



WHO Framework Convention on Tobacco Control

REYNOLDS, LA; TANSEY, EM

For additional information about this publication click this link.

<http://qmro.qmul.ac.uk/jspui/handle/123456789/2824>

Information about this research object was correct at the time of download; we occasionally make corrections to records, please therefore check the published record when citing. For more information contact scholarlycommunications@qmul.ac.uk

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

The transcript of a Witness Seminar organized by the Wellcome Trust Centre for the History of Medicine at UCL, in collaboration with the Department of Knowledge Management and Sharing, WHO, held in Geneva, on 26 February 2010

Edited by L A Reynolds and E M Tansey

©The Trustee of the Wellcome Trust, London, 2012

First published by Queen Mary, University of London, 2012

The History of Modern Biomedicine Research Group is funded by the Wellcome Trust, which is a registered charity, no. 210183.

ISBN 978 090223 877 0

All volumes are freely available online at www.history.qmul.ac.uk/research/modbiomed/wellcome_witnesses/

Please cite as: Reynolds LA, Tansey E M. (eds) (2012) *WHO Framework Convention on Tobacco Control*. Wellcome Witnesses to Twentieth Century Medicine, vol. 43. London: Queen Mary, University of London.

CONTENTS

Illustrations and credits	v
Abbreviations	vii
Witness Seminars: Meetings and publications; Acknowledgements E M Tansey and L A Reynolds	ix
Introduction Virginia Berridge	xxi
Transcript Edited by L A Reynolds and E M Tansey	1
Appendix 1 Selected provisions of the Framework Convention on Tobacco Control	73
Appendix 2 WHO regions	74
Appendix 3 WHO FCTC, timeline, 1993–2011	75
Appendix 4 World's leading unmanufactured tobacco producing, trading, and consuming countries, 1997	79
Appendix 5 Reflections on FCTC negotiations: China and Japan Dr Judith Mackay, 15 December 2011	81
References	85
Biographical notes	109
Glossary	119
Index	125

ILLUSTRATIONS AND CREDITS

Figure 1	Dr Gro Brundtland, Director-General, WHO, 1998 to 2003. Reproduced by permission of WHO.	6
Figure 2	Article 19 of the WHO constitution. Reproduced by permission of WHO.	11
Figure 3	Dr Ruth Roemer (1916–2005) and Dr Judith Mackay, WHA, May 2003. Provided by and reproduced by permission of Dr Judith Mackay.	22
Figure 4	Orchid award and Dirty Ashtray award from the FCA's <i>Alliance Bulletin</i> , 2000. Reproduced by permission of FCA.	42
Figure 5	WHO FCTC history, published on 26 February 2010, the fifth anniversary of the Framework Convention. Reproduced by permission of WHO.	49
Figure 6	Death clock displayed at pre-INB-6 sessions, Geneva, February 2003. Provided by and reproduced by permission of Dr Judith Mackay.	58
Figure 7	The first session of the Conference of the Parties following the FCTC coming into force, 17 February 2006. Provided by and reproduced by permission of WHO.	59
Table 1	Outline programme for 'WHO Framework Convention on Tobacco Control' Witness Seminar	7
Table 2	Health and global change in the 1900s. Adapted from Yach and Bettcher (1998): 737.	14
Table 3	Big six tobacco companies, details from company websites, 14 February 2012.	17

Table 4	Global cigarette market share, per cent of total number of cigarettes produced, 2000 and 2008. Provided by Dr Judith Mackay.	26
Table 5	Recipients of FCA awards by Framework Convention <i>Alliance Bulletin</i> , Issues 1–45, 1999–2003, adapted from Mamudu and Glantz (2009): 158.	43

ABBREVIATIONS

ACS	American Cancer Society
AFRO	Regional Office for Africa, WHO
ASEAN	Association of Southeast Asian Nations
BAT	British American Tobacco
CARICOM	Countries of the Caribbean Community
CCLAT	Convention-cadre pour la lutte antitabac (French, FCTC)
CICG	Centre International de Conférences Genève, Geneva, Switzerland
COP-n	Conference of the Parties, the governing body of the FCTC made up of all Parties to the FCTC.
DG	Director-General
EC	European Community
ECOSOC	Economic and Social Council, UN
EMRO	Regional Office for the Eastern Mediterranean, WHO
EURO	Regional Office for Europe, WHO
FAO	Food and Agriculture Organization of the United Nations
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control, WHO
GATT	General Agreement on Tariffs and Trade, Geneva (the World Trade Organization from 1994)
IMF	International Monetary Fund
INB-n	Intergovernmental Negotiating Body for FCTC, six bodies met, 2000–03
Infact	Infant Formula Action Coalition (1977–84), Infact (1984–2004), Corporate Accountability International (2004–)

INFOTAB	A conglomeration of all the tobacco companies in the UK (Tobacco Documentation Centre from 1992), Brentford, Middx
ITGA	International Tobacco Growers Association, formed in 1984 by growers' organizations from Argentina, Brazil, Canada, Malawi, United States and Zimbabwe, of which only Brazil and Canada have ratified the FCTC
NATT	Network for Accountability of Tobacco Transnationals includes 75 NGOs from 50 countries
NGO	Non-governmental organization
PAHO	Pan-American Health Organization, WHO
SEARO	Regional Office for South East Asia, WHO
STAT	Stop Teenage Addiction to Tobacco
TFI	Tobacco Free Initiative, WHO
TobReg	WHO Study Group on Tobacco Product Regulation
UNCTAD	UN Conference on Trade and Development
UNDCP	UN Office on Drugs and Crime
UNICEF	UN Children's Fund
VCLT	Vienna Convention on the 'law of treaties'
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

WITNESS SEMINARS: MEETINGS AND PUBLICATIONS¹

In 1990 the Wellcome Trust created a History of Twentieth Century Medicine Group, associated with the Academic Unit of the Wellcome Institute for the History of Medicine, to bring together clinicians, scientists, historians and others interested in contemporary medical history. Among a number of other initiatives the format of Witness Seminars, used by the Institute of Contemporary British History to address issues of recent political history, was adopted, to promote interaction between these different groups, to emphasize the potential benefits of working jointly, and to encourage the creation and deposit of archival sources for present and future use. In June 1999 the Governors of the Wellcome Trust decided that it would be appropriate for the Academic Unit to enjoy a more formal academic affiliation and turned the Unit into the Wellcome Trust Centre for the History of Medicine at UCL from 1 October 2000 to 30 September 2010. The History of Twentieth Century Medicine Group has been part of the School of History, Queen Mary, University of London, since October 2010, as the History of Modern Biomedicine Research Group, which the Wellcome Trust continues to fund.

The Witness Seminar is a particularly specialized form of oral history, where several people associated with a particular set of circumstances or events are invited to come together to discuss, debate, and agree or disagree about their memories. To date, the History of Twentieth Century Medicine Group has held more than 50 meetings, most of which have been published, as listed on pages xiii–xvii.

Subjects are usually proposed by, or through, members of the Programme Committee of the Group, which includes professional historians of medicine, practising scientists and clinicians, and once an appropriate topic has been agreed, suitable participants are identified and invited. This inevitably leads to further contacts, and more suggestions of people to invite. As the organization of the meeting progresses, a flexible outline plan for the meeting is devised, usually with assistance from the meeting's chairman, and some participants are invited to 'set the ball rolling' on particular themes, by speaking for a short period to initiate and stimulate further discussion.

¹ The following text also appears in the 'Introduction' to recent volumes of *Wellcome Witnesses to Twentieth Century Medicine* as listed on pages xiii–xvii.

Each meeting is fully recorded, the tapes are transcribed and the unedited transcript is immediately sent to every participant. Each is asked to check his or her own contributions and to provide brief biographical details. The editors turn the transcript into readable text, and participants' minor corrections and comments are incorporated into that text, while biographical and bibliographical details are added as footnotes, as are more substantial comments and additional material provided by participants. The final scripts are then sent to every contributor, accompanied by forms assigning copyright to the Wellcome Trust. Copies of all additional correspondence received during the editorial process are deposited with the records of each meeting in archives and manuscripts, Wellcome Library, London.

As with all our meetings, we hope that even if the precise details of some of the technical sections are not clear to the non-specialist, the sense and significance of the events will be understandable. Our aim is for the volumes that emerge from these meetings to inform those with a general interest in the history of modern medicine and medical science; to provide historians with new insights, fresh material for study, and further themes for research; and to emphasize to the participants that events of the recent past, of their own working lives, are of proper and necessary concern to historians.

ACKNOWLEDGEMENTS

WHO FCTC was suggested as a suitable topic for a Witness Seminar by Dr Sanjoy Bhattacharya, who assisted us in planning the meeting. We are very grateful to him and to Dr Faith McLellan for her excellent moderating of the occasion. We are particularly grateful to Professor Virginia Berridge for writing the Introduction to the published proceedings. We thank Dr Judith Mackay, Dr Hoomen Momen of the the Department of Knowledge Management and Sharing and co-ordinator of WHO press and Dr Doug Bettcher, WHO TFI, for their help with the photographs; and Professor Richard Ashcroft for reading the final draft. For permission to reproduce images included here, we thank the World Health Organization. Additionally, we would like to thank Ms Marine Perraudin and Dr Hooman Momen of the Department of Knowledge Management and Sharing at the Geneva headquarters of WHO for their help with the meeting.

As with all our meetings, we depended a great deal on the audiovisual department, catering, reception, and security at the Geneva headquarters of WHO to ensure its smooth running; Mr Akio Morishima has supervised the design and production of this volume; we thank our indexer, Ms Liza Furnival, and our readers, Mrs Sarah Beanland, Ms Fiona Plowman and Mr Simon Reynolds. Mrs Debra Gee is our transcriber, and Mrs Wendy Kutner assisted us in running this meeting. Finally, we thank the Wellcome Trust for supporting this programme.

Tilli Tansey

Lois Reynolds

School of History, Queen Mary, University of London

VOLUMES IN THIS SERIES

1. **Technology transfer in Britain: The case of monoclonal antibodies
Self and non-self: A history of autoimmunity
Endogenous opiates
The Committee on Safety of Drugs (1997)**
ISBN 1 86983 579 4
2. **Making the human body transparent: The impact of NMR and MRI
Research in general practice
Drugs in psychiatric practice
The MRC Common Cold Unit (1998)**
ISBN 1 86983 539 5
3. **Early heart transplant surgery in the UK (1999)**
ISBN 1 84129 007 6
4. **Haemophilia: Recent history of clinical management (1999)**
ISBN 1 84129 008 4
5. **Looking at the unborn: Historical aspects of
obstetric ultrasound (2000)**
ISBN 1 84129 011 4
6. **Post penicillin antibiotics: From acceptance to resistance? (2000)**
ISBN 1 84129 012 2
7. **Clinical research in Britain, 1950–1980 (2000)**
ISBN 1 84129 016 5
8. **Intestinal absorption (2000)**
ISBN 1 84129 017 3
9. **Neonatal intensive care (2001)**
ISBN 0 85484 076 1

10. **British contributions to medical research and education in Africa after the Second World War (2001)**
ISBN 0 85484 077 X
11. **Childhood asthma and beyond (2001)**
ISBN 0 85484 078 8
12. **Maternal care (2001)**
ISBN 0 85484 079 6
13. **Population-based research in south Wales: The MRC Pneumoconiosis Research Unit and the MRC Epidemiology Unit (2002)**
ISBN 0 85484 081 8
14. **Peptic ulcer: Rise and fall (2002)**
ISBN 0 85484 084 2
15. **Leukaemia (2003)**
ISBN 0 85484 087 7
16. **The MRC Applied Psychology Unit (2003)**
ISBN 0 85484 088 5
17. **Genetic testing (2003)**
ISBN 0 85484 094 X
18. **Foot and mouth disease: The 1967 outbreak and its aftermath (2003)**
ISBN 0 85484 096 6
19. **Environmental toxicology: The legacy of *Silent Spring* (2004)**
ISBN 0 85484 091 5
20. **Cystic fibrosis (2004)**
ISBN 0 85484 086 9
21. **Innovation in pain management (2004)**
ISBN 978 0 85484 097 7

22. **The Rhesus factor and disease prevention (2004)**
ISBN 978 0 85484 099 1
23. **The recent history of platelets in thrombosis and other disorders (2005)**
ISBN 978 0 85484 103 5
24. **Short-course chemotherapy for tuberculosis (2005)**
ISBN 978 0 85484 104 2
25. **Prenatal corticosteroids for reducing morbidity and mortality after preterm birth (2005)**
ISBN 978 0 85484 102 8
26. **Public health in the 1980s and 1990s: Decline and rise? (2006)**
ISBN 978 0 85484 106 6
27. **Cholesterol, atherosclerosis and coronary disease in the UK, 1950–2000 (2006)**
ISBN 978 0 85484 107 3
28. **Development of physics applied to medicine in the UK, 1945–1990 (2006)**
ISBN 978 0 85484 108 0
29. **Early development of total hip replacement (2007)**
ISBN 978 0 85484 111 0
30. **The discovery, use and impact of platinum salts as chemotherapy agents for cancer (2007)**
ISBN 978 0 85484 112 7
31. **Medical ethics education in Britain, 1963–1993 (2007)**
ISBN 978 0 85484 113 4
32. **Superbugs and superdrugs: A history of MRSA (2008)**
ISBN 978 0 85484 114 1

33. **Clinical pharmacology in the UK, c. 1950–2000: Influences and institutions (2008)**
ISBN 978 0 85484 117 2
34. **Clinical pharmacology in the UK, c. 1950–2000: Industry and regulation (2008)**
ISBN 978 0 85484 118 9
35. **The resurgence of breastfeeding, 1975–2000 (2009)**
ISBN 978 0 85484 119 6
36. **The development of sports medicine in twentieth-century Britain (2009)**
ISBN 978 0 85484 121 9
37. **History of dialysis, c.1950–1980 (2009)**
ISBN 978 0 85484 122 6
38. **History of cervical cancer and the role of the human papillomavirus, 1960–2000 (2009)**
ISBN 978 0 85484 123 3
39. **Clinical genetics in Britain: Origins and development (2010)**
ISBN 978 0 85484 127 1
40. **The medicalization of cannabis (2010)**
ISBN 978 0 85484 129 5
41. **History of the National Survey of Sexual Attitudes and Lifestyles (2011)**
ISBN 978 0 90223 874 9
42. **History of British intensive care, c.1950–c.2000 (2011)**
ISBN 978 0 90223 875 6

43. WHO Framework Convention on Tobacco Control (2012)

ISBN 978 0 90223 877 0 (this volume)

44. History of the Avon Longitudinal Study of Parents and Children (ALSPAC), c.1980–2000 (2012)

ISBN 978 0 90223 878 7

All volumes are freely available online at www.history.qmul.ac.uk/research/modbiomed/wellcome_witnesses

Hard copies of volumes 21–44 can be ordered from www.amazon.co.uk; www.amazon.com; and all good booksellers for £6/\$10 each plus postage, using the ISBN.

UNPUBLISHED WITNESS SEMINARS

- 1994 **The early history of renal transplantation**
- 1994 **Pneumoconiosis of coal workers**
(partially published in volume 13, *Population-based research in south Wales*)
- 1995 **Oral contraceptives**
- 2003 **Beyond the asylum: Anti-psychiatry and care in the community**
- 2003 **Thrombolysis**
(partially published in volume 27, *Cholesterol, atherosclerosis and coronary disease in the UK, 1950–2000*)
- 2007 **DNA fingerprinting**

The transcripts and records of all Witness Seminars are held in archives and manuscripts, Wellcome Library, London, at GC/253.

OTHER PUBLICATIONS

Technology transfer in Britain: The case of monoclonal antibodies

Tansey E M, Catterall P P. (1993) *Contemporary Record* **9**: 409–44.

Monoclonal antibodies: A witness seminar on contemporary medical history

Tansey E M, Catterall P P. (1994) *Medical History* **38**: 322–7.

Chronic pulmonary disease in South Wales coalmines: An eye-witness account of the MRC surveys (1937–42)

P D’Arcy Hart, edited and annotated by E M Tansey. (1998)
Social History of Medicine **11**: 459–68.

Ashes to Ashes – The history of smoking and health

Lock S P, Reynolds L A, Tansey E M. (eds) (1998) Amsterdam: Rodopi BV, 228pp. ISBN 90420 0396 0 (Hfl 125) (hardback). Reprinted 2003.

Witnessing medical history. An interview with Dr Rosemary Biggs

Professor Christine Lee and Dr Charles Rizza (interviewers). (1998)
Haemophilia **4**: 769–77.

Witnessing the Witnesses: Pitfalls and potentials of the Witness Seminar in twentieth century medicine

Tansey E M, in Doel R, Söderqvist T. (eds) (2006) *Writing Recent Science: The historiography of contemporary science, technology and medicine*. London: Routledge: 260–78.

The Witness Seminar technique in modern medical history

Tansey E M, in Cook H J, Bhattacharya S, Hardy A. (eds) (2008) *History of the Social Determinants of Health: Global Histories, Contemporary Debates*. London: Orient Longman: 279–95.

Today’s medicine, tomorrow’s medical history

Tansey E M, in Natvig J B, Swärd E T, Hem E. (eds) (2009) *Historier om helse (Histories about Health, in Norwegian)*. Oslo: *Journal of the Norwegian Medical Association*: 166–73.

INTRODUCTION

Internationalism in health has a long history. The nineteenth century international sanitary conferences were part of a process which led to the inter-war League of Nations, its health committee, and its work on standardization. In the years after World War Two, the World Health Organization (WHO) developed cross-national programmes and initiatives in areas as diverse as malaria, mental health, smallpox, and subsequently HIV/AIDS.¹

Internationalism and globalization in health was the subject of this witness seminar, which brought together people who had been involved since the 1990s in WHO's emergent role in tobacco control. The idea of a 'framework convention' was new, and the seminar tells us much about how that mechanism, never used before, was chosen (pages 28, 11, 18, 30 and 44).

The timeline covered in the seminar begins in 1993, but the international networks which led to that series of events had a longer history. In the immediate postwar years, such connections did not exist. Wynder and Graham in the US² and Doll and Hill in the UK³ published their research on smoking and lung cancer at the same time, but one set of researchers did not know the other.⁴ Networks developed in the 1970s. The World Conferences on tobacco or health became an important meeting place for smoking researchers and activists. The first was held in New York in 1967, with Robert Kennedy as keynote speaker, followed by one in London in 1971.⁵ George Godber, the Chief Medical Officer (CMO) of the Department of Health and Social Security (1960–73), who had

¹ Professor Virginia Berridge wrote: 'Earlier sections of this introduction are based on research for my book *Marketing Health* (Berridge (2007)) and also given as a paper for the Global Health Histories seminar at WHO in October 2010.' Note on draft introduction, 30 March 2012.

² Wynder and Graham (1950).

³ Doll and Hill (1950).

⁴ Berridge (2007): 36; Doll (1991); although this was not mentioned in his contribution to Lock *et al.* (1998): 135.

⁵ Berridge (2007): 162.

been instrumental in pushing forward the first Royal College of Physicians report on smoking in 1962, gave a rousing address, 'It Can be Done'.⁶ He looked to international networks to take forward the anti-smoking case.

Older international organizations changed to take on tobacco as an issue. Sir John Crofton in Edinburgh, and his wife Eileen, the first director of ASH Scotland, were early advocates of smoking control through his initial interest in tuberculosis (TB). In his unpublished autobiography,⁷ he recalled how the International Union against Tuberculosis (IUAT) became the International Union against TB and Lung Disease (IUAT LD) in 1984.⁸ It set up a special committee on smoking. Crofton and Kjell Bjartveit from Norway produced a booklet, *The Smoking Epidemic: How You can Help*, which was distributed to all IUAT LD members and affiliated organizations.⁹

The role of personalities was important and also the cross-national transfer of national experiences. A key figure was Nigel Gray in Australia, director of the Anti-Cancer Council of Victoria from 1968 until 1995. Gray became the director of the smoking work of the International Union against Cancer in 1974.¹⁰ Here was another international organization which, with Norwegian funding, changed its emphasis and began to do work in developing countries. Successful examples of anti-tobacco activity were used as models for action internationally. Gray's work on the Victoria Tobacco Act of 1987 which raised taxes and restricted advertising, was used in this way.¹¹

⁶ Berridge (2007): 164 n3 ; see also TNA MH154/861. Godber G, Platt R. (1971) Part vii: Smoking as International Public Health Problem 'It Can Be Done', 24 September 1971. Bates no. TIMN0106201-TIMN0106205, freely available at <http://tobaccodocuments.org/ti/TIMN0106201-6205.html> (visited 27 March 2012); see also the House of Lords debate on health education, in *Hansard*, 20 December 1967, vol 287 cols 1464–1553 at <http://hansard.millbanksystems.com/lords/1967/dec/20/health-education-1> (visited 27 March 2012).

⁷ Sir John Crofton (1912–2009) was Professor of Respiratory Diseases and TB at the University of Edinburgh (1952–77); see Dalyell (2009). His unpublished autobiography has been deposited in the archives of the Royal College of Physicians of Edinburgh and is freely available online at www.rcpe.ac.uk/library/read/biography/sir-john-crofton/sir-john-crofton-autobiography.pdf (visited 11 May 2012), particularly 'War with the weed' from page 611.

⁸ See www.theunion.org/index.php/en/who-are-we/history-of-the-union (visited 27 March 2012).

⁹ Crofton and Bjartveit (1986); see also International Union against Tuberculosis and Lung Disease and International Union against Cancer (1986).

¹⁰ Gray (ed.) (1977), the outcome of the Workshop on Smoking and Lung Cancer, held in Geneva, 13–17 December 1976; Gray and Daube (eds) (1980).

¹¹ See Borland *et al.* (2009).

The pace quickened. More organizations were developing an international focus – for example David Simpson, the director of British ASH, set up his International Agency on Tobacco and Health in 1991, which specifically focussed on low-income countries and on Eastern Europe, on information dissemination, on providing the tools for activism.¹²

Europe started to play a role – the impetus came with the establishment in 1987 of the Europe against Cancer programme, initially as a response to Chernobyl, but also expanding its remit as Europe developed its competence to take on matters of public health. Directives and resolutions on tobacco began to be adopted there in the late 1980s and early 1990s.

WHO began to be involved, although progress was initially slow. There was only one officer in Geneva at that time, Dr Roberto Masironi, Tobacco or Health programme coordinator, with a small budget and little support.¹³ Crofton, and John Reid, CMO for Scotland, who was also on the WHO Board, met Halfdan Mahler, Director-General (DG) of WHO, and tried to persuade him to take up the issue. Despite a couple of reports from expert committees, the issue had not been very prominent and Mahler agreed, at the 6th international conference in Tokyo in 1987, to convene a group to prepare a Global Action Plan on Tobacco or Health. This met in Geneva in 1988 with Judith Mackay as rapporteur. Although adopted by the World Health Assembly unanimously in 1988, matters stalled again with the advent of Nakajima as DG and changes in the tobacco unit which caused some disruption – these are touched upon in the witness seminar discussion (pages 31–2) and also in Crofton's unpublished memoir.

Personalities and new areas of research were crucial. The role of Judith Mackay, covered in the seminar, was an important one (pages 27–9, 31). Mackay had been a student of the Croftons in Edinburgh in the 1960s and has attributed

¹² See Simpson and Lee (2003).

¹³ Dr Roberto Masironi wrote: 'Four major benchmarks ought to be emphasized as the early WHO action, namely: the World Health Assembly resolution WHA24 on 20 May 1971, which first requested WHO to initiate action on the control and prevention of smoking; the first WHO Expert Committee on smoking and its effects on health, which I organized in 1973; the launching of the annual World Tobacco Day on 7 April 1988 on the anniversary of the founding of WHO, still ongoing; and the founding of the Tobacco or Health programme, initiated by me, based on the 41st World Health Assembly resolution on 13 May 1988. Several years later what was originally the Tobacco or Health programme became the Tobacco Free Initiative created by Dr Brundtland in 1998, as it is at present. After retirement from WHO in 1991, I became president of the European Medical Association on Smoking or Health (EMASH), my present position.' E-mail to Mrs Lois Reynolds, 29 March 2012. See, for example, <http://legacy.library.ucsf.edu/tid/fqj84b00/pdf;jsessionid=9D6FCDB7E1708C72BED946726A930279.tobacco03> (visited 28 March 2012); Masironi and Gibson (1988).

her subsequent interest in smoking to their influence. China became an area of concern, in part because of her work. Changes in epidemiological research also impacted. Richard Peto's epidemiological research went global, looking at the implications of the 'smoking epidemic' for China (page 20). Christopher Murray and Alan Lopez in their *World Development Report* in 1993 highlighted tobacco and Lopez moved into WHO tobacco control.¹⁴

Hirayama's research on passive smoking emanated from Japan.¹⁵ New forms of epidemiology were based on new international networks. In the crucial area of health economics, similar networks developed. The health economist Joy Townsend recalled how she first became involved at a World Conference in Winnipeg in 1983 and how subsequently a very strong international tobacco control constituency developed within health economics.¹⁶ The World Bank became involved and its report *Curbing the Epidemic*, was published in 1999.¹⁷

Matters came to a head in the 1990s, as the transcript makes clear. There was pressure from without. In 1993, Ruth Roemer at UCLA, with long standing WHO advisory connections, and Allyn Taylor decided to apply Taylor's argument that WHO had the constitutional power to develop international conventions to advance global health to tobacco control. Despite initial opposition by WHO officials, the idea gained wide acceptance for tobacco (page 44).

A head of steam from outside was important. Roemer brought the issue to the first All Africa Conference on Tobacco or Health co-chaired by Derek Yach, who was then with the Medical Research Council (MRC) of South Africa.¹⁸ Strong support emerged from Judith Mackay, by then director of the Asian consultancy for tobacco control, who helped with drafting a resolution at the Ninth World Conference in Paris in 1994 (pages 10, 20, 33).

¹⁴ World Bank (1993); see also Lopez *et al.* (eds) (2006).

¹⁵ Hirayama (1981); see also Ong and Glantz (2000a); Appendix 5, pages 81–3.

¹⁶ Dr Joy Townsend, MRC Epidemiology and Medical Care Unit, Harrow, delivered a paper at the Fifth World Conference on Smoking or Health, Winnipeg, Canada, 10–15 July 1983 on 'Cigarette Tax and Social Class Patterns of Smoking', freely available at <http://www.legacy.library.ucsf.edu/documentStore/z/v/n/zvn93f00/Szvn93f00.pdf> (visited 27 March 2012). Interview with Professor Joy Townsend by Dr David Reubi, April 2011, London School of Hygiene and Tropical Medicine.

¹⁷ World Bank (1999).

¹⁸ For details of the First All African Conference on Tobacco or Health, 14–17 November 1993, held in Harare, Zimbabwe, see http://www.who.int/tobacco/dy_speeches8/en/ (visited 27 March 2012); See Chapman *et al.* (1994); for a review of the developments, see Roemer *et al.* (2005).

Support came from Jean Larivière, a senior medical adviser at Health Canada, who drafted a resolution tabled at WHO executive board in January 1995. It requested that the DG report to the board on the feasibility of developing an international convention. Mackay was a key figure in pushing this forward and in promoting the idea of a framework convention rather than a code, as had been the case with breastmilk substitutes (page 38).

The election of Dr Gro Harlem Brundtland as DG in 1998 made a difference. Matters had developed so far, but there was still a lack of support at the political and global level. Her two priorities were tobacco control and malaria. The Tobacco Free Initiative, headed by Yach, was charged with developing the framework convention. Brundtland had been the Norwegian Prime Minister and had experience within WHO and the United Nations (UN) – she had been commissioner of the sustainable development commission for the Secretary-General in the 1980s and knew how to get things done (pages 34–9).

The growth and influence of coalitions was important, encompassing both rich and poor countries and those in between. The example of how such coalitions had operated to mobilize support for other areas, such as in the environmental field, was drawn upon. Canada had a long track record in international public health, dating back to the Lalonde report in the 1970s.¹⁹ But resource-poor countries and countries like Brazil, one of the top three tobacco growing countries, were also involved. France, Finland, and Switzerland made contributions to get the treaty underway. NGOs from the south also helped drive the process. South Africa and Kenya were centrally involved. The other UN agencies were brought on board with a Secretary-General's United Nations Ad Hoc Interagency Task Force on Tobacco Control operating from 1999.

Even the tobacco industry could see some advantages to the new system (pages 62, 67, 68). Philip Morris and the Big Three realized that it might be an opportunity for them. It would open markets, give them more power, destroy smaller companies and make the bigger ones grow. The convention split the industry. A country such as Japan with a strong national tobacco industry worked in the opposite direction, to water down the convention (pages 81–2). On-going revelations from tobacco industry archives emerged from the late 1990s also put pressure on and aided activism; so a form of history had its role to play (pages 16, 19, 20).

¹⁹ Canada, Department of National Health and Welfare (1974), known as the Lalonde Report after Mr Marc Lalonde, the Minister of National Health and Welfare at the time.

In 1996, WHO voted to proceed with development of the convention, it was adopted in 2003 and came into force in 2005. There have been further networks developing since then (pages 54–60). The treaty strengthened the international tobacco NGO community. The Framework Convention Alliance was set up in 1999 and is made up of over 35 organizations from 100 countries working on the development of the treaty. Funding from the Bloomberg initiative and from Gates has followed, offering serious financial support for tobacco control in low- and middle-income countries.

The Framework Convention, it is clear from the seminar, has taken on a life of its own and is an on-going enterprise. It offers a different model to that of international drug control, in some ways its closest comparator. Contributors to the seminar make it clear that that model of supply control, in operation since the 1920s, was seen as one to avoid (pages 3, 21, 41). The Framework Convention was conceived as a model of demand reduction and its advocates envisage a long-term restructuring of global economies to take account of that aim.

Virginia Berridge

London School of Hygiene and Tropical Medicine, London

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

The transcript of a Witness Seminar organized by the Wellcome Trust Centre for the History of Medicine at UCL, in collaboration with the Department of Knowledge Management and Sharing, WHO, held in Geneva, on 26 February 2010

Edited by L A Reynolds and E M Tansey

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Participants

Dr Najeeb Al-Shorbaji

Dr Mary Assunta

Dr Douglas Bettcher

Dr Sanjoy Bhattacharya

(co-moderator)

Mr Neil Collishaw

Dr Vera Luiza da Costa e Silva

Mr Rob Cunningham

Dr Martina Pötschke-Langer

Dr Judith Mackay

Dr Faith McLellan (co-moderator)

Ms Kathy Mulvey

Dr Haik Nikogosian

Dr Ahmed Ezra Oghwell

Professor Tilli Tansey

Dr Thomas Zeltner

Others attending the meeting: Mr Nils Fietje, Dr Hooman Momen,
Ms Marine Perraudin, Dr David Reubi, Ms Liz Shaw, Mr Vijay Trivedi

Dr Haik Nikogosian: Good afternoon, colleagues, and thank you very much for attending this Witness Seminar. I understand this is the first Witness Seminar in the series of prestigious seminars to be held outside of London. In that case, it could also be part of history. [Laughter] The World Health Organization (WHO)'s Department of Knowledge Management and Sharing, and colleagues at the Wellcome Trust Centre for the History of Medicine at UCL have organized this seminar in connection with the fifth anniversary of the Framework Convention on Tobacco Control (FCTC) because we felt that, firstly, there is a strong history to be reviewed in more detail with the witnesses. Secondly, this occasion was a very nice one, because most of the people who were involved in the past were here in Geneva, which is why I sent additional letters to the people who I felt could be part of this, asking: 'Would you please also contribute to this seminar after the main anniversary event?' I am very grateful for your acceptance and availability. Thank you very much.

Continuing on from this morning's event,¹ the Convention Secretariat are ready, so that we can touch on the high points in the *History of the WHO Framework Convention on Tobacco Control*, because, to us, it goes beyond the issue of tobacco control. This convention is a milestone in public health, a new instrument in public health.² This new legal dimension for international cooperation possibly opens new horizons for global thinking in public health – new expectations in global cooperation for public health. We would like very much to see all these angles reviewed and given attention as much as possible. I won't say more now: my role is to open this meeting, and to pass on the best wishes of the Convention Secretariat for the seminar. I am going to a press conference for the fifth anniversary event now, so I'll be busy in a similar engagement with the media.

Professor Tilli Tansey: I'd like to begin by thanking Dr Nikogosian and the FCTC Secretariat for setting up this meeting. I'd also like to thank Dr Al-Shorbaji, the director of the Department of Knowledge Management and

¹ The launch of the *History of the WHO Framework Convention on Tobacco Control* (WHO, Framework Convention on Tobacco Control Secretariat (2010)) was held at the Geneva headquarters of WHO on 26 February 2010. The convention, 'an evidence-based treaty that presents a regulatory strategy for addressing addictive substances and stresses the importance of strategies for reducing both demand and supply' (WHO (2008): 3) entered into force on 27 February 2005, the 90th day after the 40th ratification and had 174 parties as of 21 June 2011. For the convention, see www.who.int/tobacco/framework/WHO_FCTC_english.pdf (visited 21 February 2012); for details of WHO and WHA, see Glossary, page 123; Figure 7.

² Mackay (2003). See also notes 56 and 82; Appendix 1, page 73. For a background to international legal instruments of tobacco control, see Taylor and Bettcher (2000); Taylor *et al.* (2003).

Sharing at WHO, and Dr Momen of WHO press, who first proposed having such a seminar to Dr Sanjoy Bhattacharya some months ago. I'm also very grateful to all of you for attending this meeting.

As Dr Nikogosian said, this is the first Witness Seminar that we have held outside London. A Witness Seminar is a specialized form of oral history, a technique to record contemporary medical history.³ It involves a round-table discussion guided by facilitators between individuals who were involved in particular debates, discussions or discoveries. We want to hear what happened, and how and why. These meetings are recorded, transcribed and edited for publication. You will be provided with the draft transcript of the meeting so you may amend it in any way you wish, and of course, nothing will be published without your express written permission. The facilitators of these meetings play a vital role in the smooth running of them, and we're delighted that Dr Faith McLellan has volunteered to help us in this way. Faith is a distinguished medical writer and commentator, and she is supported by my colleague Dr Sanjoy Bhattacharya, who is a distinguished medical historian of global health issues. So, without any further ado, I'm going to hand the meeting over to Faith and Sanjoy.

Dr Sanjoy Bhattacharya: I too would like to thank the Department of Knowledge Management and Sharing for suggesting that we hold a Witness Seminar today. Dr Momen and Dr Al-Shorbaji were very supportive in helping us set up this collaboration with the FCTC Secretariat, and we're very grateful for all the hard work that the FCTC Secretariat has done over the past weeks. I would just like to second my colleague's (Tansey's) thanks to all of you for attending; we know you are very busy people. It's an important day and you have other business, I'm sure. But thank you very much for attending. I am sure the Witness Seminar volume that will arise from this will be an important document – important historically – for academics and for students of medicine and public health.

Dr Faith McLellan: I'd like to add my welcome and, without much further ado, get on with the programme of the afternoon. Does everybody know each other? Would it be helpful to say your name and where you're from? Dr Ogwell, can we start with you?

³ See 'What is a Witness Seminar' at www.history.qmul.ac.uk/research/modbiomed/what-is-a-witness-seminar/index.html (visited 21 February 2012). For a description of conventions and protocols, see Glossary, page 120.

Dr Ahmed Ezra Ogwell: I'm proud to be Kenyan, but am currently with the Convention Secretariat of the WHO FCTC here in Geneva.

Dr Mary Assunta: I'm a Malaysian and on the board of directors for the Framework Convention Alliance (FCA).

Ms Kathy Mulvey: I'm from the US and work in the non-governmental organization (NGO) Corporate Accountability International, which was known as Infact during the negotiations.

Dr Vera Luiza da Costa e Silva: I am a Brazilian medical doctor and I was the director of the Tobacco Free Initiative (TFI) during the period 2001–05,⁴ therefore I oversaw the work of WHO's Secretariat when the treaty was negotiated.⁵

Dr Najeeb Al-Shorbaji: I work as director for the Department of Knowledge Management and Sharing here at the WHO headquarters, Geneva. It's a pleasure and honour to have you all around this table for this first Witness Seminar organized with the Wellcome Trust Centre for the History of Medicine and WHO. So, welcome. Please, feel at home. At least those who are not from headquarters. [Laughter]

Dr Martina Pötschke-Langer: I'm a German medical doctor working in the German Cancer Research Center as head of the Unit Cancer Prevention, and for WHO as head of the WHO Collaborating Centre on Tobacco Control.

Dr Douglas Bettcher: I'm Canadian, a medical doctor and a public health and international relations specialist. I was the co-coordinator for the Framework Convention negotiations from 1998 to 2007 and I have been the director of the WHO TFI programme for WHO since 2007.

Mr Neil Collishaw: I'm currently the research director at Physicians for a Smoke-free Canada in Ottawa. From 1991 to 1999 I served here in Geneva as part of the secretariat working in the 'Tobacco or Health' programme of WHO and was involved in some of the very early stages of getting the convention on the road.

⁴ The Tobacco Free Initiative was established by WHO in 1998 under the directorship of Dr Derek Yach (1998–2000). See, for example, Wipfli *et al.* (2004); note 13, page xxiii.

⁵ Dr Vera Luiza da Costa e Silva wrote: 'I have been senior public health consultant and associate professor at the National Public Health School, Oswaldo Cruz Foundation in Rio de Janeiro since 2011.' Note on draft transcript, 26 January 2011.



Figure 1: Dr Gro Brundtland, Director-General, WHO, 1998 to 2003.

Mr Rob Cunningham: I'm with the Canadian Cancer Society and I was involved in an NGO capacity throughout the negotiations.

Dr Thomas Zeltner: Until a couple of weeks ago I was director-general of health and secretary of health in Switzerland, and head of the Swiss delegation to WHO since 1991. At the critical phase of starting the FCTC negotiations, I was a member of the executive board of WHO and chair of the committee that was asked by Dr Gro Harlem Brundtland, former prime minister of Norway and Director-General (DG) of WHO, to look into the ways the tobacco industry was using to try to influence the policies of WHO.⁶ In 2010 I was a fellow of the Advanced Leadership Initiative of Harvard University.

