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Overview of Japan's Compliance with the Framework Convention on Tobacco Control



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ABSTRACT

The worldwide scientific community has repeatedly proven that smoking has various harmful effects. The World Health Organization (WHO) has been promoting measures and campaigns against the harmful effects of tobacco since 1970 and adopted the Framework Convention on Tobacco Control (FCTC) in 2003, which has been in force since 2005. To help countries fulfill their FCTC obligations, in 2008 the WHO launched MPOWER; a plan summarizing six specific actions. This aimed to reduce the use and purchase of tobacco, prevent passive smoking, and curb future smoking. However, the progress of these efforts varies across countries. This study introduces the practical situation of MPOWER in Japan and describes how far it is progressing compared to other countries.



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INTRODUCTION

The consensus of the worldwide science community is that smoking is harmful. Compared to nonsmokers, smokers are more prone to cancer, subarachnoid hemorrhage, myocardial infarction, and angina, chronic bronchitis, and have a higher mortality rate.¹ Research has shown that not only smokers themselves but also people close to them are harmed by side-stream (second-hand) smoke; smoke that is inhaled through the smoker's mouth is called mainstream, and smoke that comes from the tobacco product is called side-stream). Legislation and administrative measures are recommended in each country, including the World Health Organization (WHO) international treaties. However, the degree of progress of these measures varies considerably between countries.

Japan has implemented several measures; for example, to prevent underage smoking, TV commercials are limited in time, and age is confirmed when purchasing cigarettes. Other measures include cigarette packaging that indicates the harmful effects of smoking, taxes have been raised and many domestic purchase prices have doubled.² Despite these measures, critics have said that the measures in Japan are not yet sufficient.³ In 2008, the WHO launched action promotion measures using the tobacco control package, MPOWER, which is derived from the initials (M, P, O, W, E, and R) of the six actions. In this paper, we explain the factors in Japan that are said to be insufficient and give the opinions of the authors.

Harm of smoking

The number of deaths in Japan caused by smoking is 120,000–130,000 per year (the total population of Japan is approximately 130 million), which is more than 20 times that of traffic accidents.¹ Tobacco smoke contains more than 60 kinds of carcinogens, including nicotine and carbon monoxide, which hurt health. Carcinogens not only cause lung, bronchial, oral, and pharyngeal cancers from direct contact with smoke but also move into the bloodstream and permeate the body, affecting other organs. Smoking is associated with approximately 30% of cancer causes.¹ Research has shown that the number of years of smoking and the number of cigarettes smoked daily indicate a relationship between cancer mortality and dose-response. Starting smoking from a young age not only increases the number of cigarettes smoked in a lifetime but also increases the risk of carcinogenesis at a young age. Nicotine increases blood

pressure and the risk of heart and cerebrovascular disease. Nicotine constricts the blood vessels, reduces circulatory blood flow, impairs skin health, damages the stomach, and reduces appetite. By inhaling carbon monoxide contained in smoke, the amount of carbon monoxide in the blood increases, and the amount of oxygen decreases. When pregnant women smoke, the contraction of blood vessels impairs blood circulation to the fetus, increasing the likelihood of low-birth-weight infants.¹Side-stream and mainstream smoke affect the health of nearby people even though they are not smoking directly, a phenomenon called passive smoking. Acute effects include an increase in blood pressure and heart rate, irritation of the airway mucosa, and chronic effects include asthma, lung cancer, bronchitis, pneumonia, and even sudden infant death Syndrome.¹

The smoking rate(percentage of people who smoke every day) of the Japanese is about 27% for men and about 8% for women, both of which have been declining in the last 10 years (Fig. 1); however, the problem is that the age at which smoking begins is getting younger (Fig. 2). In Japan, adults are aged 20 years, and smoking is allowed from the same time. Smoking rates in other developed countries are in the 20–30% range for men and 10–20% for women, and the smoking rate for men in Japan is higher than that for men in Europe and the United States. Another problem was that young Japanese women regarded smoking as fashionable and downplayed the dangers. However, in 2017, the smoking rate of women in their 20s dropped to 6.3%.¹The reason why the smoking rate is decreasing year by year is thought to be that the harmful effects of cigarettes and their price have increased in another questionnaire.

