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Comprehensive review of Pacific Island countries' reports on the Framework Convention on Tobacco Control (2007–2023): progress, challenges and opportunities

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► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/tc-2024-059251).

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Received 20 December 2024
Accepted 13 June 2025

ABSTRACT

Objective Consistent with the role of the WHO Framework Convention on Tobacco Control (FCTC), the aims of this study were to review the FCTC progress reports submitted by the Pacific Island Countries (PICs) and assess regional FCTC progress.

Data source and extraction We searched FCTC: (1) Global Progress Reports for any information related to PICs; and (2) country-specific reports for all PICs. All reports submitted by PICs from 2007 to 2023 were reviewed. Information such as smoking prevalence for adult and young populations by sex/gender and age, objectives, targets, legislation, regulation and policies for tobacco control were extracted.

Data synthesis Ten global progress and 69 country-specific reports from 14 PICs were reviewed. In the most recent reports, daily smoking prevalence among males ranged from 15.8% in Niue to 64.8% in Kiribati, while among females, it ranged from 1.6% in Vanuatu to 31.8% in Kiribati. Current smoking prevalence among boys and girls ranged from 10% in Marshall Islands to 43% in the Federated States of Micronesia and from 1.5% in Marshall Islands to 28.8% in Palau, respectively. Price and tax measures, along with bans on tobacco sales to and by minors, were the most reported tobacco control strategies.

Conclusions While the PICs have ratified the FCTC and made strides to fight tobacco use and its consequences, they still face significant challenges to fully implement the FCTC. Building local and regional capacity and capability to implement and monitor progress with tobacco control policies is essential to reducing tobacco-related death and disease in the PICs.

INTRODUCTION

The history of the tobacco industry in the Pacific is deeply rooted in the broader colonial agricultural economy that often exploited local labour and resources, reinforcing economic dependence on colonial powers.[1 2] We have known about the harms of commercial tobacco use (box 1) for over 70 years, causing an estimated 8 million early deaths each year[3] and costing $1.4 trillion annually due to healthcare and productivity losses globally.[4] Pacific Island Countries (PICs) face a disproportionate burden of tobacco-related harm relative to their population. Commercial tobacco smoking among youth and adults contributes to cardio-respiratory diseases, cancer and diabetes, the leading causes of premature death in the region.[5] In 2019, estimated tobacco-related cancer deaths in the PICs ranged from 13.4% in Fiji to 24% in Nauru, and overall death rate and economic costs attributed to tobacco use are also substantial.[6 7] About half of the adults in the PICs smoke daily,[8] and a significant portion of youths initiate smoking daily.[9]

The WHO Framework Convention on Tobacco Control (FCTC) is an international treaty that supports Parties to protect the public from tobacco-related harms. These supports include tobacco control capacity building and development, such as provision of comprehensive guidelines and best practice; training and education; facilitation of technical and financial assistance; public health protection, global cooperation; and monitoring and reporting.[10–12] Article 21 of the treaty highlights the obligation of Parties to submit reports regularly. All PIC nation states, with the exception of those ineligible for Party status under the FCTC,[13] are Parties to the Convention and expected to submit regular reports.

Despite efforts by PICs to regulate tobacco and its use, the absence of strong measures against the industry and industry interference,[14] and the increasing trend of importation of commercial tobacco and related products[15] cause harms to health across the region. The tobacco industry continues to undermine tobacco control through well-documented tactics: misleading product claims, targeted advertising, funding health programmes to obscure its role in harm and delaying regulation.[16 17] In the Pacific, these strategies exploit structural inequities, often through racialised marketing that deepens health injustice.[18–20]

Efforts to reduce non-communicable diseases (NCDs) across the PICs are closely aligned with tobacco control measures, which are critical to achieving the Sustainable Development Goals (SDGs). Reflecting this commitment, Pacific Health Ministers adopted the Tobacco-Free Pacific 2025 Goal at their July 2013 meeting, pledging to reduce adult tobacco use prevalence to below 5% in each country.[21] Furthermore, a few PICs set different tobacco supply and demand reduction-related action plans. For example, the Cook Islands set a goal to reduce tobacco use prevalence among adults and youths by 30% by 2031.[22]

The FCTC secretariat developed a standard reporting template and a compendium of

To cite: Odo DB, Semos I, Toloube O, *et al*. *Tob Control* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/tc-2024-059251