Dr Judith Mackay: I'm a medical doctor from Edinburgh and have lived in Hong Kong since 1967, quite a long time. I've been involved with the FCTC negotiations since their conception, as a WHO consultant, not as an NGO. Being on the WHO team has enabled me to nurture the FCTC throughout. I'm currently working for World Lung Foundation, a component of the Bloomberg Initiative, to reduce tobacco use in low- and middle-income countries.⁷

⁶ Dr Gro Harlem Brundtland was three-times prime minister of Norway in 1981, 1986–89, and 1990–96 and Director-General of the World Health Organization from 1998 to 2003. She appointed the Committee of Experts on the Tobacco Industry, which reported in 2000 (Zeltner *et al.* (2000)).

⁷ For further discussion on whether the currently acceptable term is 'developing countries' or 'low- and middle-income countries', see note 74. Terms used in the meeting have been retained.

What preceded the FCTC in WHO, in relation to anti-smoking and anti-tobacco lobbies?
What was the role of the WHO Director-General's office in encouraging the move towards the FCTC?
What was the role of the countries in making FCTC possible? Who played an important part in lobbying for the convention?
What was the role played by different non-governmental organizations (NGOs) in supporting – and opposing – FCTC?
Who were the dissenters? What was the role played by pro-tobacco lobbies and who were they?

Table 1: Outline programme for 'WHO Framework Convention on Tobacco Control' Witness Seminar

McLellan: A quick word about logistics. You have before you the five topics for discussion this afternoon (Table 1).

When I was asked to do this, I couldn't quite figure out why I'd been asked to moderate this session. I thought I heard a few things like 'loud-mouthed American' and 'ruthless time-keeper', so I will try to keep us to a schedule that gets us out of here by tomorrow. But, by the same token, we want all voices to be heard here, so I will try, as the Quakers say, 'to achieve the sense of the meeting' as we move from one question to another. I hope that we'll have a lively and informal discussion.

If you'd like to loosen your tie, we're interested in the real story today, we want to know what happened. The other thing is, I think it's usually best in this kind of forum if the moderator doesn't know a lot about the topic, so fine, I'm eminently qualified because I don't know very much about the Framework Convention, so I'll be interested to hear the real history of it.

However, I think the people who asked me probably did not know what my real connection to tobacco is: I was born into a tobacco-farming community in the largest tobacco-growing county – Johnston county – of the largest tobacco-growing state in the US – North Carolina. I went to an undergraduate college funded by one, Mr R J Reynolds.⁸ [Laughter] I went to graduate school at

⁸ The surviving children of R J Reynolds (1850–1918) donated part of the family estate for Wake Forest University campus and funded the university's relocation to Winston-Salem, see www.wfu.edu/history/HST_WFU/perry.html; James Buchanan Duke (1856–1925) endowed Duke University through his family foundation, see www.dukeendowment.org/about-us/our-history (both visited 7 February 2012).

a university funded by the other North Carolina tobacco magnate, James Buchanan Duke. So, I feel eminently qualified to be in the milieu of the discussion.

Mackay: May I ask a question about sensitive information? The previous published Witness Seminars name the contributors for what is said, which is fine. But we are asked to look at some of the obstructions and some of the difficulties, because the real story does involve some quite sensitive issues, both within and outside of WHO. I think you mentioned earlier that we're going to have an opportunity to review this before it goes out, so do you have any guidelines on that for us?

Tansey: Yes. As I said, you will get the transcript. If there is material you don't want published, just indicate it. What we also do with this material, with your permission, is to put it in the archives of the Wellcome Library for present and future scholars. Again, if there is material that you don't want in the public domain at the moment, you just strike it out. We encourage you to put some sort of publishing embargo on the release of sensitive or confidential information, but we would appreciate it if you could be frank today. We have had this situation before with some of our other meetings, as you can probably guess, looking at the titles.⁹ We have embargoed materials in the archives at the request of participants.

Cunningham: Would an option be to make certain comments, to make them expressly anonymously? If we give you no names, and say 'this is from an anonymous person'.

Tansey: That would be an option we could discuss if we were going to publish it. We would prefer to be able to attribute your comments to you, because if it's attributable to you, it has authority. But we could discuss that.

Bettcher: In WHO, where members speak for different organizations, it is difficult to know which countries they represent, for example. It's easy for WHO to cite countries or groups moving in the positive sense. But it is more difficult for WHO to be cited as criticizing particular member states. NGOs would be

⁹ See pages xiii–xvii, for a list of published transcripts in the *Wellcome Witnesses to Twentieth Century Medicine* series.

more able to freely discuss and cite these. For WHO, it would be very difficult if a country was going to be cited by name, to say XYZ countries did such and such, and that this was very negative in a certain phase of the negotiations.¹⁰

Tansey: Yes, we entirely understand and are sensitive to the issues.¹¹

Bhattacharya: From what I understand, we are seeking to achieve a diversity of views today and often, as an historian, silences tell me a lot. So if a colleague says something and you don't disagree, then it's wonderfully informative. [Laughter]

McLellan: If hard on the moderators. So, with all that behind us, shall we move along? To set the Framework Convention in context, we'd like to talk first about what preceded it. I'm sure there were some anti-tobacco and anti-smoking efforts in WHO before the Framework Convention, so who would like to tell us how it all began.

Mackay: As the oldest person here, and possibly having the longest association with WHO since the 1970s, I will have the first stab at this. I think that we have to remember what happened in WHO before the convention came in. If you look back at the 1970s, there were already resolutions at the World Health Assembly (WHA) on smoking. The first committee on smoking was formed in 1973, which was the Expert Committee. I joined the Expert Advisory Panel on Tobacco or Health in the 1980s.¹² And, I've got here a list as long as your arm of publications that came out of this panel on tobacco and women, and other tobacco issues. Various expert panels were set up; we discussed many issues, including smokeless tobacco. There is quite a long and rich history and I'm happy to note some of the details of this.

WHO involvement was not only at headquarters but also at the regional level. For example, the Western Pacific region, which is where I live, had its first five-year action plan starting in 1990, and they've had five-year action plans ever since then.¹³ Many of the regions had undertaken quite a lot of activities, so

¹⁰ For a sense of the activities and attitudes of national interest groups, see Legacy Tobacco Documents Library, University of California, San Francisco, entering queries at <http://legacy.library.ucsf.edu/action/search/basic;jsessionid=D17B281F4E5550EF6FB390EF93A3F344.tobacco03> (visited 9 February 2012).

¹¹ See, for example, the catalogue for records of Witness Seminar meetings held in archives and manuscripts, quote GC/253 under Reference, at <http://library.wellcome.ac.uk/node49.html> (visited 25 October 2011).

¹² See, for example, WHO (1975, 1979, 1983, 1988); Masironi (1979, 1984); see also page xxiii.

¹³ See, for example, WHO, Western Pacific Regional Office (2005, 2009).

I think that when we are documenting this history, we need to look back and recognize the efforts that went on quite a long time before people like Neil Collishaw, Derek Yach and Vera da Costa e Silva and others came on the scene.

Collishaw: I'm not sure I can agree that Judith is the oldest person here.

McLellan: Our first point of disagreement. [Laughter]

Collishaw: I certainly defer to Judith's experience, if not her age. As I mentioned, I began in the secretariat in 1991, but I would like to reinforce what Judith said: there were many resolutions passed by the WHA beginning in 1970, continuing right up until the 1990s.¹⁴ These resolutions, if you add them up, all called for comprehensive tobacco control, much as we see in the Framework Convention, but I think the member states came to realize that these resolutions were not being implemented. They also realized the power of resolutions, even if resolutions are a consensus statement of all the member states, they are also a consensus of good intentions and – a place that we're all familiar with – the road is paved with good intentions and it went there. Long experience of more than two decades, with many resolutions – there were 14 adopted from 1970 to 1996 – taken together, called for comprehensive tobacco control, but did not achieve it.¹⁵ That became part of the motivation in 1995 and 1996 when the executive board and the WHA got the idea that they could have an international treaty, and many people who had been associated with those resolutions said: 'Yes, yes, we need something stronger.' This is part of the reason why consensus was rapidly achieved for a convention.

Since you asked about anti-tobacco lobbies, I would like to tell you one story: it turned out, as we all know, that Malawi is one of the countries in the world that is heavily dependent on tobacco-growing. During the late 1980s and the 1990s, the minister of health for Malawi would frequently stand up when these tobacco resolutions were being debated in the WHA and ask for something to be inserted at the behest of both his country and the people who bought its products – the tobacco industry. If you look through those resolutions, you will

¹⁴ The World Health Assembly is an association of 194 governments under the auspices of WHO. The 48th WHA in 1995 passed resolution WHA48.11, 'An international strategy for tobacco control', based on approaches adopted at the 9th World Conference on Tobacco or Health in Paris, October 1994, citing resolutions WHA33.35, WHA39.14, WHA43.16 and WHA45.20. See www.searo.who.int/LinkFiles/WHO_FCTC_WHA_48_11.pdf (visited 10 August 2010); see also Barnham (1994); Glossary, page 122–3.

¹⁵ Mr Neil Collishaw wrote: 'The WHA adopted an additional five FCTC-related resolutions from 1995 to 2001 and then the final one (WHA56.1) to adopt the FCTC in 2003.' Note on draft transcript, 25 March 2010; see also page xxiii.

always find something that I came to fondly call the ‘Malawi clause’ and usually had to do with the need to acknowledge tobacco farmers, which everybody agreed was a good thing to do.¹⁶ There was a constant pressure through the voice of this official representative to the WHA for a weakening of these resolutions. To the credit of everybody else, I think the potential damage was always limited, but I think it is important to signal that, indeed, there was pressure going the other way that the WHA had to deal with.

Bettcher: Let me start where Neil left off. Before the 1999 resolution to put in place the machinery for tobacco control negotiations was agreed by the WHA – something that WHO had never done – there was Article 19 of our constitution. Some people thought we would never use it, that we were too conservative an organization to get into a treaty negotiation.

McLellan: Article 19 gives us the power to make a treaty?

Article 19: The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

Figure 2: Article 19 of the WHO constitution.¹⁷

Bettcher: It does, yes. In the mid-1990s, there was a review of our constitution and some countries thought that Article 19 could be dropped; it had never been used. It seemed to be rather dormant. Did WHO need to develop treaties? There was also a sense at WHO that it had been a scientific organization since its inception and that it didn’t get into politics. Of course, that’s pretty illusory, as there was all of our work on HIV/AIDS and breastmilk substitutes in the late 1980s,¹⁸ so that argument was a bit of a fig leaf, but we have kept up the pretence.

¹⁶ For details of the case of Malawi, see Otañez *et al.* (2009). For example, the CIA website notes that ‘landlocked Malawi ranks among the world’s most densely populated and least developed countries. The economy is predominately agricultural with about 80 per cent of the population living in rural areas.... The economy depends on substantial inflows of economic assistance from the IMF, the World Bank, and individual donor nations.’ See www.cia.gov/library/publications/the-world-factbook/geos/mi.html (visited 28 October 2011). Malawi was the tenth largest producer of tobacco in 2000, the product accounting for more than 70 per cent of its export income.

¹⁷ The WHO constitution, adopted in 1946, is freely available at www.who.int/governance/eb/who_constitution_en.pdf (visited 21 July 2010).

¹⁸ For WHO activities described at the 2007 Witness Seminar on ‘The Resurgence of Breastfeeding’, see Crowther *et al.* (eds) (2009).

Jumping into the deep end of a treaty negotiation seemed pretty intimidating. Those 16 WHA resolutions, which were adopted before the treaty mechanics were set up, covered almost everything, I would say, except tobacco product regulation and the new areas, such as the illicit trades like smuggling.¹⁹ That particular issue hadn't been touched, it was something that hadn't been seen to overlap with the competencies of WHO. Also, product regulation was the preserve of the International Organization for Standardization (ISO). This was a troubling piece of history as well, because, for a few decades, a tobacco group at ISO had been developing testing mechanisms, and then tobacco companies re-engineered their products in line with the ISO methods to be able to sell light/mild products,²⁰ so then they could deceive the customers that these were safer.²¹ WHO was not present in these product regulation discussions; the tobacco companies dominated the ISO processes. So product regulation was missing from our remit.

What was also missing in 1996 was the sense that tobacco control is a transnational problem. In the early years there was a lack of understanding or a notion that there is a transnational aspect,²² that you can't only regulate at a domestic level alone, that there will be certain international features of our control, like differential taxes, advertising across borders, differences between countries, smuggling, products being dumped without the appropriate warning labels.²³ This became described as part of WHO dealing with the globalization of public health.²⁴

I was brought onto the team after I finished my doctorate at the London School of Economics to work in the area of globalization. One of my specialties was international relations, so I did some of the first work in the Organization on

¹⁹ It was estimated in 1992 that 10–35 per cent or 171 billion cigarettes worldwide were smuggled (Mackay and Crofton (1996): 217). See, for example, Collin *et al.* (2004); Lee and Collin (2006); Legresley *et al.* (2008); see also Youderian (2009).

²⁰ For an analysis of ISO standards based on tobacco industry documents, see Bialous and Yach (2001): 96; see also Glossary, page 120–1.

²¹ For a discussion of light/mild ratings as misleading, see Jarvis *et al.* (2001); Glossary, page 121. See also US, Food and Drug Administration (2010). It could be said that the Tobacco Working Group at ISO was manipulating the standards on issues such as tar and nicotine yields to facilitate the marketing of light and mild products.

²² See Baris *et al.* (2000).

²³ See, for example, LaFaive *et al.* (2008).

²⁴ Yach and Bettcher (1998a and b); for an earlier approach, see Roemer and Roemer (1990); Table 2, page 14.

defining what globalization meant for WHO. Dr Derek Yach and I published some of the first articles in the *American Journal of Public Health* on the globalization of public health.²⁵ Globalization was really picked up as a theme for the pre-negotiations and negotiations of the treaty. In fact, there are ‘global goods’ for public health, but there are also ‘global bads’, which are associated with trade liberalization and moving and liberalizing products across borders and allowing marketing and advertising.²⁶ That issue had never been grappled with by WHO, for example, in the area of tobacco control. During the two years before I took up work with the Tobacco Free Initiative, we had defined many of these globalization issues for public health.

The tobacco control community hadn’t worked much with a transnational definition that tobacco was a ‘global bad’, and by virtue of being a ‘global bad’, it was something that should not be subject to trade liberalization, where opening up of borders, etc., would lead to a dissemination of products to underdeveloped countries, thus to increased marketing and increased consumption. There were some very good economic studies, starting in the late 1980s, that showed that low-income countries in an era of liberalization were more vulnerable.²⁷ There are two or three econometric studies that show that what happens is that you get more advertising, you get more competition, the prices of the tobacco products fall, and therefore you get more consumption. In the early days, that notion was missing.²⁸

WHO was starting to grapple with that problem just in the run up to the negotiations. It created a dynamic, especially for low- and middle-income countries then, to say why we need a global regulatory complement to national laws to regulate the tobacco companies.²⁹ As I’ve described it in the past, it is necessary to ‘make the international and global regulatory environment as

²⁵ See, for example, Yach and Bettcher (1998a and b, 2000); for one evaluation of the background, see Brown *et al.* (2006).

²⁶ See, for example, Callard *et al.* (2001), freely available at www.smoke-free.ca/pdf_1/Trade&Tobacco-April%202000.pdf (visited 31 January 2012); see also Mamudu *et al.* (2011).

²⁷ See, for example, Chaloupka and Laixuthai (1996); Hsieh *et al.* (1999); Taylor *et al.* (2000); Bettcher *et al.* (2001).

²⁸ See, for example, Yach (1998); World Bank (1991); Taylor and Roemer (1996); Bettcher *et al.* (2000); Bettcher and Yach (1998); Brown *et al.* (2006).

²⁹ See, for example, Townsend (1998); see also British American Tobacco (1994); Diethelm *et al.* (2005); Gilmore *et al.* (2007).

Global transnational factor	Consequences and probable impact on health status
Macroeconomic prescriptions Structural adjustment policies and downsizing Structural and chronic unemployment	Marginalization, poverty, inadequate decreased social safety nets ^a Higher morbidity and mortality rates ^b
Trade Tobacco, alcohol, and psychoactive drugs Dumping of unsafe or ineffective pharmaceuticals Trade of contaminated foodstuffs/feed	Increased marketing, availability and use ^b Ineffective or harmful therapy ^b Spread of infectious diseases across borders ^b
Travel More than 1 million persons crossing borders/day	Infectious disease transmission and export of harmful lifestyles (eg high-risk sexual behaviour) ^c
Migration and demographic Increased refugee populations and rapid population growth	Ethnic and civil conflict and environmental degradation ^c
Food security Increased demand for food in rapidly growing economies, for example, countries in Asia Increase in global food trade continuing to outstrip increases in food production, and food aid continuing to decline	Structural food shortages as less food aid is available and the poorest countries of the world are unable to pay hard currency ^b Food shortages in marginalized areas of the world; increased migration and civil unrest ^a
Environmental degradation and unsustainable consumption patterns Resource depletion, especially access to fresh water Water and air pollution Ozone depletion and increases in ultraviolet radiation Accumulation of greenhouse gases and global warming	Global and local environmental health impact ^b Epidemics and potential violence within and between countries (water wars) Introduction of toxins into human food chain and respiratory disorders Immunosuppression, skin cancers, and cataracts Major shifts in infectious disease patterns and vector distribution (eg malaria), death from heat waves, increased trauma due to floods and storms, and worsening food shortages and malnutrition in many regions of the world
Technology Patent protection of new technologies under the trade-related aspects of intellectual property rights agreement	Benefits of new technologies developed in the global market are unaffordable to the poor ^c
Communications and media Global marketing of harmful commodities such as tobacco	Active promotion of health-damaging practices ^b
Foreign policies based on national self-interest, xenophobia, and protectionism	Threat to multilateralism and global cooperation required to address shared transnational health concerns ^c

^a Possible short-term problem that could reverse in time; ^b Long-term negative impact;

^c Great uncertainty

Table 2: Health and global change in the 1900s.

Adapted from Yach and Bettcher (1998): 737.

For country-by-country mortality attributable to tobacco, see WHO, TFI (2012).

difficult and as strict as possible for the tobacco companies’, because before the FCTC the transnational regulatory environment was a global void, a black hole. The companies didn’t like the proposed global regulation, and that’s when they started talking about ‘sensible regulation’, ‘voluntary regulation’ and that sort of stuff.

McLellan: That got their attention, I’m sure.

Bettcher: It certainly did.

da Costa e Silva: During the period between the 1970s and the 1990s, including the end of the 1990s when the negotiations of the treaty were initiated, I worked as coordinator of the Brazilian Tobacco Control Programme. What I saw at that point was that the Pan-American Health Organization (PAHO) was not very involved in tobacco control. Dr Enrique Madrigal, an adviser for alcohol control, was the only person in power who managed to do something about tobacco control.³⁰ Do you remember him, Neil? The American Cancer Society (ACS) was the organization that was trying to bring together the medical associations in the different Latin American countries in order to push forward the process in the region to undertake tobacco control as a real activity.³¹ A representative from PAHO was attending the meetings, especially those of the *Comite Latino Americano Coordinador del Control del Tabaquismo* (CLACCTA), a specialist committee that was created with support from ACS.³² It was through the creation of this committee and through the Brazilian doctors’ associations that Brazil’s tobacco control movement from the health groups started to reach the government. As part of the Brazilian Ministry of Health’s National Cancer Institute (INCA), we were contacted for the first time in the 1990s by Neil Collishaw from WHO Geneva. He didn’t have a department or a strong standing in the organization as far as I can remember – please correct me if I’m wrong – no funding and a lack of people; he was the king of a reign with himself. This was the early stages of tobacco control. For Brazil, for instance, and probably for all tobacco-growing countries, the reaction was: ‘Let’s not address

³⁰ Dr Vera Luiza da Costa e Silva wrote: ‘Dr Enrique Madrigal worked at PAHO during the 1990s as regional adviser on alcohol and tobacco, coordinating PAHO work in the region of Americas and supporting government initiatives in these areas, and collaborating with the American Cancer Society in the establishment and organization of CLACCTA’s work and meetings.’ Note on draft transcript, 26 January 2012.

³¹ See press release, ‘Regional plan to control tobacco’, Office of Public Information, Washington, DC (PAHO), 21 May 1999 at www.paho.org-rl99518c (visited 6 October 2011).

³² See page 30.

tobacco control, because it's too complicated an issue to discuss'. I think this was the reality for most countries, even for those that were not tobacco growers during this period. I am talking about 20 years ago, between 1970 and close to 2000 when the treaty negotiating process was initiated.

Zeltner: May I add three points here. One is that if you want to write a history of tobacco control and WHO, you need to look at the regions as well.³³ Because the regions are very active in some areas, tobacco control is typically one where there were major differences at regional level: the European region being very active, with the Nordic countries in the driving seat, pushing the agenda at the regional level. From that perspective, it's very interesting how things may move on, and that's why it is interesting to look at public health history: some issues may be raised or have their origin, babyhood and childhood in a region and then come to the centre. I think that is what happened in WHO. The tobacco industry's Boca Raton action plan was the Philip Morris plan to fight against WHO and dates from 1988.³⁴ It was well before that time when the tobacco industry said: 'WHO is one of our no. 1 enemies'. This is very surprising because if you look at the programme here (Table 1, page 7), it was not. If you look at the tobacco industry statements, they say: 'We need to get the developing countries to understand that it is a first-world issue.' That's why Malawi and all these countries were so important for the tobacco companies. So, you need to see how these things moved in the regions and how it then became a global issue at some stage and moved here to Geneva, at the centre.³⁵

³³ The 194 member countries of WHO are divided into six regions and their headquarters are: Africa (Brazzaville, Congo); the Americas (Washington, DC); South-East Asia (New Delhi, India); Europe (Copenhagen, Denmark); Eastern Mediterranean (Cairo, Egypt); Western Pacific (Manila, Philippines); for a complete list see Appendix 2, page 74.

³⁴ The meeting of Phillip Morris executives from which the action plan took its name was held in Boca Raton, Florida, 29 November–3 December 1988. The WHO Committee of Experts on Tobacco Industry Documents wrote: 'The Plan identified 26 global threats to the tobacco industry and multiple strategies for countering each. First among these threats was the World Health Organization'. (Zeltner *et al.* (2000): 4; freely available at: www.who.int/tobacco/media/en/who_inquiry.pdf (visited 6 January 2012). The 13 December 1988 document, Bates No. 2021596422/6432 (see Glossary, page 119), said: '(1) WHO/ UICC/IOCU INITIATIVE: This organization has extraordinary influence on government and consumers and we must find a way to diffuse [*sic*] this and re-orient their activities to their prescribed mandate.' See Legacy Tobacco Documents Library, University of California, San Francisco, at <http://legacy.library.ucsf.edu/tid/izf58e00> (visited 26 September 2011). See also Kaufman (2000); for an example of more recent litigation against Uruguay, see Lencucha (2010).

³⁵ See pages 32–3.

Company	Subsidiaries and brands
Philip Morris/Altria (US)	Renamed as Altria in 2003 and is the parent corporation of Philip Morris USA. Four strong premium brands: Marlboro, Copenhagen, Skoal and Black & Mild (www.altria.com/en/cms/About_Altria/Financial_Strength/default.aspx?src=top_nav (visited 14 February 2012)).
Philip Morris International Inc (Swiss)	A separate international operation created in 2008 by the sale of all shares of Philip Morris International to Altria's shareholders, based in Lausanne, Switzerland, operating in 180 countries, with an estimated 16 per cent share of the international cigarette market outside of the US or 27.6 per cent excluding the People's Republic of China (2010). Top 25 PMI brands: Marlboro, L&M, Bond Street, Philip Morris, Chesterfield, Fortune, Parliament, Sampoerna A, Lark, Morven Gold, Dji Sam Soe, Next, Optima, Red & White, Muratti, Diana, Merit, Sampoerna Hijau, Champion, Virginia Slims, Apollo-Soyuz, Hope, Delicados, Benson & Hedges, Longbeach (www.pmi.com/eng/pages/homepage.aspx (visited 14 February 2012)).
Reynolds American Inc (US)	A new publicly traded parent company (RAI) from the merger of Brown & Williamson (formerly BAT) and R J Reynolds in 2004, whose subsidiaries are: R J Reynolds Tobacco Company (second-largest US tobacco company); American Snuff Company (smokeless tobacco); Santa Fe Natural Tobacco Company, Inc. (additive-free tobacco products); Nicotivum AB (nicotine replacement therapy) and produces five of the 10 best-selling US cigarette brands: Camel, Winston, Kool, Salem and Doral (www.reynoldsameric.com/index.cfm (visited 14 February 2012)).
British American Tobacco (UK)	A joint venture between the UK's Imperial Tobacco Company and the American Tobacco Company founded by James Buchanan Duke in 1902; acquired American Tobacco Company in 1994 and Rothmans International in 1999; divested Brown & Williamson in 2004 to R J Reynolds, retaining a 42 per cent share in RAI. BAT's 200 brands include the 4 'global drive brands' of Dunhill, Kent, Lucky Strike and Pall Mall, as well as cigars and smokeless tobacco (www.bat.com/ (visited 14 February 2012)).
Japan Tobacco (Japan)	Wholly owned by the Japanese government from 1904 to exclude James Buchanan Duke's American Tobacco Company from Japanese commerce [†] ; renamed Japan Tobacco and Salt Public Corporation (JTSPC) from 1949. Japan Tobacco Incorporation Law, 1984, required the Minister of Finance to hold two-thirds of JT's stock, which fell to 50 per cent from April 2004. [‡] Acquired all R J Reynolds non-US operations in 1999 (Camels, Winstons or Salems sold outside the US); acquired UK's Gallaher Group in 2007; and in 2009 acquired part of Tribac Leaf Limited, which trades tobacco in Africa. Brands: Benson & Hedges, Mayfair, Ronson, and Silk Cut, Camel, Mild Seven, Salem, Winston, Winchester, Gold Coast, Genghis Khan, and Peace (www.jt.com/About/about_history (visited 14 February 2012)).
Imperial Tobacco (UK)	Bristol-based, started as a WD & HO Wills shop in 1786; in brief ownership by the American Tobacco Co., Ogden's became a branch of Imperial Tobacco in 1902; by 1980s 22 constituent companies reduced to three, WD & HO Wills, John Player & Sons and Ogden's; briefly owned by Hanson plc, returning to corporate independence in 1996. Acquisitions: Reemtsma (2002, mainly EU and rest of the world), Commonwealth Brands (2007, Americas) and Altadis (2008). Brands: Davidoff, Gauloises Blondes and fine cut tobacco, cigars, papers and tubes (www.imperial-tobacco.com/index.asp?page=43 (visited 14 February 2012)).

[†] Kolandai (2007) [‡] Levin (2004) at Levin-tobacco-control-policy-2004 (visited 6 January 2012)

Table 3: Big six tobacco companies, details from company websites, 14 February 2012.

See Table 4, page 26, for market share in 2000 and 2008.

The second point I would like to make is, properly speaking, the FCTC is the first convention on public health globally. There are, however, three others: the Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971) and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). Many of the ministers of health or delegates sit in WHO in Geneva and at the UN Drug Control Programme (UNDCP) in Vienna and, frankly speaking, many of us do not think the conventions of Vienna are a great achievement for public health. Some of the more progressive people even thought that conventions are a difficult way to go, because – and we see this with the conventions in Vienna – once you have more than 170 country signatures, you cannot change the convention any more. The coca leaf regulation,³⁶ and the prohibition of cannabis, which only slipped into these conventions by chance in the late night hours of negotiations, have major negative consequences up until today: the ‘social use of cannabis, in many developing countries seen as comparable to the social use of alcohol in the developed world at the time, and chewing or drinking coca in the Andean region, comparable to drinking coffee, were thus condemned to be abolished.’³⁷ Being now encoded in the 1961 convention, you can’t get rid of these regulations.³⁸ These international conventions can also block developments in public health.³⁹ Some of us were somewhat reluctant because we thought: ‘Yes, tobacco needs to be regulated, but this is dangerous.’

The last point – not alluded to during this morning’s celebrations⁴⁰ – is that we have to salute the US and its lawyers. Without the lawsuits against the tobacco industry in the US and the opening of the files of Philip Morris, we would never have seen the creation of such a strong anti-tobacco movement.⁴¹ I think that’s another lesson: the law can be an extremely powerful instrument in public

³⁶ A UN commission of inquiry went to Peru and Bolivia during the autumn of 1949 to investigate the effects of chewing the coca leaf and the possibilities of limiting production and controlling distribution (see *Bulletin on Narcotics* 1, October 1949) and reported in May 1950. For the Commission’s method of work, its conclusions and recommendations, see www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1950-01-01_4_page005.html (visited 7 July 2010).

³⁷ Bewley-Taylor and Jelsma (2012): 78.

³⁸ For a discussion of the 1925 League of Nations’ International Opium Convention, see Crowther *et al.* (eds) (2010): 4.

³⁹ See Carter (2002).

⁴⁰ See note 1.

⁴¹ See note 45.

health. Doctors tend to think that public health is mostly about caring for people, but actually, I think these legal issues in the US created the momentum for things to start happening globally.

Bettcher: In 1994 the first box of documents were left in Stan Glantz's office at the University of California, San Francisco. It is known as the 'Mr Butts' story.⁴² Then in 1998, 1999 was the Blue Cross and Blue Shield of Minnesota case against the tobacco companies for health damages (1994–99), which then led to the litigation by the Minneapolis-based law firm of Robins, Kaplan, Miller and Ciresi.⁴³ Roberta Walburn, one of the top world litigators, had been involved in the Bhopal case (the government of India on behalf of the victims of the Bhopal disaster against Union Carbide) and the Dalkon Shield case (women injured by the Cu-7 intrauterine device against G D Searle Co., the manufacturer),⁴⁴ and she took them to task. The lawyers locked themselves up in a St Paul/Minneapolis hotel for about eight months and started requesting the documents from the tobacco companies.⁴⁵ It turned out there were over 70 million pages of documents hidden under client–attorney privilege going back to the 1950s,

⁴² For further details, see www.pbs.org/wgbh/pages/frontline/shows/settlement/interviews/glantz.html (visited 7 July 2010). See also Glantz (1996); Brandt (2007). For a guide to searching the documents, see www.emro.who.int/tfi/TobaccoIndustry-English.pdf (visited 16 November 2011). For one analysis of how the dollars from of tobacco industry settlement have been spent, see www.legacyforhealth.org/PDFPublications/TobaccoAsASocialJusticeIssue.pdf (visited 20 December 2011).

⁴³ See Ciresi *et al.* (1999); for background details of tobacco litigation, see <http://law.jrank.org/pages/10805/Tobacco-Tobacco-Litigation.html>; for Blue Cross and Blue Shield of Minnesota, see *Group Health Plan, Inc., vs Philip Morris, Inc., R J Reynolds Tobacco Co., Brown & Williamson Tobacco Corp., BAT Industries plc, Lorillard Tobacco Co., American Tobacco Co., Liggett Group, Inc., the Council for Tobacco Research – USA, Inc., and the Tobacco Institute, Inc.*, including not only tobacco companies as named defendants, but also the Kimberly-Clarke Corporation, the developer of the tobacco reconstitution process that enables tobacco companies to manipulate nicotine levels, see www.bluecrossmn.com/bc/wcs/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=Latest&dDocName=POST71A_016058 (both sites visited 7 July 2010). See also Lilyard and Anderson (2000).

⁴⁴ For details of the class actions (mass tort cases) of Robins, Kaplan, Miller, and Ciresi, see www.rkmc.com/results.aspx?group=1259 (visited 7 July 2010).

⁴⁵ For details of the decision by the Minnesota Court of Appeals, in the 1995 settlement between the State of Minnesota, Blue Cross and Blue Shield of Minnesota and Philip Morris Incorporated, R J Reynolds Tobacco Company, Brown and Williamson Tobacco Corporation, BAT Industries plc, Lorillard Tobacco Company, the American Tobacco Company, Liggett Group Inc., the Council for Tobacco Research and the Tobacco Institute, see <http://law.jrank.org/pages/10805/Tobacco-Tobacco-Litigation.html> (visited 7 July 2010); for the Legacy Tobacco Documents Library, University of California, San Francisco, see <http://legacy.library.ucsf.edu/> (both visited 26 September 2011); see also Infact (2003).

which had nothing to do with the client–attorney privilege. The documents described how the tobacco companies had defrauded countries and customers; how they had manipulated and re-engineered the product and described the whole insider story of nicotine spiking,⁴⁶ where tobacco companies converted nicotine from a salt to its base form, adding ammonia to cigarettes in the early 1970s to create a cigarette equivalent of crack cocaine, a ‘free-base nicotine’ cigarette.⁴⁷ The documents also described how the industry tried to get kids hooked; how the industry was dreaming about penetrating markets in China through trade liberalization. The documents unlocked Pandora’s box for us. At around the same time, Dr Zeltner was appointed by Dr Brundtland to chair an expert group to investigate the implications of 50 years’ actions by the tobacco companies for WHO and other UN organizations.⁴⁸

Pötschke-Langer: I fully agree that the emotional impact factor of the tobacco industry documents was overwhelming, I would say, for the whole world. We never thought that the tobacco industry would be so strong and could influence governments and health authorities in such a way. Coming from countries in Central or Eastern Europe, with not very well-developed tobacco control activities, we said: ‘No, this cannot be true, and we must act immediately; we must form this international group and support all activities very strongly.’ This was a very moving, a very touching issue. Then in the 1990s, two other events were very important for us: the conference of Paris in 1994 when Richard Peto presented the data on the tobacco epidemic worldwide.⁴⁹ I will never forget the big book of Sir Richard Peto and his colleagues.⁵⁰ This was so impressive that we all said: ‘Look at the data; it’s so visible and we must act immediately.’ The

⁴⁶ For a description of nicotine manipulation, see Kessler (1994); for a retraction of an earlier analysis of WHO that relied on work by an American economist paid by BAT, see Godlee (2000), discredited by WHO’s Committee of Experts on Tobacco Industry Documents (Zeltner *et al.* (2000): 128).

⁴⁷ Pankow *et al.* (2003); Ashley *et al.* (2009); Stevenson and Proctor (2008); for research on the role of ammonia from Philip Morris, see Callicutt *et al.* (2006).

⁴⁸ WHO, Committee of Experts on Tobacco Industry Documents (Zeltner *et al.* (2000)). The members of this committee, established in 1999, were: Professor Thomas Zeltner, director, Federal Office of Public Health, Switzerland and chairman; Dr David Kessler, dean, Yale School of Medicine, USA; Dr Anke Martiny, executive director of Transparency International, Germany; Dr Fazel Randera, inspector general of intelligence, South Africa. The Committee was assisted by eight outside researchers. Freely available at: www.who.int/tobacco/media/en/who_inquiry.pdf (visited 9 January 2012).

⁴⁹ Peto and Lopez (1990); see also Crofton (1990); Simpson (1994).

⁵⁰ Peto *et al.* (1994); see also Biographical notes, page 115.

other factor was the World Bank report, *Curbing the Epidemic*, which brought up measures of what we could do in the political and economic fields.⁵¹ To my mind, these three points were the breakthrough.

McLellan: I'd like to move us to the question of the role of the Director-General in pushing the agenda.

Collishaw: I would like to come back to regulatory toxicology and pharmacology,⁵² and to something my colleague Dr Zeltner said. I think I can summarize it as: 'There are good treaties and not so good treaties.'⁵³ In the mid-1990s, in addition to my responsibilities for tobacco control, for a time I acquired other responsibilities here in the secretariat on controlling alcohol and illicit drugs as well. They didn't give me any money for those either. [Laughter] However, they did send me to Vienna occasionally and I worked with colleagues who were administering the treaties that Dr Zeltner mentioned. So, at the same time, I was trying to think of ideas to follow up on the 1995 and 1996 resolutions of the WHA: 'How were we going to create a treaty?' Like Dr Zeltner, I concluded that these narcotics-control treaties, in terms of public health, were in the 'bad treaty' class from a public health point of view; they wouldn't help us. On the other hand, with the advice and encouragement from Ruth Roemer and Allyn Taylor,⁵⁴ who had been working

⁵¹ World Bank (1999), freely available at: www.usaid.gov/policy/ads/200/tobacco.pdf, report team led by Prabhat Jha and Frank J Chaloupka (visited 1 December 2011). Demand-reduction measures suggested: raising taxes, non-price measures (bans on advertisements, counter advertisements; prominent health warnings on packaging, research findings on health consequences, restriction of smoking in public places) and nicotine replacement and cessation therapies; supply restrictions are not very successful (alternative crops, diversification, trade restrictions), with the exception of action against smuggling (prominent trade stamps on packages, local language warnings and aggressive enforcement of laws against smuggling) (World Bank (1999): 6–8).

⁵² Tobacco product regulation is covered by FCTC's Articles 9 and 10 (see page 73 and Glossary, page 122). A WHO Study Group (TobReg/IARC) working group wrote: 'Existing product regulatory strategies based on the machine-measured tar, nicotine and carbon monoxide (CO) yields per cigarette with the current ISO regimen are causing harm. By allowing communication of the yields as measures of exposure or risk, they mislead smokers into believing that low-yield cigarettes carry less risk and are a reasonable alternative to cessation. This harm precludes continued acceptance of strategies of product regulation based on per-cigarette machine-measured tar and nicotine and necessitated the development of a new approach.' WHO, Study Group on Tobacco Product Regulation (2008): 45, freely available at www.who.int/tobacco/global_interaction/tobreg/publications/9789241209519.pdf (visited 6 March 2012); see also note 172.

⁵³ For discussion of bad treaties, see page 18.

⁵⁴ See Roemer *et al.* (2005); see also Figure 3, page 22.



