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TOBACCO CONTROL GOVERNANCE IN SUB-SAHARAN AFRICA

Implementing Article 5.2(a) of the World Health Organization Framework Convention on Tobacco Control

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

DISCUSSION PAPER

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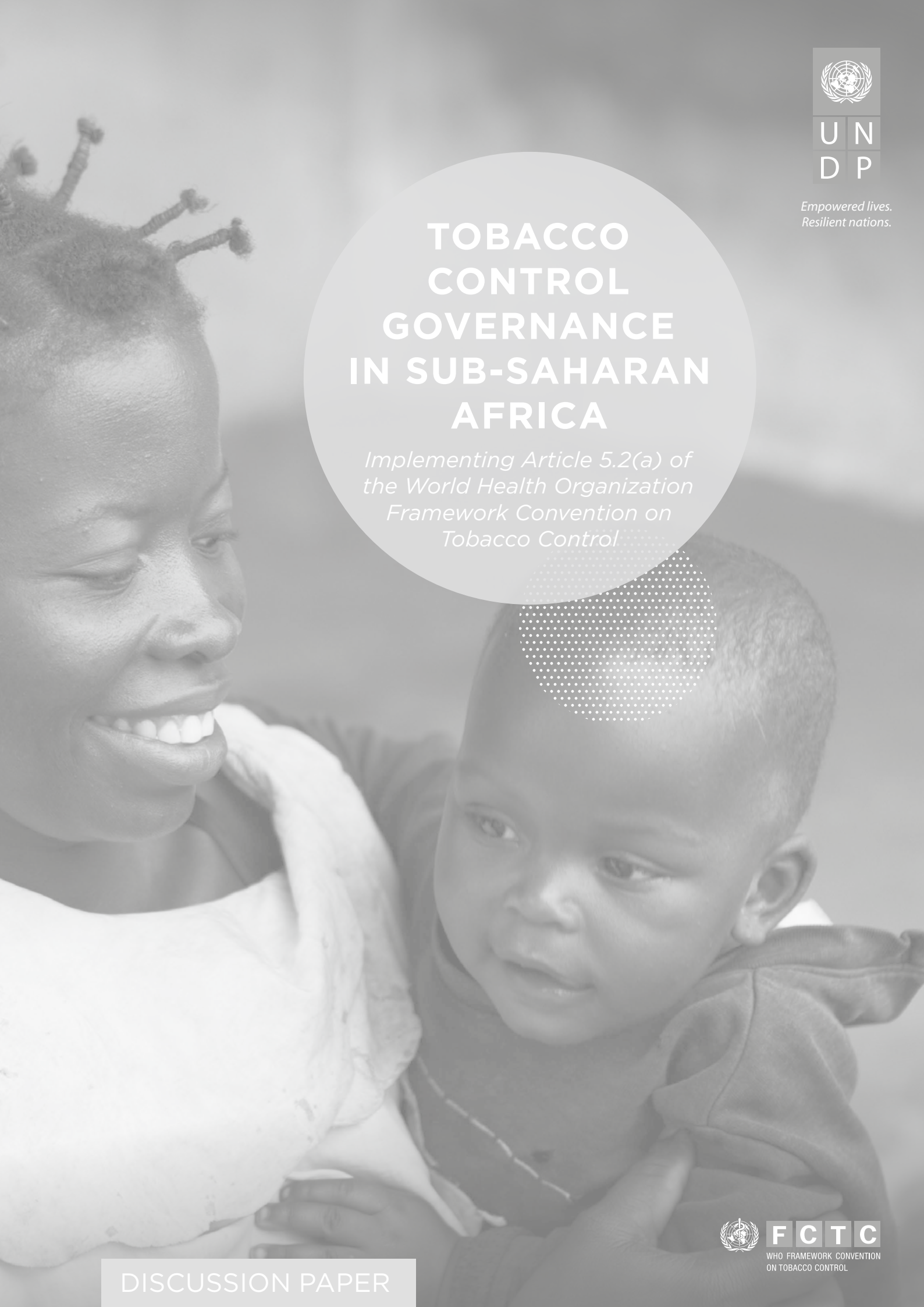