Box 1 Tobacco definition—commercial and sacred/ceremonial tobacco

There are numerous different species of tobacco plants that are sacred to many Indigenous populations since time immemorial. Sacred tobacco was appropriated by early European explorers and later co-opted by European settlers, industrialising and modifying tobacco for commercial purposes as a plantation crop. This was fuelled by colonisation and was a driving factor in the incorporation of African slave Labour. In this paper, commercial tobacco is defined as cigarettes and other commercial tobacco products, manufactured for the purpose of nicotine dependence by a profit-driven industry. This should not be conflated with sacred tobacco, used for Indigenous ceremonial purposes.[2]

indicators,[23] with the first FCTC report compiled in 2007 and covering the initial 2 year period after the FCTC was enacted. An evaluation of the 2007 report indicated substantial differences in tobacco control programmes and policies between countries and commitments to the FCTC.[24] Progress in implementing FCTC obligations varies across PICs. The FCTC reports are available to review as summary Global Progress Reports across all Parties or as individual country reports.[23] The objectives of this review are to assess tobacco use prevalence, efforts to reduce tobacco supply and demand, as well as policies and legislations in PICs from 2007 to 2023. Understanding these trends is critical for informing regional support, policy coordination and capacity-building efforts.

METHODS

Research team

This research is guided by our understanding and experiences in the contexts and cultures of PICs. Our team acknowledges the importance of reflexively considering and describing our own backgrounds, perspectives and values that we each bring to this review. Specifically, the research team brings the Pacific lived experience (VW, IS, OT, DT, RM, MP), Indigenous lived experiences (VW, IS, OT, DT, RM, MP), experience in Pacific tobacco control research (VW, IS, OT, DT, RM, DBO), practical experience in Pacific health programme (VW, IS, OT, DT) and public health (VW, IS, OT, DT, RM, DBO). Additionally, the research team has FCTC experiences regionally and internationally on FCTC strategies and commitment to support member Parties to advance implementation (VW, IS, OT, DT, RM, MP). The PICs have great interest in supporting sustainable development through trusted partnerships, including on the elimination of tobacco-generated harms.

Data source and search strategy

In this review, PICs are nation states located in the Pacific Ocean that are eligible or have become Party to the FCTC and submitted at least one Convention progress report. Accordingly, we included 14 PICs that are Parties to the FCTC, namely the Cook Islands, Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

We searched two data sources from the WHO website: (1) FCTC Global Progress Reports, and (2) country-specific reports

Table 1 Adult tobacco smoking prevalence by sex and overall, from the most recent FCTC report

Country	Reporting period	Data source (year and name of survey/report/database)		Smoking status	Prevalence (%)*		
		Year	Survey name		Male	Female	Total
Cook Islands	2023	2013/15	STEPS Survey	Current	37.9	27.7	32.6
				Daily	28.4	20.6	24.3
Federated States of Micronesia	2023	2012	National Outcome Measure Survey	Current	49.7	17	31.6
				Daily	39.8	25.4	35.4
Fiji	2023	2011	NCD STEPS Survey	Current	47	14.3	30.8
				Daily	27.1	6	16.6
Kiribati	2023	2015/16	NCD STEP Survey	Current	68.2	34.5	49.9
				Daily	64.8	31.8	46.9
Marshall Islands	2023	2014	RMI Behavioural Profile 2014	Current	13.3	7.7	9.3
Niue	2020	2018	Niue health information database	Current	22.6	13	17.7
				Daily	15.8	7.6	11.6
Palau	2020	2016	Hybrid Survey Report	Current	30.9	9.7	20.4
				Daily	22	5.3	13.7
Papua New Guinea	2023	2007	STEPS Survey	Current	60.3	27	44
				Daily	59.9	26.6	43.7
Samoa	2023	2016	Samoa needs assessment report 2018	Current	36.5	13.7	25.6
				Daily	33.4	12.2	23.3
Solomon Islands	2020	2015	STEPS Survey data	Current	55.9	21.2	37.3
				Daily	50.2	17.2	32.5
Tonga	2023	2017	STEPS Survey	Current	40	15.9	24.5
				Daily	37.8	14.5	22.8
Tuvalu	2023	2015	NCD STEPS Report	Current	48.6	22.4	35
				Daily	46.9	22	32.9
Vanuatu	2020	2011	NCD STEPS Survey	Current	45.8	4	23.7
				Daily	24.6	1.6	12.4

*Reported tobacco smoking prevalence (%), as directly extracted from the most recent report.
FCTC, Framework Convention on Tobacco Control; NCD, non-communicable disease; RMI, Republic of the Marshall Islands; STEPS, Stepwise survey that assess the NCDs risk factor among the general population.

from FCTC commencement (2007–2023). For country-specific reports, we searched for all 14 included PICs.

