnings are an effective and inexpensive measure to raise health literacy, with the costs borne by the tobacco industry.

**Implementing plain packaging of tobacco products (WHO FCTC Guidelines for implementation of Article 11 and WHO FCTC Guidelines for implementation of Article 13).** Parties should give serious consideration to joining the growing number of countries requiring plain packaging to stop the promotion of tobacco through enticing branding, and increase the prominence of health warnings on packs [102], [103].

**Enacting and enforcing a comprehensive ban on all forms of tobacco advertising, promotion and sponsorship (TAPS)(WHO FCTC Article 13).** While 75 percent of WHO FCTC Parties report having a comprehensive ban on TAPS, less than one in 10 report having banned TAPS fully in line with the WHO FCTC *Guidelines for implementation of Article 13* [100]. The tobacco industry has exploited the COVID-19 crisis to market its products (**Box 7**) [104]. To close loopholes that the industry can exploit, governments should ban TAPS in all forms. TAPS bans should include cross-border TAPS, TAPS pertaining to novel tobacco products, all corporate social responsibility (CSR) activities, free giveaways of tobacco, and social media promotions. Online sales and home delivery of tobacco products must also be fully regulated to prevent TAPS from taking place on the internet, as well as to prevent sales to minors.

**Promoting and strengthening public awareness of tobacco control issues, including the health risks of tobacco use and tobacco smoke, addiction, and the benefits of cessation (WHO FCTC Article 12).** Effective tobacco control messaging through public awareness measures, such as mass media, is also needed. This should leverage digital media and regularly evaluate impact, in accordance with Article 12 of the WHO FCTC and its guidelines for implementation [13], [105].



Photo credit: © UNDP



**Promoting cessation of tobacco use and treatment for tobacco dependence by training health professionals to provide brief advice to quit tobacco use (WHO FCTC Article 14).** When countries advance strong demand-reduction measures, more users consider quitting tobacco use. It is therefore critical for Parties to fully implement the recommendations in the WHO FCTC *Guidelines for implementation of Article 14* [106] to offer evidence-based assistance to people to help them completely quit tobacco use. The COVID-19 pandemic is an opportunity to raise awareness of health risks and empower people to improve their health. The *WHO Global Investment Case for Tobacco Cessation* finds that contributing US\$1.68 per capita annually to a combination of population-level and pharmacological cessation interventions could help 152 million tobacco users around the world successfully quit by 2030 [107]. Artificial intelligence and digital technologies can support efforts to close the global gap in access to tobacco cessation support, while combatting misinformation and disinformation.

**In addition to the above tobacco control measures set out in the WHO FCTC, Parties should consider:**

**Including tobacco control in planning and financing for tackling COVID-19, addressing pandemics and achieving the SDGs.** Despite the multisectoral benefits of WHO FCTC implementation, tobacco often remains a problem that is left to the health community to solve on its own. Analysis by UNDP has found low levels of WHO FCTC integration in development planning during the COVID-19 pandemic,<sup>2</sup> a problem that carries over from pre-COVID-19 times [108], [109]. To realize the full benefits of WHO FCTC implementation, Parties should consider integrating tobacco control into development planning and financing. Commitments should be SMART<sup>3</sup> and gender responsive.

Opportunities include:

- *National deployment and vaccination plans* for COVID-19 vaccines, and plans for other COVID-19 tools and countermeasures, could consider vulnerabilities among smokers and people living with NCDs in efforts to ensure equitable access.
- *Pandemic prevention, preparedness, response and recovery plans* could include WHO FCTC implementation for its contributions to health, human security<sup>4</sup> and sustainable development.
- *Economic growth and recovery plans* could include WHO FCTC implementation for its ability to safeguard human capital and productive capacities.
- *Food security and green recovery plans* could include WHO FCTC implementation for its promotion of growing nutritious foods as an alternative livelihood for tobacco farmers and the environmental benefits of moving away from tobacco growing. Green recovery plans could further consider the substantial environmental, climate and health impacts of tobacco.
- *Financing frameworks for COVID-19, health systems strengthening, pandemic prevention, preparedness and the SDGs* could include tobacco taxation as a strategy to increase domestic resources and strengthen tax administration while advancing health and development.