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ABBREVIATIONS

ANVISA	Agência Nacional de Vigilância Sanitária (National Health Surveillance Agency, Brazil)
CEDAW	The Convention on the Elimination of all Forms of Discrimination Against Women
CONICQ	National Commission for the Implementation of the WHO FCTC (Brazil)
COP	Conference of the Parties to the WHO FCTC
CSO	Civil society organization
CVD	Cardiovascular disease
DALY	Disability-adjusted life year
ECOSOC	UN Economic and Social Council
GDP	Gross domestic product
HIV	Human immunodeficiency virus
IAC-T	Inter-Agency Committee – Tobacco (Philippines)
INCA	National Cancer Institute (Brazil)
ITC	International Tobacco Control Policy Evaluation Project
LMICs	Low– and middle-income countries
MDGs	Millennium Development Goals
NCD	Non-communicable disease
NCM	National coordinating mechanism
NGO	Non-governmental organization
SDGs	Sustainable Development Goals
SSA	Sub-Saharan Africa
TB	Tuberculosis
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
WHO	World Health Organization
WHO AFRO	World Health Organization African Region
WHO FCTC	World Health Organization Framework Convention on Tobacco Control
YLDs	Years lived with disability
YLLs	Years of life lost

EXECUTIVE SUMMARY

Tobacco use is not just one of the world's largest, most pressing and most preventable health concerns, it is also a major barrier to sustainable development. Rooted in social inequities, tobacco use imposes significant social, economic and environmental harm on individuals, families and national economies. The causes and consequences of tobacco use are endemic to countries at all stages of development.

Sub-Saharan Africa (SSA), where tobacco use is increasing dramatically, is uniquely vulnerable. Most sub-Saharan African countries are in the early stages of the tobacco epidemic and have yet to endure the full consequences of tobacco-related death and disease. This situation is fast-changing. The region's rising incomes and young populations, among other factors, have made it a primary target of tobacco industry efforts to expand markets for its lethal products. Without urgent responses, hard-won development gains in sub-Saharan African are at risk of stagnation or reversal.

The recently endorsed 2030 Agenda for Sustainable Development sends a strong and clear message that current tobacco trends and sustainable development cannot coexist. Target 3.a. of the Sustainable Development Goals (SDGs) commits all countries to strengthen implementation of the main tool in the global fight against tobacco: the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). Strengthened implementation of the WHO FCTC, an international and legally binding treaty, with 180 Parties as of February 2016, is crucial to reduce premature mortality from non-communicable diseases (NCDs, target 3.4). Strengthened implementation would also deliver shared gains across the entire agenda, given the multidirectional relationship between tobacco, poverty, inequalities and other goals and targets.

The WHO FCTC acknowledges that most well-proven tobacco control measures require the meaningful engagement of sectors beyond health, such as finance, tax, justice, agriculture, trade, labour, education, youth and others. Taxation on tobacco products – by far one of the WHO FCTC's most effective demand reduction measures – is an example. Though health officials help to develop health-optimal frameworks for taxing tobacco products, the finance ministries and/or revenue authorities typically have core taxation responsibilities. Herein lies one of the greatest challenges that countries face in developing and maintaining a set of comprehensive tobacco control policies: establishing a governance framework, or leveraging an existing one, that can coordinate the complexities of tobacco control interventions while facilitating cooperation between sectors and administrative bodies.

> **WHO FCTC Article 5.2(a):** Towards this end, each Party shall, in accordance with its capabilities: (a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control.

WHO FCTC Article 5.2(a) addresses directly the complexities – and opportunities – of involving various government sectors in tobacco control. It obliges Parties to establish or reinforce, and then finance, a governance process for WHO FCTC implementation.

The two entities called for in Article 5.2(a) – tobacco control focal points and national coordinating mechanisms (NCMs) – are intended to serve different though related and mutually reinforcing functions. The focal point refers to a central contact person(s) or institution within government responsible for facilitating WHO FCTC implementation and communicating information about implementation within and outside the country. An NCM refers to the multisectoral institution established by the government to coordinate tobacco control within the country and with international entities such as the WHO FCTC Convention Secretariat, and to oversee general governance-related issues for tobacco control. Focal points and NCMs can both help manage intra-governmental conflicts, promote policy coherence, protect against tobacco industry

interference in policymaking, improve information sharing, and facilitate co-benefit analysis, planning and financing. Both are critical for tobacco control generally and WHO FCTC implementation specifically.