Data extraction tool and process

We developed a data extraction tool based on the FCTC reporting guidelines and tested on both the FCTC Global and Country-specific Reports. To ensure data quality and consistency, two authors performed data extraction independently, with subsequent comparison of their results to resolve discrepancies and confirm agreement. The two authors who did the extraction then conducted a cross-check on the extracted data for any missed and inconsistent extracts prior to finalisation. The main information extracted includes overall youth and adult smoking prevalence, prevalence by sex and age, prevalence of smokeless tobacco use, percentage of exposure to secondhand smoke (SHS) at home, tobacco products included in calculating tobacco consumption prevalence and any objectives, target legislation, regulation and policies for tobacco control. We also extracted any measures taken by countries to reduce supply and demand for tobacco use and whether Parties had information on the practices of the tobacco industry in their jurisdictions.

RESULTS

Overall, 10 global progress reports (all reports to date) and 69 country-specific reports were reviewed. The Federated States of Micronesia submitted eight reports (most), and Nauru submitted one report (fewest). Table 1 presents current and daily smoking prevalence in the adult population by gender and overall, as extracted from the most recent progress report. The total current smoking prevalence ranged from 9.3% in Marshall Islands to 49.9% in Kiribati (table 1). Nauru's report lacks an overall smoking prevalence figure for the adult population, hence is not included in table 1. The prevalence data extracted from all the reports submitted to date, including the sources of each report, are presented in the supplementary file (online supplemental table S1).

Definitions of current and daily smoking from the FCTC and other survey sources used in the reviewed reports are listed in supplementary file (online supplemental table S2). Of the 14 countries which submitted reports to the FCTC secretariat, 13 of them included youth smoking data. A majority of these countries reported current smoking status only. Based on data from the most recent reporting cycle, current smoking prevalence ranged from 10% in Marshall Islands to 43.0% in Federated States of Micronesia among boys, and from 1.5% in Marshall Islands to 28.8% in Palau among girls (table 2). Niue's report lacks youth smoking prevalence data. The smoking prevalence data for boys, girls, and overall, as extracted from all the reports submitted to date, are presented in the supplementary file (online supplemental table S3).

We extracted tobacco products used in the estimation of tobacco consumption prevalence from the most recent progress report submitted by each country. This includes factory-manufactured cigarettes and locally produced tobacco (table 3).

Of the countries that reported the prevalence of exposure to SHS, 10 reported prevalence of exposure at home. Kiribati reported 62.7% exposure at home, followed by Fiji, 60.2%. Table 4 presents a percentage of exposure to SHS at home in 10 countries.

Smokeless tobacco use

Three countries reported smokeless tobacco use prevalence among adults. The highest prevalence was reported by Palau (current use: 48.8% in females and 40.2% in males), and the lowest by Kiribati (current use: 1.4% in females and 7.6% in males) (online supplemental table S4). Similarly, smokeless tobacco use among youth was reported by six countries, with the highest prevalence reported by Kiribati (current use: 42.5% in boys and 35.3% in girls) and the lowest by Samoa (current use: 3.1% in boys and 1.6% in girls) (online supplemental table S4).

Table 2 Tobacco smoking prevalence among young persons (boys and girls), from the most recent FCTC report

Country	Reporting period*	Age group of young persons	Smoking status	Tobacco smoking prevalence (%)†	
				Boys	Girls
Cook Islands	2018	13–15	Current	21.4	20.7
Federated States of Micronesia	2023	NR	Current	43	24.4
Fiji	2012	13–15	Current	12.3	7.9
Kiribati	2023	13–15	Current	37	22.5
Marshall Islands	2014	<18	Current	10	1.5
Nauru	2007	15–24	Daily	45.5	48.0
Palau	2020	13–15	Current	42.3	28.8
Papua New Guinea	2023	13–15	Current	34.9	18.2
Samoa	2023	13–15	Current	23.7	7.2
Solomon Islands	2020	13–15	Current	24.3	23.4
Tonga	2023	13–15	Current	22.1	6.8
Tuvalu	2023	13–15	Current	30.4	11.2
Vanuatu	2020	13–15	Current	16.7	11.7

*Year progress report submitted to the FCTC.
†Reported tobacco smoking prevalence (%), as directly extracted from the most recent report.
FCTC, Framework Convention on Tobacco Control; NR, not reported.