2 Unpublished analysis of COVID-19 socioeconomic response and recovery plans, UNDP.

3 Specific, measurable, attainable, relevant, time-bound.

4 For more on the human security concept, please see: <https://www.un.org/humansecurity/what-is-human-security/>

### Box 6. Options to integrate tobacco control into country-level capacity for addressing pandemics

- Embedding tobacco-related data in health security surveillance to understand population risk profiles and inform resource mobilization and planning;
- strengthening health workforce capacities, including of primary health care and community health workers, to provide tobacco cessation support alongside infectious disease prevention and control efforts;
- ensuring that vaccine equity strategies account for any increased vulnerabilities of tobacco users; and
- including effective public messaging around tobacco-related vulnerabilities in risk communication [110].



Photo credit: © WHO



**Strengthening tobacco taxation to improve health, avoid the costs of poor health and raise domestic revenue.** The revenue from tobacco taxes can help finance COVID-19 response and recovery priorities. *A Global Deal for Our Pandemic Age: Report of the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response* notes the priority of developing resilient domestic finances for pandemic prevention and preparedness. As part of this, it calls on governments working with international financial institutions to “embark on a major agenda of reform to mobilize and sustain additional domestic resources”, linking with efforts to strengthen national health systems and achieve universal health coverage (UHC). In this regard, it states, “Taxing tobacco products and other ‘health bads’ to reflect their full health and economic costs remains a promising option in many countries” [111]. Integrated national financing frameworks [112], supported by UNDP and the United Nations Department of Economic and Social Affairs, are an opportunity to leverage taxes on tobacco and other health-harming products in country-level efforts to achieve the SDGs, in line with the *Addis Ababa Action Agenda* on financing for development [91].

**Embed tobacco control into revamped national systems for health that address comorbidities and advance universal health coverage.** The COVID-19 pandemic has underscored the urgent need to invest in stronger systems for health that respond effectively and equitably to all people’s needs, even during crisis. This need has been articulated in high-level reports and resolutions [111], [113], [114]. Advancing UHC [115] requires greater focus on NCD and infectious disease interactions, and mobilizing sustainable domestic resources. Given the vast amounts spent on treatment of tobacco-related disease, commitment to comprehensive WHO FCTC implementation with investment in necessary resources is vital to protecting health systems from burdens that can be prevented. Stronger national health systems are also important given the implications of long COVID or post-COVID health conditions for NCD care [116]. Parties should consider, for example:

- *Ensuring affordable access to tobacco dependence and cessation services, including as an essential component of primary health care.* Integrating this into the work of frontline health workers can be cost-effective. The WHO FCTC *Guidelines for implementation of Article 14* [106] as well as WHO guidance can support Parties to implement services to help tobacco users quit [117]. Countries should also explore digital technologies to increase access, such as cessation services powered by artificial intelligence.
- *Integrating tobacco control into HIV and TB responses.* Tobacco use threatens gains made in the fight against HIV and TB. Integration of tobacco control into HIV and TB responses can help to “accelerate the shift from more siloed interventions to more integrated, people-centred models of prevention, treatment and care, so that individuals’ holistic health needs are met”, in line with the vision of *Fighting Pandemics and Building a Healthier and More Equitable World: The Global Fund Strategy (2023–2028)* [118]. Affordable access to tobacco cessation support will help realize the target in the United Nations General Assembly *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030* that 90 percent of people living with, at risk of and affected by HIV access care for NCDs and mental health [119]. *Reimagining PEPFAR’s Strategic Direction: Fulfilling America’s Promise to End the HIV/AIDS Pandemic by 2030* also embraces a patient and people-centred approach to health service delivery [120]. UNDP and the Secretariat of the WHO FCTC have produced guidance for how tobacco cessation might be integrated into HIV and TB responses [49].

- *Reducing pressures on health systems and increasing sustainable financing for health through policy, legislative and regulatory measures in line with the WHO FCTC.* As tobacco use is among the world’s leading causes of preventable death, disease and disability, WHO FCTC implementation can play a major role in alleviating current and future pressures on health systems. Tobacco taxation offers additional benefits for its ability to help finance UHC. As of 2017, at least 80 countries were earmarking general tax revenue for health financing, with at least 35 countries earmarking all or a portion of revenues from tobacco tax [121].

**Ending tobacco industry interference in policymaking.** The COVID-19 pandemic has led to closer examination of how “business as usual” impacts sustainable development, including the crucial need for enhanced policy coherence across sectors in line with SDG 17. The tobacco industry’s business as usual includes profiting at the expense of people’s health and the UN Global Goals, while interfering in policymaking, for example, on taxation, financial incentives, tobacco farming, and trade and investment agreements. Tobacco industry tactics to influence health and development responses have been prominent during the COVID-19 crisis (**Box 7**). Parties’ most frequently reported barrier to WHO FCTC implementation is tobacco industry interference in policymaking [100]. Countries should urgently implement measures to protect against industry interference in policymaking, in line with Article 5.3 of the WHO FCTC and its guidelines for implementation, including stopping the tobacco industry’s CSR activity [122].