Figure 3: Dr Ruth Roemer (1916–2005) and
Dr Judith Mackay, WHA, May 2003.

on some of the legal aspects, the concept of a framework treaty was a more flexible instrument where you could adopt protocols and was, I saw, a good direction to go. There were other treaties in this class – many of the environmental treaties – and in particular the Vienna Convention for the Protection of the Ozone Layer and related Montreal protocol.⁵⁵ The Vienna Convention was a good model for us. It is a framework convention with very little of substance in it, other than general agreement to do something about the hole in the ozone layer, and, importantly, the authority to negotiate protocols with more detailed agreements on just how to protect the ozone layer. The subsequent Montreal Protocol is just such a detailed agreement. The Vienna Convention with its protocols were, and are, very successful international agreements. And they served as good models for preparing for negotiations on a new tobacco treaty.⁵⁶ So, these were good models, and we pushed things in that direction. They continued in that direction, and I'm happy

⁵⁵ The Montreal protocol of the Vienna Convention for the Protection of the Ozone Layer concerns substances that deplete the ozone layer opened for signature in September 1987 and entered into force in January 1989, with seven revisions. For further details, see http://ozone.unep.org/Ratification_status/evolution_of_mp.shtml (visited 8 July 2010).

⁵⁶ For the text of the Vienna Convention for the Protection of the Ozone Layer, see http://ozone.unep.org/new_site/en/Treaties/treaty_text.php?treatyID=1 (visited 19 January 2012).

to say that the FCTC eventually adopted the best of both worlds, because there are many substantive elements in the treaty itself, but it also has the capacity of having protocols added, and we're seeing one now⁵⁷ and there might be more in the future.

There is another 'bad example' I would like to talk about when I was trying to talk up the treaty in the mid-1990s – a lonely occupation. I'd say: 'Well, you know, we have the "Law of the Sea" now.' It is a book several inches thick.⁵⁸ It took 25 years of negotiations up to that point, and it had been concluded. There it was, hundreds of pages of gobbledygook and nobody can change a word in it ever again.' I said: 'We don't want one of those. We want something that's small and flexible, and is going to move with the times, because we know there are forces against us and we're going to have to be nimble and adapt to them.'

Ogwell: Many times whenever we look at this treaty, I think it is the comprehensive nature of it that will strike you, as it cuts across many aspects of society. One section that stands out to me is the one on tobacco farmers.⁵⁹ The farmers have been looked at as the impediment, the barrier, in very many instances. But the truth is, and I speak for the African region here, if it were not for the farmers, the African region would not have come out as strongly as it did.⁶⁰ Evidence was very thin in Africa as far as tobacco use is concerned. Our heads of state, especially in the mid-1990s, were a very closed group of relatively old chaps whose word, basically, was law and who didn't see the

⁵⁷ The final negotiations on a protocol to the FCTC (Article 15) on 'Illicit trade in tobacco products', were conducted at INB-5 in March–April 2012 in Geneva, see www.who.int/fctc/protocol/illicit_trade/en (visited 31 January 2012).

⁵⁸ The UN Convention on the 'Law of the Sea' began with the work of the Seabed Committee in 1968, was adopted in 1982 and came into force in November 1994 with 60 signatories. For further details, see www.un.org/Depts/los/convention_agreements/convention_historical_perspective.htm#The%20Future (visited 8 July 2010). For details of these precedents, see <http://apps.who.int/gb/fctc/PDF/inb6/einb6id2.pdf> (visited 19 July 2010).

⁵⁹ The International Tobacco Growers Association (ITGA) describes itself as a non-profit organization founded in 1984 to represent the interests of the tobacco farmers, with members from Argentina, Brazil, Canada, Malawi, US and Zimbabwe, of which only Brazil and Canada have ratified the FCTC. Its role is 'presenting the cause of millions of tobacco farmers to the world...to provide a strong collective voice on an international and national scale in order to ensure the long-term security of tobacco markets...run as a three-person organization from its headquarters in the eastern Portuguese city of Castelo Branco.' See www.tobaccoleaf.org/conteudos/default.asp?ID=7&IDP=2&P=2 (visited 28 November 2011). For further discussion, see pages 24, 41, 42, 54 and 56.

⁶⁰ Of the 46 countries in the WHO African region, Eritrea, Ethiopia, Malawi, Mozambique and Zimbabwe have not ratified the FCTC.

link between tobacco use and health. The information coming from farming communities is what galvanized the need to broaden any tobacco control issues with the interests of the farmers. If the interests of the farmers had not been well catered for, the African region would probably not have played the key role that they did during the negotiations. Farmers, for us, have contributed a lot to the success that brought together the whole of the African region, because we have some very key tobacco growing countries, whose leaders were pretty influential on the African continent and whose resistance to a position that would not include solutions for them would have actually resulted in a very big barrier.⁶¹ When there was appreciation that the farmers would be catered for, the comprehensive nature of discussing the convention as an agricultural issue, as a development issue, under the WHO then that made a lot of the countries comfortable enough to be able to go along with what their public health colleagues were proposing. So when farmers are considered – in fact they are exposed more than any smoker, any chewer of tobacco – because their work is with tobacco every day, all day. The level of exposure they have to tobacco as a plant is more than can be said of any other tobacco users and their experiences resulted in the pressure for colleagues, especially from the African region, to take them into account during the negotiations. I think this was key in opening up the multi-sectoral nature of the treaty that we have today. There are many things that can be said negatively about the farmers but, for me, they were the original anti-tobacco lobby, because they suffered this health risk every day. Whenever we look at the history, the farmer is the original anti-tobacco lobby.⁶²

⁶¹ Commercial tobacco growers in Africa include Kenya, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe among others.

⁶² Ms Kathy Mulvey wrote: 'I have some concerns about this representation of the motives underlying African solidarity and leadership on the FCTC. As I remember it, the strong positions of the AFRO region were driven primarily by a desire to stop the spread of this preventable epidemic – and its negative health, social and economic consequences. African leaders pushed for the concerns of farmers to be addressed, in large part because the tobacco industry was spreading misinformation and attempting to divide the region. See the Johannesburg Declaration of March 2001 (www.who.int/inf-pr-2001/en/note2001-04.html, visited 21 July 2010) as the initial expression of a unified African position. See also the 1999 WHO/World Bank monograph *Curbing the Epidemic* on pages 21 and 30 and for insights into the tobacco industry's strategy, see Carter (2002).' Note on draft transcript, 20 July 2010. Dr Ahmed Ogwell wrote: 'My point was and still is that by addressing the issue of farmers we brought everybody in our region on board. Not doing this would have been divisive and we avoided that by ensuring that the FCTC was encompassing all issues, particularly including alternative livelihoods for tobacco farmers.' Note on draft transcript, 2 April 2012.

Assunta: Earlier, someone queried how many resolutions there have been at the WHA since 1970. There were 17. When I discovered the number of resolutions by the WHA sometime in the 1990s, I used to wonder how our governments kept going to the WHA, why they kept drawing up resolution after resolution, to come back home and do so little? It was one of the questions that I asked myself.

Coming from a developing country and starting to do tobacco control in the 1980s, I found that there was very little documented evidence or information that I could obtain from Malaysia or from other developing countries. So I appreciated the documentation that was put out by WHO. I also appreciated all the wonderful reports that came from the US and the UK⁶³ and from our colleagues who had started on this work much earlier. I used to try to localize some of those reports, so that I could put together information to take to my government and ask for policy change. Without that information my government would come back to me and say: ‘That’s in the US; it doesn’t apply to Malaysia.’

Having said that, I also found that in the international arena – this was particularly so in the mid-to-late 1990s when I started to get involved in international tobacco control – that the perspective from developing countries was lacking. Many of the policy measures being proposed would work very well in an environment where considerable effort had already gone into tobacco control, along with freedom of information and freedom of the press. Those conditions might not necessarily apply to some countries in my part of the world. Therefore I took it upon myself to ensure that I would carry the perspective of developing countries to the international arena, bringing a different perspective and a different sense of reality to some of the policy measures. Having said that, of course, I had a particular interest in tracking the transnational tobacco companies and the big three: Philip Morris, BAT (British American Tobacco) and Japan Tobacco. I knew that to address the smoking epidemic we needed international action, that there was very little that I could accomplish working in Malaysia alone.

⁶³ See, for example, Doll and Hill (1950, 1952, 1954, 1956a and b, 1964a and b, 1966); see also Larson *et al.* (1961); for details of Glantz’s work on tobacco control in the UK, see Berridge *et al.* (2006): 35–6. For post-Doll and Hill tobacco industry tactics, see Brandt (2012).

Company	Global Market Share (%)	
	2000	2008
Philip Morris International	15.5%	17.4%
Altria/Philip Morris USA	3.8%	2.8%
British American Tobacco	11.0%	12.0%
Japan Tobacco International	7.2%	9.6%
Imperial Tobacco	0.8%	4.9%
China National Tobacco Corporation	33.3%	37.1%
Other	32.2%	19.0%

Source: *The Tobacco Atlas*, 4th Edition. Chapter 18. Tobacco Companies. Data derived from ERC. (2010). World cigarette reports 2010.

Table 4: Global cigarette market share, per cent of total number of cigarettes produced, 2000 and 2008; see also Table 3, page 17.

My third point has to do with the treaty-making process: I had zero experience or knowledge in treaty-making, and you know that very often in international treaty-making, developing countries do not provide leadership or drive the process. Therefore I had very little experience to fall back on, or even people to talk to in Malaysia when I was trying to find out what one could do. Where does one start with treaty-making? I was starting from scratch.

So it was quite difficult, because we had very little information. Therefore I had to talk to my friends from the north and I proceeded to participate in the start of the FCTC negotiations, armed only with strategies in international tobacco control, learning as I went along. I think this also applied to many of my colleagues from developing countries.

Cunningham: In terms of what preceded the FCTC, I think one very important factor was successful country experience in many of the subject areas that became the articles of the FCTC. We had many countries that had banned advertising; we had learned the arguments and counter-arguments – how to defeat the tobacco industry on that issue.⁶⁴ We had the experience that partial advertising bans were inadequate. For package warnings and labelling, Brazil banned light and mild descriptors in 2001, followed by adoption of the European Community Directive later in 2001. That was incorporated as it was

⁶⁴ Framework Convention Alliance (2005); ASH (1996); World Bank (1999).

in Article 11.⁶⁵ Canada's picture warnings were adopted in 2000, followed in 2001 by adoption of the EC Directive with optional use of picture warnings, and by Brazil's requirement for picture warnings.⁶⁶ These formed the basis for Article 11. If you look at liability, had the FCTC been negotiated ten years earlier, it would have been far weaker. Even a section on liability, you know, on taxation, was good. We had lots of country experience on taxation and we were able to say conclusively that taxation decreases consumption.⁶⁷ Areas like cessation or education or sales to minors, were all influenced by country experience.⁶⁸ We also had people who had been working on the issue for many years, inside of government and outside. There was some capacity to successfully influence the negotiations, with fairly strong content for many issues. There was also recognition that this was the right thing to do, in terms of tobacco control. Why do we have the FCTC? It's the right thing to do. I think many people in many countries – more in developing countries, but also some in developed countries – said they needed help. They wanted to do this, they were faced with tobacco industry opposition, they faced opposition from other parts of government. This treaty would help them, and they were right. Those are some of the things that preceded the FCTC.

Mackay: I would like to document the role of Ruth Roemer in this, because I think history demands it. In 1993 Ruth Roemer read an article by Allyn Taylor in the *American Journal of Law and Medicine* calling on WHO to use

⁶⁵ For the Brazilian ban on tobacco advertising, RDC n° 46 of 28 March 2001, see www.tobaccocontrol.org/legislation/country/brazil; for the European Community's ban on tobacco advertising, see note 139 and Directive 2001/37/EC of the European Parliament and of the Council of June 5 2001...concerning the manufacture, presentation and sale of tobacco products, *Official Journal of the European Communities* L194/26 at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:194:0026:0034:EN:PDF>; for details of the European implementation of the FCTC, see and www.smokefreepartnership.eu/IMG/pdf/ers-SL-01.pdf; for a discussion of deceptive labels 'mild', 'light', etc., see note 21. For the provisions of the FCTC, see Appendix 1, page 73 and at www.who.int/tobacco/framework/WHO_FCTC_english.pdf, page 9–10, and a database of pictorial health warnings at www.who.int/tobacco/healthwarningsdatabase/en/index.html (all sites visited 21 February 2012).

⁶⁶ For the Brazilian requirements for picture warnings, RDC n° 104 of 31 May 2001, see www.tobaccocontrol.org/legislation/country/brazil; for regulations in Canada, see Tobacco Products Information Regulations, SOR/2000-272, see <http://laws.justice.gc.ca/eng/regulations/SOR-2000-272/20110922/P1TT3xt3.html> (all sites visited 21 February 2012).

⁶⁷ See also note 27, page 69 and Appendix 5.

⁶⁸ See note 187.

a legal mechanism for the ‘health for all’ goal.⁶⁹ Ruth Roemer contacted Allyn Taylor and suggested that she applied her ideas to tobacco control. So there was a twin birth. What then happened was that Ruth Roemer met with me at a meeting in the US on 26 October 1993 and said to me: ‘Has WHO ever thought of having a convention?’ I replied: ‘Oh, they have conventions all the time. The last thing they want are more conventions,’ thinking she was meaning meetings, such was my ignorance of this possibility at the time. She said: ‘No, no, I don’t mean meeting-kind-of-convention, but having a UN-style convention on tobacco issues.’ We discussed this and she said: ‘You are a WHO consultant. Can you go back to WHO with the idea?’ My initial role was as a messenger. Commensurate with that was that Ruth and I drafted a resolution for the 1994 Conference on Tobacco or Health, which called upon WHO to adopt a tobacco control convention. This is why this treaty has its roots in civil society. Frankly speaking, I think it is true to say that in 1993, 1994, 1995 – while Neil was struggling on his own at HQ – the resolution had a very bleak reception in WHO. The first thing that was said was: ‘It takes ten years to develop a treaty.’ Well, that’s fine, ten years passes, as indeed we know. ‘It was too difficult; it was a very different mechanism from anything that WHO had undertaken.’ I have to say there was a lot of very negative caution, and even antagonism, towards the idea. And then, what Ruth did was to draft a lot of preparatory papers, which went to the United Nations Conference on Trade and Development (UNCTAD), which then went backwards and forwards. I think the role of the late Ruth Roemer needs to be most clearly placed in this history,⁷⁰ and that of Allyn Taylor. Of course, when we come to Dr Brundtland’s role as Director-General (DG) of WHO, I can certainly explain how tobacco control came to be her cabinet project.

The second thing I would just like to comment on is Dr Zeltner’s comments about the tobacco industry documents. I think it came as a shock to all of us to realize how early on the tobacco industry had been tracking us, looking at us, criticizing WHO internally,⁷¹ much earlier than we ever dreamt of. The

⁶⁹ Dr Halfdan Mahler, WHO Director-General (1973–83), set ‘Health for All’, as one programme goal of WHO, in 1981 (Mahler (1981); WHO (1981)).

⁷⁰ See Biographical note for Dr Ruth Roemer (1916–2005) on page 115.

⁷¹ Dr Judith Mackay wrote: ‘There are 13 million tobacco industry documents with 70+ million pages that can be accessed and searched at: <http://legacy.library.ucsf.edu/> (visited 14 February 2012).’ Note on draft transcript, 26 January 2012. See also note 42.

documents gave us a sense of betrayal, because they showed that many of our colleagues, in public health in particular, had been paid off by the industry to deny the evidence, particularly on issues of passive smoking, and to try to obstruct tobacco control legislation. In most countries in Asia there were two or three people who had been recruited, including people I myself knew in Hong Kong – I was shocked, really shocked, to realize that the tobacco industry had recruited colleagues. It was called Project Whitecoat in Asia. They recruited the whitecoats, that is, the doctors and scientists, and paid them to try to obstruct tobacco-control measures.⁷²

Although it pre-dated and was in a sense divorced from the treaty, I think another key event was in 1985, when many of us were working separately all over the world in tobacco control. The American Cancer Society (ACS) held a meeting in Washington, DC, which in true American style was called the First International Summit of World Smoking Control Leaders [laughter],⁷³ which slightly amused the non-Americans in its grandiose terminology. But many of us met together then for the first time and realized what was happening in other countries. It was the first time I personally met colleagues from China, for example, which was a very, very important connection as it so happened. I think the ACS needs to be recognized for having facilitated the particular meeting that brought us all together.

My final plea is that when this is all written up, may we use the term ‘low- and middle-income countries’ rather than ‘developing’ and ‘developed’? I can argue this forever, but the former term does give respect to developing countries, and the latter is erroneous in so many respects. I put that plea on the table.⁷⁴

⁷² For an example of ‘whitecoats’ documents, see <http://legacy.library.ucsf.edu/tid/yqu78e00> (visited 16 November 2011). For one background on ‘fake experts’, see Hirschhorn (1999) at www.globalink.org/tobacco/docs/secretdocs/whitecoat.shtml (visited 9 July 2010); Diethelm *et al.* (2005, 2009).

⁷³ In September 1985, world smoking control leaders from 39 countries recommended that a task force from major international non-governmental health organizations be convened, chaired by Dr Charles LeMaistre, then ACS national president. See http://tobaccodocuments.org/pm/2501109726-9727.html?pattern=&ocr_position=&rotation=0&zoom=750&start_page=1&end_page=2#images (visited 9 July 2010). LeMaistre was a director of Enron Corporation (1985–2001). See also page 15. A list of the 1985 international experts, provided by Dr Judith Mackay, will be deposited, along with other records of this meeting, at GC/253, archives and manuscripts, Wellcome Library, London.

⁷⁴ Participants’ own descriptions of countries have been retained throughout.

da Costa e Silva: By the end of the 1990s, Brazil already had almost 15 years of tobacco control and many measures were already in place.⁷⁵ At this point in WHO, by the mid-1990s, either colleagues like Neil or consultants like Judith were promoting the idea that a treaty was needed. The first person I heard talking about a convention was Neil. He said: ‘We need a Framework Convention on Tobacco Control’, and at that point, I could not understand what it was all about. Additionally, through the commitment of some people from key organizations and countries and from those that were part of the executive board, efforts were made to establish a strategy, which was fully supported when Dr Brundtland joined WHO.⁷⁶ Some factors impacted on the momentum that resulted in the establishment of the treaty’s negotiation mechanism, including the creation of a cabinet project at the TFI, which was absolutely relevant for tobacco control. Furthermore, Thomas Zeltner’s committee study on the interference of the tobacco industry on WHO’s policies created indignation against the tobacco industry’s misleading strategies to oppose public health.⁷⁷ WHO had also funded the World Bank’s economic study *Curbing the Epidemic* as a strategy to bring the World Bank on board, giving the intersectoral dimension and visibility to the real economic arguments about the problem and also bringing in the global aspects of the tobacco epidemic.⁷⁸ In the end, Brazil was invited to co-chair the first intergovernmental working group that prepared the basis of the treaty negotiations,⁷⁹ along with China – both tobacco-growing developing countries – and chaired by Finland, a member state from the executive board pushing for the treaty negotiation, and having Japan as rapporteur, a country that had a very strong tobacco industry influence at that point.⁸⁰ I think

⁷⁵ Dr Vera Luiza da Costa e Silva wrote: ‘Brazil has banned misleading descriptors on cigarette brands through a legally binding resolution from the Brazilian regulatory agency, Agência Nacional de Vigilância Sanitária (ANVISA) resolution issued in March 2001.’ Note on draft transcript, 26 January 2012. Freely available at http://portal.anvisa.gov.br/wps/wcm/connect/62382e804745885f91e3d53fb4c6735/A_ANVISA_E_O_CONTROLE_DOS_PRODUTOS_DERIVADOS_DO_TABACO_PORT_De08_M_AC.pdf?MOD=AJPERES (visited 27 January 2012); see also www.who.int/bulletin/volumes/87/11/09-031109/en/index.html (visited 28 October 2011).

⁷⁶ See note 6.

⁷⁷ See Zeltner *et al.* (2000).

⁷⁸ World Bank (1999); see also notes 51 and 109.

⁷⁹ See, for example, Lee *et al.* (2010).

⁸⁰ For a review of China’s progress in tobacco control during six years since ratification of the FCTC, see Gao *et al.* (2011); for a discussion of Japanese tobacco control, see Kolandai (2007); see also Appendix 5, page 81.

this was all about using successful strategies at WHO, with the support of those people who were either part of WHO, friends of WHO or consultants to WHO. Anyway, this was to bring WHO member states on board to start to negotiate the treaty. Finally, selecting Brazil to chair the negotiation of the treaty for the same reasons, because Brazil was a big tobacco-growing country and, furthermore, already had a strong tobacco control movement at that point, has proven to be the right choice.⁸¹ This is how I perceived the process of initiation of the practical negotiations of the Framework Convention.

Bhattacharya: I have a question, perhaps, that links us to the second theme to be discussed. One of the things I'm not hearing about is what happened during the Nakajima tenure.⁸² Specifically, I understand that there was a Swiss government report about conflict of interest in relation to the tobacco industry.⁸³ Did that report have any impact on fuelling the move towards FCTC, I wonder?⁸⁴ It's just an innocent question from an historian.

⁸¹ See notes 65 and 66.

⁸² Director-General Nakajima asked Dr Judith Mackay in spring 1995 to conduct a formal review of the WHO Programme on Substance Abuse (which included tobacco), and she wrote: 'I strongly recommended an FCTC as a core component of future development. In May 1995, WHA Resolution WHA48.11 outlined the concept of an international strategy for tobacco control, which marked the start of the formal WHO process.' (Mackay (2003): 551). Dr Nakajima wrote in 1997: 'Tobacco-related diseases represent a global problem of epidemic proportions. This transnational health issue should also be a matter of concern for foreign policymakers.' (Nakajima (1997): 327). Samet *et al.* (1998a) reported on the deliberations of working groups at the Tenth World Conference on Tobacco or Health in Beijing and these were published in the *British Medical Journal*. See also Nakajima (1995); notes 85, 86 and 87.

⁸³ Lee and Glantz (2000). The report, prepared in response to a request from the WHO's Tobacco Free Initiative and available at: <http://www.library.ucsf.edu/tobacco/swiss> (visited 27 January 2012), remarked: 'A first comprehensive 5-year tobacco prevention program, 1996 to 1999, issued by the Swiss Federal Office of Public Health lacked adequate financial resources, focus on specific interventions, cooperation between partners for tobacco prevention, and program coordination and management. It ignored the role of the tobacco industry.' (page 3). Dr Thomas Zeltner wrote: 'The co-author Chung-Yol Lee had been a collaborator of the Swiss Federal Office of Public Health for couple of years. Before joining the team of the office, Yol Lee spent time as a research associate at a certain time at Stan Glantz's lab. He had a grant from the Swiss National Science Foundation. The report (Lee and Glantz (2000)) was not, however, commissioned by the Swiss Government or the Federal Office of Public Health. The report got some media attention in Switzerland when published at the time. I don't know, however, whether it had any impact on the elaboration of the FCTC.' Note on draft transcript, 30 January 2012.

⁸⁴ Dr Judith Mackay wrote: 'There have been three reports on this: Zeltner (2000); Lee and Glantz (2000) and WHO, TFI (2008).' Note on draft transcript, 26 January 2012.

Zeltner: Good question and I can't give you an answer. But maybe Neil can, because, yes, I know, we were always a little puzzled about a couple of things of transparency in WHO, Nakajima's election included.⁸⁵ But I don't know whether the Swiss request had any impact.

Collishaw: I was in the secretariat in the 1990s and I'm not aware of the report you're talking about, so I would guess it didn't have much impact. However, I can say your question pertains to the role of the Director-General's office. Certainly Dr Nakajima – the DG for most of my tenure in WHO – was always very interested in tobacco control.⁸⁶ He was supportive of what we were doing. He was not particularly successful in attracting funding from member states for tobacco control.⁸⁷ He was somewhat successful particularly with respect to his home country, but other than that, perhaps not so successful. But he was interested in tobacco control. It was not an initiative of the Director-General's office that we ought to be working on a convention, but he did not put up roadblocks to any such development, and certainly he was interested in stronger tobacco control and made many speeches in that regard.

However, in the early 1990s, as both Judith and Vera have alluded to, this was a very unfamiliar concept and there were few people in this institution who understood what tobacco control was about. Previously WHO had been

⁸⁵ Dr Hiroshi Nakajima (b. 1928), the first Japanese to lead a UN agency and a specialist in drug monitoring and evaluation, directed WHO Western Pacific Regional Office, Manila, before becoming Director-General (1988–98). See Lewis (1988); “Fire in the global village” is how Dr Hiroshi Nakajima termed the tobacco epidemic’ at the Tenth World Conference on Tobacco or Health, Beijing (WHO (1997b)).

⁸⁶ A 1998 editorial in *Tobacco Control* noted: ‘WHO had let its practical commitment to tobacco wither away, from a staff of 10.5 in the early 1990s, to just 3.5 by early 1998, and from four regular budget posts to one. This had come about through a lack of senior-level advocacy on tobacco within WHO, the apparent demotion of the Tobacco or Health Unit (TOH) by its absorption into the Programme on Substance Abuse, and cutting, freezing, or sharing of TOH positions, ending up with only one full-time staff member (and that a one-year post ending in December), and the other two posts being spread over five people, all part-time or temporary.’ Anon. (1998): e227. For alternative analyses, see Walt (1993); Godlee (1993, 1994a–c, 1995a–b, 1997, 1998a–b)). Note that Godlee retracted some of her previous *Lancet* analysis following the release of the tobacco legacy documents (Godlee (2000)), see note 46 and Zeltner *et al.* (2000): 128.

⁸⁷ The Zeltner committee wrote: ‘It would appear that WHO is unwilling to boost the [Tobacco or Health] programme significantly, either in terms of budget or status within the Organization [WHO] for fear of offending its biggest budgetary contributor, the USA, whose pro-tobacco lobby is still powerful in Congress, a body that loses no opportunity to threaten the UN system with cuts in funding.’ Zeltner *et al.* (2000): 37. Quote cited from CASIN, 11 January 1991. British American Tobacco Company. 300557237–7259 at 7241. Guildford Document Depository. UQ 33350. The Guildford depository is run by BAT. For difficulties searching the tobacco documents, see Zeltner *et al.* (2000): 27.

devoted to public health and science and didn't bother with conventions at all. I have to say that my initial reaction was supportive when Ruth Roemer first broached the subject with me in 1994 after she'd spoken to Judith about it. My initial reaction was supportive but cautious. But over time, I became very enthusiastic and by late 1994 I'd become a fervent in-house advocate of the concept to the extent that a public servant in this place can be an advocate of anything. [Laughter]

However, there was some suspicion about it and in 1995, after the initial resolution calling for a feasibility study to look at whether this could be done, it was adopted. I became aware that this was like waving a red flag in front of our legal counsel. Since the WHO had such good success in the past without conventions, our legal counsel pretty much had a policy that we didn't like conventions in WHO: 'They were just a bunch of trouble in the other branches of the UN and we weren't going to have them because they'd get in the way, because, after all, who could be against getting rid of smallpox?' Or 'Who could be against getting rid of onchocerciasis?'⁸⁸ Some of these other success stories of WHO, to which I obviously replied: 'Well, there are lots of people who are against getting rid of tobacco, including those people who sell it to you.' So the legal department and I had many discussions, and, I think that if it were up to them, which, of course, it was not, they probably would have said: 'Let's not have one of those.' But, of course, it was not up them; it was up to the WHA. When the WHA adopted the 1996 resolution there was not much room for the legal department to continue with its opposition. Now, I'm sure Doug would say some of his strongest support comes from the office of the legal counsel in operating this treaty.

Bettcher: There's a missing link here: at the World Conference on Tobacco or Health in Paris in 1994, a resolution was adopted supporting the idea of an international law for tobacco control.⁸⁹ As I recall it was an NGO movement in Canada that linked up with the Canadian government after the World Conference in 1994 to promote the idea of a treaty for tobacco control. In this regard, a name that hasn't appeared in our history is Dr Jean Larivière, who was the head the Canadian delegation to the WHO executive board in January

⁸⁸ The eradication of smallpox was certified in 1979 by WHO (see WHO factsheet at: www.who.int/mediacentre/factsheets/smallpox/en/ (visited 14 November 2011)). For details of the WHO onchocerciasis programme, see www.who.int/topics/onchocerciasis/en/ (visited 18 October 2010); see also page 44.

⁸⁹ For resolution WHA48.11, 'An international strategy for tobacco control', see www.who.int/tobacco/framework/wha_cb/wha48_11/en/ (visited 28 November 2011). For a contemporary report on the Ninth World Conference on Tobacco or Health, see Simpson (1994): 302.

1995. Larivière got a caucus of countries together in January 1995, despite the caution of the legal counsel of WHO, to get a resolution to do a feasibility study on a possible treaty solution to be commissioned. He continued to support the idea of a treaty in the executive board in January 1996, which led to the first launch of the idea of a tobacco control treaty, not the mechanism to negotiate it, but just saying it should be done. The name of Jean Larivière is an important part of the history.

Assunta: I want to put on record that an article by Roemer *et al.* called ‘Origins of the WHO FCTC’ captures quite a bit of this and appeared in June 2005.⁹⁰ To take off from the point that Doug made about Larivière, Roemer and Taylor presented an outline of the treaty on 27 July 1995, the options for an international legal strategy to WHO, and on 28 July a letter was sent in reply to Roemer criticizing the proposal as ‘ambitious, to a fault’ and that it was important to be ‘realistic’. The recommendation was that there should be a non-binding code instead. We have Drs Kimmo Leppo from Finland and John Hurley from Ireland to thank, because they sponsored the resolution, which went up at the WHA in May 1996.⁹¹

McLellan: I’m going to move along to a quick question, which I want to spend a few minutes on, and then to what I think is the heart of this history today, which is country experience, NGO experience, and to get the kind of tales on record that have not been published. So, we’ve got Mr Collishaw sitting in his office with no money and no staff; probably Dr Zeltner is in the same position, and maybe others of you. How would you characterize the importance of the influence of one person at that time – the Director-General – on moving this forward? You only get three sentences each.

Mackay: I was on Dr Brundtland’s transition team. She was looking for a second cabinet project: malaria was already a done deal,⁹² so she invited different specialties to make a presentation. Sir Richard Peto from Oxford,⁹³ and Neil Collishaw and I put forward to her the idea that tobacco could be a very appropriate project, she accepted that and the rest is history.

⁹⁰ Roemer *et al.* (2005).

⁹¹ See WHO, FCTC Secretariat (2010); see also note 92.

⁹² ‘Roll back malaria’, the RBM partnership, was launched in 1998 by WHO, UNICEF, UNDP and the World Bank, in an effort to provide a coordinated global response to the disease.

⁹³ For a contemporary description of Richard Peto’s work in China, see Anon. (1999). For tobacco-induced mortality in China, see Liu *et al.* (1998); Peto *et al.* (1999); Lam *et al.* (2001); see also Chen *et al.* (2003).

Zeltner: I think Dr Brundtland was very instrumental. She was, to some extent, I think, torn. One interesting point is that she had hired a bunch of very active people like Derek Yach and Chitra Subramaniam, and others in the headquarters of WHO didn't like it. I recall, and we will come back to that in a minute, when these people in the tobacco programme started looking at the documents of the tobacco companies and made the preliminary report, which showed that there had at least been trials to influence WHO.⁹⁴ I don't know whether someone can expand on this, but there was a debate very close to her: 'Do we need to look into that or don't we need to look into that?' Of course, the tobacco-control people said: 'Yes, we need to' and others wanted not to do so, because they thought it would be such a big mess and so difficult to consider. But, in the end, she decided: 'Yes, we must do that before we start getting into the Framework Convention'. Again, two things were important: the tobacco industry documents were key, because they pushed the agenda such that WHO and the DG couldn't look away.⁹⁵ The second very interesting thing is to see how a couple of key people could move things along very fast. The history of public health is also a history of personal courage, seizing the moment and saying: 'We can and need to do something.' Dr Brundtland was certainly very instrumental in that.

Bettcher: Courage certainly is an important variable. Everyone can agree that Dr Brundtland is a very courageous person. If you embark on using Article 19 of the WHO Constitution for the first time, you can't be a timid DG. She's not like that. She's been known all the way through her political career as having courage and foresight. She played a critical part in this undoing of WHO's conservative, very narrow model of public health; this idea that you can't have legal instruments and the WHO is afraid of messy political negotiations and all that stuff. She had been, as you remember, the commissioner of the Sustainable Development Commission for the UN Secretary-General in the 1980s. She knew all about complex negotiations.⁹⁶ She was the Norwegian prime minister three times, so she was much attuned with how health links with foreign affairs, how it links with different sectors, how it links with social determinants and

⁹⁴ Zeltner *et al.* (2000); see also note 6.

⁹⁵ See page 19; for the companies named in the 1995 settlement, see note 45.

⁹⁶ The Brundtland report, *Our Common Future*, was published in 1987 by the World Commission on Environment and Development, 'called for' by the General Assembly of the UN. The report laid out the concept of sustainability as containing environmental, economic and social aspects, freely available at: www.un-documents.net/wced-ocf.htm (visited 15 November 2011).

how negotiations can be a messy mud fight. But she was committed that WHO had to do it, had to get in there and had to stand up for the truth and what is right. Also, she realized you can't do that with the small budget that WHO had for tobacco control. WHO said: 'Of course, tobacco control is a great priority, it's a total priority, it's the largest preventable cause of death.' But poor Neil only had one staff member with him, and there was one regional adviser in Europe working on tobacco control almost full-time; for other regions there were only staff working part-time for tobacco control. So Dr Brundtland said: 'We have to have a platform for this. We need a high-level cabinet project in WHO to advance tobacco control, and this project is very important. The tobacco-control group must be accountable to me. It's got to be accountable to my office, to my cabinet. I'm going to watch the negotiation of the treaty closely. I'm going to make sure this is a success. It's got to have money, and we've got to do it now, and we have to get moving, and we have to develop the mechanics for the negotiation to proceed.' WHO had never had a notion of how to develop a treaty negotiation-making apparatus, so she sent us out in the field to the other treaty secretariats to get the precedents and get moving with the precedents to develop the mechanics to do this. She also established a new budgeting system.

Before, we had a kind of system for planning our budget that was like a patchwork quilt. It was a lot of little things, and we never really knew what the priorities were. She developed a notion of budget prioritization in the WHO, and tobacco became one of the top priorities. The prioritization was done on the basis of disease burden, death and the potential to make a public health impact, which also put tobacco up towards the top. We were then placed in a situation where we could do this. We were living in the real world. When she retired, I remember, in July 2003, Dr Brundtland was quoted on the BBC in answer to the question: 'What were your greatest successes of your administration?' She said: 'Controlling SARS and the adoption of the Framework Convention on Tobacco Control.'

da Costa e Silva: One very important aspect here, apart from WHO's political priority, is that the financial resources were often scarce and insufficient for the TFI, Dr Brundtland's cabinet project, established in 1998. Some funds were regularly allocated to the initiative after the establishment of TFI, but for the treaty negotiation and regular tobacco control activities implemented by WHO, neither TFI nor even the non-communicable disease cluster has hardly ever received financial priority. At one point TFI was getting less than 1 per cent of the organization's total budget, considering the global burden of

diseases and deaths caused by tobacco use.⁹⁷ As a result, there was no regular budget allocated for most meetings held during the negotiation period of the treaty. There was a need to identify another budget line in order to run the treaty-related activities. In fact, there were many competing themes and the treaty was only one among WHO's many priorities, and, as a result, funding had to be identified for every single session of the negotiation. This was a real battle during the entire period of negotiation. I think that neither tobacco control, nor even non-communicable diseases in general, had ever received more than insufficient funds to fully move the agenda requested by member states. Even though the treaty negotiation was seen as a top priority and even though this was a cabinet project, the tobacco control agenda never received a sound regular financial contribution for its implementation. Nevertheless, the project's progress was due to more than financial resources: it was about people's commitment and political will.

Mulvey: I'll get a word in here as another loud-mouthed American. A lot of what people have been describing here is the transformation of tobacco control from a public health issue to a political issue for the public health community. For the tobacco industry, and for the tobacco transnationals in particular, all along it has been a political and economic issue, but it was a learning curve, in which the Director-General played an instrumental role. I think that initiating the inquiry (Zeltner committee) when the tobacco-industry documents became available⁹⁸ was the first point that we as an NGO noticed the stepping up of WHO activity around this subject, and applauded it. This decision and the report by Dr Zeltner's committee led to a further series of decisions within this process, which took account of tobacco control as a political and economic issue.⁹⁹ It led to the decision not to give the tobacco industry a role in the negotiating process, which was fundamental to the success of the convention, it led to WHA Resolution 54.18 on transparency in tobacco control,¹⁰⁰ it led

⁹⁷ One critic suggested that \$8m of the more than \$9m budget for TFI in 2000–01 came from outside sources, including pharmaceutical companies supplying nicotine replacement therapy. See www.forces-nl.org/WHO/ (visited 13 December 2011); for a similar stance, see Scruton (2000).

⁹⁸ See pages 19–20.

⁹⁹ See Zeltner *et al.* (2000); see also note 48.

¹⁰⁰ For the 2001 resolution WHA54.18 on transparency in tobacco control, see www.who.int/tobacco/framework/wha_cb/wha54_18/en/index.html (visited 21 July 2010).

to the inclusion of Article 5.3 in the convention itself,¹⁰¹ and it is still playing out in the implementation of the convention now.¹⁰² I think the other point where the leadership was critical was in looking for a new partnership with civil society and evolving WHO's work with civil society beyond where it had been in the past. We, as Infact then,¹⁰³ were asked to conduct a study of the role of NGOs and the media in mobilizing support for other international codes and conventions in the environmental field.¹⁰⁴ But also here at WHO itself, where the only other time that WHO had taken on a commercial issue, the code of marketing on breastmilk substitutes, which had helped to demonstrate that a code wasn't a sufficient instrument for this political issue.¹⁰⁵

Bettcher: Exactly what I wanted to say: she had been a head of state. When things got dicey, she could phone heads of state. When it got messy, she could phone them up and say: 'Get your act together!'