Other nicotine and non-nicotine products

Only Kiribati and Vanuatu reported the use of new industry products, including electronic non-nicotine delivery systems (ENNDS) and electronic nicotine delivery systems (ENDS) by young people. Accordingly, the prevalence of ENNDS and ENDS, respectively, was 19.1% and 8.4% in Kiribati and 18.5% and 19.5% in Vanuatu. The reported prevalence of ENNDS and ENDS in Vanuatu is higher than youth tobacco smoking prevalence.

Tobacco demand and supply reduction measures

Table 5 outlines various key tobacco control measures and strategies. These efforts commonly involve raising taxes on tobacco products, enacting laws to establish smoke-free public areas, requiring health warnings to educate consumers about the dangers of smoking, imposing restrictions on tobacco product marketing and promotion, and providing support for individuals trying to quit smoking.

DISCUSSION

This review shows that smoking prevalence among adult people continues in many PICs, consistent with existing regional and global evidence.[7] Similarly, the observed prevalence of smoking among youth in the region remains a significant public health challenge. Research indicates that 90% of individuals who initiate smoking become addicted by the age of 25, with the likelihood of starting to smoke after this age being notably low.[3] This trend is particularly concerning in light of the predatory behaviours

Table 3 Types of tobacco products used to estimate smoking prevalence, from the most recent FCTC report

Country	Reporting period	Tobacco products reported
Cook Islands	2023	Manufactured cigarettes and hand rolled cigarettes.
Federated States of Micronesia	2023	All manufactured cigarettes.
Fiji	2023	Cigarettes and locally grown tobacco (RYO).
Kiribati	2023	All smoking tobacco products (cigarettes, cigars or rolled tobacco).
Marshall Islands	2018	Cigarettes.
Nauru	2007	Cigarettes, cigars or pipes.
Palau	2020	Manufactured cigarettes, hand-rolled cigarettes, pipes of tobacco, cigars and cigarillos.
Papua New Guinea	2023	Manufactured cigarettes.
Samoa	2023	Manufactured cigarettes, hand-rolled cigarettes, rolled tobacco cigars and cheroots.
Solomon Islands	2018	Factory manufactured cigarettes and local household produced tobacco (lekona).
Tonga	2023	Manufactured tobacco products such as cigarettes, cigars and pipes.
Tuvalu	2023	Manufactured cigarettes, hand-rolled cigarettes, cigars and pipes.
Vanuatu	2023	Manufactured cigarettes, hand-rolled cigarettes, hand-rolled 'traditional' (local) cigarettes, loose tobacco in pipe, cigars and cigarillos.

FCTC, Framework Convention on Tobacco Control.

exhibited by the tobacco and nicotine industries, especially with regard to e-cigarettes (vapes) and other nicotine products.[25] Kiribati and Vanuatu have reported on the use of these products, including ENDS, among young persons. Meanwhile, the Cook Islands have taken a proactive stance by recently banning the manufacture, importation, sale, distribution and advertising of cigarette alternatives, such as e-cigarettes.[26]

Table 4 Prevalence of tobacco smoke exposure by sex and/or gender and overall, from the most recent FCTC report

Country	Data source and year	Prevalence (%) of tobacco smoke exposure at home		
		Male/boy	Female/girl	Total
Cook Islands	2015 STEPS	35.3	38.1	36.8
Fiji	2011 STEPS	58.5	62.2	60.2
Kiribati	2015/16 STEPS	63.7	61.9	62.7
Marshall Islands	2009 GYTS	54.7	50.5	52.1
Palau	2017 GYTS	–	–	35.6
Papua New Guinea	2016 GYTS	56.9	57.8	57.5
Samoa	2017 GYTS	31.1	48.6	51.7
Tonga	2017 STEPS	33.9	31.5	32.4
Tuvalu	2015 STEPS	53.4	51.9	52.6
Vanuatu	2011 STEPS	–	–	39.7

.FCTC, Framework Convention on Tobacco Control; GYTS, Global Youth Tobacco Survey; NCD, non-communicable disease; STEPS, Stepwise survey that assess the NCDs risk factor among the general population.

Additionally, the high prevalence of smokeless tobacco use and exposure to SHS at home are major public health concerns in PICs. There is a clear need to strengthen strategies like education to denormalise indoor smoking, emphasise the importance of smoke-free policies, bans on smokeless tobacco and better quit services.