Overview of MPOWER

The WHO has been promoting measures and campaigns against tobacco harm since 1970, the Framework Convention on Tobacco Control (FCTC) was adopted in 2003.¹The WHO FCTC symbolizes the global political will to tighten tobacco control and save lives.⁴ The FCTC is an international treaty that imposes legal obligations on signatory countries and provides the basis for developing and implementing tobacco control programs to reduce the growing impacts of tobacco. As of 2018, the FCTC had 195 member countries that covered 94% of the world's population. To help countries fulfill their FCTC obligations, the WHO launched a plan in 2008 under the name MPOWER, summarizing the actual measures of tobacco control proven to reduce tobacco use and deaths in six areas.⁴This program describes measures to practically

support the enactment of national legislation to implement effective policies that reduce tobacco consumption. The contents are as follows: M, monitor tobacco use and prevention policies; P, protect people from tobacco use; O, offer help to quit tobacco use; W, Warn about the dangers of tobacco; E, Enforce bans on tobacco advertising, promotion, and sponsorship; R, Raise taxes on tobacco.^{5,6} Through these measures, MPOWER aims to reduce the use and purchase of tobacco, prevent passive smoking, and curb smoking in the future. Based on a comparison of MPOWER achievements in 2008 and 2018, we observed that many countries are moving in the direction of smoking prevention (Fig. 3). W-1 shows a warning sign about the danger to cigarette packages in the contents of W (warn about the dangers of tobacco), and W-2 shows the contents of a smoking cessation media campaign. In 2020, Japan will reevaluate *complete measures, only a few measures, medium measures, medium measures, complete measures, no measures, and medium measures* for M, P, O, W-1, W-2, E, and R, respectively. In the UK, all are *complete measures*, except E, which is a *medium measure*.

Initiatives in Japan

The measures taken in Japan were delayed in comparison to those in other developed countries. However, Japan recently prioritized the issue of tobacco in Health Japan 21, a national health promotion campaign based on a novel approach to realize the health of each Japanese resident in the 21st century. In addition, the Health Promotion Act of 2003 includes provisions on preventing side-stream smoke in facilities used by many people, such as public transportation and schools.¹ Table 1 summarizes Japan's efforts, based on each item of MPOWER. As shown in Fig. 3, the evaluations of P and E are particularly low compared to those of other countries. This may be due to the insufficient setting of non-smoking areas and numerous cigarette advertisements.

Therefore, it is necessary to disseminate accurate knowledge about tobacco to prevent smoking. With the enactment of the WHO FCTC in 2005 and the adoption of the “Guidelines for Protection from Exposure to Tobacco Smoke” in 2007, the promotion of tobacco control is required in Japan. For example, smoking nearby has a strong psychological effect, such as discomfort; therefore the government recently recommended separating or banning smoking in public places, such as restaurants and transportation.

Measures to prevent underage smoking included introducing adult identification cigarette vending machines, mandatory age confirmation and face-to-face selling, banning smoking commercials, and refraining from beautifying smoking in movies and TV. In 1996, outdoor cigarette vending machines were voluntarily restricted from operating between 11 pm and 5 am under administrative guidance. However, with the installation of adult identification vending machines in 2008 and the “Taspo” card (an RFID identification card issued to adults wanting to buy tobacco), this regulation was lifted, and, it became possible to purchase tobacco even at night.¹ However, lending and borrowing a Taspo to purchase cigarettes is a current problem.

Explanations for insufficient efforts in Japan

The WHO FCTC came into effect in February of 2005; however, Japan tightened tobacco advertising regulations before it entered into force, such as the prohibition of advertising principles on TV, according to the guidelines of the Ministry of Finance in March 2004. In 2005, after implementation, FCTC began to print its written cautionary statements on cigarette packages.³ Although it is still only an obligation to make efforts, establishments have taken measures to prevent passive smoking in the workplace since June 2015. The effects of FCTC and MPOWER are significant; according to a three-year (2006–2009) comparative study in FCTC countries, smoking rates of men and women have reduced by 1.1 % and 1.0% worldwide, respectively.³ In addition, according to a 10-year evaluation (2007–2017), the implementation of MPOWER measures significantly reduced the number of deaths from smoking-related diseases by approximately 22 million people worldwide. If FCTC-contracting countries implement public health policies such as MPOWER, the mortality rate of non-communicable diseases such as cancer, respiratory diseases, and cardiovascular diseases may be reduced by one third by 2030.³

Currently, measures against passive smoking at work and restaurants are still obligatory, with no official penalties enforced. The national-level passive smoking prevention bill continues to stall, and it is unclear what the contents of the amendment will be.⁵ The liaison conference of the ministries and agencies related to tobacco control has not occurred since 2013, and the Ministry of Health, Labor, and Welfare has organized very few media campaigns to widely publicize the health hazards of tobacco. Despite the need to regulate advertising further, Japan Tobacco (JT) is still running commercials on TV and in major newspapers. Even if the tobacco tax is raised, the

price of tobacco in Japan is still cheaper than in Europe and the United States.³Currently, Japan's tobacco control measures are insufficient and delayed, both globally and among the FCTC signatories.⁵The Tokyo Olympics and Paralympics were held in 2021; however, Japan could not establish a passive smoking prevention ordinance that would meet the standards for tobacco-free Olympics required by the International Olympic Committee (IOC).

