Addiction & Health

https://ahj.kmu.ac.ir
doi:10.34172/ahj.1759
Addict Health 2026;18:1759

Letter to Editor

Article 5.3 of the WHO FCTC: A smokescreen?

Alain Braillon*

Independent Researcher, 80000 Amiens, France

***Corresponding Author:** Alain Braillon, Email: braillon.alain@gmail.com

Citation: Braillon A. Article 5.3 of the WHO FCTC: A smokescreen?. Addict Health 2026;18:1759. doi:10.34172/ahj.1759

Received: November 5, 2025, **Accepted:** April 8, 2026, **epublished:** April 18, 2026

Introduction

Rani et al. should be commended for investigating barriers to implementing tobacco control measures—specifically Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC).[1] Their preregistered analysis[2] addresses a major issue. Yet, deeper concerns deserve mention.

First, it must be acknowledged that the FCTC has largely failed to accelerate progress. Between 1980 and 2004—the year of the Convention—the annual decline in daily smoking prevalence reached 2%, but it subsequently plateaued. By 2012, the annualized rate of change was almost zero.[2] Hoffman et al., updating data to 2015, found "no evidence that global progress in reducing cigarette consumption has been accelerated by the Convention."[3] More recently, the GBD 2019 Tobacco Collaborators reported a significant increase in smoking prevalence since 2005 in 111 countries.[4] These results are unacceptable, given that one in two smokers dies prematurely from smoking.

Second, Rani et al. correctly identify "conflicts of interest involving government officials, lobbying by the tobacco industry, resource constraints, and weak regulatory frameworks."[1] Yet these are only the tip of the iceberg. Lobbying is not only natural but also legal, and the phrase "conflicts of interest" is a troubling euphemism for what often amounts to corruption. Public officials who choose to protect a lethal industry over their citizens' health are not victims of lobbying—they are, at times, its active accomplices.[5]

In my opinion, the WHO FCTC has become a smokescreen:

1. The WHO has remained blind and silent in the face of inertia and open breaches of the Convention by signatory countries, rendering it little more than a symbolic document.[5] This reflects not soft diplomacy but a bureaucratic laissez-faire.
2. The WHO has shown little willingness to defend states that act. Uruguay, for example—the first country to require 80% cigarette pack warnings—was sued in 2009 by Philip Morris before the World Bank's tribunal. It was Michael Bloomberg, not the WHO, who funded Uruguay's legal defense. It is noteworthy that Uruguay GDP was $31 billion while Philip Morris total revenues was $25 billion for a market capitalization of $95 billion.
3. The WHO has failed to promote nicotine reduction—a measure long recognized as central to the tobacco endgame.[6] The technology exists, yet the precedent is telling: in the 1960s, a low-nicotine cigarette (Sano) achieved the lowest sales among 40 brands, while Philip Morris boosted nicotine bioavailability through ammonia "freebasing," propelling Marlboro to dominance.[7,8]
4. Finally, the WHO has not updated the Convention to address electronic nicotine delivery systems (ENDS), despite evidence of their addictive and carcinogenic potential.[9,10]

If Article 5.3 was meant to shield public health from industry influence, its implementation has instead exposed, one more, the limitations of the WHO courage and expertise.[11]

Competing Interests

The author declared no conflict of interest.

Ethical Approval

Not applicable.

Funding

This work received no specific grant.

References

1. Rani N, Wasnik M, Singh S. Navigating challenges in tobacco control: a systematic review of barriers to implementing article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC). Addict Health 2025;17:1603. doi:10.34172/ahj.1603
2. Ng M, Freeman MK, Fleming TD, Robinson M, Dwyer-Lindgren L, Thomson B, et al. Smoking prevalence and cigarette consumption in 187 countries, 1980-2012. JAMA 2014;311(2):183-92. doi:10.1001/jama.2013.284692

3. Hoffman SJ, Poirier MJP, Rogers Van Katwyk S, Baral P, Sritharan L. Impact of the WHO Framework Convention on Tobacco Control on global cigarette consumption: quasi-experimental evaluations using interrupted time series analysis and in-sample forecast event modelling. BMJ 2019;365:l2287. doi:10.1136/bmj.l2287
4. GBD 2019 Tobacco Collaborators. Spatial, temporal, and demographic patterns in prevalence of smoking tobacco use and attributable disease burden in 204 countries and territories, 1990-2019: a systematic analysis from the Global Burden of Disease Study 2019. Lancet 2021;397(10292):2337-60. doi:10.1016/s0140-6736(21)01169-7
5. Braillon A. Industry to influence policymaking: it takes two to tango, and the industry is not the leader. Public Health Res Pract 2023;33(3). doi:10.17061/phrp3332327
6. Braillon A. The Framework Convention on Tobacco Control. Lancet 2016;387(10031):1907. doi:10.1016/s0140-6736(16)30420-2
7. Benowitz NL, Henningfield JE. Establishing a nicotine threshold for addiction. The implications for tobacco regulation. N Engl J Med 1994;331(2):123-5. doi:10.1056/nejm199407143310212
8. Stevenson T, Proctor RN. The secret and soul of Marlboro: Phillip Morris and the origins, spread, and denial of nicotine freebasing. Am J Public Health 2008;98(7):1184-94. doi:10.2105/ajph.2007.121657
9. Arora M, Kulkarni MM, Ghosal S, Sathyan A, Gupta M, Verma S, et al. E-cigarettes and the nicotine epidemic: statement from the international pediatric association. Pediatrics 2025;156(5):e2025072337. doi:10.1542/peds.2025-072337
10. Braillon A, Lang AE. The International Agency for Research on Cancer and e-cigarette carcinogenicity: time for an evaluation. Eur J Epidemiol 2023;38(4):391. doi:10.1007/s10654-023-00993-7
11. Braillon A. Global health challenges facing bureaucracy: democratization or revolution? Public Health 2014;128(12):1134-5. doi:10.1016/j.puhe.2014.10.007