Despite sustained leadership and policy innovation across the Pacific, tobacco and nicotine industries continue to operate with impunity—exploiting regulatory gaps, targeting young people and undermining public health sovereignty.[27] These actions are not incidental; they are deliberate strategies designed to entrench addiction, delay collective progress and extract profits at the expense of Indigenous lives. PICs have taken important steps, including bans on alternative nicotine products in the Cook Islands, but systemic industry interference remains a critical challenge.[28]

Structural conditions shaped by colonial legacies, global trade agreements and underinvestment from donor, government and commercial actors have made it harder—not for lack of will or capacity, but due to external constraints—for many PICs to implement and sustain the full spectrum of tobacco control measures. While some countries have yet to enact all FCTC components, this reflects broader dynamics such as limited financial resources, absence of political support, industry interference and extractive development[13]—not deficiencies within Pacific health systems or communities.

Five out of 14 PICs reported that they had information on the tobacco industry practices in their jurisdiction, and many PICs did not monitor the illicit trade of tobacco products. Although advertising and promotion bans help reduce smoking and prevent initiation,[29] many PICs lack regulations on tobacco product contents and do not enforce advertising bans, especially at points of sale. Implementing full tobacco cessation support requires diagnosis, treatment, approved medications and Quitline services, but many PICs offer only some of these, not all. This gap in the provision of comprehensive tobacco dependence and cessation services in this study corroborates earlier findings from these countries.[30]

The FCTC offers a global framework for tobacco control,[31] yet PICs navigate structural and commercial barriers and challenges which arise from limited resources, structural constraints and competing priorities, such as other health issues, climate change and sea level rises.[13 32 33] Without robust legal frameworks and institutional capacity, countries struggle to implement coordinated actions, adopt effective measures and achieve goals such as 5% smoking prevalence by 2025 set by Health Ministers of PICs, which has not been achieved. Strengthening political commitment, supporting tobacco cessation efforts and safeguarding tobacco control policies are crucial steps to phase out commercial tobacco and nicotine sales and in improving public health in the region. Gaps in these areas are frequently exploited by the tobacco industry, which employs various tactics to influence policymaking processes and obstruct the implementation of robust tobacco control measures.[16 17 34 35]

Furthermore, several countries relied on older surveys for their FCTC reporting, limiting comparability and hindering effective monitoring. Establishing routine and timely data collection is critical to advancing tobacco control across the region. This should be aligned with broader public health goals—including the SDGs,[21] the Tobacco-Free Pacific Goal,

Table 5 Tobacco demand and supply reduction measures reported, from the most recent FCTC report

Demand and supply reduction measures and other information	Cook Islands	Federated States of Micronesia	Fiji	Kiribati	Marshall Islands	Nauru	Niue	Palau	Papua New Guinea	Samoa	Solomon Islands	Tonga	Tuvalu	Vanuatu
Prohibiting sales to and by minors	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Monitoring illicit tobacco products				✓						✓	✓			
Regulation of the contents of tobacco products			✓	✓						✓		✓		✓
Regulation of tobacco product disclosures	✓		✓	✓			✓			✓	✓	✓		✓
Packaging and labelling measures	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Protect people from tobacco smoke	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Implementation of tobacco dependence and cessation measures	✓	✓	✓	✓			✓	✓		✓	✓	✓		✓
Prohibiting tobacco advertising, promotion and sponsorship	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓		✓
Price and tax measures on tobacco	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Data on emerging tobacco and nicotine products				✓										✓
Data on tobacco-related health and economic burden		✓			✓									
Information on the practices of the tobacco industry	✓			✓						✓	✓	✓		

Any form of implementation, whether it was partial or complete is marked in this paper as yes (✓). For example, tobacco advertising, promotion and sponsorship ban might not cover at points of sales and the internet, and implementation of tobacco dependence and cessation measures might only be availability of nicotine replacement therapy (eg, no Quitlines). Similarly, a country might report tobacco-related mortality but not tobacco-related costs, and a specific form of tax (eg, valorem tax only).
FCTC, Framework Convention on Tobacco Control.

and the Healthy Islands vision[36]—and supported through regional coordination and international collaboration.