The WHO evaluates each FCTC member country on their tobacco control measures, including MPOWER. , Table 2 shows a comparison between Japan and each country. These results cannot be interpreted solely by looking at the measures in Japan, however, it is well understood that the measures in Japan are progressing comparatively slower than in other countries. Key points are the lack of free telephone consultation, presence or absence of media campaigns, and display area of cigarette packages. Despite the WHO's compilation in 2017, Japan has yet to provide the tobacco control budget amount.³ Smoking support, including outpatient smoking, is not as effective as a treatment only with drugs such as nicotine patches; smokers need psychological treatment, such as counseling, concurrently with medication. For that reason, free telephone consultation is effective, and an introduction is required in Japan.³For example, a national institution once piloted free smoking counseling but it was discontinued. Therefore, implementation is left to local governments, but the current situation is that few are practically operated. In addition, smoking campaigns from the government through mass media such as television are important, and FCTC-signing countries, such as Thailand and South Korea, are actively working on them. Even in Japan, the Cabinet Office has made a commercial to spread awareness of the harmful effects of tobacco, but the broadcast has ended after a short period, and there are no plans to rerun it.

It is at the discretion of the contracting state government to operate the contents of the FCTC as substantive regulation. Although the prevention of side-stream smoke was strengthened, the consensus is that the Japanese government lacks any serious compliance with the treaty even though it is an FCTC signatory.³ There are various reasons for this, such as tobacco tax revenue, but the biggest one is that the government (Minister of Finance) holds about 30% of JT's shares. Members of the Diet, who are from the Ministry of Finance, have a history of opposition to anti-tobacco bills, such as strengthening the prevention of side-stream smoke, to protect the dividend profit (tobacco interest) from JT, which is ultimately the ministry's profit.³

As with the standards for the prevention of side-stream smoke required at the 2021 Tokyo Olympics and Paralympics, noncompliance with the provisions of international treaties is a national credit problem. The Japanese should be aware that, for many of the MPOWER categories mentioned previously, the current situation in Japan is far behind international standards.

CONCLUSION

In this study, we focused on smoking control measures in Japan and described whether Japan can comply with the FCTC advocated by the WHO. Looking at the behavior in Japan without comparing it with other countries, it seems that the federal and local governments are actively working on tobacco control. However, when comparing such actions with other countries and confirming their achievement level of MPOWER, Japan has not achieved significant progress. Therefore, stricter measures must be taken in the future. Given the interests of the state and members of parliament, it seems challenging to promote such harsh actions, leading us to conclude that it is difficult for Japan to comply with the FCTC guidelines.

In summary, tobacco is harmful, and it is important to protect the health of people who do not want to smoke by eliminating the effects of side-stream smoke. It is essential to consider specific methods for this purpose, create a system, and penalize violations. To achieve this, it is necessary to first promote activities at the citizen level and enlighten them about the harmful effects of tobacco without relying on public institutions.

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Table no 1: FCTC-related initiatives in Japan

Classification	Details of efforts
M	<p>Implementation of National Health and Nutrition Survey</p> <p>Survey on the smoking/drinking situation of minors</p> <p>Support for research on the economic effects of smoking and smoking cessation</p>
P	<p>Health Japan 21 (Thorough separation of smoke in public places and workplaces, dissemination of knowledge about highly effective smoke separation)</p> <p>Health Promotion Act</p> <p>Guidelines for smoking control in the workplace</p> <p>Tobacco control promotion project (support for local governments that take measures to prevent passive smoking)</p> <p>Study group on the ideal way of measures to prevent passive smoking</p> <p>Formulation of cancer countermeasure promotion basic plan</p> <p>Strengthening smoking health guidance in specific health checkups and specific health guidance</p> <p>Promotion of measures to prevent passive smoking in the workplace due to the revision of the Industrial Safety and Health Act (obligation to make efforts)</p> <p>Enforcement of ordinance to protect children from side-stream smoke (no penalties, Tokyo)</p> <p>Enforcement of Passive Smoking Prevention Ordinance in Public Facilities (with penalties, Kanagawa and Hyogo prefectures)</p>
O	<p>Health Japan 21 (Dissemination of smoking cessation support program)</p> <p>Creation, dissemination, and utilization of smoking cessation support manuals</p>

