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GLOBAL FRAMEWORK CONVENTION ON TOBACCO CONTROL – THE IMPLICATIONS FOR ORAL HEALTH

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At the World Health Assembly in May 2003 the Member States of the World Health Organization (WHO) have agreed on a groundbreaking public health treaty to control tobacco supply and consumption. The text of the WHO Framework Convention on Tobacco Control (FCTC) covers tobacco taxation, smoking prevention and treatment, illicit trade, advertising, sponsorship and promotion, and product regulation.

The negotiations, the final round of which began on 17 February 2003, concluded four years of work to produce an international tobacco control treaty. The agreement is part of a global strategy to reduce tobaco-related deaths and disease around the world. The convention is a real milestone in the history of global public health and in international colloboration. It means nations will be working systematically together to protect the lives of present and future generations, and take on shared responsibilities to make this world a better and healthier place.

The final text was presented to the World Health Assembly in Geneva. After its agreement, the FCTC will be opened for signature by Member States. The treaty will come into force shortly after it has been ratified by 40 countries.

The text requires signatory parties to implement comprehensive tobacco control programmes and strategies at the national, regional and local levels. In its preamble, the text explicitly recognizes the need to protect public health, the unique nature of tobacco products and the harm that companies that produce them cause. Some of the key elements of the final text include:

Taxes – The text formally recognizes that tax and price measures are an important way of reducing tobacco consumption, particularly in young people, and requires signatories to consider public health objectives when implementing tax and price policies on tobacco products.

Labelling – The text requires that at least 30 per cent – but ideally 50 per cent or more – of the display area on tobacco product packaging is taken up by clear health warnings in the form of text, pictures or a combination of the two. Packaging and labelling requirements also prohibit misleading language that gives the false impression that the product is less harmful than others. This may include the use of terms such as "light", "mild", or "low tar".

Advertising – While all countries agreed that a comprehensive ban would have a significant impact on reducing the consumption of tobacco products, some countries have constitutional provisions – for example, those covering free speech for commercial purposes – that will not allow them to implement a complete ban in all media. The final text requires parties to move towards a comprehensive ban within five years of the convention entering into force. It also contains provisions for countries that cannot implement a complete ban by requiring them to restrict tobacco advertising, promotion and sponsorship within the limits of their laws.

The text also explicitly requires signatories to the convention to look at the possibility of a protocol to provide a greater level of detail on cross-border advertising. This could include the technical aspects of preventing or blocking advertising in areas such as satellite television and the internet.

Liability – Parties to the convention are encouraged to pursue legislative action to hold the tobacco industry liable for costs related to tobacco use.

Financing – Parties are required to provide financial support to their national tobacco control programmes. In addition, the text encourages the use and promotion of existing development funding for tobacco control. A number of countries and development agencies have already pledged their commitment to include tobacco control as a development priority.

The text also requires countries to promote treatment programmes to help people stop smoking and education to prevent people from starting, to prohibit sales of tobacco products to minors, and to limit public exposure to second-hand smoke.

The elements of the treaty reflect WHO and World Bank policies on a comprehensive plan to reduce global tobacco consumption. While there have been nearly 20 World Health Assembly resolutions to support tobacco control since 1970, the difference with this treaty is that these obligations will become legally binding for Parties to the convention once it has come into force.

Implications for oral health

There are several ethical, moral and practical reasons why oral health professionals should strengthen their contributions to tobacco-cessation programmes, for example:

* They are especially concerned about the adverse effects in the oropharyngeal area of the body that are caused by tobacco practices.

* They typically have access to children, youths and their caregivers, thus providing opportunities to influence individuals to avoid all together, postpone initiation or quit using tobacco before they become strongly dependent.

* They often have more time with patients than many other clinicians, providing opportunities to integrate education and intervention methods into practice.

* They often treat women of childbearing age, thus are able to inform such patients about the potential harm to their babies from tobacco use.

* They are as effective as other clinicians in helping tobacco users quit and results are improved when more than one discipline assists individuals during the quitting process.

* They can build their patient's interest in discontinuing tobacco use by showing actual tobacco effects in the mouth.

Oral health professionals and dental associations worldwide should consider this platform for their future work and design national project(s) jointly with health authorities. Tobacco prevention activities can be translated through existing oral health services or new community programmes targeted at different population groups. In particular, Health Promoting Schools provide an effective setting for tobacco prevention amongst children and youth.

The WHO Oral Health Programme aims to control tobacco-related oral diseases and adverse conditions through several strategies. Within WHO, the Programme forms part of the WHO tobacco-free initiatives, with fully integrated oral health-related programmes. Externally, the Programme encourages the adoption and use of WHO tobacco-cessation and control policies by international and national oral health organizations. Primary partners are WHO Collaborating Centres and NGOs who are in official relations with WHO, i.e. the International Association for Dental Research (IADR) and the FDI World Dental Federation. A number of projects have been initiated in Canada, European Union countries, Japan, New Zealand and the USA and more programmes are being considered in India and China. The WHO Oral Health Programme will strengthen work for tobacco control in the future, particularly through support to countries having them incorporate oral health in their tobacco prevention policies. Evaluation and sharing experiences from tobacco-cessation programmes are important for such global initiatives and the WHO Oral Health Programme looks forward to effective collaboration with the oral health science community in this activity.