The United Nations Development Programme (UNDP) supports countries to implement the SDGs, including through mainstreaming, acceleration and policy support. With respect to tobacco control, UNDP leverages its core competencies in poverty and inequality reduction and multisectoral governance. UNDP's collaboration with the Secretariat for the WHO FCTC to help countries implement Article 5 of the Convention also contributes directly to its broader efforts in supporting countries to develop effective, accountable and transparent institutions. This report, jointly produced by UNDP and the Convention Secretariat, examines current and historical efforts across SSA to establish functioning tobacco control focal points and NCMs, in furtherance of Article 5.2(a). Based on an in-depth review of WHO FCTC Party reports, official needs assessments and internal government documents from select countries, as well as a wide set of key informant interviews with focal points, members of NCMs and civil society leaders, the report makes two main contributions in supporting WHO FCTC Parties to fulfil their Article 5.2(a) obligations. The first is a deep exploration of the lessons, experiences and good practices that have accrued amongst the now 43 SSA Parties since the treaty came into force in 2005. These are presented around six key areas for governments to consider with respect to focal points and in the design of their NCMs: (1) leadership; (2) composition, including size and membership; (3) lines of authority and statutory power; (4) funding; (5) international linkages; and (6) fitting within the broader NCD agenda.

The report's second main contribution is a set of pragmatic recommendations for policymakers to institutionalize well-functioning and reliably financed tobacco control focal points and NCMs. Key recommendations urge that these entities are established or reinforced with: clear and significant legitimacy; sufficient technical expertise in tobacco control; and the ability to coordinate and engage with key stakeholders, including possibly disputatious ones. Both entities must also prioritize transparent, comprehensive and accurate reporting, particularly given the persistent threat of tobacco industry interference in policymaking. Above all, their functions, roles and responsibilities should at all times advance the overarching policy objectives of the WHO FCTC.

The report's intended audience is those involved in developing, implementing and strengthening intra-governmental mechanisms to implement the WHO FCTC. While the report is perhaps most relevant to policymakers and civil society organizations working on tobacco control in SSA, many of its reflections and recommendations are applicable to other contexts, and to multisectoral health and development issues beyond tobacco. The intention is that WHO FCTC Parties will use the report to realize the social, economic and environmental benefits of strengthened tobacco control governance.

Structure of the document

Background discusses the health and development dimensions of tobacco, the need for urgent action in SSA, and the WHO FCTC's coordinated, multisectoral approach to tobacco control.

CHAPTER 1

Focal points and national coordinating mechanisms provides a conceptual discussion of the two governance entities called for in Article 5.2(a) of the WHO FCTC, noting their mutually reinforcing functions for tobacco control and treaty implementation.

CHAPTER 2

Methodology presents the study's research methodology, including its minor limitations.

CHAPTER 3

Findings and discussion first provides an overview and analysis of key findings. It then offers a deep exploration of six key areas governments should consider routinely with respect to tobacco control focal points and in the design of their NCMs.

CHAPTER 4

Recommendations provides concrete suggestions, based on the analysis, for Parties seeking to institutionalize tobacco control focal points and NCMs in furtherance of WHO FCTC implementation.

CHAPTER 5

The conclusion recaps the paper's high-level messages and reiterates the importance of strong tobacco control governance in sub-Saharan Africa and beyond.

CHAPTER 1 – BACKGROUND

"The inclusion of tobacco control within the SDGs sends a strong and clear message that current tobacco trends and sustainable development cannot coexist."

Tobacco is a significant health and development challenge

In 2013, tobacco accounted for 6.1 million deaths and a staggering 143.5 million disability-adjusted life years (DALYs)[1][1]. Tobacco use is the only behavioural risk factor common to the four main non-communicable diseases (NCDs) – cardiovascular disease (CVD), cancer, diabetes and chronic respiratory disease – that now account for more deaths globally than all other causes combined.[2] Tobacco use is also co-morbid with tuberculosis (TB) and HIV,[3] two of the major infectious diseases with which developing countries still grapple as they confront fast-rising NCD burdens [*see* 3].