		Applying health insurance for smoking cessation treatment
W	W-1,2	Health Japan 21 (Dissemination of sufficient knowledge about the effects of smoking)
	W-2	Holding a symposium commemorating Smoking Cessation Week and World No Tobacco Day
E		Advertising regulations (guidelines for advertising related to manufactured tobacco)
R		Increasing tobacco tax and price Re-request for a tobacco tax increase for tobacco control (gradual increase, long-term study issue)

In W (warn about the dangers of tobacco), W-1 indicates a warning sign action on the tobacco package, and W-2 indicates a mass media campaign.^{5,6}



Table no 2:2016 country-specific tobacco control survey results

Country	Smoking rate (%)	Tobacco control budget (the US \$ 100 million)	Free telephone consultation	Harmful content display area on the package (%)	Media campaign	Advertising restrictions (TV/newspaper)
Japan	18.2	No answer	×	30	×	△ (substantially self-restraint)
Korea	22.6	2.6	○	50	○	△ (without newspaper)
Thailand	20.7	0.01	○	85	○	○
Australia	14.5	1.4	○	83	○	○
USA	15.1	No answer	○	50	○	△ (without newspaper)
Canada	13.0	0.4	○	75	×	○
UK	18.3	No answer	○	65	○	○
Germany	24.5	0.06	○	65	○	○
France	34.1	0.4	×	65	No answer	△ (without newspaper)
Switzerland	24.9	No answer	○	43	○	△ (without newspaper)

Excerpt from “WHO Report on the Global Tobacco Epidemic, 2017 -Monitoring tobacco use and prevention policies,” where the smoking rate indicates the rate at which one cigarette was smoked within a certain period in the past. Media campaigns and advertising regulations differ in each country; therefore, they cannot be compared unconditionally.³

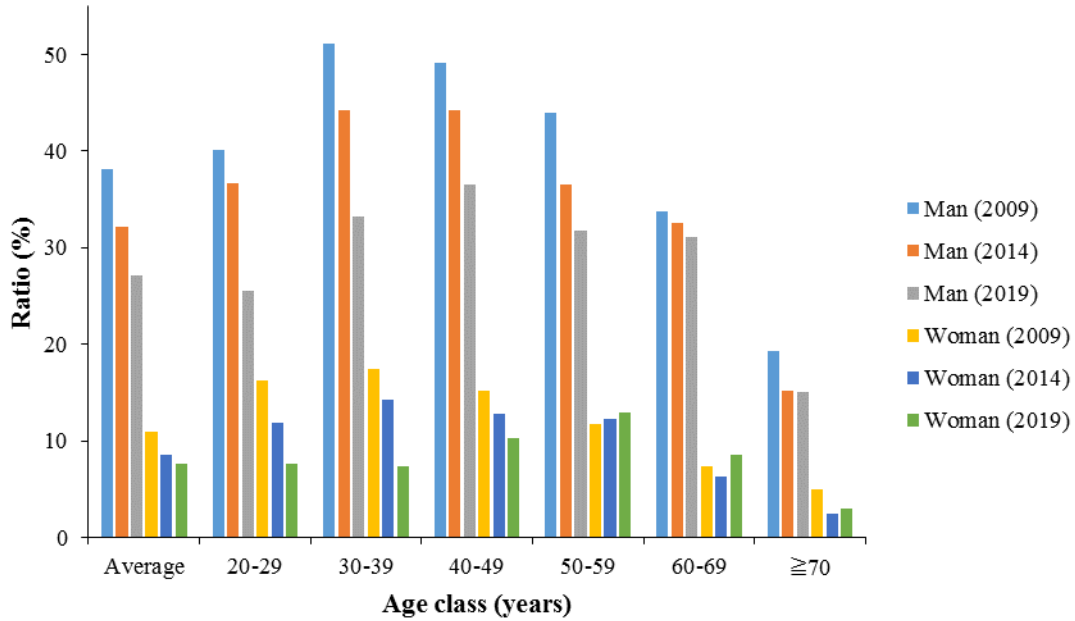


Figure no 1: Results from the National Health and Nutrition Survey, showing the percentage of men and women who smoke daily or occasionally.⁷