### **Box 7. The tobacco industry during the COVID-19 crisis – fuelling the fire**

Early in the COVID-19 pandemic, the role of tobacco in worsening COVID-19 outcomes had not yet been scientifically established. The tobacco industry seized upon this ambiguity to market its products as somehow protective, leveraging mostly non-peer-reviewed articles and social media to spread self-serving misinformation. This birthed the erroneous “nicotine hypothesis” that smokers are less likely to contract COVID-19, and other false claims such as “a bidi stick a day keeps the pulmonologist away” [104], [123].

Fragility and crisis opened the door to other forms of commercial exploitation. According to WHO, the tobacco industry used the COVID-19 pandemic to build influence with governments in 80 states [124]. It used the COVID-19 crisis to attempt to whitewash its image and lobby for weaker tobacco control. Most ironically, the tobacco industry – a top contributor to respiratory diseases – provided governments with ventilators during the pandemic. It lobbied for tobacco to be classified as an essential good. The tobacco industry also provided governments with cash and personal protective equipment, collaborated on COVID-19 vaccine development while funding efforts to block intellectual property waivers that would support global access, and dispersed branded face masks to social media influencers [104], [125], [126].

These are just some subversive tactics of an industry with a refined playbook and long history of attempts to imbue itself to governments and the public, maintain the status quo of inadequate tobacco control and maximize financial gain. Unfortunately for health and development, the tobacco industry’s tactics worked. For example, at the end of 2020, as the pandemic inflicted incalculable losses on the world, the major tobacco companies raised their sales and profit targets [127]. Building forward better must include addressing the Achilles’ heel of health and development: negative commercial determinants.

**Reinforcing multisectoral governance for tobacco control.** The COVID-19 pandemic reinforces the importance of whole-of-government, whole-of-society responses to complex health and development challenges. Such responses deliver society-wide benefits. The WHO FCTC makes effective governance, including multisectoral planning, coordination, financing and prevention of industry interference in policymaking, a general obligation (WHO FCTC Article 5). Parties should strengthen multisectoral governance as a prerequisite for effective WHO FCTC implementation. That includes establishing or reinforcing an effective, sustainably financed multisectoral coordination mechanism for tobacco control and empowering it to address key links with COVID-19 recovery, other epidemics and pandemics, and the SDGs. Opportunities for integrating tobacco control into other relevant governance mechanisms should be considered in turn. The Secretariat of the WHO FCTC and UNDP have developed step-by-step toolkits for Parties to strengthen multisectoral tobacco control planning and coordination [128], [129].

### **Box 8. The Protocol to Eliminate Illicit Trade in Tobacco Products**

Parties should consider joining the Protocol to Eliminate Illicit Trade in Tobacco Products [130]. Illicit trade is a multisectoral challenge to tobacco control partly because it can contribute to lower prices but mostly because governments use it as a reason to slow or stop tobacco control measures, including during the COVID-19 pandemic [131].

The Protocol was developed in response to the growing international illicit trade in tobacco products, which poses a serious threat to public health. Illicit trade increases the accessibility and affordability of tobacco products, thus fuelling the tobacco epidemic and undermining tobacco control policies. It also causes substantial losses in government revenues, and at the same time contributes to the funding of transnational criminal activities [132].

The Protocol assists in the elimination of illicit tobacco, which will also help to safeguard government revenues that could be invested in COVID-19 recovery as well as wider health and sustainable development activity [23].