Pötschke-Langer: For me, three points were of interest. Dr Brundtland was very popular, a charismatic personality with a high reputation, especially in the European region. Governments as well as NGOs appreciated her very much. The second was about the creative team, a team of fantastic people, enthusiastic and also very motivating. This team succeeded because of one very important thing: building up a network. I must remind you that one TFI programme was called 'Don't be duped, the change agents programme'. People from all regions were

¹⁰¹ See guidelines for implementation of Article 5.3 (2008), online at www.who.int/fctc/guidelines/article_5_3/en/index.html (visited 21 July 2010); see also note 102.

¹⁰² For documents reporting discussions during the implementation of the FCTC, see <http://apps.who.int/gb/fctc/> (visited 14 November 2011). Activities prohibited by Article 5.3: partnerships, non-binding or non-enforceable agreements between tobacco industry and governments; contributions by tobacco industry to government; tobacco industry-drafted legislation or policy, or voluntary codes as substitutes for legally enforceable measures; investments by governments or public officials in tobacco industry; tobacco industry representation on government tobacco control bodies or FCTC delegations. See www.14wctoh.org/abstract/abstract/NCPA/09%20-%20March/1330%20-%201500%20hrs/Experimental%20Theatre/Why_Securing_Article_5.pdf (visited 5 December 2011).

¹⁰³ Ms Kathy Mulvey wrote: 'The organization changed its name from Infact to Corporate Accountability International in 2004.' Note on draft transcript, 20 July 2010.

¹⁰⁴ WHO, TFI (1999a), WHO/NCD/TFI/99.3, prepared by Infact.

¹⁰⁵ See WHO, TFI (1999a and b), freely available at http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.3.pdf and http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.4.pdf (visited 16 December 2011); see also Crowther *et al.* (2009): 25–6, 35, 43–8, 54–5; WHO/UNICEF (1989).

taught and empowered.¹⁰⁶ The capacity-building process was done with NGOs and individuals in the regions. The last point was that we also set up a health communication network, very well run by Franklin Apfel.¹⁰⁷ He worked at the WHO regional office for Europe (EURO) together with Chitra Subramaniam at the WHO headquarters and made a tremendous success of communicating about tobacco control. I think it was very important to involve the media.

McLellan: I'm going to ask Dr Ogwell in just a minute to restart our discussion on the role of countries: 'What was the role of countries in making the Framework Convention possible?' I was very struck by your observation about farmers being an important part, and I'd like to hear from the rest of you as we discuss the role of countries. If there is something very specific that stands out for you about how countries either helped, or perhaps, impeded your work?

Ogwell: I was going to take a different position in as far as the DG's office is concerned – and not negatively – before I talk about the country level. Not negatively. The question for me is: 'What should the DG's office role be?' We have a lot of praise for Dr Brundtland, and I think her leadership was excellent, spot on. It has not been repeated in any field of public health to date, at least from the way I read public health. But she was doing exactly what someone in her position should do. Are we, in retrospect, saying that the others who were in leadership were not doing exactly what they should have done? Is that why she stands out so far ahead of everyone? This is what has been playing on my mind. I think your students of public health history need to dig into some of these questions. She did well – way, way above average. But was she being compared with average people or people below average? This is a good question. [Laughter]

Now, let's go to the role of the countries. At least from the Kenyan angle, I will say that we suffered some of the very early pressures from the industry when it came to the negotiation of the FCTC. The first days when we were developing

¹⁰⁶ 'Tobacco Kills – Don't be Duped', a two-year UN Foundation-sponsored project on media and NGO advocacy for policy change in 1999, was piloted in 16 countries: South Africa, Zimbabwe, Mali, Pakistan, India, Islamic Republic of Iran, China, Ukraine, Germany, Venezuela, Brazil, Switzerland, Lebanon, Thailand, and the Philippines. See WHO, TFI (2000) at http://www.who.int/ncd/mip2000/documents/annual_tfi_en.pdf (visited 14 February 2012).

¹⁰⁷ Dr Franklin Apfel was managing director of World Health Communication Associates in Axbridge, Somerset (see www.whcaonline.org/about-us.html (visited 28 October 2011)). See, for example, Semenza *et al.* (2008); see also www.euro.who.int/__data/assets/pdf_file/0006/97827/WHYReport_Bonn.pdf (visited 22 July 2010).

the initial positions, I think it must have been prior to the intergovernmental negotiating body (INB-3), our technical boss, then the permanent secretary in the Kenyan Ministry of Health received visitors one evening – it must have been on a Friday because people were travelling on Saturday – a tobacco industry member came to his office with a raft of proposals on how Kenya would handle the negotiations, which were tilted towards the general codes of self-regulation. He was very insistent that global frameworks like the FCTC would not work. He informed us at about 7pm that Friday evening and said that he was not very sure that he was going to be in post on Monday. We were very curious why he thought so. And he said: ‘You see, the industry representative came and tried to influence us.’ The Kenyan voice was pretty significant in the African group. If the tobacco industry could influence the group’s position in certain areas, they could tilt them towards this self-regulating position. They were very clear with him: ‘You know, if you don’t take the money and influence your team, then you’ll not be in a job come Monday.’ For sure, come Monday, on the 1 o’clock news – usually the time when people were sacked from or appointed to government in Kenya – he was no longer the permanent secretary, but was sent to a country as ambassador, which is a step down in the civil service. Before countries engaged at the regional and global level, there were a lot of challenges at country level.

I think that the challenges being faced at the national level were way above those that we were seeing at the global level, where we could easily identify who was from where. At country level it was the ministry of health on its own, and very often it would be two if you were lucky, but often only one person within the ministry who was truly passionate enough about the development of a treaty, not the rest of the ministry, because they had a million other things to worry about. So the challenges faced at country level disappear when we talk about the global level negotiations, but these, I think, were very key in the kind of positions that eventually were taken at the global level.

Most delegates did not know anything about negotiation at international level, as you (Mary Assunta) were saying. What drove most of the delegates was a passion for tobacco control. That was it; that was all that they had, and they gave it their all. Everyone learned along the way what needed to be done. I must say that the small, low-resource countries were the ones driving the process. It was not the big countries; it was not the rich countries; it was the truly, truly resource-poor countries that drove this process. Without them standing on a platform for public health, we would have a very different convention from the one we have now.

Bettcher: I was going to address the issue of which country was selected and then became the chair for the negotiations, because, I think, the selection of a chair from Brazil was so crucial for the success of this negotiation. It does come down to addressing both the supply and demand issues of tobacco control.¹⁰⁸ No other drug treaty had ever touched demand reduction before. All the drug-control treaties that Thomas Zeltner referred to concentrate on supply measures only. I recall that some Scandinavian countries in the early 1990s tried to launch a demand-reduction drug-control treaty, but it was resisted by other states.¹⁰⁹ Countries said: ‘Demand-reduction for drugs is our sovereign prerogative: stay away from that.’ From our experience with the drug treaties, we know that reducing supply is not going to reduce demand. If demand is still there, it’s going to crop up somewhere else – no pun intended.

The question of alternative livelihoods was an important door to get through in order to negotiate the demand-reduction measures in the treaty.¹¹⁰ It is the political economy of tobacco control: you’ve got to deal with those issues – both supply and demand – especially in countries that are very dependent on either tobacco manufacturing or agricultural production. Having a middle-income country (Brazil), one of the top three growers of tobacco, in favour of tobacco control was very important in the negotiation of the WHO FCTC. Because, as Vera has described, Brazil decided in the 1980s that tobacco-growing and tobacco-control issues weren’t mutually exclusive, you could do strong tobacco control and also deal with the inevitable restructuring of your economy sometime later on down the road. I remember discussing this with a top-level diplomat: ‘In the first half of the twentieth century it would have been inconceivable to think that typewriters would gradually become redundant. But that’s exactly what happened from the 1980s. There was a gradual period of phasing out typewriter production and its replacement with the modern computer. This is what will happen with tobacco production. Tobacco will not disappear overnight as the scare-mongering tactics of the tobacco companies to counteract effective tobacco control regulation. The phasing out of tobacco will be a gradual process, which will certainly benefit humankind.’ Brazil was

¹⁰⁸ See page 21.

¹⁰⁹ For demand reduction measures in the FCTC, see the Framework Convention Alliance ‘Part III: Measures relating to the reduction of demand for tobacco’ at www.fctc.org/index.php?option=com_content&view=article&id=25&Itemid=31 (visited 15 November 2011).

¹¹⁰ For demand and supply measures, see note 51; see also Nutt *et al.* (2007).



Orchid Award
Dr. Thomas Zeltner
Led effort to expose tobacco industry infiltration of WHO



Dirty Ashtray Award
We're watching....

All five newsletters published this week, 16-20 October 2000, are available online at

<http://www.fctc.org>

The Negotiations: Quotes of the Day

<p>Egypt – “Tobacco product companies in recent times have fixed their trademarks on various other products – matches, suitcases, and other products, including products that children like. We must be aware of this hidden publicity.”</p> <p>Jordan – “Tobacco represents a threat for all age groups. In Jordan, we prohibit advertising aimed at the population as a whole, not just children and adolescents, but adults as well.”</p>	<p>Kenya – “We wish to include strong anti-tobacco advertising in addition to restricting and if possible prohibiting all forms of tobacco advertising, promotion and sponsorship.”</p> <p>Paraguay – “Advertising is what has made tobacco into an epidemic and a public health problem.... In the developing countries, we are invaded by tobacco advertising and publicity. They will use any kind of gap, any kind of kink, to get in and exploit this opportunity.”</p>	<p>Sri Lanka – “Partial restrictions have been of little use in reducing consumption. Therefor, we recommend a total ban on all direct and indirect tobacco advertising, promotion and sponsorship.”</p> <p>Switzerland – “In reality, it is extremely difficult to distinguish between advertising targeted at minors and advertising targeted at adults. It is practically impossible to make that distinction in practice.”</p>
--	--	--

ALLIANCE BULLETIN 20 October 2000 3

Figure 4: Orchid award and Dirty Ashtray award from the FCA's *Alliance Bulletin*, 2000.¹¹¹

a country willing to stand up firmly and to broker a way forward that would accommodate the needs of countries that were producers and growers, etc., and with those that weren't.¹¹²

Pötschke-Langer: I think we have wonderful historical documents in the form of the FCA *Bulletins* (see, for example, Table 5), the newsletter of the Framework Convention Alliance, where we listed those countries, organizations and individuals that were the 'good countries', the supportive countries and received the Orchid award from the very beginning; those countries and others that were the 'bad countries' received the Dirty Ashtray award. I think this list is very impressive, and thus you see very well all the countries and organizations

¹¹¹ The image chosen for World No-Tobacco Day 1999 was an orchid in an ashtray – a symbol of life not death; a flower instead of ashes. (WHO, Western Pacific Regional Office (1999): 11); see also Glossary, page 122.

¹¹² Ms Kathy Mulvey wrote: 'It may be important to emphasize that this does not mean a compromise with the tobacco industry, but instead a treaty that addresses the economic concerns of growers (whose interests are not truly represented by the tobacco transnationals), as well as the enormous harm to health.' Note on draft transcript, 20 July 2010.

Dates of INB sessions	Orchid award	Dirty Ashtray award
INB-1 16–21 October 2000	Canada, Uganda, Kenya and Thomas Zeltner	Tobacco Industry and Marketing Board of Zimbabwe, and CIGG Lobby Vending Machine
INB-2 30 April–5 May 2001	Brazil, Hungary, South Africa and Russia (pre-INB2), WHO African region (AFRO), WHO Southeast Asian region (SEARO), countries in support of total ban on tobacco advertising, Canada and India Delegation	Nottingham University (before INB2, see note 116), British American Tobacco (2*), Philip Morris, Japan Tobacco, countries determined to exclude NGOs from working groups, the USA, countries that did not support total ban on tobacco advertising and China
INB-3 22–28 November 2001	President Arap Moi of Kenya, Kenya Medical Association, Kenya Dental Practitioners Association, <i>Kenya Times</i> newspaper, and local and international NGOs, Ireland, Palau and India	Philip Morris, the USA, tobacco companies, Germany, International Tobacco Growers' Association and Japanese government
INB-4 18–23 March 2002	David Byrne (EU Commissioner for Health and Consumer Protection), the Espresso guy at CIGG**, Pacific and Caribbean countries, Palau, Thailand, India and AFRO	Zigarettenrepublik Deutschland, speakers of Working Group 1 of the CCLAT, Australia, Canada, the UK, Pakistan and Japan
INB-5 14–25 October 2002	Malaysia, WHO Director-General Gro Harlem Brundtland, Ireland, SEARO, AFRO, European Forum of Medical Association, Commonwealth and World Medical Association, the Pacific Islands, English-speaking Caribbean nations and Maldives	Japan Tobacco (3*), Singapore, Germany, the USA, Pakistan, organizations and countries that sought consensus on issues where there should be no compromise, countries that seek to exclude civil society groups from the negotiation, WHO European region (EURO)
INB-6 17–28 February 2003	AFRO(2*), SEARO(2*), Pacific Islands (2*), Iceland, China, Saudi Arabia, Baltic States, WHO Eastern Mediterranean region (EMRO), English-speaking Caribbean states and India	The revised chair's text (before INB6), Argentina, the USA(2*), China(2*), Russia, United Nations and WHO, Cuba, Greek presidency of EU, Germany and Lifetime Achievement Award for the USA

* The number of awards received in a single INB session

** Centre International de Conférences Genève, Geneva, where the hearings took place

Table 5: Recipients of FCA awards by Framework Convention Alliance Bulletin, Issues 1–45, 1999–2003, adapted from Mamudu and Glantz (2009): 158. See also Figure 4.

that were under heavy influence of the tobacco industry.¹¹³ These were the big countries, the high-income countries; the others that were not so influenced, or where NGOs were much stronger received the Orchid awards. [Dr Pötschke-Langer left the meeting at this point.]

Zeltner: I'll come back to the committee¹¹⁴ and why I think the issue that we were dealing with here is important to your question about what made the Framework Convention possible.

I don't know why Dr Brundtland asked me to chair that committee. [Laughter] No, it is an interesting question and I don't know why, but I bring that question up. She called me in the summer of 1999, because there was a short internal report prepared by the Tobacco Control Unit (Derek Yach and Chitra Subramaniam)¹¹⁵ and everybody seemed a little bit annoyed, first of all in the WHO legal office. The first thing we did together was to look into the mandate of such a committee. I was working with her, the legal counsel, plus David Nabarro,¹¹⁶ who was very instrumental at that phase in the work. The main question was whether it

¹¹³ Nottingham University appears in Table 5 as a recipient of the Dirty Ashtray award, having accepted £3.8 million from British American Tobacco in 2000 to establish an International Centre for Corporate Social Responsibility, resulting in the resignation of several teaching staff, including Dr Richard Smith, editor of the *BMJ* (1991–2004), who resigned his unpaid part-time professorship of medical journalism. For details of the episode, see the ASH website at www.ash.org.uk/information/tobacco-industry/university-funding-the-tobacco-industry; for one discussion of the ethical, legal and policy issues associated with tobacco industry funding, see <http://cancercontrol.cancer.gov/tcrb/tfms.pdf> (both visited 15 November 2011).

¹¹⁴ The Committee of Experts on the Tobacco Industry Documents, chaired by Professor Thomas Zeltner, reported in 2000 (Zeltner *et al.* (2000)); see also notes 6, 48, 77, 103, 121 and 149.

¹¹⁵ Dr Derek Yach wrote: 'I recall very clearly why Chitra Subramaniam, my Tobacco Free Initiative media head, and I suggested Zeltner to Brundtland. We needed a solid public health person with a law background from a country that was home to a tobacco company and would stick to what was best for public health! The report motivated for an unprecedented review to be done of the impact of a multinational on UN policy development. The legal office was deeply fearful of what it might show. We had worked with Roberta Walburn (a lead litigator on the Minnesota Court case) to prepare the report using a few documents from the court case, showing several specific examples of how Philip Morris and BAT had tried to subvert WHO tobacco control policy on marketing restrictions, epidemiology of second-hand smoke by IARC and more. It was convincing enough to get Brundtland to initiate the review....Our legal office had to undertake new research to find out how to ensure all these people were covered by an international convention to protect against litigation! At the time of the FCTC work, we in TFI employed more and a diverse range of lawyers than the law office... another reason they felt threatened.' E-mail to Mrs Lois Reynolds, 28 February 2012. For the composition of the Zeltner committee, see note 48.

¹¹⁶ Head of the WHO's Roll Back Malaria project (1998–2003) and executive director in the Office of the Director-General, was a former chief of health and strategic director of the UK's Department for International Development. For the importance of 'health for all', see Brown (1999).

should be just a report looking into the documents or should the report also have recommendations? I advocated recommendations very strongly, but some people in WHO didn't want that. Then we moved on to the question of who should be on the committee. That brings me back to the point I want to make: we were looking to get members from low- and middle-income countries and we asked a couple of people, but they all refused. They all said: 'It's too dangerous for us: we will lose our jobs because the influence of the tobacco industry, of our economy or our farmers is way too high to allow me to accept, and I even fear for my family.' We had a couple of people who said: 'I wish I could do, but I will not.' We were very happy at the end to get one person, Dr Fazel Randera from South Africa, to come onto the committee.¹¹⁷ We wanted to have someone from a very low-income country, but we didn't find anyone.

The next point relevant to today's discussion is that we then came up with recommendations, many had to do with transparency that were implemented very rapidly by WHO. Two key recommendations were never implemented, the first being that the country delegations coming to the WHA should be transparent about the affiliation of their members, because we feared that the tobacco companies or their front organizations might be sitting on some of the delegations. This had happened in the past and could jeopardize the whole process. There was a short debate on that recommendation in the executive board. The US delegation of the time was against it: 'We do not accept that point, because it involves national sovereignty. Membership of the delegations is our business and we're not open to this kind of disclosure.' It is quite interesting that Mary Assunta says that the smallest countries were eventually clean of that kind of influence.

The second thing, which I still think is a little puzzling, is that we had not even looked through all the documents. You may remember that the tobacco companies never had to disclose the most controversial documents.¹¹⁸ So

¹¹⁷ For the background to the appointment of 1999 Committee of Experts to research tobacco company documents publicly available as a result of lawsuits against the tobacco industry in the US and its report, *Tobacco Industry Strategies to Undermine Tobacco Control Activities at the World Health Organization*, included a case study on Philip Morris' 1988 Boca Raton action plan (Zeltner *et al.* (2000): 4–6 at www.who.int/tobacco/media/en/who_inquiry.pdf (visited 22 July 2010)). See also, for example, Ong and Glantz (2000b).

¹¹⁸ The terms of the 1995 settlement between the State of Minnesota, Blue Cross and Blue Shield of Minnesota and the tobacco companies (see note 43), required the tobacco companies to place material in the public domain, but excluded public access to 'privileged documents and Category II trade secret documents (relating to blends and formulae)' and should be open to the public for a period of 10 years from February 1998. For further details, see www.publications.parliament.uk/pa/cm199900/cmselect/cmhealth/27/2718.htm (visited 29 November 2011).

we only saw the documents that were innocuous. Then we made another recommendation, we asked WHO to make sure that other UN agencies undertook the same procedure, because it was very obvious from looking into the documents that Food and Agriculture Organization (FAO) and other organizations had the same problem, if not a bigger one.¹¹⁹ That has never been done. So, there was no transparency at that time on how much influence the tobacco companies might have had via these organizations and through the delegations coming to the Framework Convention debates.

da Costa e Silva: I think that the role of countries in making the FCTC possible is pretty evident. The FCTC exists because countries were able to push the process to the end. But this, I think, was not an easy process for many reasons. Firstly, the delegations were mainly composed of the same people who came to the World Health Assemblies. That means doctors and public health people, people who were used to dealing with health-related issues, but had no understanding of the economics of illicit trade, marketing, advertising or any other issues not directly related to health. What could they say about issues such as liability or sustainable alternatives to tobacco crops?

Secondly, even though there were around 17 WHA resolutions, governments were mostly not implementing tobacco-control measures at home. Even the US, which was heavily involved in litigation against the tobacco industry, and with preparing the Surgeon General's reports on smoking and the consequences to health that were so important during this process,¹²⁰ didn't have a strong national tobacco-control programme to demonstrate the way forward. Few states had strong programmes, and at that point we could not say that apart from isolated experiences and the evidence-base produced by their academic institutions, the US could lead the process of international tobacco control by sharing their own best practices. Even other developed countries with quite a lot of the tobacco companies under their domain had difficulties in this regard.

¹¹⁹ See, for example, UN, FAO (2003), freely available at: www.fao.org/docrep/006/y4997e/y4997e00.htm#Contents (visited 22 July 2010).

¹²⁰ See US, Surgeon General, Advisory Committee on Smoking and Health (1964), freely available at <http://profiles.nlm.nih.gov/NN/Views/Exhibit/narrative/smoking>; US, Department of Health and Human Services (1981, 1989); for a 1989 evaluation of progress, see http://profiles.nlm.nih.gov/NN/B/B/X/S/_/nnbbxs.ocr; for a list of the Surgeon General's reports on tobacco and smoking, see www.cdc.gov/tobacco/data_statistics/sgr/pre_1994/index.htm; for Centers for Disease Control and Prevention factsheet on health effects of cigarette smoking, see www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/ (all sites visited 15 February 2012).

The treaty negotiation process therefore had two objectives: the first and most important was to negotiate an international treaty, which could tackle the international dimension of tobacco control. The second was to create awareness, to bring more people from other sectors on board, to establish a consensus on some approaches to various aspects of tobacco control and to stimulate exchange of countries' experiences. In this respect some African and South East Asian countries have offered sound examples of how the dynamics of the negotiation process have definitely changed tobacco control reality on the ground.¹²¹ If you compare the way some countries started the negotiation of the treaty, and how they ended the negotiation process, you could see representatives of the health sector just growing, growing, growing in terms of addressing the multisectoral nature of the issue, participation, discussion and implementation of tobacco-control measures in their own countries. In this regard, I think WHO also played a very important role, facilitating regional meetings and integrating the different groups, including the full participation of the civil society. The negotiation process was also a sort of Open University.¹²² The NGOs also had a very important role in this regard. There was a huge 'behind-the-scenes' workload in terms of bringing people together to make them more aware of the complexities of tobacco control.

Thirdly, the tobacco industry was present, many times as part of member states' delegations, as they are still, and will continue to be, present in every government and at every single meeting where tobacco control is discussed. I think one issue of the utmost importance is monitoring the tobacco industry, in terms of implementation of the treaty. This is not something that most governments were regularly doing at this point. Therefore there are still countries today that have signed the treaty but have not yet ratified it, because of the interference of the tobacco industry.¹²³ Among other arguments, they use the tobacco growers to

¹²¹ Ms Kathy Mulvey wrote: 'The 46 member states of the WHO African region negotiated as a block from INB-2 onward. See Johannesburg Declaration (March 2001) at www.who.int/inf-pr-2001/en/note2001-04.html (visited 21 July 2010)).' Note on draft transcript, 20 July 2010.

¹²² Dr Vera Luiza da Costa e Silva wrote: 'Many sessions of the INB took place in a two-week period with extensive cross-fertilization of ideas and views between participants. Furthermore, every single time slot was used to promote awareness: several lunchtime briefing seminars were convened either by WHO or by the NGO community, providing an opportunity for delegates to learn from each other.' Note on draft transcript, 25 June 2010.

¹²³ See notes 59, 60 and 61.

make the case of a doomsday scenario with the loss of employment by farmers, to avoid the ratification of the treaty, a third component adding complexity to the negotiations.¹²⁴

Collishaw: I wish to make three points about the countries' roles, and going back to the very beginning when countries got involved. The resolutions of 1995 and 1996 were adopted unanimously by WHA, and that was quite a remarkable achievement, because this was breaking new ground. We've talked about certain individuals who have helped to germinate the idea and bring it along.¹²⁵ Eventually it all came to the WHA, and they adopted the 1995 and 1996 resolutions unanimously, a strong expression of consensus.¹²⁶ That was a vote of confidence from member states that something ought to happen.

However, the 1996 resolution was a grand statement commanding the Director-General and staff to go forth and produce a Framework Convention; it didn't actually come with any money. Now I want to go back to the comment made by my colleague here about 'poor Neil'. 'Poor' has a couple of meanings in English and I'm going to assume that this wasn't my performance evaluation, Doug, that you were giving there? [Laughter] Ah, it was 'impecunious Neil' that you were talking about. Well, yes, at that point we had zero money to actually implement what the WHO and the WHA were talking about.¹²⁷ I'd like to refer to this wonderful book, which was released today (Figure 5), and I wish to thank my friend Vera very much for its production.¹²⁸

¹²⁴ BAT's 'Grower Public Relations Programmes' targeted the FCTC and was designed to demonstrate the importance of the tobacco crop to poor farmers (Rimmer (2005): 14, note 72 at http://www.ash.org.uk/files/documents/ASH_371.pdf (visited 3 November 2011)); see also Infact's guidelines for ratification at: www.ctcpak.org/docs/fctc/Rat_handbook.pdf (visited 16 November 2011).

¹²⁵ Mr Neil Collishaw wrote: 'Ed Aiston of Canada deserves a lot of credit. Along with his colleague Jean Larivière of Canada, both successfully guided the groundbreaking 1995 and 1996 resolutions through the executive board and the WHA. Ed remained a strong booster and tireless supporter of the FCTC from initiation in 1995 to adoption in 2003. Individuals can get things started, but nothing much happens around here unless there is consensus.' Note on draft transcript, 25 March 2010.

¹²⁶ During the 1995 WHA, resolution 48.11 officially introduced the concept of an international strategy for tobacco control. Resolution 49.17 in 1996 asked the WHO Director-General to initiate preparation of a framework convention on tobacco control. For discussion of the importance of the WHA resolutions, see pages 10, 12, 21, 33–4 and 37; see also Roemer *et al.* (2005).

¹²⁷ See page 21 and note 86.

¹²⁸ WHO, FCTC Secretariat (2010): 40–1. Freely available at http://whqlibdoc.who.int/publications/2009/9789241563925_eng.pdf (visited 5 November 2010); for timeline, see Appendix 4, page 79.



Figure 5: WHO FCTC history, published on 26 February 2010, the fifth anniversary of the Framework Convention.

If you look in the back on page 40, you'll see a timeline that mysteriously skips from 1996 to 1998. It's as if 1997 didn't exist, but that was the year in which the impecunious Neil, ably assisted by Barbara Zolty, another tireless tobacco-control worker who continues to work for TFI here in WHO, had to go round to raise some money from, guess whom? Member states. I'm proud to say that there were four member states that made voluntary contributions to WHO to get the treaty under way and I'm happy to name them: France, Finland, Canada and Switzerland. The largest contribution of these four was given by Switzerland, and I'm very confident, through the good offices of Dr Zeltner, that Switzerland will indeed ratify the treaty, perhaps some day before I retire.¹²⁹ [Laughter] But let the record show that Switzerland – I think it was one of Zeltner's employees,

¹²⁹ See also note 83.

Brigitte Caretti, who must have persuaded him to open up his pockets – helped to fund the Framework Convention. The \$750 000 or so raised from those four member states in that year became the seed money, the initial investment that allowed the Framework Convention to take off, beginning with the other work you see in the timeline in 1998 and 1999 (Appendix 4).

The third point about member states is that in my initial thinking about the FCTC, I thought that this was going to be quite a modest undertaking and that there wouldn't be that many people who would sign up, because, after all, most of what was being talked about could be done in national law. I thought the more important things a treaty had to address were those that crossed national boundaries. The outstanding examples of cross-border advertising that I saw in the early 1990s, a big problem at the time, were Formula 1 racing and smuggling.¹³⁰ What I didn't see, and what I am delighted to have been wrong about, is how quickly this treaty would be embraced by low- and middle-income countries, because they were facing such problems, some of which we've heard about today. They could not get tobacco on the national agenda, and without an international standard and the force of international law, tobacco control at the national level in many low- and middle-income countries was going to go nowhere. It is still a very big challenge in many of these countries, but at least we're much, much farther ahead and it's those countries that have made the treaty into what it is, and it has succeeded way beyond my initial far-too-modest expectations.

Cunningham: On the first question: there was a pre-negotiation phase and there were six Intergovernmental Negotiating Bodies (INBs).¹³¹ Before the INBs, there were two working group meetings that involved all parties. I think that it was important to sensitize countries, to get them to the issue, to get them involved, so when the negotiations began the government delegations weren't starting from scratch.¹³² Even before that, there were some meetings in Vancouver and Halifax

¹³⁰ For background briefing on cross-border advertising, see http://apps.who.int/gb/fctc/PDF/cop4/FCTC_COP4_10-en.pdf (visited 15 February 2012); see also note 19.

¹³¹ The six INB meetings were held in Geneva (Table 3, page 44) with regional meetings leading up to some INBs, documents freely available at www.who.int/fctc/about/whofctc_inb/consultations/en/ (visited 19 July 2010).

¹³² Professor Judith Mackay wrote: 'The truth is we were all starting from scratch.' Note on draft transcript, 26 January 2012.

to generate ideas that contributed to this process.¹³³ The phrase ‘the power of the process’ I think happened here, where governments learned, parties learned, and in many cases, they implemented, measures as the process of negotiations went along, which increased their stake to see a successful outcome, and to see those measures they had adopted included in the final treaty.

Regions were very important to these negotiations and the regional consensus that you had in the African region (AFRO), the Eastern Mediterranean region (EMRO) and the South East Asia region (SEARO) was in support of a strong FCTC. The Western Pacific region included Japan and China, dissenters on many issues, that region split and could never come to a consensus. The subregions involved were the Pacific Islands and also the Association of Southeast Asian Nations (ASEAN) countries with very strong voices.¹³⁴ There was also a Caribbean subgroup (CARICOM) supporting a strong FCTC.

The regional meetings that preceded the INBs were helpful for preparation of government delegations and having a stronger position as a region. Greg Jacob, a lawyer for the US delegation, wrote an article where he complained. The US was not happy with the outcome – they didn’t get what they wanted – so they complained.¹³⁵ One of these complaints was that US responses to regions had no effect on regional positions. That was part of the dynamic. Two examples of country champions – we don’t have time to name them all – one is Thailand, which had been on the receiving end of a US government trade challenge to its

¹³³ For the report of the Vancouver public health experts meeting, December 1998, see http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.7.pdf (visited 23 July 2010).

¹³⁴ The Association of Southeast Asian Nations (ASEAN), established in 1967, consists of Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam.

¹³⁵ Jacob (2004). Ms Kathy Mulvey wrote: ‘This commentary (not peer-reviewed) was a political attack. I don’t think it merits inclusion in the history of the FCTC. But if it is cited, please also include the rebuttal by Corporate Accountability International.’ Note on draft transcript, 20 July 2010. Ms Kathy Mulvey’s letter to the editor in reply to the Jacob article, noted: ‘The activities of the tobacco transnationals were the target of the treaty, not the US government.’ No date, one of several documents attached to an e-mail to Mrs Lois Reynolds, 20 July 2010, which will be deposited along with other records of the meeting in archives and manuscripts, Wellcome Library, London, in GC/253. Ms Kathy Mulvey wrote: ‘The letter, submitted in May 2005, was not published. It did rebut some specific complaints by Mr Jacobs (this is the rebuttal by Corporate Accountability International).’ Note on draft transcript, 30 January 2012. Other concerns on the 10-year treaty negotiations are discussed in Lo (2006).

earlier advertising ban and its other tobacco legislation.¹³⁶ At INB-1 (October 2000), Thailand raised the issue of trade and tobacco and the need for some protection.¹³⁷ At INB-2 (April–May 2001), ‘trade and health’ became a huge issue, and continued to be so throughout, until the very end of INB-6. It is still an issue. But in a passionate plea at INB-1, Thailand began that part of the process, although it’s not as if the issue hadn’t come up before that statement.

The second is Ireland: the advertising ban was a big issue there and the European Community (EC) had a common position, where almost every country among the then 15 countries in the EC – plus the ten accession states and the latest two make 27 EC countries – were in favour of a comprehensive advertising ban, except for Germany.¹³⁸ The usual protocol when the EC went into negotiations with a common voice. Well, people were just so fed up with this that Ireland led the ranks, broke protocol and at INB-5 (October 2002) they called in negotiations for a total ban on tobacco advertising. That broke the ice and many other EC members followed on to the floor. It was an incredible display of what’s not supposed to happen when the EC is involved in negotiations. Ultimately, the outcome was very good.

It is surprising to note that when negotiations were complete – INB-6 (February 2003) – the EC was short of consensus only because of Germany. The negotiations were complete, it was only Germany that held out by 26 to 1 and eventually they buckled.¹³⁹ By the time the 56th WHA received the convention in May 2003, the EC was on board. But note, certain countries were very good champions, although on certain issues it wasn’t necessarily 100 per cent. So, you could be good on most things, but it could vary on the issue.

¹³⁶For details of the 1990 case involving Thailand’s ban on cigarette imports and advertising, see GATT (1990); Taylor *et al.* (2000): 348–50; see also note 192.

¹³⁷See, for example, Vateesatokit *et al.* (2000).

¹³⁸For details of German tobacco industry support, see http://www.who.int/tobacco/dy_speeches4/en/ (visited 1 March 2012).

¹³⁹The EC’s Directive 98/43/EC to end all tobacco advertising and sponsorship in EC member states by 2006 was first proposed in 1989, adopted in 1998 and annulled by the European Court of Justice in 2000 (Neuman *et al.* (2002)). A limited version, Directive 2001/37/EC, banning misleading descriptors and introducing voluntary graphic health warnings, was approved in 2001. A revised directive is not expected to be proposed until 2012. See www.no-smoking.org/oct03/10-02-03-1.html (visited 3 November 2011). The tobacco industry lobbied individual member states of the EC to prevent the introduction of a total ban on tobacco advertising in 1998 (Neuman *et al.* (2002); see also www.who.int/tobacco/policy/advertising/en/ (visited 3 November 2011)).

Mulvey: In answer to the question about countries, the Framework Convention is fundamentally about countries: it is a multilateral, international legal instrument. So the decision had to be made by political bodies. The role of NGOs working with that leadership from low- and- middle-income countries was absolutely critical, and a number of people have alluded to that.¹⁴⁰ Therefore, for NGOs to underscore that it was global South-led and global South-driven was critical as well.¹⁴¹ Because the tobacco industry had said that this was a first world issue, it was critical to get across the message of the preventive benefit and to turn off the tap of this epidemic in countries where it had not even hit yet, and where we could stop it.

Secondly, Rob has spoken of the solidarity within the regional groups – the unprecedented work that started with the Johannesburg Declaration in 2001, but then the cross-regional consensus among the African group (AFRO), the South East Asia group (SEARO) and the Eastern Mediterranean (EMRO) group was also critical.¹⁴² Those three regions worked together and kept the bar as high as it could be.

Again the tobacco industry mapped out its own plan,¹⁴³ with the public relations firm Burson-Marsteller¹⁴⁴ – Mary Assunta can probably speak more about this – and Mongoven, Biscoe and Duchin, to undermine the negotiations, to weaken and delay the convention.¹⁴⁵ It had to do so by trying to use the regional groupings as the way to bring it down to the lowest common denominator. The low- and middle-income countries were able to resist that strategy. As Vera said, the tobacco industry was there, is there, will continue to be there, and the NGOs play a

¹⁴⁰ See pages 24, 56, 71, 81.

¹⁴¹ See Assunta (1999); Mulvey (1999).

¹⁴² See FCA (2001).

¹⁴³ See Malone (2002).

¹⁴⁴ For details of this public relations company's work, see Burson-Marsteller and Philip Morris (1986) at <http://tobaccodocuments.org/landman/2046875317-5351.html> (visited 16 March 2012).

¹⁴⁵ Ms Kathy Mulvey wrote: 'Burson-Marsteller worked with Philip Morris to implement the Boca Raton Action Plan at <http://legacy.library.ucsf.edu/tid/xke42e00/pdf;jsessionid=30E2ACD5BD035CEB8E285FC8392534BA> (visited 23 July 2010). The report of the Committee of Experts on Tobacco Industry Documents (Zeltner *et al.* (2000)) exposed the Boca Raton plan, including Philip Morris's strategy to use its food businesses to gain influence with WHO and other UN agencies.' Note on draft transcript, 20 July 2010. See note 117; see also Carter (2002); Muggli *et al.* (2004); Gonzalez *et al.* (2011).

critical role in monitoring and in watchdog activities. Corporate Accountability International, working with allies in the Network for Accountability for Tobacco Transnationals (NATT) and pursuant to WHA Resolution 54.18, was monitoring in-country during the negotiating process, and brought reports like ‘Dirty Dealings’¹⁴⁶ to the negotiations, but also systematically asked everyone that we encountered there who they were and who they represented. This ferreting out of tobacco industry allies – law firms, the tobacco growers’ groups, the duty-free groups – that were fronting for them and publishing that information for delegates in NATT updates and the FCA *Bulletin*, were NGO activities at the INBs. In addition to the Orchid and the Dirty Ashtray awards, there were also the Marlboro Man awards,¹⁴⁷ which went to the countries that were behaving most like the tobacco industry in the negotiations. Three wealthy countries consistently came to the top of the list: the US,¹⁴⁸ Japan and Germany. Of course, the tobacco industry was actually on delegations in the form of state-owned tobacco companies as well as through the growers – one of the Malawian delegates was with the ITGA;¹⁴⁹ one Russian delegate was actually a BAT employee.¹⁵⁰ I think all of this came to light through the watchdog activity, and helped to neutralize the negative roles being played by certain countries.

Cunningham: To add to the subject of NGOs, I agree that the NGOs had a positive role in the negotiations. Some delegates remarked on the passion that the NGOs had, and I think that the NGOs were perceived to be very credible about wanting to have a convention that did the right thing. So, there were no ulterior motives, no splits at the ministries. The NGOs also had a lot of technical expertise to counter either tobacco industry arguments or arguments as to why something couldn’t be done. There were a variety of backgrounds among the NGO delegations, including lawyers and physicians. NGOs prepared ‘side-by-sides’ with recommended amendments to the chair’s text for various stages of the negotiations. There were two main umbrella groups: the Framework Convention

¹⁴⁶ Mulvey (ed.) (2002), freely available at: www.stopcorporateabuse.org/sites/default/files/Dirty_Dealings.pdf (visited 15 November 2011).