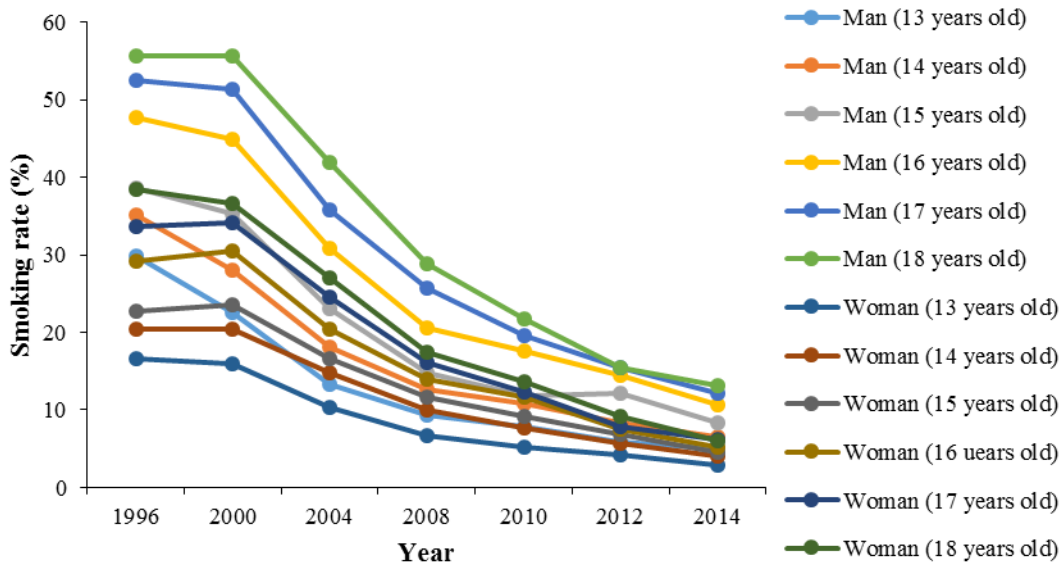


Figure no 2: Trends in smoking rates for minors (≤20 years old) from 1996–2014.²

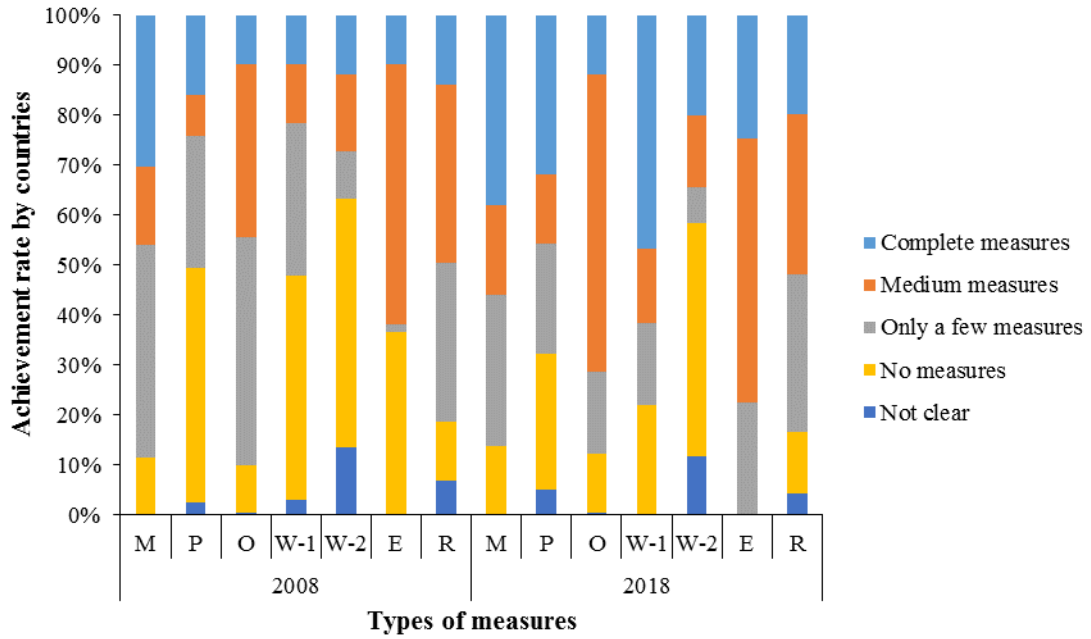


Figure no 3: Differences between 2008 and 2018 achievements of MPOWER by countries.

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