Tobacco – cultivation, production and consumption – does not just burden health and strain health systems. Rooted in social inequities, tobacco inflicts significant social, economic and environmental harm on individuals, families and national economies. For low– and middle-income countries (LMICs), the economic costs from the four main NCDs are estimated to exceed US$ 7 trillion over the period 2011-2025 [4]. Tobacco use alone costs the world 1-2 percent of its gross domestic product (GDP) each year [5]. These macroeconomic figures can sometimes obscure tobacco's devastating impacts on households, where tobacco can expand and deepen poverty, perpetuate intergenerational deprivation and reinforce gender inequities [*see* e.g. 49, 50].[4]

Tobacco and NCDs were notably omitted from the Millennium Development Goals (MDGs), despite strong evidence that both impede progress on every MDG[5] [*see* 6 and 7]. The 2030 Agenda for Sustainable Development, endorsed by the United Nations General Assembly (UNGA) in September 2015, rectifies this omission. The SDGs, under Goal 3 on health, include two NCD-specific targets: 3.4 on reducing premature mortality from NCDs and 3.a on strengthening implementation of the World Health Organization Framework Convention on Tobacco (Control WHO) FCTC [*see* 36]. The inclusion of these targets sends a strong and clear message that tobacco control is a priority issue, not just for health but also for sustainable social, economic and environmental development.[6] Scaled-up implementation of the WHO FCTC would contribute directly to efforts to reach other SDGs, such as Goal 1 on poverty eradication, Goal 8 on good jobs and economic growth and Goal 10 on reducing inequalities, to name just three. Scaled-up implementation of the WHO FCTC would also signify progress on Goal 16, given the treaty's emphasis on effective, transparent and accountable institutions.

Sub-Saharan Africa is vulnerable to tobacco use and its consequences

Due largely to a combination of rising incomes, young populations and the tobacco industry's vigorous marketing, tobacco use in sub-Saharan Africa (SSA) is increasing rapidly – both in combustible (e.g. cigarettes) and non-combustible (e.g. e-cigarettes) forms. Méndez et al. (2013) estimate that in 2010, smoking prevalence in the World Health Organization (WHO) African Region (WHO AFRO) was 15.8 percent. They predict that, without proven policy interventions like those in the WHO FCTC, smoking prevalence

1 DALYs are the sum of years of life lost (YLLs) and years lived with disability (YLDs). The figure for tobacco smoke is inclusive of second-hand smoke.
2 NCDs were responsible for 38.3 million of the 54.9 million deaths globally in 2013 (~70 percent) [*see* 2].
3 Smoking increases the risk of latent TB, active TB, and TB recurrence after successful treatment [*see* 40, 41]. Globally, up to one in five deaths from TB would be avoided if people did not smoke [*see* 42]. A 2011 review projected that, worldwide, unaltered smoking trajectories would produce an excess of 18 million TB cases and 40 million TB deaths between 2010 and 2050 [*see* 40]. Because smoking weakens the immune system and disrupts normal lung function, it also makes it more difficult for people living with HIV to fight off serious HIV-related infections [*see* 43].
4 In every region of the world, lower-income groups are more likely to use tobacco [44]. Spending on tobacco and resulting medical costs can shift household income from other important goals such as asset accumulation, education and food security [*see* 6]. Meanwhile, productivity losses from a sick, disabled or deceased family member impair the ability of the household to generate income, increasing the risk or severity of poverty. Children may drop out of school to care for a sick family member or to find work. Caregivers, often women and girls, may suffer from stress, further compounding family difficulties and increasing vulnerabilities [45].
5 Despite their noted shortcomings, tremendous progress has been achieved on the MDGs since their inception. The MDGs are widely acknowledged to have succeeded in mobilizing funding and establishing concrete, time-bound goals and targets. The MDGs also laid the groundwork for the more ambitious SDGs.
6 Given the interlinks between tobacco and other goals and targets, progress across the agenda, for example on poverty eradication (SDG 1) and reducing inequalities within and among countries (SDG 10), can advance tobacco control and vice versa [*see* 8].

in Africa will increase to 21.9 percent by 2030 – the fastest increase of any region over the next 20 years [9]. A 2015 global analysis confirms this finding, projecting that, by 2025, smoking rates will have increased most rapidly among men in Africa and among women in the eastern Mediterranean [10]. Blecher and Ross (2013) depict the same troubling story: inaction could allow the number of smokers in Africa to grow from 77 million in 2013 to roughly 600 million or more by 2100 [11].