¹⁴⁷ Ms Kathy Mulvey wrote: ‘At INB-5 in October 2002, Marlboro Man awards went to the US, China, Germany, BAT and Japan. At INB-6 in February 2003, Japan, Cuba, the US (twice) and the chair of the negotiations received this dubious honour.’ Note on draft transcript, 20 July 2010. See Table 5, page 43.

¹⁴⁸ For evidence of US obstruction of other treaties, see Mulvey (ed.) (2003).

¹⁴⁹ For details, see Infact (2003).

¹⁵⁰ See INB-6 delegate list online at <http://apps.who.int/gb/fctc/PDF/inb6/einb6d2r1.pdf>, and FCA *Bulletin* article of 27 February 2003 for details (visited 10 January 2012).

Alliance (FCA) and the Network for Accountability of Tobacco Transnationals (NATT).¹⁵¹ The FCA did not have formal observer status, so they were like other NGOs, in that their delegates were members of International Union Against Cancer, World Heart Federation, International Union Against Tuberculosis and Lung Disease and so on. The FCA's *Alliance Bulletin* was widely read by delegates, and the first thing they did on receipt would be to turn to the last page to see who had won the Dirty Ashtray and who had won the Orchid (see Figure 4).

Mackay: Kathy has said quite a number of the things that I was going to say. I would say that we are all rather reluctant to identify some of the real baddies here. I have often said that I thought this treaty got through because of them. Some of the big countries were very overbearing, very bullying and offered inducements. There was a groundswell of feeling among the low- and middle-income countries that they didn't want to be bullied in this way. In fact, we'll have to look back at the record, but I think it was the Indian minister of health, who said at one point on the floor that 'public health could not be bought.' In a sense, the real big baddies helped us, because many nations felt that they were not going to be browbeaten: they were going to get this treaty through. So, in a funny sense, I think they were quite helpful to the process. [Laughter]

Assunta: Rob and Kathy have covered some of the points I also wanted to make, but I think the concept of 'champion countries' was very important to the NGOs and we needed to identify who our champion countries were. One point that I made earlier when I talked about what happens when low-income countries and poorly resourced countries go into the international arena, the message we want to bring with us is the connection between tobacco and poverty. When the countries spoke, often this experience and the reality of tobacco being a poverty issue, I think, was very evident on the floor. And, I agree with Ahmed that it was the low-income and the poorly resourced countries that drove the process.¹⁵² So, I'm going to name names.

¹⁵¹ Corporate Accountability International founded the Network for Accountability of Tobacco Transnationals (NATT), a group of more than 100 consumer, human rights, environmental, faith-based and corporate accountability non-governmental organizations (NGOs) in 50 countries. NATT developed a 'Gold Standard' text for the treaty and published *Key Principles for a Strong, Effective FCTC* in 2001, and provided legal, technical, and advocacy support. See NATT (2003). A copy of *Gold Standard FCTC* will be deposited along with other records of the meeting in GC/253.

¹⁵² Ms Kathy Mulvey wrote: 'Absolutely essential point. Mary Assunta says it beautifully in *Making a Killing: Philip Morris, Kraft and Global Tobacco Addiction*, a documentary video by AndersonGold Films, 2000, at https://salsa.democracyinaction.org/o/2215/t/9547/shop/item.jsp?storefront_KEY=629&t=&store_item_KEY=2283.' Note on draft transcript, 20 July 2010. For the script of the 30-minute film, see www.streetparty.sk/subtitles/ (visited 23 July 2010).

There were two levels at which we had our champion countries and our champion regions. I'm told that for the first time the AFRO region galvanized and spoke as one voice, and that was important and I'm told that this had not happened in other treaty experiences. South Africa played a crucial role in the galvanizing, as did Kenya. You've already heard about the Framework Convention Alliance's Dirty Ashtray and Orchid awards: the African region received the Orchid from us at least four times. This is to give you an idea of how this system of supporting and also acknowledging the countries that played a positive role worked, and shaming countries that tried to derail or to undermine the process with the Dirty Ashtray. Kenya, for example, was awarded the Orchid three times, and India, mentioned earlier by Judith, together with Thailand, played a very important part in the SEARO region. India, by virtue of its sheer size and the kind of complex problems that it has in implementing tobacco control was evident. As a country, Thailand has suffered under the hands of the US government through the World Trade Organization (WTO), but went on to put in place strong tobacco control measures.¹⁵³ Therefore the powerful combination of India and Thailand, two countries supporting tobacco control issues, provided very important leadership to the SEARO region. Of course, Australia and New Zealand in the Western Pacific region were our champions, because they stood up to some of the weak proposals and positions that were being put forward by China and Japan.¹⁵⁴ So, there were regions, and countries as well, that supported civil society's positions, and this needs to be recognized, I think. Canada, for example, and, of course, South Africa and the Eastern Mediterranean region, stood up for NGOs and insisted that NGO participation and involvement and engagement were essential in tobacco control. Hence you have the word 'essential' in the FCTC.

My other point is that size did not matter, so you had little Palau with a population of 20 000 standing up and pushing for Article 5.3, being the conscience of the treaty negotiation process. One anecdotal comment about creativity: I still remember in INB-6 when, speaking on behalf of the region, a South African delegate held up a little T-shirt and said that this illustrated why it was important to have a comprehensive ban on tobacco advertising and sponsorship activities, because the little child-sized T-shirt promoted or advertised for Marlboro.

¹⁵³ See pages 52 and 68.

¹⁵⁴ As did the Pacific Islands. For further details on the role of China and Japan, see notes 80, 93 and Appendix 5, page 81. For tobacco news, see <http://act.tobaccochina.com/englishnew/index.HTM> (visited 21 February 2012).

In terms of the role of NGOs in supporting the FCTC: yes, we learned as we went along. Rob Cunningham spoke about the diversity of the expertise that the NGOs drew upon. We operated under several principles: the first was that we all had an equal voice and that we were as inclusive as possible. We left our egos outside the door, so when we were inside, the focus was on getting the best outcome in the negotiations. We also learned to speak with one voice. Not only did we have members from individual organizations, we had alliances who were also our members. The richness of this diversity can be quite difficult when it comes to making decisions. But we applied one principle, the ‘can we live with it?’ principle, and that helped us tremendously.

You’ve already heard about the publication of the newsletter, the FCA’s *Alliance Bulletin*. One of the things that we realized was that a lot of words spoken from the floor were not crystallized into key points. To set out what we wanted to achieve, to summarize the points to give to the delegates in a very simple form was very important, I think. The FCA played this role through the *Bulletin* and through daily reporting. The *Bulletin* also made some very candid comments in order to bring some life into an otherwise very, very serious and complex, and very highly legal process. The shaming symbolism and the awarding symbolism worked very effectively and applied pressure. Of course, there was media advocacy.¹⁵⁵ You’ve heard about the ‘death clock’ (Figure 6), and I think we needed this image to symbolize the urgency in the process, because there were times when the delegates had no qualms about spending three hours discussing one sentence. [Laughter] The process would start with ‘there’s one death every six seconds’, but when it came to the actual wording of the treaty, that urgency went out of the window. Therefore we started every INB with a death clock just to remind people.

McLellan: May I take the chair’s prerogative to intervene for just a moment. My reputation for ruthless time-keeping has been destroyed. This is your meeting, this is your history and I would like to go on, with your pleasure. We’re going to spend 10–15 minutes, letting everybody say the most important thing they need to say on any of these topics, but in a very brief, concentrated, not ‘three-hour negotiation over the sentence’ fashion, if you would please, and then I’ll wind us up. Is that acceptable to everybody?

¹⁵⁵For guidelines for advocacy, see American Cancer Society and International Union Against Cancer (2003).



Figure 6: Death clock displayed at pre-INB-6 sessions, Geneva, February 2003.

Bettcher: I want to highlight how fast the NGO movement galvanized itself in this process. When we sat together in a meeting that Dr Brundtland convened in October 1998, there were five NGOs, all from the North, that knew about the Framework Convention.¹⁵⁶ There wasn't a movement, at least on these global issues. The movement replicated itself very, very quickly; the UN Foundation, Ted Turner's foundation,¹⁵⁷ also helped to support the movement by providing a grant to TFI to support civil society to advance tobacco control and the negotiation of the WHO FCTC. It has now become a self-sustaining movement, which has different NGOs from around the world as members. Different movements have come out of the WHO FCTC negotiation process and this is indeed a very positive outcome for tobacco control. We published Kathy Mulvey's paper in early 1999, which is very important, because a health

¹⁵⁶ Dr Doug Bettcher wrote: 'Five is an estimate of the number of NGOs I met with.' Note on draft transcript, 6 February 2012.

¹⁵⁷ See, for example, a collection of newspaper articles on the UN Foundation, created and chaired by Ted Turner, who is described as an 'advocate for the UN and a platform for connecting people, ideas, and capital to help the UN solve global problems' (www.unfoundation.org/) at www.apfn.org/apfn/turner.htm (both sites visited 16 July 2010).



Figure 7: The first session of the Conference of the Parties following the FCTC coming into force, 17 February 2006. L to R: Dr Yumiko Mochizuki-Kobayashi, director, TFI (2005–07), Dr Douglas Bettcher, FCTC coordinator and director, TFI (2007–), and Dr Lee Jong-wook, D-G, WHO (2003–06).

group had not previously negotiated a treaty. NGOs had never been galvanized to support a treaty-making process.¹⁵⁸ Kathy's paper looks at the experience of the environmental treaty movement and how the tobacco-control movement could learn from the successes of the movement that civil society built to successfully support the negotiation of environmental agreements such as the Basel Convention and the climate-change convention.¹⁵⁹

The public hearings before the negotiations started in October 2000 are another issue. Dr Brundtland called them, because very many groups said they were being left out, including tobacco companies. But also let's not forget the NGO community is not homogeneous; there's a whole NGO community in favour of the tobacco industry, loves the tobacco industry and are front groups for the tobacco industry. They were all there at the WHO public hearings as well.¹⁶⁰

¹⁵⁸ WHO, TFI (1999a). Ms Kathy Mulvey was Infact's executive director (1996–2007) and international policy director of Corporate Accountability International until 2009.

¹⁵⁹ WHO, FCTC (1999b); see also Malone (2002).

¹⁶⁰ Ms Kathy Mulvey wrote: 'BINGOs (business-interest not-for-profit organizations) funded by the tobacco industry.' Note on draft transcript, 20 July 2010. See also note 151; for another view of NGOs, see <http://info.babymilkaction.org/node/458> (visited 20 December 2011).

A whole group of governments and NGOs spoke on behalf of comprehensive regulation, but then the tobacco industry and their front groups were also there talking about minimalist approaches, such as youth access restrictions, which don't work very well, and nothing much else.

There were very key players like the ITGA, which Ahmed referred to earlier.¹⁶¹ The farmers are virtuous, but then front groups of the tobacco companies – the ITGA, for example – used the arguments of the plight of the farmers to their advantage. During the negotiation they sent a book with about 5000 letters signed by farmers to put on Dr Brundtland's desk saying: 'Stop the negotiations.'

The tobacco industry also tried to manipulate the process through the use of front groups. For example, the International Hotel and Restaurant Association is a group that focuses on small bars and restaurants, etc. Every time a round of negotiations would gear up, the tobacco industry would be up to some funny business, like getting these front groups to gather the letters from the farmers, or getting the hospitality sector to create a kind of ruckus, or to try to influence finance ministers, etc.¹⁶²

Something we haven't mentioned is what other UN agencies did about tobacco. Here is a very interesting history from 1992 or 1993: a resolution was passed in the Economic and Social Council (ECOSOC), one of the main governing bodies of the UN that brings together the specialized UN agencies, like the World Bank, the IMF, UNICEF, WHO, ILO, FAO etc. ECOSOC had agreed to have a 'focal point', one who was established at UN Conference on Trade and Development (UNCTAD). When the tobacco industry documents become publically available in 2000 – I won't mention a name, you can research it – this person's name was everywhere as the focal point. The documents commented how much they appreciated the focal point's work.¹⁶³ He was apparently friendly to the industry positions and he had a lot of meetings with the tobacco companies.

¹⁶¹ See note 59 and page 63.

¹⁶² See, for example, Dearlove *et al.* (2002).

¹⁶³ The focal point is a person appointed by a UN organization to be the 'point person' on an issue. The ECOSOC resolution was no. 1993/79; see Zeltner *et al.* (2000): 44–5. For early discussions on the FCTC, see tobacco industry papers, for example, <http://legacy.library.ucsf.edu/tid/qme18a99/pdf>; <http://legacy.library.ucsf.edu/tid/fvf63a99/pdf> (both visited 7 February 2012).

The light of day that came with these industry documents also saw the messy business that was going on within the UN, vis-à-vis inter-agency cooperation. Dr Brundtland got hold of Kofi Annan and also the head of UNCTAD, Rubens Ricupero,¹⁶⁴ and said: ‘We’d like a more comprehensive mechanism for UN cooperation on tobacco control. We’d like to bring the agencies together at one table. We’d like a task force; we need the agencies to work together to support this, so we’d like to propose a mechanism to change this.’ Finally a resolution in the summer of 1999 established the Secretary-General’s UN Task Force on Tobacco Control, with WHO in the chair.¹⁶⁵ We had our eighth meeting last week in New York (February 2010).

This is not one of those dead-letter groups that go to sleep as soon as they are created; there are UN task forces that do that, but this one hasn’t. It was crucial in looking at key issues that were plaguing the negotiations. For example, the whole issue of the tobacco companies saying: ‘If this treaty comes into effect the sky will fall, millions of jobs will be lost; we’re all dead.’ That’s crazy, but we knew it was crazy. The World Bank, FAO and WHO got together and actually mobilized funds from a Swedish donor to support the Food and Agriculture Organization to do a study. Their study projected agricultural production to the year 2010.¹⁶⁶

The report showed a restructuring of agricultural farming going on, with a reduction of tobacco farming in high-income countries. In low- and middle-income countries, the trend right now is for more jobs, and the transfer of growth is from high- to low- and middle-income countries. The FAO study showed that the trend would be for more tobacco-growing jobs in low- and middle-income countries. The reduction of tobacco farming jobs in low- and middle-income countries would be in the more distant future. The World Bank came to every

¹⁶⁴ Mr Kofi Annan was Secretary-General of the United Nations (1997–2006) and Mr Rubens Ricupero was Secretary-General of UNCTAD (1995–2004).

¹⁶⁵ The UN Ad Hoc Interagency Task Force on Tobacco Control was established in 1999 to coordinate tobacco-control work carried out by different UN agencies. Their focus was the implementation of multisectoral collaboration on ‘tobacco or health’, in particular the development of appropriate strategies to address the social and economic implications of the impact of tobacco or health initiatives. See for example, UN Ad Hoc Interagency Task Force on Tobacco control (1999, 2000); see also note 52.

¹⁶⁶ The FAO study, started in March 2000, made projections for the year 2010 on the economic impact of a fall in tobacco consumption and considered economic growth, GDP, employment in agricultural and non-agricultural industries, household income, government revenue and food security, including a set of projections on tobacco production, consumption and trade, along with country case studies on China, India, Malawi, Turkey and Zimbabwe and Brazil. See UN, FAO (2004); see also Appendix 4, page 79.

session of the treaty negotiations, so when claims were made by countries that might not be so friendly to the treaty (regarding job losses, for example), the World Bank would be there to say: 'I'm sorry, in fact, that is not going to affect jobs and there is going to be redistribution, with jobs created elsewhere.' Due to the close collaboration between the UN organizations made possible by the creation of the UN Task Force, there would always be the capacity to respond to these types of issues. So we reformulated UN cooperation and started to use our collaboration with UN agencies. WHO chaired the task force to address the crucial questions about tobacco supply issues, the economic questions of tobacco trade, etc., which WHO couldn't speak about on its own.

Zeltner: I will try to be brief, and speak about the last point on the programme (see Table 1) about the tobacco industry. I think we have to be aware that there were two groups: the 'big three' and then the rest.¹⁶⁷ And now I come to the point – and I agree with Vera da Costa e Silva – we stopped being as cautious and as observant as we should have been at both the country level and at WHO level. I have the feeling, but can't prove it, that rather early in the process, the big three – first of all, Philip Morris – realized that the FCTC might be an opportunity for them. They figured out that the convention could open markets, give them more power, would probably destroy small companies and make bigger ones grow. That is something, I think, we will have to look into much more carefully in the future, because member states tend to believe that everything is under control now we have the FCTC and attention directed towards the tobacco industry is actually decreasing. This lack of awareness is a window of opportunity for the tobacco companies. I very strongly sense that with Philip Morris.¹⁶⁸

McLellan: The next three parts of this meeting will take place as follows: Part no. 1 – instructions will be given in just a moment. That will take ten minutes. Sanjoy, my co-moderator, who is supposed to break up fights and has had nothing to do, will then speak. And then I will turn it over to Tilli to wrap up. So, we're going in alphabetical order, conveniently for Dr Assunta, and I'll give you one minute – one minute only, I've got my watch with the second hand – to tell us something you meant to say but you forgot; something that nobody knows; or one thing that is utterly essential to the living history of this issue.

¹⁶⁷ The big three in the 1990s: Philip Morris, BAT (British American Tobacco) and Japan Tobacco. See Tables 3 and 4, pages 17 and 26, for the current composition of the tobacco industry.

¹⁶⁸ Altria since 2003. See, for example, Philip Morris International (2011). Kelsey (2011); see also www.tobacco.org/resources/documents/secretdocuments.html (visited 9 February 2012).

Don't forget, I'm wearing the crest of the McLellan family today. It is a head impaled on a sword. So, I just need to set the tone for the last few minutes of this very interesting discussion.

Assunta: I spoke about the candid language, the description of the US, Japan and Germany as 'the axis of evil'¹⁶⁹ worked very well, especially on Japan, because the advocates were able to use that terminology back in Japan to lobby their government and thus helped to make their delegation behave better at the negotiations. I spoke about the ITGA and I wanted to say that this was a group that was set up to 'front' for the third world farmers to lobby against WHO. It was run by a PR company based in the UK that also had BAT as their client.¹⁷⁰ Doug referred to the submissions and I have to say while there were 514 written submissions to the WHO FCTC public hearings in October 2000, 80 per cent of those were supportive and, I think, those submissions sent a very strong signal of initial support for the treaty. The most important thing is that the treaty has some 'wiggle room', which is why there is a lot of support for it. Countries like Japan and China were able to go away with something that they could implement. They may not actually change legislation, because there is 'wiggle room', through words in the FCTC like 'administrative process'.¹⁷¹ On the other hand, there's enough language in there for countries to do far more than what is indicated. This satisfied the groups that wanted to establish a much higher standard, I think. The treaty therefore has something in it for every country, whether they want to put in stringent measures or weaker ones. Those are some of the main points that I wanted to make, and my one minute is up.

da Costa e Silva: The first of two things I have to say is that the tobacco industry came up with strategies to derail the treaty negotiations. The three main transnational tobacco companies came up with a voluntary agreement to counteract the treaty and wanted to be part of the discussion, claiming to be part of the solution, trying to engage in a dialogue with WHO. WHO's Secretariat addressed the issue by creating the Scientific Advisory Group on

¹⁶⁹ Assunta and Chapman (2004): 755.

¹⁷⁰ In 2001, Hallmark Public Relations, Winchester, UK, served the ITGA (Must (2001)), freely available at: www.healthbridge.ca/itgabr.pdf; www.hallmarkpr.co.uk (visited 3 November 2011); see also Rimmer (2005).

¹⁷¹ For international convention flexibility, see Taylor and Bettcher (2000): 922.

Tobacco Product Regulation.¹⁷² During the meetings of this group, we were able to listen to presentations from the tobacco industry. This was an open door for the tobacco industry to bring information, while keeping the organization, WHO, protected from any mention of a non-existent ‘dialogue’. The group has recently changed the focus because the tobacco industry was not bringing relevant input. In fact, it looked like they didn’t want to collaborate, they just wanted to move their agenda of advancing their business forward.

The second thing is that we had three important players there: the governments, of course; the NGO community, of course; and the WHO Secretariat, which is barely mentioned. The importance of the secretariat in supporting the process and in continuing the work on tobacco control with the different WHO member states proved to help the process itself. Finally, I think that the multisectoral approach to tobacco control is still the big challenge – for example, to make tobacco control an integral part of the UN agenda – but we are still not there yet. At the country level, the challenge is the same. Efforts to bring the ministries for culture and trade on board and to have tobacco control on their agendas have proven very difficult. Finally, I think we have a successful story here that is an example for other programmes: for health promotion, for non-communicable diseases and for other areas of public health.

Cunningham: First of all, the secretariat was very important in terms of the success of the treaty, because of their high capabilities and their energy. On the last question, please note: the industry *did* make a lot of effort to weaken things. The duty-free lobby was present throughout negotiations, especially in week two of the INB-6 (February 2003), when the tobacco industry started appearing in numbers all over the place. The voluntary tobacco advertising code, released in September 2001, was a major tobacco industry initiative to weaken the advertising provisions.¹⁷³ They had the coincidence of launching

¹⁷² See, for example, the Scientific Advisory Group’s third report, freely available at http://whqlibdoc.who.int/publications/2009/9789241209557_eng.pdf (visited 5 December 2011); see also Glossary, page 122.

¹⁷³ British American Tobacco (BAT), along with Philip Morris and Japan Tobacco, announced International Tobacco Product Marketing Standards in 2001 and invited international discussion. The companies agreed voluntarily to adopt measures that would prevent tobacco marketing activities directed at young people. It is claimed that voluntary codes of advertising were first adopted in the US, Canada and Britain in the 1960s. See Saloojee and Hammond (2001); see also Assunta and Chapman (2004); Mamudu *et al.* (2008).

that initiative on 11 September 2001.¹⁷⁴ They had been preparing this public relations initiative for a very long time and received no public relations impact, because there was no media coverage; it was launched in Europe before the disaster, which dominated the media for months afterwards.¹⁷⁵

So what are some big picture comments? The FCTC has been an incredible success. Personally, I started to appreciate the full potential of this fact only at INB-1 (October 2000). When I saw what happened at INB-1, I thought: ‘We could achieve something here’, in a way that I hadn’t fully appreciated before this date. The success of the convention has exceeded my expectations. People said: ‘If you implement the advertising ban, people aren’t going to ratify it’ and stuff like that. The ratifications have been fantastic. People are implementing their obligations and let’s just keep at it. We have a lot of work to do and there are going to be more issues, you know, for example, plain packaging, which has been cited in the most recent Guidelines for Article 11, Article 13 – that’s an issue for the future, which will require the involvement of all the stakeholder groups around this table.¹⁷⁶

Mackay: I think the FCTC has brought about a sea change from 30 years ago when many of us started working in tobacco control. There’s no doubt about it. This treaty makes it much more difficult for the industry to pick off individual countries, one-by-one, and influence them. They can’t go to Laos and say: ‘No-one in their right mind would ban advertising.’ It has given a sense of togetherness, community and information sharing, so the tobacco companies can’t do that any more.¹⁷⁷

Secondly, it’s worth putting on record that the inclusion of the NGOs in this process was treated with quite a bit of negativity by some of the government delegations – whether the NGOs should even be allowed to participate or be

¹⁷⁴ The date of the destruction of the Twin Towers in New York and the attack on the Pentagon, 9/11.

¹⁷⁵ See also notes 144 and 145.

¹⁷⁶ For one debate surrounding plain packaging of cigarettes, see the Parliament of Australia’s Tobacco Plain Packaging Bill 2011, which received Royal Assent on 1 December 2011, at <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=customrank;page=0;query=plain%2Bpackaging%2Bdebate;rec=0;resCount=Default> (visited 30 April 2012). For seven guidelines for the implementation of Articles 5.3, 8, 9 and 10, 11, 12, 13 and 14, see FCTC (2009b) at: www.who.int/fctc/guidelines/en/ (visited 16 July 2010).

¹⁷⁷ For an ASH briefing on the UK tobacco advertising and sponsorship ban following the implementation of the Tobacco Advertising and Promotion Act 2002, see www.ash.org.uk/current-policy-issues/advertising/why-ban-tobacco-advertising (visited 17 November 2011).

allowed to speak. This was quite controversial in the beginning.¹⁷⁸ But anyhow, that prevailed. The treaty considerably strengthened the international NGO tobacco-control community.¹⁷⁹

Thirdly, this treaty has also lent itself to funding. We now have big funders for tobacco control, like Bloomberg and Gates, with funding going to government organizations, NGOs and WHO's TFI, although unfortunately, not directly to the FCTC process. The problem here is that, firstly, the funders felt that it would be difficult for foundations to give money to governments. And secondly, if they did so, then this act of giving would reduce the responsibility of governments to fund the FCTC. Funding went to countries and is being used, but not directly for the FCTC process.

Finally, for the first time in Asia we are now seeing a whole set of new arguments to try to fight against the FCTC. I would say that it is only within the last six to nine months (2009/10) that they, these extreme right-wing libertarian arguments, have, are and will be calling for 'less government, not more government', and describe tobacco-control measures as 'heavy-handed, paternalistic'. In fact we discovered that one of these right-wing groups, funded by the industry, actually said in public in 2010 that government does not have the responsibility to care for the health of its people.¹⁸⁰ It's ridiculous. I know some of you have had this for a long time, but this argument is now being used in the low- and middle-income countries of the world.

¹⁷⁸ Ms Kathy Mulvey wrote: 'The WHA resolution launching the negotiations (May 1999, online at http://apps.who.int/gb/archive/pdf_files/WHA52/ew38.pdf) included strong language in support of NGO participation, and the May 2000 WHA resolution on the FCTC (WHA53.16, online at http://apps.who.int/gb/archive/pdf_files/WHA53/ResWHA53/16.pdf) called on the INB "to examine the question of an extended participation, as observers, of non-governmental organizations according to criteria to be established by the Negotiating Body." As a result, WHO adopted an accelerated process for admitting NGOs into official relations, and two NGOs (Infact and INGCAT) were so admitted in 2002.' Note on draft transcript, 20 July 2010.

¹⁷⁹ Dr Judith Mackay wrote: 'For example, the Framework Convention Alliance (FCA) was founded in 1999 and now [in 2010] is made up of over 350 organizations from more than 100 countries working on the development, ratification and implementation of the international treaty, the WHO's FCTC. In addition, funding from the Bloomberg Initiative and subsequently from the Bill and Melinda Gates Foundation followed, offering serious funding for tobacco control for the first time in low- and middle-income countries in support of the FCTC.' Note on draft transcript, 1 July 2010. See www.gatesfoundation.org/topics/Pages/tobacco.aspx; www.tobaccocontrolgrants.org/Pages/44/About-the-Bloomberg-Initiative (both visited 5 December 2011).

¹⁸⁰ For another view of the effects of the 50 per cent increase in Hong Kong tobacco tax in 2009, see Alpert (2010).

Mulvey: I have three points, one on NGOs, one on the industry and one on the other players. One critical issue around NGOs was their involvement beyond the public health community and their ability to draw in environmental groups, groups working on fair trade, consumer groups and faith organizations. A big part of the draw was the potential precedents that this treaty could set for the other issues that NGOs care about and are working on, particularly with regard to placing health before trade and preventing commercial conflicts of interest from intruding into public policy-making. The NGOs could name names – we’ve spoken about this, but just to say it clearly – it gave us a different role in the process. Also, we haven’t spoken much about the media today, but as Dr Mackay said earlier, when we first heard the word ‘convention’, we thought it was a meeting – I thought that the first time too. So, we needed to be able to take what was happening here and translate it in a way that could then go out through the media to the public, and there were critical points where media attention, either internationally or in particular countries, made a huge difference in the negotiations.¹⁸¹

In terms of the tobacco industry: to follow up on what Dr Zeltner said about Philip Morris.¹⁸² While I think they express support for the treaty, they have an ‘à la carte’ menu approach to it. The tobacco industry doesn’t like the advertising ban, they don’t like that the treaty addresses litigation, they don’t like taxation,¹⁸³ and last year when we asked them about Article 5.3, they said they would never back off from public policy-making.¹⁸⁴ So they are definitely trying to put a

¹⁸¹ Ms Kathy Mulvey wrote: ‘At INB-6 in February 2003, media coverage helped put pressure on negotiators to deliver a strong, effective text. For example, Infact and NATT gave the chair, Ambassador Luis Felipe de Seixas Correa, the Marlboro man award on the opening day of INB-6, because in our analysis the chair’s text was too weak to reverse the global tobacco epidemic. The award received extensive media coverage in Brazil, the chair’s home country, including in the major national newspaper *O Estado de São Paulo*, which put significant pressure on him to respond to the majority of countries that were calling for the text to be strengthened dramatically.’ Note on draft transcript, 30 January 2012.

¹⁸² See note 117.

¹⁸³ Ms Kathy Mulvey wrote: ‘See Philip Morris/Altria/Philip Morris International annual reports for their corporate responses to the FCTC. For a critique of current tobacco industry positions on the FCTC and the proposed Illicit Trade Protocol, see my commentary (Mulvey (2010)).’ Note on draft transcript, 20 July 2010.

¹⁸⁴ For Article 5.3, see Appendix 1, page 73. See *Clearing the Smoke-Filled Room: An exposé on how the tobacco industry attempts to undermine the global tobacco treaty and the illicit trade protocol* (Corporate Accountability International and NATT, 2009, online at www.stopcorporateabuse.org/sites/default/files/INB3%20English%20FINAL.pdf) for details (visited 18 April 2012).

positive face forward. A final point on this process: it strikes me – this has been a fascinating discussion – I’m sure the lead negotiators, the bureau members, the people who kept their regional groups together could add so much richness to this discussion.¹⁸⁵

Ogwell: As we close this Witness Seminar, I have two things to say: first is that history teaches us that history doesn’t teach us anything. [Laughter] I say this, because we have had a lot of discussion at the international level since, I think, the mid-1990s, and, as far as tobacco control at the international level is concerned, we are stuck there. We don’t seem to be moving to where the industry is. And on Zeltner’s ‘split theory’: it’s not a theory, it is reality.¹⁸⁶ The split is on two levels: internationally, so we start seeing that this group says this and that group says that, and we are mesmerized by the fact that: ‘Some are actually saying something that sounds like us.’ Yet it is all by design. I say it’s by design, because at the national level, there are the local industries and then there are the multinationals. The multinationals play the good chaps and the local industry play the bad chaps. The local industry is local, so it strikes a very good tone with the local politicians. In the meantime, when push comes to shove, then the multinationals provide the funds to be able to disorganize any activities of tobacco control within the country. So we are stuck with discussions at the international level and we have not got to the country level yet. Having said that, I must say that the convention has been a huge success at the global level, but we still need to do more at the national level.¹⁸⁷

This brings me to my second point. We have been led to believe that we need a lot of money to be able to achieve success. Wrong. Look at all the countries that have achieved huge improvements, such as Thailand.¹⁸⁸ They didn’t get

¹⁸⁵ For the background to the composition of this Witness Seminar, see pages 3–4.

¹⁸⁶ See page 62.

¹⁸⁷ One example of the lack of improvement at national level is the absence of national support for cessation, see Meier (2005). For comments on the FCTC’s failure to address directly smoking cessation and harm-reduction strategies, see Meier and Shelley (2006); for a rational scale of assessment of potential harm of tobacco, see Nutt *et al.* (2007).

¹⁸⁸ Thailand established the National Committee for Control of Tobacco Use in 1989 and the Institute of Tobacco Consumption Control under the Ministry of Public Health in 1990. Thailand’s Parliament passed the Nonsmoker’s Health Protection Act and the Tobacco Products Control Act in 1992, under the guidance of Dr Hatai Chitanondh. See, for example, Chitanondh (2001); see also Vateesatokit (2003); Roemer (2004); for other champion countries, see pages 24, 43, 56, 69, 81.

any money internationally, everything was national. Now if we reorganize our debates, if we reorganize our thoughts and messages to the local people, then we can get the successes that we are looking for now. It's not necessary for money to come from outside, but it's good to support the international processes, meetings, conventions, etc. It does not contribute to the successes at the national level. It is local resources that will achieve what is required. By local resources, it is going to be tax money, because this tax money comes from me and you as the taxpayer, so it is our money that is actually going to make the difference.¹⁸⁹ But, we have been led to believe that we should wait for this big money to come internationally, so that it trickles down to the national level. A lot of the international money disappears in travel, meetings and payments to whatever, the system that supports the process, not the activities at national level. If we stop thinking of this big international money and start thinking of the little national level resources, and fix our attention on that, then we are going to be able to win the next level of the discussion. But the tobacco industry has focused our discussion on international issues and we have ignored the fact that it is the national level that will help us to achieve our goal. But I hope that this history will actually teach us something.

McLellan: Dr Zeltner, by virtue of the Z, you have the last word. Unfortunately you have minus three minutes to speak. [Laughter]

Zeltner: I will be very brief. I think there are lessons to be learned and I'm glad that you will write this up. There are three things that strike me: one is the disruptive power of transparency, of bringing hidden facts into the public domain. The second lesson is that leadership is key. I think maybe five people have made that happen, in the end. One is Amorim, one is Brundtland, and some others, some are the staff at WHO. The reason that could happen brings me to my third lesson, which is that telling a convincing story is very important and allows new alliances to emerge that did not seem possible before. A story that makes people think: 'Yes, we need to do something now.' And then to say: 'We submit ourselves to leaders and these leaders commit themselves not to

¹⁸⁹ Ms Kathy Mulvey wrote: 'I think Dr Ogwell may have meant taxation and the "polluter pays" principle. If so, it would be helpful to make it clear that this is not talking about voluntary industry contributions, but compensation due to legal settlements or mandated by law or legally binding and enforceable agreements (see Recommendation 6.4 of the Article 5.3 implementation guidelines, online at www.who.int/fctc/guidelines/article_5_3.pdf).' Note on draft transcript, 20 July 2010.

egoism, but to this story and to bringing it to a positive ending.’ I think that this history has shown us that great steps forward can be made, and that’s a wonderful lesson from the FCTC.

Bhattacharya: This has been fascinating. Thank you all for joining us. As a student of the history and politics of global health, what I take home today is the importance of HQ-level action at the WHO. But I also recognize that regions and countries play an incredibly important role. So when I get legions of MA and PhD students to look at global health in critical ways, this is the message I will give them; the message I’m taking back from all of you. Multisectoral action is very important; it’s something that’s underlined in the official histories that have been distributed. But, you know, documents are often a product of a particular age. What this highlights is the importance of horizontal action. This is, after all, the age of the resurgence of primary health care. However, I think vertical actions, from what you’ve said, are also very important. What do I mean by vertical? The global strengthening of national positions, something Dr Assunta was able to talk about in a very sensitive way. So, horizontal action within nations is important, but the vertical where international bodies can step in and empower governmental agencies at crucial moments, seems to be very important. So I would call this what I like to label in my classes as ‘intermeshed histories’; histories that don’t ignore the many facets of a very complex mosaic.

Tansey: May I finally reiterate our thanks to staff here at the WHO, to thank Sanjoy and in particular, Faith, for excellent facilitation. Your timekeeping has been shot to pieces, Faith, but we gave you an absolutely impossible task. Thank you very much. Thank you all very much for coming, for participating so engagingly and whole-heartedly. This is not my field at all, but I have learned so much, and I am going back to London with so many ideas. But, I also have all your addresses and your e-mails [laughter] and we will continue to be in touch with you as we transcribe and start editing this material.

Al-Shorbaji: Thank you, Faith, for moderating the session, and I hope you will continue to provide this support in future series. It has been a pleasure to have all of you, and, of course, to have colleagues from the Wellcome Trust Centre for the History of Medicine at UCL.¹⁹⁰ Since this is the first Witness Seminar in collaboration with WHO, I hope it will be the first in a series of seminars that we will collaborate on, as there are so many other topics, other public health issues,

¹⁹⁰ Reconstituted as the History of Modern Biomedicine Research Group at the School of History, Queen Mary, University of London, from October 2010, funded by the Wellcome Trust.

this wealth of knowledge that we probably need to explore, to experience and to learn from history. I would sincerely like to thank you for joining us today and for sharing with us and the world these historical moments. We look forward to seeing the published transcript of this seminar. I hope the final publication will also be augmented by regional inputs on the topic. I am aware of the efforts made by many staff in WHO regional offices to convince governments and to lobby with governments and the NGOs to ratify the FCTC. When I was working for the WHO Regional Office for the Eastern Mediterranean in Cairo, there was a lot of lobbying and working with community and religious leaders to secure their support for the convention and to ban smoking by all means.¹⁹¹

Ogwell: From the Convention Secretariat's perspective, I think our message is that history is still being made, as we speak.¹⁹² The FCTC is being implemented at country level; the first protocol of the Convention itself is also currently being negotiated. A lot of history is still being made, and the lesson we take away is that we need to keep our records a little bit better [laughter], in order to to record some of these issues when they are still fresh in our minds, so that the students of tomorrow will be able to utilize that information.

¹⁹¹ See, for example, WHO, EMRO (2002). Freely available as a revised edition at: www.who.int/tobacco/communications/TI_manual_content.pdf (visited 16 November 2001).

¹⁹² See, for example, www.bbc.co.uk/news/world-11845158 (visited 3 April 2012). The final negotiations on an FCTC protocol (Article 15) on 'Illicit trade in tobacco products', were conducted in March–April 2012 in Geneva, see www.who.int/fctc/protocol/illicit_trade/en (visited 3 April 2012).