### III. Powering WHO FCTC implementation through multilateralism

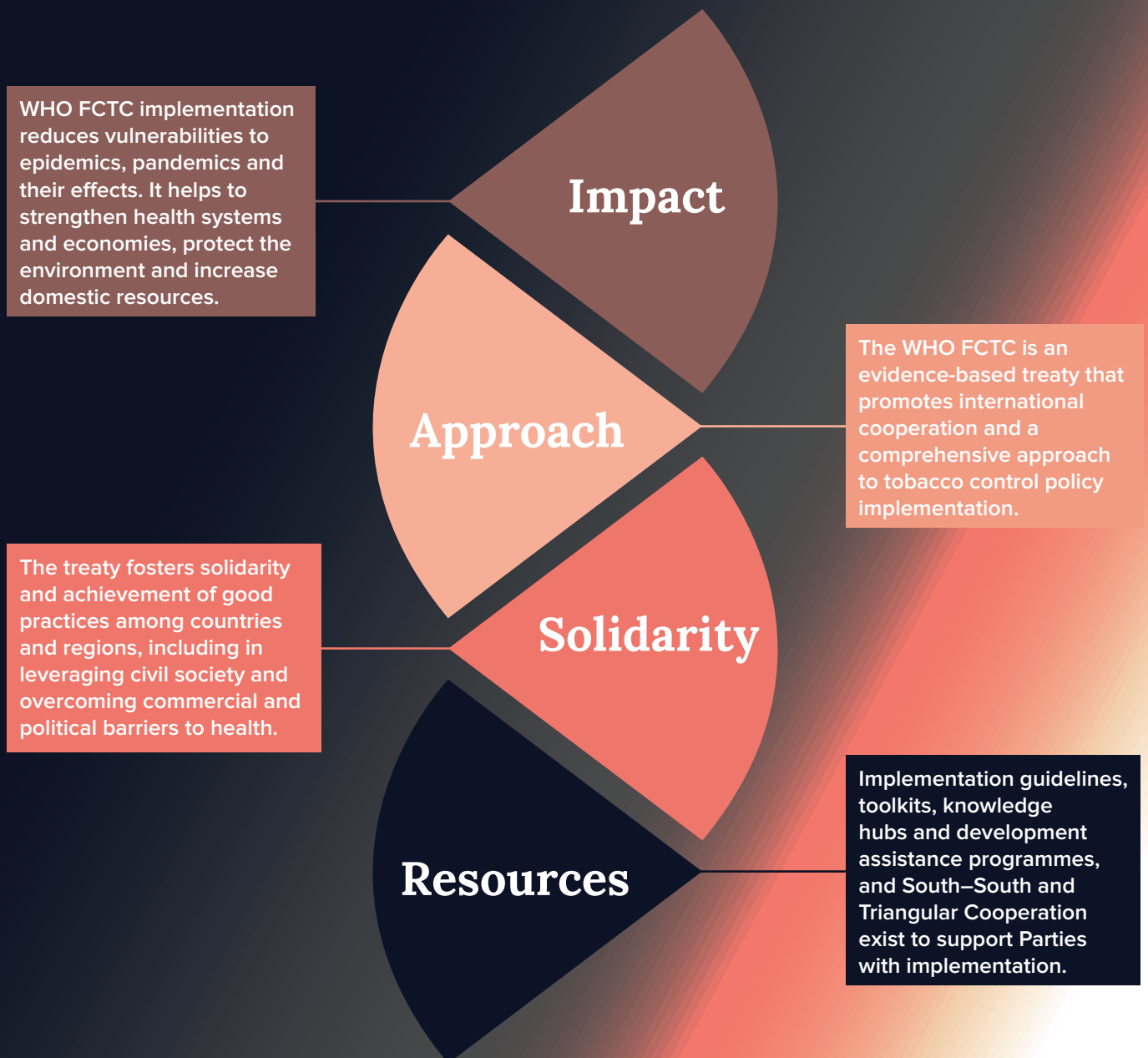
As part of ensuring a more equitable, healthier and sustainable future, the global community should accelerate tobacco control to better protect present and future generations from tobacco's wide-ranging harms. Accelerating WHO FCTC implementation requires governments, policymakers, United Nations agencies, civil society and development partners, especially those working in non-health sectors, to strengthen their engagement and commit to undertaking or supporting necessary action. Global, national and local partners should work together to:

**Increase multilateral support for WHO FCTC implementation in LMICs.** Like COVID-19 vaccines, realizing the full protections offered by the evidence-based measures in the WHO FCTC requires high levels of implementation and uptake around the world. Parties continue to identify gaps between resources available and needs assessed in implementation of the WHO FCTC, with lack of sufficient financial resources the most frequently mentioned gap. The most urgent WHO FCTC articles for Parties to address comprehensively are Article 5 (General Obligations), Article 6 (Price and tax measures to reduce the demand for tobacco), and the time-bound measures under Article 8 (Protection from exposure to tobacco smoke), Article 11 (Packaging and labelling of tobacco products) and Article 13 (Tobacco advertising, promotion and sponsorship) [100]. Increased technical and financial support to LMICs for WHO FCTC implementation could help realize the full benefits of tobacco control for COVID-19 response and recovery, and for addressing epidemics and pandemics.