In summary, enhancing capacity for tobacco control in the PICs needs investment in routine tobacco surveillance, leadership development, policy advocacy and enforcement of tobacco control laws. As such, this review draws the following specific recommendations for policies, practice and research:

Building capacity, capabilities and supporting sustainable development

1. Building local capacity and capabilities to sustainably invest in systems, leadership and infrastructure to support tobacco control in PICs. This includes strengthening surveillance and data systems (FCTC: Article 20), enhancing legal capacity to implement and defend public health laws (FCTC: Articles 5.1, 22) and embedding tobacco control within national development planning (FCTC: Article 5.1). Promising models include the McCabe Centre for Law and Cancer, which supports legal preparedness and regional collaboration aligned with the WHO FCTC.
2. WHO recently launched a leadership programme for tobacco control for country heads with the aim to deepen understanding of policies, evidence and strategies to advance tobacco control efforts.[37] Leveraging such programme to enabling Pacific-led approaches and prioritising Indigenous knowledge systems and sovereignty are essential to reducing tobacco harms and achieving regional health and development goals.

3. Further gains can be made through investment in local epidemiological expertise and coordination mechanisms like the Pacific Monitoring Alliance for NCD Action (MANA) Dashboard.

Commitment and coordination

1. Continuous support to implement and enforce the FCTC, including through integration of tobacco control measures into sustainable development agendas and public health priorities (eg, Tobacco-Free Pacific and Healthy Islands) is essential.
2. Coordinating regional tobacco control initiatives across the Western Pacific Region could assist with the development, implementation, monitoring and evaluation of tobacco control programmes and policies. In this regard, Australia and Aotearoa New Zealand have a key role, but this must involve genuine power-sharing, codesign and long-term support.
3. By building robust systems to monitor, expose and counteract tobacco industry tactics—both locally and across the Pacific—governments and communities can reclaim regulatory power and protect public health sovereignty from commercial interference.

Economic development to resist tobacco industry influence

Ensuring sustainable economic development in the PICs would be essential to break the dominant economic discourse, which the tobacco industry and its allies use to challenge the elimination of tobacco and tobacco-related problems in the Pacific and globally.

However, without confronting and dismantling the structural and commercial power of the tobacco industry, no amount of technical or policy reform will be sufficient to eradicate tobacco-related harms, disease and death in the Pacific.

Strengths and limitations

This review is among the first comprehensive investigations into the prevalence of tobacco use among youth and adult population, exposure to SHS, tobacco products (eg, manufactured and locally produced) used to estimate smoking prevalence in the FCTC report, e-cigarettes (vapes) and tobacco control measures in the PICs. Additionally, all reports submitted are thoroughly reviewed and use a standard template, offering an indication of the progress made by PICs in their commitment to the FCTC.

However, the generalisability of these results is subject to several limitations. The FCTC progress reports are based on self-reported data, and as such, may not fully capture the scope or implementation of tobacco control measures in each country. Some reporting cycles were skipped, while others included figures that appeared high or low (as shown in tables 1, 2 and 4, online supplemental S1), suggesting inconsistencies in data quality. Additionally, several reports lacked key information or used older survey data, limiting our ability to conduct robust comparisons. These limitations may, in part, reflect the considerable external demands placed on PICs to comply with detailed and resource-intensive international reporting processes and limited infrastructure, including up-to-date data, research, monitoring and evaluation. Despite these challenges, the reports remain a valuable source of insight—offering a window into national priorities and capacity for tobacco control and resistance and highlighting areas for improved support and coordination.

CONCLUSIONS AND RECOMMENDATIONS

Consistent with the FCTC Reporting Guidelines, a range of tobacco control measures, such as taxation, sale and advertisement restrictions and smoke-free legislation have been reported by Parties. Although considerable efforts have been undertaken by PICs, often in collaboration with WHO and regional partners, progress has been systematically undermined by industry interference and external barriers, with progress remaining insufficient to meaningfully reduce and eradicate commercial tobacco use and related death and disease. The limitations of the FCTC reports suggest that these documents may not fully reflect on-the-ground realities. As such, findings should be interpreted with caution, with further regional studies needed to compare FCTC implementation and validate current results. Greater investment in sustainable data systems, regional coordination and technical supports is essential to strengthen reporting and ensure that monitoring obligations do not overburden national systems.

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Contributors All authors contributed to the design of the research, revised and approved the final manuscript. DBO and RM conducted data extraction, analysis and interpretation, wrote original draft and performed reviewing and editing. IS, OT, MP, VW and DT contributed to data interpretation, writing original draft, reviewing and editing. RM provided guidance and support in all steps of executing the manuscript. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted. DBO is the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests No, there are no competing interests.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available in a public, open access repository.

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