Appendix 1

Selected Provisions of the FCTC¹⁹³

Article	Topic	Measure
Article 5.3	Lobbying	Call for a limitation in the interactions between lawmakers and the tobacco industry
Articles 6 & 7	Demand-reduction	Price and non-price measures and tax measures to reduce the demand for tobacco
Article 8	Passive smoking	Obligation to protect all people from exposure to tobacco smoke in indoor workplaces, public transport and indoor public places
Article 10	Regulation	The contents and emissions of tobacco products are to be regulated and ingredients are to be disclosed
Articles 9 & 11	Packaging and labelling	Large health warning – at least 30 per cent of the packet cover; 50 per cent or more recommended; deceptive labels – 'mild', 'light', etc. – are prohibited
Article 12	Awareness	Education, communication, training and public awareness for the consequences of smoking
Article 13	Tobacco advertising	Comprehensive ban on tobacco advertising, promotion and sponsorship, unless the national constitution forbids it
Article 14	Addiction	Demand-reduction measures concerning tobacco dependence and cessation
Article 15	Smuggling	Action is required to eliminate illicit trade in tobacco products
Article 16	Minors	Restricted sales to minors
Article 17	Viable alternatives	Provision of support for economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers
Article 18	Environment	Protection of the environment and the health of persons
Article 19	Liability	Legislative action or promotion of existing laws, to deal with criminal and civil liability, including compensation
Articles 20, 21 & 22	Research	Tobacco-related research and information sharing among the parties

¹⁹³ See www.who.int/tobacco/framework/WHO_FCTC_english.pdf (visited 16 July 2010).

Appendix 2

WHO regions

Regional Office for Africa (Brazzaville, Congo)	Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
Regional Office for the Americas (Washington, DC)	Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States of America, Uruguay, Venezuela (Bolivarian Republic of)
Regional Office for South-East Asia (SERO, New Delhi, India)	Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste
Regional Office for Europe (EURO, Copenhagen, Denmark)	Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan
Regional Office for the Eastern Mediterranean (EMRO, Cairo, Egypt)	Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, South Sudan, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen
Western Pacific Regional Office (WPRO, Manila, Philippines)	Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Federated States of Micronesia, Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu, Vietnam

Appendix 3

WHO Framework Convention on Tobacco Control, timeline, 1993–2011¹⁹⁴

1993/4	Initial conceptualization of an international legal approach to tobacco control
1994	October: resolution passed at the 9th World Conference on Tobacco or Health in Paris urging adoption of an international instrument for tobacco control
1995	12 May: World Health Assembly officially introduces the concept of an international strategy for tobacco control in resolution WHA48.11
1996	25 May: WHA requests (resolution WHA 49.17) the WHO Director-General to initiate preparation of a framework convention on tobacco control
1998	15 May: Dr Gro Harlem Brundtland elected WHO Director-General and makes tobacco control one of her priorities July: WHO Tobacco Free Initiative is created
1999	25 May: WHA decides (resolution WHA.52.18) to establish an intergovernmental negotiating body (INB) to draft and negotiate a framework convention on tobacco control and a working group of WHO member states to undertake preparatory work for the intergovernmental negotiating body 25–29 Oct: first meeting of the FCTC technical working group
2000	27–29 Mar: second meeting of the FCTC technical working group 20 May: FCTC Working Group reports to WHA and WHA recognizes (resolution WHA53.16) that proposed draft elements of the framework convention as a basis for initiating negotiations by the intergovernmental negotiating body, and requests the WHO Director-General to convene the first negotiating session 12–13 Oct: WHO conducts public hearings on the proposed framework convention on tobacco control 16–21 Oct: INB-1 with Ambassador Celso Nunes Amorim of Brazil as chair; work on chair's text of the framework convention starts
2001	Jan: INB chair's text of the framework convention is released

¹⁹⁴ Adapted from WHO, FCTC Secretariat (2010): 40–1; for budget details of the Convention, see FCTC/COP4(20) 'Workplan and budget for the financial period 2012/13', freely available at pages 78–96 at www.who.int/fctc/copdecisionrevone.pdf (both visited 6 December 2011). For other timeline details, see Framework Convention Alliance at www.fctc.org/index.php?option=com_content&view=article&id=7&Itemid=8 (visited 21 December 2011); for Conference of the Parties, see Glossary, page 119–20.

	<p>Mar–May: regional inter-sessional consultations are held in preparation for INB-2 session</p> <p>30 Apr–5 May: second INB meeting produces first partial draft of framework convention</p> <p>Sep–Nov: regional inter-sessional consultations are held in preparation for the third INB session</p> <p>22–28 Nov: INB-3 meeting</p>
2002	<p>Feb–Mar: regional inter-sessional consultations are held in preparation for the fourth INB session</p> <p>18–23 Mar: INB-4 meeting; Ambassador L F de Seixas Corrêa replaces Amorim as chair and a revised chair's text produced</p> <p>July–Aug: international technical conference at UN, New York, on illicit trade in tobacco products organized by US government</p> <p>14–25 Oct: INB-5 meeting</p>
2003	<p>Revised chair's text released</p> <p>17–28 Feb: INB-6. A draft framework convention sent to 56th WHA for adoption</p> <p>21 May: WHA unanimously adopts FCTC, and establishes an open-ended intergovernmental working group to consider and prepare proposals from the FCTC for consideration and adoption at the first session on the conference of the parties</p> <p>16–22 June: FCTC open for signature at WHO headquarters in Geneva: 28 member states and the EU sign the treaty on the first day and from 30 June at UN headquarters</p>
2004	<p>21–24 June: first meeting of the open-ended intergovernmental working group</p> <p>29 June: 168 signatories at the end of signature period</p> <p>29 Nov: The deposit of the 40th instrument of ratification brings entry into force of the FCTC, acceptance, formal confirmation or accession. Both Armenia and Ghana deposit their instruments in New York on this day</p>
2005	<p>31 Jan–4 Feb: second meeting of the open-ended intergovernmental working group</p> <p>27 Feb: WHO FCTC enters into force, 90 days after the deposit of the 40th instrument of ratification, acceptance, approval formal confirmation or accession</p>
2006	<p>February: first session of Conference of the Parties (COP-1) in Geneva</p> <p>May: convention secretariat established by 59th WHA as requested by the Conference of the Parties</p> <p>16–18 Nov: second meeting of the expert group to prepare a template for a protocol on cross-border tobacco advertising, promotion and sponsorship</p>

3–5 Dec: second meeting of the expert group to prepare a template for a protocol on illicit trade in tobacco products

2007	<p>26 Feb: public hearing for the FCTC on agricultural diversification and alternative crops to tobacco</p> <p>27–28 Feb: first meeting of the ad hoc study group on alternative crops</p> <p>30 June–6 July: COP-2. Dr Haik Nikogosian is appointed the first head of the convention secretariat</p> <p>6 July: guidelines for implementation of Article 8 (protection from exposure to tobacco smoke) are adopted by the Conference of the Parties (COP-2)</p> <p>26–28 Sep: third meeting of the working group for development of guidelines on Article 9 (regulation of the contents of tobacco products) and Article 10 (regulation of tobacco product disclosures)</p> <p>7–9 Nov: meeting of the working group for development of guidelines on implementation of Article 11 (packaging and labelling of tobacco products)</p> <p>27–29 Nov: first meeting of the working group for development of guidelines on implementation of Article 13 (tobacco advertising, promotion and sponsorship) and recommendations on key elements of a protocol or other measures that would contribute to the elimination of cross-border tobacco advertising, promotion and sponsorship</p> <p>12–14 Dec: meeting of the working group for development of guidelines on implementation of Article 5.3 (protection of tobacco-control policies from commercial and other vested interests of the tobacco industry)</p>
2008	<p>11–16 Feb: first meeting of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products in Geneva</p> <p>21–23 Feb: first meeting of the working group for development of guidelines on implementation of Article 12 (education, communication, training and public awareness)</p> <p>3–4 Mar: meeting of the drafting group for development of guidelines on implementation of Article 5.3 (protection of tobacco-control policies from commercial and other vested interests of the tobacco industry)</p> <p>4–5 Mar: meeting of the drafting group for development of guidelines on implementation of Article 11 (packaging and labelling of tobacco products)</p> <p>5–7 Mar: Fourth meeting of the working group for development of guidelines on Article 9 (regulation of the contents of tobacco products) and Article 10 (regulation of tobacco product disclosures)</p>

	31 Mar–Apr 2: second meeting of the working group for development of guidelines on implementation of Article 13 (tobacco advertising, promotion and sponsorship) and recommendations on key elements of a protocol or other measures that would contribute to the elimination of cross-border tobacco advertising, promotion and sponsorship
	3–4 Apr: meeting of the drafting group for development of guidelines on implementation of Article 13 and recommendations on a protocol or other measures to contribute to the elimination of cross-border tobacco advertising, promotion and sponsorship
	17–19 June: second meeting of the study group on economically sustainable alternatives to tobacco growing (formerly known as the ad hoc study group on alternative crops)
	20–25 Oct: second meeting of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products
	17–22 Nov: third meeting of the Conference of the Parties
	22 Nov: COP-3, held in Durban, South Africa, adopts guidelines for implementation of Article 5.3 (protection of tobacco-control policies from commercial and other vested interests of the tobacco industry); Article 11 (tobacco product packaging and labelling); and Article 13 (tobacco advertising, promotion and sponsorship)
2009	28 June–5 July: third meeting of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products, held in Geneva
2010	27 Feb: fifth anniversary of the entry into force of the convention 14–21 Mar: fourth INB on a Protocol on Illicit Trade in Tobacco Products 14–20 Nov: fourth meeting of the Conference of the Parties (COP-4) 20 Nov: COP-4 adopts guidelines for implementation of Articles 9 and 10 (partial guidelines on tobacco flavourings and additives); Article 12 (education and awareness), Article 14 (demand-reduction measures)
2011	4–8 July: first meeting of the Informal Working Group on a protocol to eliminate illicit trade in tobacco products

Appendix 4

World's leading unmanufactured tobacco producing, trading and consuming countries, metric tons dry weight, as presented to 10th World Conference on Tobacco or Health, Beijing, 24–28 August 1997

	1993	1994	1995	1996	1997*
Production					
World total	7 325 157	5 609 552	6 579 289	5 547 668	7 312 915
China, People's Republic of	3 118 000	2 000 000	2 082 600	2 910 600	3 315 600
United States	651 511	641 181	513 247	625 454	667 680
India	522 540	475 200	528 390	506 475	544 050
Brazil	509 000	365 000	323 500	367 000	497 053
Turkey	280 803	155 818	170 070	190 391	245 260
Zimbabwe	201 992	152 490	179 243	178 605	165 240
Exports					
World total	1 735 554	1 694 877	1 768 823	1 956 381	1 924 745
Brazil	243 500	275 500	256 300	282 500	294 000
United States	207 747	196 792	209 482	222 316	221 509
Zimbabwe	188 261	203 485	174 289	195 958	175 572
Turkey	91 350	112 411	136 392	170 098	156 200
India	91 000	22 390	77 680	118 000	115 000
Italy	124 563	110 332	118 839	138 829	107 000
Imports					
World total	1 765 584	1 786 902	1 797 557	1 977 436	1 939 307
United States†	359 738	264 390	199 088	326 455	306 838
Germany‡	154 175	182 785	209 761	235 855	250 000
Russian Federation	144 125	143 080	148 110	125 296	148 800
United Kingdom	124 324	97 958	141 467	166 027	131 876
Netherlands	83 623	86 546	89 075	97 368	97 500
Japan	118 651	135 543	115 072	85 634	96 000

* Estimate

† General imports (actual arrivals)

‡ Unified Germany

	1993	1994	1995	1996	1997*
Consumption					
World total	6 958 079	6 860 867	6 332 896	6 504 763	6 303 870
China, People's Republic of	2 907 029	2 808 734	2 208 554	2 313 705	2 115 134
United States	725 241	667 146	699 200	714 138	710 000
India	426 045	438 605	463 920	472 070	478 760
Indonesia	139 733	165 786	183 050	196 670	200 550
Japan	179 235	190 000	196 900	197 250	195 700
Brazil	143 000	152 500	166 900	179 400	187 400

* Estimate

† General imports (actual arrivals)

‡ Unified Germany

Source: US Department of Agriculture, Foreign Agricultural Service,
Circular Series FT-02-98, February 1998, Table 1, page 8.
Adapted from: Samet *et al.* (1999): 77.

Appendix 5

Reflections on FCTC negotiations: China and Japan

Dr Judith Mackay, 15 December 2011

The FCTC negotiations were complex for both China and Japan, particularly as China is the world's biggest producer and both countries being large tobacco manufacturing states. In fact, the Chinese government is the largest tobacco company in the world, with approximately a one-third share of the global market.¹⁹⁵ The concerns voiced by these two nations were principally economic: the misconception that tobacco control would be an economic debit and harmful to their tobacco industries and, for example, leading to loss of jobs and decreased tobacco tax revenues. The reality has been the opposite. Because of population expansion in the low- and middle-income countries, there will be more smokers up to at least 2035, even if prevalence is reduced. Both countries received the NGO Framework Convention Alliance 'Dirty Ashtray' awards for bad behaviour during the negotiations: China (4 times) and Japan (14 times, the most given to any single country). In March 2002 at INB-4, Japan was openly labelled by an NGO as an 'axis of evil', which had an impact on Japan's negotiating stance.¹⁹⁶ Latterly both countries won an Orchid award for recognition of leadership.

Japan

The Japanese government is also an important shareholder in the Japanese tobacco industry. Negotiations to develop the WHO FCTC were based on consensus, resulting in countries needing to agree to the lowest acceptable common denominator in clause development. The Japanese government's proposals for 'appropriate' and optional measures were reflected in the final FCTC text that accommodates flexibility on interpretation and implementation. Japan's success in arguing for extensive optional language seriously weakened the FCTC. Japan called for deletion of text that was too prescriptive or stringent at least 35 times during the course of the negotiations. For example, on ingredient listing, Japan proposed that the word 'all' should be deleted from 'all ingredients'¹⁹⁷ and

¹⁹⁵ Eriksen *et al.* (2012).

¹⁹⁶ Assunta and Chapman (2004): 755; see also page 63.

¹⁹⁷ WHO (2002a).

that ‘including counter advertising’¹⁹⁸ be deleted as an education and public awareness strategy. At INB-6, Japan called for a deletion of the text on liability. Accordingly, international tobacco control can be expected to be less successful in reducing the burden of disease caused by tobacco use.¹⁹⁹

In June 2004 Japan ratified the WHO Framework Convention on Tobacco Control (FCTC) being among the first 20 countries to do so.²⁰⁰ The ratification was described as an ‘extraordinary turn-around’ by the former head of the WHO’s Tobacco Free Initiative²⁰¹ and surprised many in global tobacco control. The Japanese government’s substantial ownership of the world’s fourth largest transnational tobacco company, Japan Tobacco (JT, see Table 4, page 26), was seen by many as responsible for its weak tobacco-control measures. Japan’s decision to ratify the FCTC was said to have been done with ‘marked reluctance.’²⁰² During the negotiations, Japan, along with the US and Germany were viewed as working against the FCTC.²⁰³

China

In 2000, China, along with other countries, all nations with significant tobacco industries (US, Germany, Russia, India, Argentina, Zimbabwe, Malawi and Turkey), called for a broad treaty, leaving decisions in specific matters to individual governments.²⁰⁴

In 2004, Chinese officials reputedly asked the president of Brazil’s tobacco growers association, Afubra, to intervene with the Brazilian Embassy, to ensure that Brazil did not ratify the FCTC, given that China ‘will not ratify this document’.²⁰⁵ China finally ratified in 2005, two years after signing the treaty.

¹⁹⁸ WHO (2002b).

¹⁹⁹ Assunta and Chapman (2004): 755.

²⁰⁰ For the parties to the WHO FCTC, see www.who.int/fctc/signatories_parties/en/index.html (16 December 2011).

²⁰¹ Yach (2005).

²⁰² Assunta and Chapman (2004): 751.

²⁰³ Nullis (2002); see www.tobacco.org/news/105929.html (visited 16 December 2011); Wilkenfeld (2001) at www.tobaccofreekids.org/press_releases/post/id_0416; Brinson (2003) at www.tobaccoreporter.com (both visited 16 December 2011); Assunta and Chapman (2004).

²⁰⁴ British American Tobacco (2000).

²⁰⁵ Bialous (2004).

However, China has still not fully fulfilled its FCTC commitment.²⁰⁶ Many of the tobacco-control laws remain outdated, e.g. the ban on tobacco advertising, promotion and sponsorship, and China still has only small, non-pictorial packet warnings. While tobacco tax was increased in 2009, the rise in tax was not passed on to the retail cost of cigarettes, which remained at the same retail price, defeating the whole purpose of tax increases from a public health standpoint. The Chinese tobacco monopoly is thought to be a hindrance to the effective implementation of the FCTC. There has been much discussion about separating the dual functions of the government tobacco monopoly, as in Thailand, into a commercial state-controlled organization, separate from any tobacco-control function.

More recently, China published several authoritative reports on smoking in China,²⁰⁷ and announced bans on smoking in many public places.

²⁰⁶ Lv *et al.* (2011).

²⁰⁷ Chinese Center for Disease Control (2011); China, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (2011).

References

- Abedian I, van der Merwe R, Wilkins N, Jha P. (eds) (1998) *The Economics of Tobacco Control: Towards an optimal policy mix*. Rondebosch: Applied Fiscal Research Centre, University of Cape Town.
- Action on Smoking and Health (ASH). (1996) *Tobacco Advertising: The case for a ban*, 5th edn. London: ASH.
- Alpert N. (2010) Failed tobacco tax sees hopes go up in smoke. *The Hong Kong Standard* (January 25). Available at: www.lionrockinstitute.org/english/index.php?option=com_content&view=article&id=130:failed-tobacco-tax-sees-hopes-go-up-in-smoke&catid=40:oped-a-columns&Itemid=3 (visited 5 March 2012).
- American Cancer Society and International Union Against Cancer. (2003) *Strategy Planning for Tobacco Control Advocacy*, Tobacco Control Strategy Planning Guide no. 1. Freely available at: http://strategyguides.globalink.org/pdfs/guide1_AdvocacyGuide.pdf (visited 16 November 2011).
- Anon. (1998) News analysis: Wind of change at WHO. *Tobacco Control* **7**: 227; doi:10.1136/tc.7.3.e227.
- Anon. (1999) A-rise, Sir Richard: News analysis. *Tobacco Control* **8**: 242; doi:10.1136/tc.8.3.242f.
- Anon. (2004) Editorial: publishing tobacco tar measurements on packets. *British Medical Journal* **329**: 813–14.
- Ashley D L, Pankow J F, Tavakoli A D, Watson C H. (2009) Approaches, challenges, and experience in assessing free nicotine. *Handbook of Experimental Pharmacology* **192**: 437–56.
- Assunta M. (c.1999) A perspective from the South. In *The Effects of Globalization on Health and NGOs' Role in Tobacco Control*, Report of the NGO Forum for Health symposium in May 1999. Geneva: NGO Forum for Health, 20–7.
- Assunta M, Chapman S. (2004) Research paper: the tobacco industry's accounts of refining indirect tobacco advertising in Malaysia. *Tobacco Control* **13**: ii63–ii70; doi:10.1136/tc.2004.008987.

- Baris E, Brigden L W, Prindiville J, da Costa e Silva V L, Chitanondh H, Chandiwana S. (2000) Special Communication: research priorities for tobacco control in developing countries: a regional approach to a global consultative process. *Tobacco Control* **9**: 217–23.
- Barnes D E, Hanauer P, Slade J, Bero L A, Glantz S A. (1995) Environmental tobacco smoke: the Brown and Williamson documents. *Journal of the American Medical Association* **274**: 248–53.
- Barnham H. (1994) The economic burden of the global trade in tobacco. *Tobacco Control* **3**: 358–61.
- Bates C, McNeill A, Jarvis M, Gray N. (1999) The future of tobacco product regulation and labelling in Europe: implications for the forthcoming European Union directive. *Tobacco Control* **8**: 225–35.
- Berridge V. (2006) The policy response to the smoking and lung cancer connection in the 1950s and 1960s. *Historical Journal* **49**: 1185–2309.
- Berridge V, Christie D A, Tansey E M. (eds) (2006) *Public Health in the 1980s and 1990s: Decline and rise?* Wellcome Witnesses to Twentieth Century Medicine, vol. 26. London: The Wellcome Trust Centre for the History of Medicine at UCL. Freely available at: <http://www.history.qmul.ac.uk/research/modbiomed/index.html>
- Berridge V. (2007) *Marketing Health: Smoking and the discourse of public health in Britain, 1945–2000*. Oxford: Oxford University Press.
- Bettcher D W, Yach D. (1998) The globalization of public health ethics? *Millennium: Journal of International Studies* **27**: 469–96.
- Bettcher D W, Yach D, Guindon E. (2000) Global trade and health: key linkages and future challenges. *Bulletin of the World Health Organization* **78**: doi: 10.1590/S0042-96862000000400016.
- Bettcher D, Subramaniam C, Guindon E, Perucic A M, Soll L, Grabman G, Joossens L, Taylor A. (2001) *Confronting the Tobacco Epidemic in an Era of Trade Liberalization*, WHO/NMH/TFI/01.4. Geneva: WHO, Tobacco Free Initiative.
- Bewley-Taylor D, Jelsma M. (2012) Regime change: re-visiting the 1961 Single Convention on Narcotic Drugs. *International Journal of Drug Policy* **23**: 72–81.

- Bialous S A. (2004) News analysis: Brazil: growers' lobby stalls FCTC. *Tobacco Control* **13**: 323–4.
- Bialous S A, Yach D. (2001) Whose standard is it, anyway? How the tobacco industry determines the International Organization for Standardization (ISO) standards for tobacco and tobacco products. *Tobacco Control* **10**: 96–104.
- Borland R, Winstanley M, Reading D. (2009) Legislation to institutionalize resources for tobacco control: the 1987 Victorian Tobacco Act. *Addiction* **104**: 1623–9.
- Brandt A M. (2007) *The Cigarette Century: The rise, fall, and deadly persistence of the product that defined America*. New York, NY: Basic Books.
- Brandt A M. (2008) FDA regulation of tobacco – pitfalls and possibilities. *New England Journal of Medicine* **359**: 445–8.
- Brandt A M. (2012) Inventing conflicts of interest: a history of tobacco industry tactics. *American Journal of Public Health* **102**: 63–71.
- Brinson F B. (2003) Who's in control? *Tobacco Reporter* (July) at www.tobaccoreporter.com (visited 16 December 2011).
- British American Tobacco (BAT). (1994) *Tobacco Taxation Guide: A guide to alternative methods of taxing cigarettes and other tobacco products*. Woking: The Printing Group, Optichrome.
- BAT. (2000) *Future Business Environment 2000*. Bates number 321519460-321519525 at <http://bat.library.ucsf.edu/tid/ylk93a99>
- British Medical Association. (1986) *Smoking Out the Barons. The campaign against the tobacco industry. A report of the British Medical Association Public Affairs Division*. Chichester: Wiley.
- Brown P. (1999) News: WHO urges 'coverage for all, not coverage of everything'. *British Medical Journal* **318**: 1305; doi: 10.1136/bmj.318.7194.1305.
- Brown T M, Cueto M, Fee E. (2006) Public health then and now: the World Health Organization and the transition from 'international' to 'global' public health. *American Journal of Public Health* **96**: 62–72.

- Burson-Marsteller, Philip Morris. (eds) (1986) *Philip Morris and Burson-Marsteller: A Partnership*. Bates number: 046875317/5351. at <http://tobaccodocuments.org/landman/2046875317-5351.html> (visited 10 May 2012).
- Callard C, Collishaw N E, Swenarchuk M. (2001) *An Introduction to International Trade Agreements and their Impact on Public Measures to Reduce Tobacco Use*. Ottawa: Physicians for a Smoke-Free Canada; London: Commonwealth Medical Association.
- Callicutt C H, Cox R H, Hsu F, Kinser R D, Laffoon S W, Lee P N, Podraza K F, Sanders E B, Seeman J I. (2006) The role of ammonia in the transfer of nicotine from tobacco to mainstream smoke. *Regulatory Toxicology and Pharmacology* **46**: 1–17.
- Canada, Department of National Health and Welfare. (1974) *A New Perspective on the Health of Canadians: A working document*. Ottawa: Department of National Health and Welfare.
- Carter S. (2002) Mongoven, Biscoe and Duchin: destroying tobacco control activism from the inside. *Tobacco Control* **11**: 112–18; doi:10.1136/tc.11.2.112.
- Chaloupka F J, Laixuthai A. (1996) *US Trade Policy and Cigarette Smoking in Asia*, NBER Working Paper No. 5543. Cambridge, MA: National Bureau of Economic Research.
- Chen Z M, Liu B Q, Boreham J, Wu Y P, Chen J S, Peto R. (2003) Smoking and liver cancer in China: case-control comparison of 36 000 liver cancer deaths vs 17 000 cirrhosis deaths. *International Journal of Cancer* **107**: 106–12.
- China, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. (2011) *China: Global Adult Tobacco Survey (GATS): Fact Sheets, 2010*. Available at: www.cdc.gov/tobacco/global/gats/countries/wpr/fact_sheets/china/2010/pdfs/china_2010.pdf (visited 20 January 2011).
- Chinese Center for Disease Control. (2011) *Tobacco in China*, Joint Assessment Report 2011. Beijing: Chinese Center for Disease Control.
- Chitanondh H. (2001) *The World Landmark Case: The Thai–US cigarette dispute, defeat in trade, victory in health*. Bangkok: Thailand Health Promotion Institute; freely available at www.thpinhf.org/LANDMARK.pdf (visited 7 February 2012).

- Ciresi M V, Walburn R B, Sutton T D. (1999) Decades of deceit: document discovery in the Minnesota Tobacco Litigation. *William Mitchell Law Review* **25**: 477–566.
- Collin J, Legresley E, MacKenzie R, Lawrence S, Lee K. (2004) Complicity in contraband: British American Tobacco and cigarette smuggling in Asia. *Tobacco Control* **13** (Suppl. 2): 104–11.
- Corporate Accountability International and NATT. (2009) *Clearing the Smoke-Filled Room: An exposé on how the tobacco industry attempts to undermine the global tobacco treaty and the illicit trade protocol*, online at www.stopcorporateabuse.org/sites/default/files/INB3%20English%20FINAL.pdf (visited 7 March 2012).
- Cox H. (2000) *The Global Cigarette: Origins and evaluation of British American Tobacco, 1880–1945*. New York, NY: Oxford University Press.
- Crofton J. (1990) The Seventh World Conference on Tobacco or Health. *Thorax* **45**: 560–2.
- Crofton J, Bjartveit K. (1986) *The Smoking Epidemic. How you can help*. Paris: International Union against Tuberculosis and Lung Disease.
- Crowther S M, Reynolds L A, Tansey E M. (eds) (2009) *The Resurgence of Breastfeeding, 1975–2000*. Wellcome Witnesses to Twentieth Century Medicine, vol. 35. London: The Wellcome Trust Centre for the History of Medicine at UCL. Freely available at: <http://www.history.qmul.ac.uk/research/modbiomed/index.html>
- Crowther S M, Reynolds L A, Tansey E M. (eds) (2010) *The Medicalization of Cannabis*. Wellcome Witnesses to Twentieth Century Medicine, vol. 40. London: Wellcome Trust Centre for History of Medicine at UCL. Freely available at: <http://www.history.qmul.ac.uk/research/modbiomed/index.html>
- Cunningham R. (1996) *Smoke and Mirrors: The Canadian tobacco war*. Ottawa: International Development Research Centre.
- Dalyell T. (2009) Sir John Crofton: Physician whose research revolutionised the treatment of tuberculosis and lung disease. *Independent* (5 November): <http://www.independent.co.uk/news/obituaries/sir-john-crofton-physician-whose-research-revolutionised-the-treatment-of-tuberculosis-and-lung-disease-1814817.html?printService=print> (visited 19 April 2012).

- Davey Smith G, Egger M. (2005) The first reports on smoking and lung cancer: why are they consistently ignored? *Bulletin of the World Health Organization* **83**: 799–800.
- Dearlove J V, Bialous S A, Glantz S A. (2002) Tobacco industry manipulation of the hospitality industry to maintain smoking in public places. *Tobacco Control* **11**: 94–104.
- De Beyer J, Brigden L. (eds) (2003) *Tobacco Control Policy: Strategies, successes and setbacks*. Washington, DC: World Bank and Research for International Tobacco Control (RITC).
- Diethelm P A, McKee M. (2009) Denialism: what is it and how should scientists respond? *European Journal of Public Health* **19**: 2–4.
- Diethelm P A, Rielle J, McKee M. (2005) ‘The whole truth and nothing but the truth? The research that Philip Morris did not want you to see’. *Lancet* **366**: 86–92.
- Doll R. (1991) Conversation with Sir Richard Doll. *British Journal of Addiction* **86**: 365–77.
- Doll R, Hill A B. (1950) Smoking and carcinoma of the lung; preliminary report. *British Medical Journal* **ii**: 739–48.
- Doll R, Hill A B. (1952) A study of the aetiology of carcinoma of the lung. *British Medical Journal* **ii**: 1271–86.
- Doll R, Hill A B. (1954) The mortality of doctors in relation to their smoking habits: a preliminary report. *British Medical Journal* **i**: 1451–5.
- Doll R, Hill A B. (1956a) Lung cancer and tobacco; the *BMJ*’s questions answered. *British Medical Journal* **i**: 1160–3.
- Doll R, Hill A B. (1956b) Lung cancer and other causes of death in relation to smoking: a second report on the mortality of British doctors. *British Medical Journal* **ii**: 1071–81.
- Doll R, Hill A B. (1957) Deaths from poliomyelitis among British doctors. *British Medical Journal* **i**: 372.
- Doll R, Hill A B. (1964a) Mortality in relation to smoking: ten years’ observations of British doctors. *British Medical Journal* **i**: 1399–410.

- Doll R, Hill A B. (1964b) Mortality in relation to smoking: ten years' observations of British doctors. *British Medical Journal* **i**: 1460–7.
- Doll R, Hill A B. (1966) Mortality of British doctors in relation to smoking: observations on coronary thrombosis. *National Cancer Institute Monograph* **19**: 205–68.
- Doll R, Peto R. (1981) *The Causes of Cancer: Quantitative estimates of avoidable risks of cancer in the United States today*. Oxford: Oxford University Press. First printed in the *Journal of the National Cancer Institute* (1981) **66**: 1197–1312.
- Doll R, Hill A B, Kreyberg L. (1957) The significance of cell type in relation to the aetiology of lung cancer. *British Journal of Cancer* **11**: 43–8.
- Doll R, Hill A B, Gray P G, Parr E A. (1959) Lung cancer mortality and the length of cigarette ends; an international comparison. *British Medical Journal* **i**: 322–5.
- Dresler C, Marks S. (2006) The emerging human right to tobacco control. *Human Rights Quarterly* **28**: 599–651.
- Durston B, Jamrozik K. (eds) (1990) *The Global War: Proceedings of the 7th World Conference on Tobacco OR Health*. Perth: Health Department of Western Australia.
- Eriksen M, Mackay J, Ross H. (2012) *The Tobacco Atlas*, 4th edition. Atlanta, GA: American Cancer Society.
- European Union. (2007) *Towards a Europe Free from Tobacco Smoke: Policy options at EU level, Directorate C: public health and risk assessment*. Brussels: European Commission.
- Fidler J A, Shahab L, West O, Jarvis M J, McEwen A, Stapleton J A, Vangeli E, West R. (2011) The smoking toolkit study: a national study of smoking and smoking cessation in England. *BMC Public Health* **11**: 479. Freely available at www.biomedcentral.com/1471-2458/11/479
- Fidler D P. (1997) The globalization of public health: emerging infectious diseases and international relations. *Indiana Journal of Global Legal Studies* **5**: 11–51.
- Framework Convention Alliance. (2001) Johannesburg Declaration on the FCTC. *Alliance Bulletin* **6**: 4.

- Framework Convention Alliance. (2005) *Factsheet no. 9: Tobacco advertising and Promotion*. Geneva: Framework Convention Alliance on Tobacco Control. Available at: <http://fctc.org/factsheets/9.pdf> (visited 30 March 2012).
- Gao S, Zheng R, Hu T-w. (2011) Can increases in the cigarette tax rate be linked to cigarette retail prices? Solving mysteries related to the cigarette pricing mechanism in China. *Tobacco Control* (2011); doi: 10.1136/tobaccocontrol-2011-050027
- General Agreement on Tariffs and Trade (GATT). (1990) *Thailand – Restriction on Importation of and Internal Taxes on Cigarettes. Report of the Panel*. Geneva: GATT.
- Gillman S L, Xun Z. (eds) (2004) *Smoke: A global history of smoking*. London: Reaktion Books.
- Gilmore A, Collin J, Townsend J. (2007) Transnational tobacco company influence on tax policy during privatization of a state monopoly: British American Tobacco and Uzbekistan. *American Journal of Public Health* **97**: 2001–9.
- Glantz S A. (1983) Tobacco industry response to the scientific evidence on passive smoking. In: Forbes W F, Frecker R C, Nostbakken D. (eds). *Proceedings of the 5th World Conference on Tobacco or Health*. Winnipeg, Manitoba: Canadian Council on Smoking and Health: 287–92.
- Glantz S A. (1996) *The Cigarette Papers*. Berkeley, CA: University of California Press.
- Godlee F. (1993) WHO at the crossroads. *British Medical Journal* **306**: 1143–4.
- Godlee F. (1994a) WHO in crisis. *British Medical Journal* **309**: 1424–8.
- Godlee F. (1994b) WHO in retreat: is it losing its influence? *British Medical Journal* **309**: 1491–5.
- Godlee F. (1994c) WHO at country level – a little impact, no strategy. *British Medical Journal* **309**: 1636–9.
- Godlee F. (1995a) WHO's special programmes: undermining from above. *British Medical Journal* **310**: 178–82.
- Godlee F. (1995b) The World Health Organisation (sic). WHO in Europe: does it have a role? *British Medical Journal* **310**: 389–93.

- Godlee F. (1997) WHO reform and global health. *British Medical Journal* **314**: 1359–60.
- Godlee F. (1998a) Change at last at WHO. But will the regions play ball? *British Medical Journal* **317**: 296.
- Godlee F. (1998b) Who should be the next head of the WHO? *British Medical Journal* **316**: 4–5.
- Godlee F. (2000) WHO faces up to its tobacco links. *British Medical Journal* **321**: 314–15.
- Gonzalez M, Green L W, Glantz S A. (2011) Through tobacco industry eyes: civil society and the FCTC process from Philip Morris and British American Tobacco's perspectives. *Tobacco Control* doi:10.1136/tc.2010.041657
- Gray N. (ed.) (1977) *Lung Cancer Prevention: Guidelines for smoking control*, UICC technical report series vol. 28. Geneva: International Union against Cancer.
- Gray N, Daube M. (eds) (1980) *Guidelines for Smoking Control*, 2nd edn. Geneva: International Union against Cancer.
- Grüning T, Weishaar H, Collin J, Gilmore A B. (2012) Tobacco industry attempts to influence and use the German government to undermine the WHO Framework Convention on Tobacco Control. *Tobacco Control* **21**: 30–8; doi 10.1136/tc.2010.042093
- Hammond D, Fong G T, Cummings K M, O'Connor R J, Giovino G A, McNeill A. (2006) Cigarette yields and human exposure: a comparison of alternative testing regimens. *Cancer Epidemiology, Biomarkers and Prevention* **15**: 1495–1501.
- Hirschhorn N. (1999): Industry recruitment (sic) of scientific experts: Whitecoat: Tobacco Industry Documents in the Minnesota Depository. *GLOBALink: The International Tobacco-Control Network*.
- Hsieh C R, Hu T W, Lin C F J. (1999) The demand for cigarettes in Taiwan: domestic versus imported cigarettes. *Contemporary Economic Policy* **17**: 223–34.
- Hirayama T. (1981) Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. *British Medical Journal* **282**: 183–5.

- Infact. (2003) *Treaty Trespassers: New evidence of escalating tobacco industry activity to derail the Framework Convention on Tobacco Control*, February 2003, at www.stopcorporateabuse.org/archived-publications-and-reports (visited 15 November 2011).
- INFOTAB. (1989) *World Action! A guide for dealing with anti-tobacco pressure groups*. Brentford: Tobacco Documentation Centre.
- International Union against Tuberculosis and Lung Disease and International Union against Cancer. (1986) *Stopping the smoking epidemic. An introduction for opinion leaders*. Paris: IUATLD, and Geneva: UICC.
- Jacob G F. (2004) Without reservation. *Chicago Journal of International Law* 5: 287–302.
- Jarvis M J, Boreham R, Primatesta P, Feyerabend C, Bryant A. (2001) Nicotine yield from machine-smoked cigarettes and nicotine intakes in smokers: evidence from a representative population survey. *Journal of the National Cancer Institute* 93: 134–8.
- Kaufman M. (2000) Tobacco industry scheme alleged. *Washington Post* (2 August) at www.hartford-hwp.com/archives/28/084.html (visited 26 September 2011).
- Kelsey J. (2011) *Media Release*: USNZ Council gives false comfort on tobacco controls and investment rules. *TPPWatch* (8 July): at <http://tppwatch.org/2011/07/11/usnz-council-gives-false-comfort-on-tobacco-controls-investment-rules/> (17 November 2011).
- Kessler D A. (1994) From the US Drug and Food Administration: the control and manipulation of nicotine in cigarettes. *Tobacco Control* 3: 362; doi:10.1136/tc.3.4.362.
- Kolandai M A. (2007) *The Tobacco Industry in Japan and its Influence on Tobacco Control*. Thesis submitted for PhD, School of Public Health, University of Sydney at <http://tobacco.health.usyd.edu.au/assets/pdfs/AssuntaPhD.pdf> (visited 6 January 2012).
- LaFaive M, Fleenor P, Nesbit T. (2008) *Cigarette Taxes and Smuggling: A statistical analysis and historical review*. Midland, MI: Mackinac Center for Public Policy.