**Ensure coherent global support for effective tobacco taxation, including as a means of strengthening domestic financing for addressing COVID-19 and other pandemics.** Significant funding is needed to fight pandemics and strengthen health systems. The International Monetary Fund's *A Global Strategy to Manage the Long-Term Risks of COVID-19* recommends that the international community allocate about US\$ 15 billion in grants in 2022 and US\$ 10 billion annually thereafter [133]. Recognizing that domestic financing must play a large role, the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response has called for governments, working with international financial institutions, to "...embark on a major agenda of reforms to mobilize and sustain additional domestic resources", noting the promise of tobacco taxes [111]. Greater and more aligned support for tobacco tax policy and administration across the United Nations System, international financial institutions and other multilateral organizations could help realize this vision. An opportunity exists for the Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response – *The Pandemic Fund* [134] – to incentivize LMICs to increase taxes on tobacco products and use revenue for public health and addressing pandemics. It could do this by matching the additional tax revenue raised with contributions from *The Pandemic Fund*, thereby improving the Fund's impact [134], [135].

**Further explore how WHO FCTC implementation can reinforce pandemic prevention, preparedness, response and recovery, including in relation to any future global accord.** In December 2021, the World Health Assembly formally initiated the development of a global accord on pandemic prevention, preparedness and response, and the process has since advanced [136]. Until such an accord is adopted, the WHO FCTC and the International Health Regulations (2005 and undergoing amendment) are the only legally binding international instruments specific to global health made under the *WHO Constitution*. The WHO FCTC can reinforce and inform other international public health instruments (**Figure 1**).

**Figure 1. The WHO FCTC can reinforce and inform other international public health instruments**





### **Box 9. The FCTC 2030 Project – protecting people, strengthening health systems, driving economies of well-being**

The FCTC 2030 project [17] is delivered by the Secretariat of the WHO FCTC with UNDP, WHO and other partners. It is supported financially by the governments of Australia, Norway, and the United Kingdom of Great Britain and Northern Ireland. Since its initiation in 2016, the FCTC 2030 project has gone from strength to strength in supporting countries eligible to receive ODA to achieve the SDGs by accelerating WHO FCTC implementation.

An independent evaluation found that “The FCTC 2030 programme was instrumental in progressing the implementation of WHO FCTC articles. The achievements included establishing NCMs [national coordinating mechanisms], securing sector-wide support, policy amendments, tobacco tax increases and effective implementation of existing policies.” The evaluation found “the UNDP-supported tobacco control [investment] cases were highlighted as valuable inputs across the board” and that “tobacco control governance – the bedrock for tobacco control – must continue to receive priority even if the impact is less visible in the short-term” [137].

The value of supporting Parties to strengthen core governance capacities for tobacco control, health and development has been displayed during the COVID-19 crisis. An internal review by UNDP of 71 national COVID-19 socioeconomic response plans found that countries receiving FCTC 2030 project support were more likely to have included tobacco control in their COVID-19 response efforts. For example:

- *Cabo Verde* called for an impact analysis on shifts in tobacco use during lockdown.
- *Cambodia* allocated resources to tobacco cessation in primary health care, specifying the WHO FCTC.
- *Eswatini* highlighted the links between tobacco use and premature mortality from NCDs.
- *Georgia* stressed the importance of whole-of-government and whole-of-society tobacco control and the need for technical assistance on coordination.
- *Jordan* allocated resources to tobacco cessation as part of health service continuity.
- *Sri Lanka* called for an assessment of tobacco taxation to help finance the COVID-19 response and recovery as well as sustainable development broadly.

It is important to learn from such experiences and further link WHO FCTC implementation to COVID-19 response and recovery priorities as well as pandemic prevention, preparedness, response and recovery.

## Conclusion

The COVID-19 pandemic has laid bare the multiple vulnerabilities of health systems, economies and societies. It has underscored the need to build resilience in the face of pandemics. Tobacco use, fuelled by under-implementation of the WHO FCTC, has contributed to the toll of severe disease, death, health systems pressures and socioeconomic impacts from COVID-19. It is also contributing to the world's continued vulnerability to COVID-19 as well as other health threats. Meanwhile, the social, economic and environmental harms of tobacco consumption and production continue to hinder progress toward the achievement of the *2030 Agenda for Sustainable Development*, the SDGs and the pledge to leave no one behind.

**Efforts to build forward better from the COVID-19 pandemic must include stronger, more urgent WHO FCTC implementation.**



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