- Lam T H, Ho S Y, Hedley A J, Mak K H, Peto R. (2001) Mortality and smoking in Hong Kong: case-control study of all adult deaths in 1998. *British Medical Journal* **323**: 361.
- Larson P S, Haag H B, Silvette H. (1961) *Tobacco: Experimental and clinical studies*. Baltimore, MD: The Williams and Wilkins Company.
- Lee C-Y, Glantz S A. (2001) *The Tobacco Industry's Successful Efforts to Control Tobacco Policy-Making in Switzerland*. San Francisco, CA: Division of Adolescent Medicine, Institute for Health Policy Studies, University of California. Freely available at <http://escholarship.org/uc/item/09t535s7> (visited 30 March 2012).
- Lee K, Collin J. (2006) 'Key to the future': British American Tobacco and cigarette smuggling in China. *PLoS Medicine* **3**: 228–37.
- Lee K, Chagas L C, Novotny T E. (2010) Brazil and the Framework Convention on Tobacco Control: global health diplomacy as soft power. *PLoS Medicine* **7**: e1000232; doi:10.1371/journal.pmed.1000232
- Legresley E, Lee K, Muggli M E, Patel P, Collin J, Hurt R D. (2008) British American Tobacco and the 'insidious impact of illicit trade' in cigarettes across Africa. *Tobacco Control* **17**: 339–46.
- Lencucha R. (2010) Philip Morris versus Uruguay: health governance challenged. *Lancet* **376**: 852–3.
- Levin M. (2004) *Tobacco industrial policy and tobacco control policy in Japan*. Manoa: University of Hawaii. Available at http://blog.hawaii.edu/aplpj/files/2011/11/APLPJ_06.1_levin.pdf (visited 6 January 2012).
- Lewis P. (1988) Divided World Health Organization braces for leadership change. *New York Times* (May 1): 20.
- Lilyard C, Anderson A M. (2000) The Minnesota tobacco trial, 1994–1998. *Reference Services Review* **28**: 8–17.
- Liu B Q, Peto R, Chen Z M, Boreham J, Wu Y P, Li J Y, Campbell T C, Chen J S. (1998) Emerging tobacco hazards in China: 1. Retrospective proportional mortality study of one million deaths. *British Medical Journal* **317**: 1411–22.
- Lo C. (2006) Establishing global governance in the implementation of FCTC: some reflections on the current two-pillar and one-roof framework. *Asian Journal of WTO & International Health Law and Policy* **1**: 569–87.

- Lock S, Reynolds L, Tansey E M. (eds) (1998) *Ashes to Ashes: The history of smoking and health*. Amsterdam; Atlanta, GA: Editions Rodopi BV. Reprinted in 2003.
- Lopez A D, Mathers C D, Ezzati M, Jamison D T, Murray C J L. (eds) (2006) *Global Burden of Disease and Risk Factors*. New York, NY; Washington, DC: Oxford University Press and World Bank.
- Lv J, Su M, Hong Z, Zhang T, Huang X, Wang B, Li L. (2011) Implementation of the WHO Framework Convention on Tobacco Control in mainland China. *Tobacco Control* **20**: 309–14.
- Mackay J. (2003) Editorial: the making of a convention on tobacco control. *Bulletin of the World Health Organization* **81**: 551. Freely available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2572518/pdf/14576884.pdf
- Mackay J, Crofton J. (1996) Tobacco and the developing world. *British Medical Bulletin* **52**: 206–21.
- Mackay J, Eriksen M. (2002) *The Tobacco Atlas*. Geneva: WHO. Available at www.who.int/tobacco/resources/publications/tobacco_atlas/en/index.html
- Mackay J, Eriksen M, Shafey O. (2006) *The Tobacco Atlas*, 2nd rev. edn. Atlanta, GA: American Cancer Society.
- Mahler H. (1981) The meaning of ‘Health For All’ by the year 2000. *World Health Forum* **2**: 5–22.
- Malone R E. (2002) Tobacco industry surveillance of public health groups: the case of STAT (Stop Teenage Addiction to Tobacco) and Infact (Infant Formula Action Coalition). *American Journal of Public Health* **92**: 955–60.
- Mamudu H M, Glantz S A. (2009) Civil society and the negotiation of the Framework Convention on Tobacco Control. *Global Public Health* **4**: 150–68.
- Mamudu H M, Hammond R, Glantz S A. (2008) Project Cerberus: tobacco industry strategy to create an alternative to the Framework Convention on Tobacco Control. *American Journal of Public Health* **98**: 1630–42.
- Mamudu H M, Hammond R, Glantz S A. (2011) International trade versus public health during the FCTC negotiations, 1999–2003. *Tobacco Control* **20**: e3; doi:10.1136/tc.2009.035352

- Masironi R. (1979) Controlling the smoking epidemic. A summary of the report of a WHO Expert Committee. *WHO Chronicle* **33**: 322–5.
- Masironi R. (1984) Smoking control strategies in developing countries: report of a WHO Expert Committee. *World Smoking Health* **9**: 4–6.
- Masironi R, Gibson D. (1988) *Successes Against Smoking: The story of four countries*. Geneva: WHO, Tobacco or Health Programme.
- Meier B M. (2005) Breathing life into the Framework Convention on Tobacco Control: smoking cessation and the right to health. *Yale Journal of Health Policy, Law, and Ethics* **5**: 137–92.
- Meier B M, Shelley D. (2006) The fourth pillar of the Framework Convention on Tobacco Control: harm reduction and the international human right to health. *Public Health Reports* **121**: 494–500.
- Muggli M E, Hurt R D, Becker L B. (2004) Turning free speech into corporate speech: Philip Morris' efforts to influence US and European journalists regarding the US EPA report on second-hand smoke. *Preventive Medicine* **39**: 568–80.
- Mulvey K. (c.1999) A perspective from the North. In *The Effects of Globalization on Health and NGOs' Role in Tobacco Control*, Report of the NGO Forum for Health symposium in May 1999. Geneva: NGO Forum for Health, 20–7.
- Mulvey K. (ed.) (2002) *Dirty Dealings: Big Tobacco's Lobbying, Pay-Offs, and Public Relations to Undermine National and Global Health Policies*, summary of monitoring conducted for WHO pursuant to resolution WHA 54.18 on Transparency in Tobacco Control Process. Boston, MA: Infact.
- Mulvey K. (ed.) (2003) *Cowboy Diplomacy: How the US undermines international environmental, human rights, disarmament and health agreements*. Boston, MA: Infact.
- Mulvey K. (2010) A life-saving precedent: protecting public health policy against Big Tobacco. *Tobacco Control* **19**: 95–7; doi:10.1136/tc.2009.032755
- Must E. (2001) *PATH Canada Guide: International Tobacco Growers' Association (ITGA): ITGA uncovered: Unravelling the spin – the truth behind the claims*. (June): 4, freely available at: www.healthbridge.ca/itgabr.pdf; www.hallmarkpr.co.uk (both visited 22 February 2012).

- Nakajima H. (1995) *An Appeal from the Director-General of the World Health Organization for World No-Tobacco Day*. Geneva: WHO.
- Nakajima H. (1997) Global health threats and foreign policy. *Brown Journal of World Affairs* **4**: 319–32.
- Neuman M, Bitton A, Glantz S. (2002) Tobacco industry strategies for influencing European Community tobacco advertising legislation. *Lancet* **359**: 1323–30.
- New Zealand, Toxic Substances Board. (1989) *Health OR Tobacco: An end to tobacco advertising and promotion*. Wellington: Department of Health.
- Nullis C. (2002) WHO chief renews attack on tobacco industry and appeals for strong accord. *Canadian Press* (15 October). See <http://www.tobacco.org/news/105929.html> (visited 16 December 2011).
- Nutt D, King L A, Saulsbury W, Blakemore C. (2007) Development of a rational scale to assess the harm of drugs of potential misuse. *Lancet* **369**: 1047–53.
- Ong E K, Glantz S A. (2000a) Hirayama's work has stood the test of time. *Bulletin of the World Health Organization* **78**: 938–9.
- Ong E K, Glantz S A. (2000b) Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. *Lancet* **355**: 1253–9.
- Ong E K, Glantz S A. (2001) Constructing 'sound science' and 'good epidemiology': tobacco, lawyers, and public relations firms. *American Journal of Public Health* **91**: 1749–57.
- Otañez M G, Mamudu H M, Glantz S A. (2009) Tobacco companies' use of developing countries' economic reliance on tobacco to lobby against global tobacco control: the case of Malawi. *American Journal of Public Health* **99**: 1759–71.
- Pankow J F, Tavakoli A D, Luo W, Isabelle L M. (2003) Per cent free-base nicotine in the tobacco smoke particulate matter of selected commercial and reference cigarettes. *Chemical Research Toxicology* **16**: 1014–18.
- Parkin D M, Pisani P, Lopez A D, Masuyer E. (1994) At least one in seven cases of cancer is caused by smoking. Global estimates for 1985. *International Journal of Cancer* **59**: 494–504.

- Peto R, Lopez A D. (1990) The future worldwide health effects of current smoking patterns: 1990 report to the Seventh World Conference on Tobacco or Health, on behalf of the WHO consultative group on statistical aspects of tobacco-related mortality. In Durston B, Jamrozik K. (eds) *The Global War: Proceedings of the Seventh World Conference on Tobacco Or Health*. Perth: Health Department of Western Australia.
- Peto R, Chen Z M, Boreham J. (1999) Tobacco – the growing epidemic. *Nature Medicine* **5**: 15–17.
- Peto R, Lopez A D, Boreham J, Thun M, Heath C. (1994) *Mortality from Smoking in Developed Countries, 1950–2000: Indirect estimates from national vital statistics*. Oxford: Oxford University Press.
- Petsonk A. (1993) Challenges to international governance. International land use law. *American Society of International Law* **87**: 288–9.
- Philip Morris International. (2011) *News Release*: Philip Morris International: illicit cigarettes in EU reach record levels in 2010: KPMG study shows annual consumption up by 5.1 per cent to an estimated 64 billion units. (30 June): at www.pmi.com/eng/media_center/press_releases/pages/201106300603.aspx (visited 17 November 2011).
- Pollay R W, Dewhirst T. (2002) The dark side of marketing seemingly ‘light’ cigarettes: successful images and failed fact. *Tobacco Control* **11** (Suppl. 1): 118–31.
- Proctor R N. (2004) Should medical historians be working for the tobacco industry? *Lancet* **363**: 1174–5.
- Proctor R N. (2006) ‘Everyone knew but no one had proof’: tobacco industry use of medical history expertise in US courts, 1990–2002. *Tobacco Control* **15** (Suppl. 4): 117–25.
- Proctor R N. (2012) *Golden Holocaust: Origins of the Cigarette Catastrophe and the Case for Abolition*. Berkeley, CA: University of California Press.
- Reddy S, Gupta P. (2004) *Historical Overview of Tobacco in India in Report on Tobacco Control in India*. New Delhi: Government of India, Ministry of Health and Family Welfare.

- Rimmer L. (2005) *BAT in its own words: The alternative British American Tobacco social report*. London: Action on Smoking and Health, Christian Aid and Friends of the Earth. Freely available at: http://www.ash.org.uk/files/documents/ASH_371.pdf (visited 31 January 2012).
- Roemer M I, Roemer R. (1990) Global health, national development, and the role of government. *American Journal of Public Health* **80**: 1188–92.
- Roemer R. (1993) *Legislative Action to Combat the World Tobacco Epidemic*, 2nd edn. Geneva: WHO.
- Roemer R. (2004) A brief history of legislation to control the tobacco epidemic. In Boyle P, Gray N, Henningfield J, Seffrin J, Zatonski W. (eds) *Tobacco and Public Health: Science and policy*. Oxford: Oxford University Press: 676–705.
- Roemer R, Taylor A, Larivière J. (2005) Origins of the WHO Framework Convention on Tobacco Control. *American Journal of Public Health* **95**: 936–8.
- Royal College of Physicians. (1962) *Smoking and Health*. London: Pitman Medical Publishing Company Ltd.
- Saffer H, Chaloupka F J. (2000) The effect of tobacco advertising bans on tobacco consumption. *Journal of Health Economics* **19**: 1117–37.
- Saloojee Y, Hammond R. (2001) *Fatal Deception: The tobacco industry's 'new' global standards for tobacco marketing*. Geneva: WHO.
- Samet J M, Taylor C E, Becker K M, Yach D. (1998a) Research in support of tobacco control. *British Medical Journal* **316**: 321–2.
- Samet J M, Yach D, Taylor C, Becker K. (1998b) Research for effective global tobacco control in the 21st century: report of a working group convened during the 10th World Conference on Tobacco or Health. *Tobacco Control* **7**: 72–7.
- Scruton R. (2000) *WHO, WHAT and WHY? Transnational government, legitimacy and the World Health Organization*. London: Institute of Economic Affairs, freely available at www.forces-nl.org/download/whowhat.pdf (visited 13 December 2011).
- Semenza J C, Apfel F, Rose T, Giesecke J. (2008) Commentary: A network strategy to advance public health in Europe. *European Journal of Public Health* **18**: 441–7.

- Shopland D R. (ed.) (2001) *Risks Associated with Smoking Cigarettes with Low Machine-measured Yields of Tar and Nicotine*. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute.
- Simpson D. (1994) News analysis: Global smoking mortality. *Tobacco Control* **3**: 302–6; doi:10.1016/0140-6736(92)91600-D
- Simpson D, Lee S. (2003) Tobacco: public perceptions and the role of the industry. *Journal of the Royal Statistical Society A* **166**: 233–9.
- Smith R, Beaglehole R, Woodward D, Drager N. (eds) *Global Public Goods for Health: Health, economic and public health perspectives*. Oxford: Oxford University Press.
- Stevenson T, Proctor R N. (2008) The secret and soul of Marlboro: Philip Morris and the origins, spread, and denial of nicotine freebasing. *American Journal of Public Health* **98**: 1184–94.
- Taylor A L. (1996) An international regulatory strategy for global tobacco control. *Yale Journal of International Law* **21**: 257.
- Taylor A L. (2005) Obituary: Ruth Roemer, 1916–2005. *Tobacco Control* **14**: 291.
- Taylor A L, Bettcher D W. (2000) WHO Framework Convention on Tobacco Control: a global ‘good’ for public health. *Bulletin of the World Health Organization* **78**: 920–7.
- Taylor A L, Roemer R. (1996) *International Strategy for Tobacco Control*, WHO/PSA/96.6. Geneva: WHO.
- Taylor A L, Bettcher D W, Peck R. (2003) International law and the international legislative process: the WHO Framework Convention on Tobacco Control, Chapter 11 in Smith R, Beaglehole R, Woodward D, Drager N. (eds) *Global Public Goods for Health: Health, economic and public health perspectives*. Oxford: Oxford University Press: 216–33.
- Taylor A L, Chaloupka F J, Guindon E, Corbett M. (2000) The impact of trade liberalization on tobacco consumption. In Jha P, Chaloupka F C. (eds) *Tobacco Control Policies in Developing Countries*. Oxford: Oxford University Press: 343–64.

- Townsend J L. (1998) The role of taxation policy in tobacco control. In Abedian I, van der Merwe R, Wilkins N, Jha P. (eds) *The Economics of Tobacco Control: Towards an Optimal Policy Mix*. Rondebosch: Applied Fiscal Research Centre, University of Cape Town: 85–101.
- UK, Department of Health. (1992) *Effect of Tobacco Advertising on Tobacco Consumption: A Discussion Document Reviewing the Evidence*. London: Economics and Operational Research Division, Department of Health.
- UK, Department of Health. (1994) *Smoke-free for Health: An action plan to achieve the Health of the nation targets on smoking*. London: Department of Health.
- UK, House of Commons, Health Select Committee. (2000) *Second Report: The tobacco industry and the health risks of smoking*, session 1999–2000, HC 27-I & -II. London: Stationery Office. See www.parliament.the-stationery-office.co.uk/pa/cm199900/cmselect/cmhealth/27/2702.htm (visited 12 July 2010).
- UN, Ad Hoc Interagency Task Force on Tobacco Control. (1999) *Report of the First Session*: Maurice Pate Conference Room, UNICEF, New York, USA, 29–30 September 1999, freely available at www.who.int/tobacco/media/en/unreportI.pdf (visited 2 December 2011).
- UN, Ad Hoc Interagency Task Force on Tobacco Control. (2000) *Report of the Second Session*, FAO, Rome, 7 March. Freely available at www.who.int/tobacco/media/en/unreportII.pdf (visited 4 November 2011).
- UN, Food and Agriculture Organization (FAO). (2003) *Issues in the Global Tobacco Economy: Selected case studies, Raw Materials, Tropical and Horticultural Products Service, Commodities and Trade Division*. Rome: FAO.
- UN, FAO. (2004) *Projections of Tobacco Production, Consumption and Trade to the year 2010*. Rome: FAO. Freely available at: <ftp://ftp.fao.org/docrep/fao/006/y4956e/y4956e00.pdf> (visited 17 November 2011).
- UN, World Commission on Environment and Development. (1987) *Our Common Future* (Brundtland report). Oxford: Oxford University Press. Also available at <http://www.un-documents.net/wced-ocf.htm> (visited 7 March 2012).
- US, Department of Health and Human Services. (1981) *The Health Consequences of Smoking: The changing cigarette. A report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Public Health Services, Office on Smoking and Health.

- US, Department of Health and Human Services. (1989) *Reducing the Health Consequences of Smoking: 25 Years of Progress. A report of the Surgeon General*, DHHS Publication no. CDC 89-8411. Rockville, MD: Center for Chronic Disease Prevention and Health Promotion.
- US, Department of Health and Human Services. (2000). *Reducing Tobacco Use: A Report of the Surgeon General*. Washington DC: Department of Health and Human Services, US Public Health Service.
- US, Food and Drug Administration. (2010) Guidance for Industry and FDA Staff: Use of ‘light’, ‘mild’, ‘low’ or similar descriptors in the label, labelling, or advertising of tobacco products. Rockville, MD: US Food and Drug Administration, Center for Tobacco Products, freely available at: www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm214597.htm (visited 27 September 2010).
- US, Surgeon General. (2004) *The Health Consequences from Smoking: A Report of the Surgeon General*. Bethesda, MD: Department of Health and Human Services.
- US, Surgeon General, Advisory Committee on Smoking and Health. (1964) *Smoking and Health: Report of the advisory committee to the Surgeon General of the Public Health Service*. Washington, DC: US Department of Health, Education, and Welfare, Public Health Service.
- Vateesatokit P. (2003) Tailoring tobacco control efforts to the country: the example of Thailand. In De Beyer J, Brigden L. (eds) *Tobacco Control Policy: Strategies, successes and setbacks*. Washington, DC: World Bank and Research for International Tobacco Control: 154–78.
- Vateesatokit P, Hughes B, Ritthphakdee B. (2000) Thailand: winning battles, but the war’s far from over. *Tobacco Control* **9**: 122–7; doi:10.1136/tc.9.2.122
- Walt G. (1993) WHO under stress: implications for health policy. *Health Policy* **24**: 125–44.
- Weinstein N D. (2001) Public understanding of risk and reasons for smoking a low-yield product. In Shopland D R. (ed) *Risks Associated with Smoking Cigarettes with Low Machine-measured Yields of Tar and Nicotine*. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute: 193–235.

- Wertz M S, Kyriass T, Paranjape S, Glantz S A. (2011) The toxic effects of cigarette additives. Philip Morris' Project MIX reconsidered: an analysis of documents released through litigation. *PLoS Medicine* **8**: e1001145.
- Wilkenfeld J P. (2001) *Tobacco treaty negotiations make progress despite continued US efforts to weaken key provisions*. See www.tobaccofreekids.org/press_releases/post/id_0416 (accessed 16 December 2011).
- Wipfli H, Stillman F, Tamplin S, Samet J, da Costa e Silva V, Yach D. (2004) Enabling the FCTC by investing in national tobacco control capacity. *Tobacco Control* **13**: 433–7.
- World Bank. (1991) *Policy on Tobacco* (R91–225). Washington, DC: The World Bank.
- World Bank. (1993) *World Development Report 1993: Investing in health*. New York, NY: Oxford University Press.
- World Bank. (1999) *Development in Practice: Curbing the Epidemic: Governments and the economics of tobacco control*. Washington, DC: The World Bank.
- World Health Organization (WHO). (1975) *Smoking and its Effects on Health*. WHO Technical Report Series, No. 568. Report of an Expert Committee held on 9–14 December 1974. Geneva: WHO.
- WHO. (1979) *Controlling the Smoking Epidemic*. WHO Technical Report Series, No. 636. Report of an Expert Committee on Smoking Control held on 23–28 October 1978. Geneva: WHO.
- WHO. (1981) *Global Strategy for Health for All by the Year 2000*, Health for all series no. 3. Geneva: WHO.
- WHO. (1983) *Smoking Control Strategies in Developing Countries*. WHO Technical Report Series, No. 695. Report of an Expert Committee held on 22–27 November 1982. Geneva: WHO.
- WHO. (1988) *Smokeless Tobacco Control*. WHO Technical Report Series, No. 773. Report of a WHO Study Group held on 1–6 June 1987. Geneva: WHO.
- WHO. (1997a) *Tobacco or Health: First Global Status Report*, Tobacco or Health Programme. Brighton: Myriad Editions.

- WHO. (1997b) *Press Release: The smoking epidemic: 'A fire in the global village'*, WHO/61, 25 August 1997, freely available at: <http://legacy.library.ucsf.edu/documentStore/f/a/r/far52c00/Sfar52c00.pdf> (visited 9 November 2011).
- WHO. (1998) *Guidelines for Controlling and Monitoring the Tobacco Epidemic*. Geneva: WHO.
- WHO. (2002a) *Provisional Summary Record of the Second Meeting, 24 November 2001* (A/FCTC/INB3/WG1/SR/2). Geneva: WHO.
- WHO. (2002b) *Provisional Summary Record of the Third Meeting, 25 November 2001* (A/FCTC/INB3/WG1/SR/3). Geneva: WHO.
- WHO, Committee of Experts on Tobacco Industry Documents. (2000) *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization*. Geneva: WHO. Freely available at www.who.int/tobacco/en/who_inquiry.pdf (visited 15 February 2012). Cited here as Zeltner *et al.* (2000).
- WHO, EMRO. (2002) WHO-EM/TFI/005/E/G. Cairo: WHO Regional Office for the Eastern Mediterranean.
- WHO, Framework Convention on Tobacco Control. (FCTC) (2003) *WHO Framework Convention on Tobacco Control*. Geneva: WHO. Updated reprint 2004, 2005.
- WHO, FCTC. (2009a) *Summary Report on global progress in implementation of the WHO Framework Convention on Tobacco Control, FCC/2009.1*. Geneva: WHO.
- WHO, FCTC. (2009b) *Guidelines for implementation: Article 5.3; Article 8; Article 11; Article 13*. Geneva: WHO.
- WHO, FCTC Secretariat. (2003) *Future Protocols*. Geneva: WHO, at <http://apps.who.int/gb/fctc/PDF/inb6/einb6id2.pdf> (visited 13 February 2012).
- WHO, FCTC Secretariat. (2010) *History of the WHO Framework Convention on Tobacco Control*. Geneva: WHO. Also available at: http://whqlibdoc.who.int/publications/2009/9789241563925_eng.pdf (visited 5 November 2010).
- WHO, Regional Offices for South-East Asia and the Western Pacific. (2008) *Health in Asia and the Pacific*. Geneva: WHO.

- WHO, Study Group on Tobacco Product Regulation. (2008) *The Scientific Basis of Tobacco Product Regulation: Second report of a WHO study group*, WHO Technical Report Series no. 951. Geneva: WHO, freely available at www.who.int/tobacco/global_interaction/tobreg/publications/9789241209519.pdf (visited 24 November 2011).
- WHO, Tobacco Free Initiative (TFI). (1999a) *Mobilizing NGOs and the media behind the international Framework Convention on Tobacco Control*, Technical briefing series, paper no. 3, prepared by Infact, WHO/NCD/TFI/99.3. Freely available at: http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.3.pdf (visited 3 April 2012).
- WHO, TFI. (1999b) *What Makes International Agreements Effective? Some pointers for the WHO Framework Convention on Tobacco Control*, Technical briefing series paper no. 4, prepared by Professor Daniel Bodansky, WHO/NCD/TFI/99.4. Geneva: WHO. Freely available at: http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.4.pdf (visited 3 April 2012).
- WHO, TFI. (2000) *1999 Annual Report*. Geneva: WHO, at http://www.who.int/ncd/mip2000/documents/annual_tfi_en.pdf (visited 3 April 2012).
- WHO, TFI. (2008) *Tobacco Industry Interference with Tobacco Control*. Geneva: WHO. Freely available at: <http://www.who.int/tobacco/resources/publications/Tobacco%20Industry%20Interference-FINAL.pdf> (visited 3 April 2012).
- WHO, TFI. (2012) *WHO Global Report: Mortality attributable to tobacco*. Geneva: WHO, at: http://www.who.int/tobacco/publications/surveillance/rep_mortality_attributable_tobacco/en/index.html (visited 14 February 2012).
- WHO/UNICEF. (1989) *Ten Steps to Successful Breastfeeding in Protecting, Promoting and Supporting Breastfeeding: The special role of maternity services*. A joint WHO/UNICEF statement. Geneva: WHO.
- WHO, Western Pacific Regional Office. (1999) *Regional Action Plan for the Tobacco Free Initiative on Tobacco or Health, 2000–04*. Geneva: WHO, freely available at www.wpro.who.int/internet/resources.ashx/RCM/RC50-11.pdf (visited 6 March 2012).
- WHO, Western Pacific Regional Office. (2005) *Regional Action Plan for the Tobacco Free Initiative, 2005–2009*. Geneva: WHO.

- WHO, Western Pacific Regional Office. (2009) *Regional Action Plan for the Tobacco Free Initiative, 2010–2014*. Geneva: WHO.
- Wynder E L, Graham E. (1950) Tobacco smoking as a possible etiologic factor in bronchiogenic carcinoma: a study of 684 proven cases. *Journal of the American Medical Association* **143**: 329–36.
- Yach D. (1998) *Progress Towards Global Tobacco Control*. Presented at the Joint PAHOWHO-NHLBI-FIC 50th Anniversary Conference on Global Shifts in Disease Burden, 26–28 May 1998, The Cardiovascular Pandemic, Pan American Health Organization headquarters, Washington, DC. Geneva: WHO.
- Yach D. (2005) Injecting greater urgency into global tobacco control. *Tobacco Control* **14**: 73–144.
- Yach D, Bettcher D. (1998a) The globalization of public health, I: Threats and opportunities. *American Journal of Public Health* **88**: 735–8.
- Yach D, Bettcher D. (1998b) The globalization of public health, II: The convergence of self-interest and altruism. *American Journal of Public Health* **88**: 738–44.
- Yach D, Bettcher D. (2000) Globalization of tobacco industry influence and new global responses. *Tobacco Control* **9**: 206–16.
- Yach D, Wipfli H, Hammond R, Glantz S. (2007) Globalization and tobacco. In Kawachi I, Wamala S. (eds) *Globalization and Health*. Oxford: Oxford University Press: 39–67.
- Youderian A. (2009) *Big Tobacco Loses Appeal of Racketeering Ruling* (22 May). Freely available at: www.courthousenews.com/2009/05/22/Big_Tobacco_Loses_Appeal_of_Racketeering_Ruling.htm (visited 21 July 2010).
- Zeltner T, Kessler D A, Martiny A, Rander F. (2000) *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization*. Report of the Committee of Experts on Tobacco Industry Documents, submitted to the WHO Director-General. Geneva: WHO. See www.who.int/tobacco/en/who_inquiry.pdf (visited 26 September 2011). Also known as WHO, Committee of Experts on Tobacco Industry Documents (2000).

Biographical notes*

Dr Najeeb Al-Shorbaji

PhD (b. 1954), born in Jordan, gained a PhD in information sciences in 1986 and has been director of the department of knowledge management and sharing at WHO headquarters in Geneva since September 2008. His portfolio covers WHO publishing activities and programmes, library and knowledge networks, eHealth and WHO collaborating centres.

Dr Mary Assunta

MPhil PhD (b. 1957), a Malaysian, obtained her higher degrees at the School of Public Health, University of Sydney where her research reviewed internal documents of the tobacco industry (Kolandai (2007)). She was the first chair of the Framework Convention Alliance and a member of the board until 2011. She played an active role in leading civil society participation at the INB negotiations; served on WHO's policy and strategy advisory committee on tobacco control. She previously worked with the Consumers Association of Penang as the media officer where she coordinated the anti-tobacco campaign. She received the

2003 Luther L Terry award for outstanding individual leadership in tobacco control and has been the director of the International Tobacco Control Project, Cancer Council Australia since 2008 and serves as the senior policy adviser of the Southeast Asia Tobacco Control Alliance.

Dr Douglas Bettcher

MD MPH Dip(LSE) PhD(Econ) (b. 1956) qualified at the University of Alberta, completed a Master's of public health at the London School of Hygiene and Tropical Medicine and a PhD in international relations from the London School of Economics and Political Science. He was the coordinator of the WHO FCTC Office, Tobacco Free Initiative (TFI), at WHO in Geneva (1998–2007) and its director since 2007. He sits on the editorial board of the scientific journal *Bulletin of the World Health Organization* and the journal *Global Governance*. He has served as vice-chair of the public health interest group of the American Society of International Law; was WHO's principal focal point (1998–2007) for providing Secretariat support for the negotiation of WHO's

* Contributors are asked to supply details; other entries are compiled from conventional biographical sources.

first treaty, WHO FCTC; managed the interim secretariat support to parties, and provided technical support to assist in the implementation of the treaty. He is currently responsible for coordinating the work of the TFI with the FCTC Secretariat to support the comprehensive implementation of the WHO FCTC; for the scaling up of WHO's country-level tobacco control work, as one of the five partners in the Bloomberg Initiative for Reducing Tobacco Use, and for overseeing the implementation of the new WHO project to establish a capacity building resource centre for tobacco control in Africa, supported by the Bill and Melinda Gates Foundation. He has also worked in the areas of clinical medicine, public health and, international health policy in a number of countries, notably in developing countries, including Ethiopia and Jamaica.

Dr Sanjoy Bhattacharya

MA PhD (b. 1968) was educated at St Stephen's College, University of Delhi, Jawaharlal Nehru University, New Delhi and SOAS, University of London. He specializes in the history of nineteenth- and twentieth-century South Asia, as well as the history of international and global health programmes in the Indian subcontinent and

beyond. His work examines the structures and workings of health programmes sponsored and managed by UN agencies like WHO, the development of public health and medical institutions at different levels of national and local administration, and the diversity of social and political responses to state and non-governmental organization-run schemes of preventive and curative medicine. He also continues to work on research programmes dealing with refugee health, as well as the absorption of medical professionals from across South Asia, with particular reference to India and Sri Lanka, into the UK's NHS. He has been reader in the history of medicine, department of history, University of York, and has directed the Centre for Global Health Histories there since 2010.

Mr Neil Collishaw

MA (b. 1946) worked in the Canadian Department of National Health and Welfare (1974–81); helped the Canadian government to improve Canada's tobacco control policies (1981–91) and was lead tobacco control expert with the WHO's 'Tobacco or Health' Programme (1991–99), actively supporting WHO member states in their efforts to implement comprehensive tobacco control programmes, and in initiating

action to create the FCTC. He has been the research director for Physicians for a Smoke-free Canada since 2000, and has co-authored publications for WHO (WHO (1997, 1998)). See also Callard *et al.* (2001).

Dr Vera Luiza da Costa e Silva
MD PhD MBA (b. 1952) qualified in medicine from the University of São Paulo, Brazil, in 1975 and obtained a PhD in public health epidemiology at the Fundação Oswaldo Cruz, Rio de Janeiro, Brazil, in 1997, with an MBA in the health sector in the Rio de Janeiro Federal University/COPPEAD in 1999. She began her public health career working at the National Cancer Institute of Brazil's Ministry of Health (INCA) in 1980, becoming head of the tobacco-control programme there (1985–2000), where she coordinated the INCA cancer prevention and surveillance programmes (1998–2000); was involved in legislative, economic surveillance and regulatory tobacco-control measures, the establishment of a country-wide tobacco-control network and the creation of a federal tobacco products regulatory authority. She was the director of the TFI at WHO, Geneva (2001–05), where she supervised the secretariat and the negotiations on the WHO

FCTC and had an important role in global tobacco control activities including fundraising, coordination of global campaigns, tobacco product regulation activities and capacity building activities at country level in partnership with international agencies and local governments. She was acting team leader of tobacco control and consumers' health at PAHO based in Washington, DC, in 2007. She has been a senior public health consultant to international organizations and to Brazil's government since 2006 and is a member of the WHO/US Global Tobacco Surveillance System advisory group, and the WHO Study Group on Tobacco Product Regulation. In 2011 she joined the National Public Health School, Fundação Oswaldo Cruz as associate professor.

Mr Rob Cunningham

LLB MBA (b. 1964) has been a lawyer and senior policy analyst with the Canadian Cancer Society since 1996 and has worked in tobacco control since 1988. He has contributed to numerous initiatives supporting the adoption of tobacco-control legislation in Canada, appeared in court in tobacco cases, including before the Supreme Court of Canada, participated as an NGO representative at negotiations for

the WHO FCTC and was actively involved with health warnings on tobacco packages adopted in 2000 in Canada and more recently with the international implementation of graphic health warnings. See also Cunningham (1996).

Professor Sir Richard Doll

Kt CH OBE FRCP FRS (1912–2005) was director of the MRC Statistical Research Unit (1961–69) and Regius professor of medicine at the University of Oxford (1969–79), later emeritus. He was honorary consultant, MRC/Cancer Research UK/BHF Clinical Trial Service Unit and Epidemiology Studies Unit, Radcliffe Infirmary, Oxford, from 1983 until his death.

Dr Martina Pötschke-Langer

MD MA (b. 1951) qualified at the University of Heidelberg. Since 1997 she has been head of the Unit of Cancer Prevention in the German Cancer Research Center, Heidelberg, and since 2002 head of the WHO Collaborating Centre for Tobacco Control (1997–) and has been temporary adviser to WHO (1999–). She participated in the ‘Change Agent’ programme of WHO’s ‘Don’t be duped’ campaign (1999–2003) as well as in the fellowship programme of the Advocacy Institute, Washington, DC (2000). She founded the German Quitline (1999), was joint

founder of the European Quitlines Network (2000), is a member of the steering committees of the German Smoke-Free Alliance and represents Germany in the European Network for Smoking Prevention (ENSP) (1998–2011) and the International Woman against Tobacco (INWAT Europe). She received the Order of the Cross of Merit on Ribbon of the Federal Republic of Germany for cancer prevention and nonsmokers’ rights initiatives (2007) and WHO’s Tobacco Free World Award for outstanding contributions to public health (1999), and together with her team in 2007 and 2011. She is an honorary member of the German Association of Pulmonology.

Dr Judith Mackay

OBE SBS FRCP(Edinb) FRCP(Lond) MBE (b. 1943) has lived in Hong Kong since 1967, initially working as a hospital physician, and concentrating on public health since 1984. She has been senior adviser, World Lung Foundation/Bloomberg Initiative to reduce tobacco use since 2006; director of the Asian Consultancy on Tobacco Control; and a senior policy adviser to the WHO. She has authored several atlases on health, cancer, cardiovascular disease, tobacco, surveillance and oral health. In addition to many

international awards, ranging from the WHO Commemorative Medal to the *TIME* 100 award; she received a lifetime achievement award from the *British Medical Journal* (BMJ) in 2009 for her contribution to the fight against tobacco across the world. She has been identified by the tobacco industry as one of the three most dangerous people in the world in a leaked document in October 1989 (INFOTAB (1989), <http://tobaccodocuments.org/profiles/people/tdc.html> (visited 30 January 2012)). See Figure 3, page 22.

Dr Faith McLellan

PhD (b. 1960) is a graduate of Wake Forest University, Winston-Salem, NC, and took her PhD in the medical humanities (literature and medicine) at the University of Texas medical branch in Galveston, Texas. She has been an author's editor in departments of anaesthesiology at the Bowman Gray School of Medicine, Wake Forest University, and the University of Texas Medical Branch; she was North American editor of the *Lancet* (2001–08) and came to WHO as head of the Guidelines Review Committee Secretariat in 2009.

Ms Kathryn (Kathy) Mulvey

BA (b. 1966) has been an advocate for public health, human rights and corporate accountability for more than two decades. From 1993–2009, she led Corporate Accountability International (formerly Infact) challenging 'big tobacco', contributing to the adoption of the FCTC and advancing its implementation and enforcement. She has authored and edited dozens of publications, including the WHO technical briefing document (WHO (1999)). She participated as an NGO observer throughout the WHO FCTC process, including in the working group that developed implementation guidelines for Article 5.3 (2007/8) and in a WHO TFI expert group on tobacco industry interference (2007). She presented and led workshops on tobacco industry tactics and effective advocacy at World Conferences on 'Tobacco or Health' in Paris (1994), Beijing (1997), Chicago (2000), Helsinki (2003), Washington, DC (2006) and Mumbai (2009). She trained and led delegations of activists to challenge top decision-makers of the world's largest tobacco transnational, Philip Morris International (formerly a subsidiary of Philip Morris, which changed its name to Altria in 2003) at annual

shareholders' meetings (1994–2009). Since February 2012, she has been the director of the Conflict Risk Network at United to End Genocide, working with institutional investors to pressure corporations to respect human rights and avoid complicity in mass atrocities and genocide.

Dr Hiroshi Nakajima

MD (b. 1928) qualified at Tokyo Medical University, Japan, and joined WHO in 1974 as a scientist in the drug evaluation and monitoring section. He was appointed chief of the WHO Drug Policies and Management unit where he played a key role in developing the concept of essential drugs, and was secretary of the first expert committee on the subject. He was elected regional director for the Western Pacific region (1978–88) and Director-General of WHO (1988–98) for two terms. His conflict with Jonathan Mann, then head of the WHO's AIDS programme (1986–90), is documented in the two-part US Public Broadcasting System's Frontline documentary 'The age of AIDS', (broadcast 30–31 May 2006), available at www.pbs.org/wgbh/pages/frontline/aids/ (visited 16 July 2010).

Dr Haik Nikogosian

MD PhD DSc (b. 1955) was Minister of Health (1998–2000) and chairman of the National Institute of Health of Armenia (1992–94) and has held various managerial positions with the WHO Regional Office for Europe, most recently as head of noncommunicable diseases and lifestyles (2000–07). He has been the head of WHO's FCTC Secretariat since the inception of the secretariat in June 2007, with an initial mandate for four years, renewed for a further three years in 2011. He supports the Conference of the Parties and its subsidiary bodies, translating the decisions of the conference into programme activities and supporting the parties to fulfil their obligations under the FCTC. He also promotes the implementation of the FCTC internationally, organizes the reporting arrangements and coordination with WHO and other relevant international organizations and bodies.

Dr Ahmed Ezra Ogwell Ouma

MPH PhD (b. 1969), a committed tobacco control advocate and expert, holds a Masters of Public Health from the University of Nairobi, Kenya, and a Masters of Philosophy in International Health from the University of Bergen, Norway. He has worked with

the Ministry of Health in Kenya as head of non-communicable diseases where a key activity was implementing tobacco control measures at country level and also later the head of international health relations where he was chief negotiator for public health matters for the Government of Kenya. He also served as the founding regional coordinator for the Framework Convention Alliance, an international NGO established to support implementation of the FCTC. During the Fifth Anniversary of the FCTC coming into force in 2010, Ahmed was team leader at the Convention Secretariat in Geneva and he is currently working with the WHO's Regional Office for Africa as regional advisor, one who has the unique experience of working from the government side (Kenya), with the Convention Secretariat and currently with WHO Regional Office for Africa.

Professor Sir Richard Peto

FRS (b. 1943) has been professor of medical statistics and epidemiology at the University of Oxford since 1992. He was an MRC research officer at the Medical Research Council's statistical research unit in London (1967–69) where he began work with Richard Doll. He moved to the University of Oxford in 1969, set up the Clinical Trial

Service Unit (CTSU) there in 1975 and has been its co-director with Professor Rory Collins since 1985. He received a lifetime achievement award from the *British Medical Journal (BMJ)* in 2011, for his work showing a clear link between smoking and cancer.

Professor Ruth Roemer

JD (1916–2005), 'a lawyer in a field dominated by physicians' (Taylor (2005): 291) and advocate of legislative approaches to tobacco control, was professor of health law at the University of California Los Angeles School of Public Health from 1962. She graduated from Cornell Law School in 1939, acted as a labour lawyer representing the unions and became interested in health law when working in a landmark study of the law governing New York state's admission to mental hospitals, before joining the UCLA School of Public Health in the 1960s. She was a consultant to the WHO for more than 40 years. In the early 1990s she teamed up with Allyn Taylor of the University of Maryland to initiate the idea of a convention on tobacco control and in 1993 co-authored the feasibility study for the WHO executive board that was the foundation for FCTC. See Taylor (2005); Roemer (1993). See Figure 3, page 22.

Ms Chitra Subramaniam

MA (b. 1958), an Indian journalist, was educated in English literature at Lady Sri Ram College, Delhi University, and in media and communications at Stanford University, California. She completed doctoral course work at the University of Geneva, but did not complete her thesis, which was to look at the role of communications as a determinant of public health. Her investigative work for the Bofors-India arms deal is widely believed to have led to a change of government in India in the late 1980s. She was part of Dr Gro Brundtland's campaign team for WHO's Director-General in 1997/8, which included a cabinet project with a mandate to negotiate the world's first treaty focused entirely on health. Under the guidance of Dr Derek Yach, she developed several strategies and led the work of WHO's global policy analysis and communications team in 197 countries. This work underpinned all of TFI's work, resulting in the FCTC coming into force, which has 174 parties by 2012. She has also written extensively on international trade and disarmament issues, and set up CSDconsulting in Switzerland in 2004.

Professor Tilli Tansey

PhD PhD DSc HonFRCP FMedSci (b. 1953) is convenor of the History of Twentieth Century Medicine Group – known as the History of Modern Biomedicine Research Group from 2010 – and professor of the history of modern medical sciences at Queen Mary, University of London.

Professor Allyn Taylor

JD PhD was a doctoral student at Columbia Law School when she and Ruth Roemer wrote the foundation study for the FCTC in 1993, for what became the first treaty negotiated at the WHO. She developed the idea of a framework convention on tobacco control as part of her doctoral dissertation at Columbia University School of Law and was a Ford Foundation Fellow in public international law there. She was a senior health policy and legal adviser on the staff at the WHO and the senior legal adviser for the negotiation and the adoption of the FCTC. She has been visiting professor of law, Georgetown University, Washington, DC, since 2007, an adjunct professor of international relations at the Johns Hopkins University's Paul H Nitze School of Advanced International Studies (SAIS), Washington, DC, and has taught at the Johns Hopkins Bloomberg School of

Public Health, Baltimore, MD, the University of Maryland Schools of Law and Medicine, Baltimore, MD, and the American University Washington College of Law, Washington, DC. See Taylor (1996).

Dr Derek Yach

MPH DSc(Honoris Causa) (b. 1955) was executive director of the WHO's non-communicable diseases and mental health cluster (2000–03). During the INB negotiations on FCTC, he was the project manager for WHO's TFI (1998–2000) and coordinated WHO's global consultation that led to adoption by WHO's member states of a new global policy: *Health for All in the 21st Century* (1995–98). He played a leadership role in developing South Africa's epidemiological and community health research and policy capacity (1985–95). He has been senior vice-president of global health policy and agricultural policy at PepsiCo since 2007. Previously, he headed global health at the Rockefeller Foundation and the division of global health at Yale University and professor of public health. He is on the advisory boards of the Clinton Global Initiative, the World Economic Forum's New Vision for Agriculture, the NIH's Fogarty International Center and has published over 200 articles and chapters.

Dr Thomas Zeltner

MD LLM (b. 1947) holds a specialist degree in human pathology and forensic medicine and an MD and a Master's degree in law from the University of Bern, Switzerland, where he was head of medical services (1989–90) and held various positions in the medical faculty there (1975–85) and at the Harvard School of Public Health, Boston, MA (1986–88). He has been professor of public health at the University of Bern since 1992. He was the eighth Director-General of the Federal Office of Public Health and State Secretary of Health of Switzerland (1991–2009), where he initiated several national prevention programs (including one to reduce tobacco consumption in Switzerland), some of which attracted worldwide attention for their pioneering character, a model for other countries. He was a member and vice-president of the executive board of the WHO (1999–2002) and has chaired many international committees, such as the renowned committee on multinational tobacco companies and their attempt to undermine the tobacco-control activities of the WHO (Zeltner *et al.* (2000)). He was a 2010 fellow of the advanced leadership initiative of Harvard University, is president of the Swiss Foundation Science et Cité and serves on the boards of various non-governmental organizations.

Glossary*

Action on Smoking and Health (ASH)

Established in 1971 under the auspices of the Royal College of Physicians of England to make non-smoking the norm in society, and to inform and educate the public about the death and disease caused by smoking. Its first president was Lord Rosenheim, then president of the RCP, with Professor Charles Fletcher as chairman, Dr Keith Ball was honorary secretary and Dr John Dunwoody, the first director.

Advertising bans by 2001

Countries with bans on tobacco advertising: Italy (1962); Singapore (1970); Iceland (1972); Norway (1975); Finland (1978); French Polynesia (1982); Portugal (1983); Papua New Guinea (1987); Thailand (1989); New Zealand (1990); Australia (1993); Botswana (1993); France (1993); Malaysia (1994); Maldives (1994); Mongolia (1994); Sweden (1994); Belgium (1997); Slovenia (1997); South Africa (1999). Further details at www.who.int/tobacco/policy/advertising/en/ (visited 16 July 2010); Saloojee and Hammond (2001): 11.

Bates number x

A method of indexing legal documents for easy identification and retrieval and is used to keep track of large numbers of legal documents, such as those in the Legacy Tobacco Documents. The Bates Manufacturing Company of Edison, NJ, holds the patents (1891–93) on the original Bates Automatic Numbering Machine with numbered wheels.

Conference of the Parties (COP)

The governing body of the WHO FCTC made up of all those who are party to the convention, which keeps under regular review the implementation of the FCTC and takes the decisions necessary to promote its effective implementation. The conference may also adopt protocols, annexes and amendments to the FCTC and observers may also participate in its work, which is governed by its rules of procedure. Starting from COP-3, the regular sessions are held at two-year intervals. The COP may establish such subsidiary bodies as needed, such as the INB on a Protocol on Illicit Trade in Tobacco Products. The COP also established several working

*Terms in bold appear in the Glossary as separate entries

groups to elaborate guidelines and recommendations for the implementation of different treaty provisions. See www.who.int/fctc/cop/en/ (visited 13 February 2012).

International legal instruments: framework convention–protocol

The framework convention–protocol approach in international law is a flexible combination, which permits additional protocols and annexes to a basic agreed framework as improved scientific understanding is reached and political consensus for concrete action develops. The ‘framework convention’ establishes a general consensus about the relevant facts, broad international standards and an institutional structure for global governance. Protocols supplement, clarify, amend or qualify a framework convention and usually sets out specific commitments or added institutional arrangements, which are ratified individually, separate from the convention itself. A weak convention will be ratified by most countries, but one with strong protocols may face many delays and gain few signatories, whereas a strong convention may be initially ratified by fewer countries. Taylor and Bettcher (2000): 922; see also WHO, TFI. (1999b).

International Organization for Standardization (ISO) and ISO numbers

Established in 1947 in Geneva as a worldwide non-governmental organization of national standards bodies to promote standardization. ISO standards ensure quality control among the member nations concerning, for example, surgical implant materials. Similar testing methods for tobacco and tobacco products were adopted by the ISO, known as the ISO method in Europe and separate ISO numbers issued followed by the date of issue. For example: atmosphere for conditioning and testing, ISO 3402:1999; cigarettes: determination of total and nicotine-free dry particulate matter using a routine analytical smoking machine, ISO 4387:2000; cigarettes: determination of nicotine in smoke condensates, gas-chromatographic method, ISO 10315:2000; cigarettes: determination of water in smoke condensates, part 1, gas-chromatographic method, ISO 10362-1:1999; cigarettes: determination of carbon monoxide in the vapour phase of cigarette smoke, NDIR method, ISO 8454:2007. See www.iso.org/iso/iso_catalogue/catalogue_tc/catalogue_tc_browse.htm?commid=52158 (visited

9 January 2011). For further details, see Bialous and Yach (2001); Pollay and Dewhirst (2002); Anon. (2004).

Light/mild cigarettes

Light/mild ratings are those measuring 15 mg or lower yield of tar on a standardized smoking machine compared with smoke yields from a regular cigarette. Changes in cigarette design to achieve a low-yield classification included adding filters of different size and density, ventilation holes to dilute the smoke measured, and chemical additives in the paper and/or tobacco. Advertisements to promote the low-yield cigarettes implied that they were safer than regular cigarettes. For a comparison of methods, see Hammond *et al.* (2006); for a list of permitted additives to tobacco products in the UK, see www.advisorybodies.doh.gov.uk/scoth/technicaladvisorygroup/additiveslist.pdf (visited 18 November 2011); see also Wertz *et al.* (2011).

Legacy Tobacco Documents

In 2000, the Minnesota Court of Appeals decided that tobacco company documents could be released to the public, confirming a decision made during the initial Minnesota tobacco trial (1994–98) at <http://law.jrank.org/>

pages/10805/Tobacco-Tobacco-Litigation.html (visited 7 July 2010); see also the US Department of Justice litigation against tobacco companies (1999–2007) at www.justice.gov/civil/cases/tobacco2/index.htm. The Legacy Tobacco Documents Library (LTDL), University of California, San Francisco, originally compiled by Dr Norbert Hirschhorn, contains more than 11 million documents (60+ million pages), most of which are dated 1950–2002, at <http://legacy.library.ucsf.edu/> (both visited 26 September 2011). Under the terms of a 1998 settlement with the state of Minnesota, tobacco corporations were required to disclose documents related to US tobacco litigation. This responsibility included maintaining a website until 2010, with new documents uploaded regularly. As part of the master settlement agreement, the tobacco industry was required to make the documents used during the trials available and that the industry turn over a snapshot of their sites as of July, 1999 (see Tobacco Documents Online at <http://tobaccodocuments.org/> (visited 9 February 2012)). Copies of documents are in a warehouse in Minnesota also available on the internet, and another in Guildford, Surrey, mostly from the British

American Tobacco Company, which are not online, except for a small subset used in the Minnesota trial, and a few small collections copied from Guildford by tobacco-control groups, and put on to websites, although more are being made available through the Guildford Archiving Project at <http://bat.library.ucsf.edu/history.html> and <http://cgch.lshtm.ac.uk/tobacco/guildford.htm> (both visited 16 November 2011).

Orchid and ashtray

The image adopted by WHO for World No Tobacco Day, 1999, was designed by Ashvin Gatha, a photographer and former smoker, a white marble ashtray on which is poised a bright red orchid (WHO, Western Pacific Regional Office (1999): 11). For the orchid and ashtray awards adopted by the FCA *Bulletin* during the INB meetings, see Table 5, page 43; also Figure 4.

WHO Scientific Advisory Group on Tobacco Product Regulation (SACTob)/WHO Study Group on Tobacco Product Regulation (TobReg)

Began work in 2000 in an advisory capacity (status changed to a study group in 2003) and is composed of national and international experts in product regulation, tobacco-dependence treatment, and laboratory analysis of tobacco

ingredients and emissions, with product regulation agencies' representatives and advocates whose purpose is to provide the WHO Director-General with scientifically sound, evidence-based recommendations for member states on tobacco product regulation. TobReg identifies regulation approaches for tobacco products that pose significant public health issues and raise questions for tobacco control policy under Articles 9 and 10 of the WHO FCTC. See www.who.int/tobacco/global_interaction/tobreg/en/ (visited 5 December 2011). See, for example, their third report, freely available at http://whqlibdoc.who.int/publications/2009/9789241209557_eng.pdf (visited 5 December 2011).

World Health Assembly (WHA)

The decision-making body of WHO made up of delegates from all WHO member states. Its annual meeting considers a specific health agenda prepared by the executive board and where the policies of WHO are determined, such as the appointment of the Director-General, the supervision of financial policies, and the review and approval of the proposed programme budget. The WHA is held in Geneva, Switzerland. For a list of previous assemblies, see

www.who.int/mediacentre/events/governance/wha/en/index.html
(visited 25 November 2011).

World Health Organization (WHO)

WHO is the authority for health within the United Nations system, which is responsible for providing leadership on global

health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. For the background to WHO, see www.who.int/about/en/ (visited 25 November 2011).

Index: Subject

- Action on Smoking and Health
 - see* ASH
- advertising, tobacco
 - bans, 26, 27, 52, 65, 119
 - child's T-shirt, 56
 - cross-border, 50
 - industry's voluntary code (2001), 64–5
- African region, WHO (AFRO), 23–4, 47, 51, 53, 56, 74
- Agência Nacional de Vigilância Sanitária (ANVISA), Brazil, 30
- All African Conference on Tobacco or Health, First (1993), xxv
- Alliance Bulletin* (FCA newsletter), 42–4, 54, 55, 57
- Altria/Philip Morris USA, 17, 26
 - see also* Philip Morris
- American Cancer Society (ACS), 15, 29
- American Journal of Law and Medicine*, 27–8
- American Journal of Public Health*, 13
- Americas region, WHO, 74
- ammonia, 20
- anti-tobacco/anti-smoking movement, 18–19
 - early WHO activities, xxiii–xxiv, 9–15, 32–3
 - origins, xxi–xxiii
- ASH (Action on Smoking and Health), xxiii, 119
- ASH Scotland, xxii
- Asia, 29, 66
- Association of Southeast Asian Nations (ASEAN), 51
- Australia, 56
- 'axis of evil' label, 63, 81
- BAT *see* British American Tobacco
- Bates numbers, 117
- Bhopal case, 19
- Bill and Melinda Gates Foundation, xxvi, 66
- Bloomberg Initiative, xxvi, 6, 66
- Blue Cross and Blue Shield of Minnesota, 19, 45
- Boca Raton action plan, 16, 45, 53
- Brazil, 15–16, 82
 - role in FCTC development, xxvi, 30, 31, 41–2, 67
 - tobacco control measures, 26, 27, 30
- breastmilk substitutes, 11, 38
- British American Tobacco (BAT), 17, 25, 44, 62
 - FCTC involvement, 48, 54, 63
 - global market share, 26
 - voluntary tobacco advertising code, 64
- Brundtland report, *Our Common Future* (1987), 35
- budget allocation, WHO, 36–7
- Burson-Marsteller, New York, NY 53
- Canada
 - role in FCTC, xxv–xxvi, 33–4, 49, 50–1, 56
 - tobacco control measures, 27
- Canadian Cancer Society, 6
- cannabis, 18
- Caribbean Community Countries (CARICOM), 51
- champion countries, 51–2, 55–6
- China, xxiv, 29, 81, 82–3
 - FCTC involvement, 30, 51, 56, 63, 82–3
 - tobacco industry documents, 20

- China National Tobacco Corporation, 26, 81, 83
- cigarettes
 - global market shares, 26
 - light/mild, 12, 26, 119
 - nicotine spiking, 20
 - package warnings and labelling, 26–7
 - plain packaging, 65
 - regulation, 21
- civil society, 28, 38, 47, 58–9
 - see also* non-governmental organizations
- coca leaf, 18
- Collaborating Centre on Tobacco Control, WHO, 5
- Comite Latino Americano Coordinador del Control del Tabaquismo (CLACCTA), 15
- Committee of Experts on Tobacco Industry Documents (Zeltner committee), 6, 20, 32, 37, 44–6
- Conference of the Parties (COP), 76, 77, 78, 119–20
- Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 18
- Convention on Psychotropic Substances, 18
- conventions, international *see* treaties
- Corporate Accountability International (previously Infact), 5, 38, 54, 55, 59, 67
- countries
 - champion, 51–2, 55–6
 - funding FCTC, 49–50
 - Orchid and Dirty Ashtray awards, 42–4, 56, 81
 - role in FCTC negotiations, 39, 40–4, 46–53, 63
 - tobacco producing, trading and consuming, 79–80
 - see also* high-income countries; low- and middle-income countries; tobacco-growing countries
- Curbing the Epidemic* (World Bank, 1999), 21, 30
- Dalkon Shield case, 19
- death clock, 57, 58
- demand-reduction measures, 41
- Department of Knowledge Management and Sharing, WHO, 3–4, 5
- descriptors, misleading, 26, 30, 52
- developed countries *see* high-income countries
- developing countries *see* low- and middle-income countries
- Director-General (DG), WHO
 - role in FCTC development, xxv, 28, 34–9
 - setting up Zeltner Committee, 6, 20, 37, 44–5
 - stances before FCTC, xxiii–xxiv, 31–2
- Dirty Ashtray award, 42–4, 54, 55, 56, 81, 120
- ‘*Dirty Dealings*’ report (Mulvey, 2002), 54
- documents, tobacco company *see* tobacco industry documents
- Duke University, Durham, North Carolina, 7, 8
- Eastern Mediterranean region, WHO (EMRO), 51, 53, 56, 71, 74
- Economic and Social Council (ECOSOC), UN, 60
- epidemiological research, smoking, xxi, xxiv, 20–1
- Europe against Cancer programme, xxiii
- European Community (EC), 26–7, 52

- European Medical Association on Smoking or Health (EMASH), xxiii
- European region, WHO (EURO), 16, 39, 74
- Expert Advisory Panel on Tobacco or Health, WHO, 9
- Expert Committee, WHO, xxiii
- FCA *see* Framework Convention Alliance
- FCTC *see* Framework Convention on Tobacco Control
- financing *see* funding
- Finland, xxvi, 30, 34, 49–50
- focal point, UN, 60
- Food and Agriculture Organization, UN (FAO), 46, 61–2
- Formula 1 racing, 50
- Framework Convention Alliance (FCA), xxvi, 5, 54–5, 56, 57, 66
newsletter *see* *Alliance Bulletin*
- Framework Convention on Tobacco Control (FCTC), WHO
- 5th anniversary (2010), 3, 78
 - adoption (2003), xxvi, 76
 - Article 5.3, 38, 67
 - countries' roles, 39, 40–4, 46–53, 63
 - current attitudes of tobacco
 - companies, xxvi, 62, 67–8
 - Director-General's role, 28, 34–9
 - entry into force (2005), xxvi, 3, 76
 - funding of negotiations, 36–7, 48–50
 - NGOs' participation, 39, 47, 53–60, 65–6, 67
 - origins, xxv, 10, 21–3, 28, 30–4
 - regional roles, 51, 53, 56
 - Secretariat, 3–4, 5, 71
 - selected provisions, 73
 - success, 65–6
 - timeline, 49, 75–8
 - tobacco industry involvement, 37–8, 45–6, 47–8, 53–4, 59–60, 63–5
- framework convention–protocol
approach, 22–3, 120
- France, xxvi, 49–50
- funding
FCTC negotiations, 36–7, 48–50, 58
tobacco control, 66, 68–9
- Gates Foundation, Bill and Melinda, Seattle, WA, xxvi, 66
- German Cancer Research Center, Heidelberg, 5
- Germany, 52, 54, 63
- Global Action Plan on Tobacco and Health, xxiii–xxiv
- 'global bads' for public health, 13
- globalization of public health, xxi–xxvi, 12–15
- Hallmark Public Relations, Winchester, UK, 63
- health, effects of tobacco use, xxi–xxii, xxiv, 20–1
- health communication network, 39
- health economics, xxiv
- high-income countries
implementation of tobacco control, 46
reduction in tobacco farming, 61
role in FCTC, 41, 44, 54, 55
- History of the WHO Framework Convention on Tobacco Control* (WHO, 2010), 3, 48–9
- HIV/AIDS, 11
- Imperial Tobacco, Bristol, 17, 26
- India, 55, 56
- Infact *see* Corporate Accountability International
- Intergovernmental Negotiating Bodies (INBs), 47, 50, 51–2, 75

- death clock, 57, 58
- INB-1 (October 2000), 30, 52, 65, 75
- INB-2 (April–May 2001), 47, 52, 76
- INB-3 (November 2001), 40, 76
- INB-4 (March 2002), 76
- INB-5 (October 2002), 52, 54, 76
- INB-6 (February 2003), 52, 54, 56, 64, 67, 76
- on Protocol on Illicit Trade in Tobacco Products, 77, 78
- recipients of FCA awards, 43
- International Agency for Research on Cancer (IARC), 21, 44
- International Agency on Tobacco and Health, xxiii
- International Centre for Corporate Social Responsibility, Nottingham University, 44
- International Hotel and Restaurant Association, 60
- international legal instruments
 - framework convention–protocol approach, 22–3, 120
 - see also* treaties
- International Organization for Standardization (ISO), 12, 21, 120–21
- International Summit of World Smoking Control Leaders, First (1985), 29
- International Tobacco Growers Association (ITGA), viii, 23, 54, 60, 63
- International Union against Cancer, xxii, 55
- International Union against Tuberculosis and Lung Disease (IUAT LD), xxii, 55
- internationalism in health, xxi–xxvi
- Ireland, 34, 52
- Japan, xxiv, 81–2
 - FCTC involvement, xxvi, 30, 54, 56, 63, 81–2
 - ratification of FCTC, 82
 - regional negotiations, 51
- Japan Tobacco International, Geneva, Switzerland, 17, 25, 26, 62, 64, 82
- Johannesburg Declaration (2001), 53
- Kenya, xxvi, 40, 56
- labelling, package, 26–7
- Lalonde Report (1974), Canada, xxvi
- leadership, 69
- legacy tobacco documents, 121–22
 - see also* tobacco industry documents
- legal department, WHO, 33, 44–5
- liability, 27, 82
- light/mild cigarettes, 12, 26, 121, *see also* descriptors
- litigation, against tobacco companies, 18–20, 45
- low- and middle-income countries
 - adverse effects of globalization, 13–15
 - evidence on health effects, 25
 - extreme right-wing groups, 66
 - funding for tobacco control, 66
 - perspectives on tobacco control, 23–6, 27
 - pressures from tobacco industry, 16, 40, 45
 - restructuring of farming, 61–2
 - role in FCTC, 40–1, 50, 53–4, 55–6
 - use of term, 6, 29
- lung cancer, xxi
- malaria, xxv, 34, 44
- Malawi, 10–11, 16, 54
- ‘Malawi clause,’ 11

- Malaysia, 25, 26
- Marlboro Man award, 54, 67
- media, mass, 38, 39, 65, 67
- ministries of health, 40
- Mongoven, Biscoe and Duchin, Washington, DC, 53
- Montreal protocol, 22
- ‘Mr Butts’, 19
- multisectoral approach, tobacco control, 64
- Network for Accountability for Tobacco Transnationals (NATT), 54, 55, 67
- New Zealand, 56
- nicotine spiking, 20
- non-governmental organizations (NGOs), xxvi
 - business interest, 59
 - environmental codes and conventions, 38
 - FCTC involvement, 39, 47, 53–60, 65–6, 67
- Nottingham University, UK, 43, 44
- onchocerciasis, 33
- Orchid award, 42–4, 54, 55, 56, 81, 122
- ozone layer, 22
- Pacific Islands, 51
- package warnings and labelling, 26–7
- packaging, plain, 65
- Palau, 56
- Pan-American Health Organization, WHO (PAHO), 15
- passive smoking, xxiv, 29
- Philip Morris, 25, 44
 - Boca Raton action plan, 16, 45, 53
 - current attitudes to FCTC, xxvi, 62, 67–8
 - lawsuits against, 18–19
 - subversion of WHO, 44
 - voluntary advertising code, 64
- Philip Morris International Inc., New York, NY; Lausanne, Switzerland, 17, 26
- Philip Morris USA/Altria, Henrico County, Virginia, 17, 26
- Physicians for a Smoke-free Canada, 5
- picture warnings, 27
- political issue, tobacco control as, 35–8
- poverty, tobacco and, 55
- Programme on Substance Abuse, WHO, 31, 32
- Project Whitecoat, 29
- public health, 3, 28, 55, 70
- public relations (PR) companies, 53, 63
- regions, WHO, 9–10, 16, 51, 53, 56, 74
- Reynolds American Inc., Winston-Salem, NC, 17
- right-wing groups, 66
- Robins, Kaplan, Miller and Ciresi, Minneapolis, MN, 19
- Roll Back Malaria (RBM) project, 34
- Royal College of Physicians of London, xxi–xxii
- Russia, 54
- Scientific Advisory Group on Tobacco Product Regulation (SACTob), WHO, 63–4, 120
- G D Searle Co., 19
- Secretariat, WHO, 64
- sensitive information, publication, 8–9
- Single Convention on Narcotic Drugs, 18
- smallpox, 33
- smokeless tobacco, 9
- smoking, effects on health, xxi–xxii, xxiv, 20–1

- smuggling, tobacco, 12, 50
- South Africa, xxvi, 45, 56
- South China Morning Post*, 83
- South East Asian region, WHO (SEARO), 47, 51, 53, 56, 74
- Study Group on Tobacco Product Regulation (TobReg), WHO, 21, 122
- supply measures, 21
- Switzerland, xxvi, 6, 31–2, 49–50

- T-shirt, child's, 56
- taxation, 27, 83
- Thailand, 51–2, 56, 68–9
- timeline, FCTC, 49, 75–8
- tobacco companies
 - big six, 17
 - big three, 62
 - Boca Raton action plan, 16, 45, 53
 - current attitudes to FCTC, xxvi, 62, 67–8
 - documents *see* tobacco industry documents
 - funding of universities, 7–8, 44
 - global market share, 26
 - pressures on low- and middle-income countries, 16, 40, 45
 - product regulation role, 12
 - report on activities in Switzerland, 31–2
 - role in FCTC negotiations, 37–8, 45–6, 47–8, 53–4, 59–60, 63–5
 - targeting of WHO, 16, 28–9, 30, 35, 44
 - transnational aspects of regulation, 13–15
 - UN agencies and, 60–1
 - US litigation, 18–20, 45
- tobacco control
 - American region, WHO, 15–16
 - demand-reduction approach, 41
 - early WHO actions, xxiii–xxiv, 9–15, 32
 - historical origins, xxi–xxiii
 - low- and middle-income country perspectives, 23–6, 27
 - measures preceding FCTC, 26–27, 30
 - multisectoral approach, 64
 - as a political issue, 35–8
 - transnational aspects, 12–15, 50
 - UN inter-agency cooperation, 60–2
 - WHA resolutions *see* World Health Assembly
 - WHO budget allocation, 36–7
- Tobacco Control* (journal), 32
- Tobacco Free Initiative (TFI), WHO
 - financing, 36–7, 49–50, 58, 66
 - initiation, xxiii, 75
 - report on tobacco control in Switzerland, 31
 - role in FCTC, xxv, 5, 30
 - 'Tobacco Kills – Don't be Duped' programme, UN, 38–9
 - Zeltner Committee initiation, 44
- tobacco growers/farmers
 - alternative livelihoods, 41–2, 61–2
 - FCTC negotiations and, 23–4, 47–8, 60, 63
 - WHA resolutions, 10–11
- tobacco-growing countries, 10–11, 79–80
 - Africa, 24
 - restructuring of farming, 61–2
 - role in FCTC negotiation, 30–1, 41–2
- tobacco industry *see* tobacco companies
- tobacco industry documents, 18–20, 119–20
 - influence on FCTC, 28–9, 35, 37, 44–6
 - released to public in 2000, 19–20, 119
 - UN agencies and, 46, 60–1
 - see also* Committee of Experts on Tobacco Industry Documents

- ‘Tobacco Kills – Don’t be Duped’
programme, UN, 38–9
- Tobacco or Health programme, WHO,
xxiii, 5, 32
- Tobacco or Health Unit (TOH),
WHO, 32
- tobacco products
 - manipulation and re-engineering, 20
 - regulation, 12, 21
 - see also* cigarettes
- tobacco use
 - effects on health, xxii–xxiii, xxiv,
20–1
 - see also* smoking
- trade
 - liberalization, 13, 14, 20
 - US pressures, 51–2, 56
- transnational aspects, tobacco control,
12–15, 50
- transparency, 32, 37–8, 45–6, 69
- treaties (international conventions),
18, 21–3
 - bad examples, 21, 23
 - framework–protocol approach,
22–3, 120
 - WHO power to make, 11–12, 33
- tuberculosis (TB), xxii
- typewriters, 41–2
- Union Carbide, 19
- United Nations (UN)
 - Ad Hoc Interagency Task Force on
Tobacco Control, xxvi, 61, 62
 - agencies, 46, 60–2, 64
 - Convention on the Law of the
Sea, 23
 - focal point, 60
- United Nations Conference on Trade
and Development (UNCTAD),
28, 60, 61
- United Nations Drug Control
Programme (UNDCP), 18
- United Nations (UN) Foundation, 58
- United States (US)
 - FCTC negotiation process, 45,
51–2, 54, 63
 - influence over WHO, 32
 - lawsuits against tobacco companies,
18–20, 45
 - pressure on Thailand, 51–2, 56
 - tobacco control, 46
- universities, funding by tobacco
industry, 7–8, 44
- Vancouver, Canada, 50–1
- Victoria Tobacco Act 1987, Australia,
xxiii
- Vienna Convention for the Protection
of the Ozone Layer, 22
- Vienna conventions on narcotic drugs,
18, 21
- Wake Forest University, North
Carolina, 7
- warnings, package, 26–7
- Wellcome Trust Centre for the History
of Medicine at UCL, London, 3,
70
- Western Pacific region, WHO, 9, 51,
56, 74
- WHA *see* World Health Assembly
- whitecoats, 29
- World Bank, xxiv–xxv, 21, 30, 60,
61–2
- World Commission on Environment
and Development, UN, 35
- World Conferences on Smoking/
Tobacco or Health, xxi–xxii, xxiv,
xxv, 28, 33–4
 - Paris (1994), xxiv, 10, 20, 33, 75
- World Development Report 1993*
(World Bank), xxiv
- World Health Assembly (WHA),
122–3

- resolution WHA24 (1971), xxiii
- resolution WHA41 (1988), xxiii, xxiv
- resolution WHA48.11 (1995), 31, 33, 48, 75
- resolution WHA49.17 (1996), 33, 34, 48, 75
- resolution WHA52.18 (1999), 66, 75
- resolution WHA53.16 (2000), 66, 75
- resolution WHA54.18 (2001), 37–8, 54
- resolutions on tobacco control (1970s to 1990s), 9, 10–12, 25, 46
- World Health Communication
 - Associates, Axbridge,
 - Somerset, 39
- World Health Organization (WHO),
 - Geneva, Switzerland, xxi, 123
- budget prioritization, 36–7
- Constitution, Article 19, 11, 35
- earlier anti-tobacco activities, xxiii–xxiv, 9–15, 32–3
- origins of FCTC, xxv, 10, 21–3, 28, 30–4
- Secretariat, 64
- targeting by tobacco companies, 16, 28–9, 30, 35, 44
- World Heart Federation, 55
- World Lung Foundation, 6
- World No-Tobacco Day, xxiii, 42
- World Trade Organization (WTO),
 - Geneva, Switzerland, 56
- Zeltner committee *see* Committee of Experts on Tobacco Industry Documents

Index: Names

Biographical notes appear in bold

- Aiston, Ed, 48
 Al-Shorbaji, Najeeb, 3–4, 5, 70–1, **109**
 Amorum, Celso, 69, 75, 76
 Annan, Kofi, 61
 Apfel, Franklin, 39
 Assunta, Mary, 5, 25–6, 34, 40, 45,
 53, 55–7, 62, 63, 70, **109**

 Berridge, Virginia, xxi–xxvi
 Bettcher, Douglas, 5, 8–9, 11–15, 19–
 20, 33–4, 35–6, 38, 41–2, 58–62,
 63, **109–10**
 Bhattacharya, Sanjoy, 4, 9, 31, 70, **110**
 Bjartveit, Kjell, xxii
 Bradford Hill, Sir Austin, xxi
 Brundtland, Gro Harlem, xxv, 6, 20,
 28, 30, 34–9, 44, 58, 59, 60, 61,
 69, 75

 Caretti, Brigitte, 50
 Chaloupka, Frank J, 21
 Collishaw, Neil, 5, 10–11, 15, 21–3,
 28, 30, 32–3, 34, 36, 48–50,
 110–11
 Costa e Silva, Vera Luiza da, 5, 10,
 15–16, 30–1, 36–7, 41, 46–8, 62,
 63–4, **111**
 Crofton, Eileen, xxii, xxiv
 Crofton, Sir John, xxii, xxiii, xxiv
 Cunningham, Rob, 6, 8, 26–7, 50–2,
 54–5, 57, 64–5, **111–12**

 Doll, Sir Richard, xxi, **112**
 Duke, James Buchanan, 7, 8

 Glantz, Stan, 19, 31
 Godber, Sir George, xxi–xxii

 Graham, Evarts, xxi
 Gray, Nigel, xxii–xxiii

 Hill, Sir Austin Bradford, xxi
 Hirayama, T, xxiv
 Hurley, John, 34

 Jacob, Greg, 51
 Jha, Prabhat, 21

 Kennedy, Robert, xxi
 Kessler, David, 20

 Larivière, Jean, xxv, 33–4, 48
 Lee, Chung-Yol, 31
 Lee, Jong-wook, 59
 LeMaistre, Charles, 29
 Leppo, Kimmo, 34
 Lopez, Alan, xxiv

 Mackay, Judith, xxiv, xxv, 6, 8, 9–10,
 22, 27–9, 30, 31, 33, 34, 55, 59,
 65–6, 67, 81–3, **112–13**
 McLellan, Faith, 4, 7–8, 9, 11, 15, 21,
 34, 39, 57, 62–3, 69, **113**
 Madrigal, Enrique, 15
 Mahler, Halfdan, xxiii–xxiv, 28
 Martiny, Anke, 20
 Masironi, Roberto, xxiii
 Mochizuki-Kobayashi, Yumiko, 59
 Momen, Hoomen, 4
 Mulvey, Kathryn (Kathy), 5, 24, 37–8,
 53–4, 58–9, 67–8, **113–14**
 Murray, Christopher, xxiv

 Nabarro, David, 44
 Nakajima, Hiroshi, xxiv, 31, 32, **114**
 Nikogosian, Haik, 3, 77, **114**

- Ogwell, Ahmed Ezra, 5, 23–4, 39–41, 55, 60, 68–9, 71, **114–15**
- Peto, Sir Richard, xxiv, 34, **115**
- Pötschke-Langer, Martina, 5, 20–1, 38–9, 42–4, **112**
- Randera, Fazel, 20, 45
- Reid, John, xxiii
- Reynolds, Richard Joshua, 7
- Ricupero, Rubens, 61
- Roemer, Ruth, xxv, 21–2, 27–8, 33, 34, **115**
- Seixas Correa, Luis Felipe de, 67, 76
- Simpson, David, xxiii
- Smith, Richard, 44
- Subramaniam, Chitra, 35, 39, 44, **116**
- Tansey, E M (Tilli), 3–4, 8, 9, 70, **116**
- Taylor, Allyn, xxv, 21–2, 27–8, 34, **116–17**
- Townsend, Joy, xxiv
- Turner, Ted, 58
- Walburn, Roberta, 19, 44
- Wynder, Ernst, xxi
- Yach, Derek, xxv, 10, 13, 14, 35, 44, **117**
- Zeltner, Thomas, 6, 16–19, 20, 21, 28, 30, 32, 34, 35, 37, 41, 44–6, 49–50, 62, 67, 68, 69–70, **117**
- Zolty, Barbara, 49

Key to cover photographs

Front cover, left to right

Dr Mary Assunta

Dr Thomas Zeltner

Ms Kathy Mulvey

Dr Douglas Bettcher

Dr Vera Luiza da Costa e Silva

Back cover, left to right

Mr Neil Collishaw

Dr Martina Pötschke-Langer

Mr Rob Cunningham

Dr Judith Mackay

Dr Ahmed Ezra Oghwell