The WHO FCTC requires a comprehensive and coordinated response

The WHO FCTC is the main tool for confronting the growing tobacco crisis in SSA and elsewhere. As a legally binding international treaty, it compels its 180 Parties,[7] including the 43 country Parties in WHO AFRO,[8] to develop and implement a comprehensive set of tobacco control measures. Examples include: increasing tobacco excise taxes; legislating smoke-free public and work places; implementing bans on tobacco advertising, promotion and sponsorship; and including compelling warning labels on tobacco packaging. If implemented effectively, these proven measures should help drive down and prevent consumption of deadly tobacco products. The treaty also makes connections to relevant UN conventions that protect populations, including those on human rights, particularly the right to health.[9]

Importantly, the *entire government* becomes a Party when it ratifies the WHO FCTC or accedes to it. Therefore, all relevant sectors have equal responsibility in meeting treaty obligations, including through intersectoral efforts that are coherent with other obligations. Moreover, the WHO FCTC's interventions require actors across sectors to work together to develop and implement appropriate and effective legislation, regulations and rules as well as enforcement mechanisms.[10] Taxation is an example. Although health officials can help – and have helped – to develop health-optimal frameworks for taxing tobacco products, the finance ministry and/or revenue authority typically has core taxation responsibilities. Herein lies one of the greatest challenges that countries face in developing and maintaining a set of comprehensive tobacco control policies: establishing a governance framework, or leveraging an existing one, that can coordinate the complexities of tobacco control interventions while facilitating cross-sectoral action.

> "The entire government becomes a Party when it ratifies the WHO FCTC or accedes to it. All relevant sectors have equal responsibility in meeting treaty obligations."

Given the challenges – and opportunities – of involving various government sectors in WHO FCTC

7 As of February 2016.

8 There are 47 countries in WHO AFRO. Of these, 43 countries are Parties to the WHO FCTC. Eritrea, Malawi, Mozambique and South Sudan are the notable exceptions.

9 The preamble to the WHO FCTC places the treaty in the context of human rights treaties by citing: the WHO Constitution's assertion of the fundamental right to the highest attainable standard of health without discrimination; the provision of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) that requires measures be taken to eliminate discrimination against women in the field of health care; and the right of the child to the highest attainable standard of health, as asserted in the Convention on the Rights of the Child. Human rights principles are also promoted less directly throughout the WHO FCTC, as the text clearly prioritizes the protection of the public's health [*see* 12].

10 The 2012 Global Progress Report on WHO FCTC implementation notes the continued need to broaden the range of government agencies and sectors involved in WHO FCTC implementation "to ensure that all relevant sectors of government can contribute to implementation of the Convention" [*See* 13].

implementation, Article 5 of the treaty covers tobacco control governance and related General Obligations of the Parties. For example, Article 5.1 calls upon each Party to "develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes" in accordance with the Convention and the protocols. Article 5.2(a) obliges Parties to establish or reinforce, and then finance, a governance process for managing the institutional complexities involved in doing so. And Article 5.3 requires Parties to protect their tobacco control efforts from the tobacco industry's pernicious and persistent attempts to interfere in policymaking (see Box 1).

Box 1. Article 5 of the WHO FCTC (summary)

(1) Update and review comprehensive multisectoral national tobacco control strategies, plans and programmes.

(2) Towards this end, each Party shall:

(a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and

(b) develop appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.

(3) Protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

(4) Cooperate in the formulation of proposed measures, procedures and guidelines for the implementation of the Convention and the protocols to which they are Parties.

(5) Cooperate, with competent international and regional intergovernmental organizations and other bodies, to achieve the objectives of the Convention and the protocols.

(6) Raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms.

As discussed in the following chapters, establishing robust and transparent intersectoral governance mechanisms, as required under Article 5.2(a) of the Convention (highlighted above), can help manage intra-governmental incentive conflicts, promote policy coherence, protect against industry interference and improve information sharing. It can also identify synergies and foster co-benefit analysis, planning and financing modalities. As such, Article 5.2(a), as the focus of this report, is a logical means to assist Parties in fulfilling other Article 5 General Obligations.

Purpose and scope

Since 2012, UNDP and the Secretariat for the WHO FCTC have collaborated to help countries implement Article 5 of the Convention and assist UN Country Teams in establishing tobacco control as a development priority. Among a broader division of labour within the UN regarding assistance to WHO FCTC implementation, the May 2012 report of the Secretary-General to the UN Economic and Social Council (ECOSOC) on the Ad Hoc Inter-Agency Task Force on Tobacco Control notes that UNDP take into account the requirements of Article 5, in the UNDP country-level role as convener and coordinator, where appropriate and under its governance programmes. UNDP supports countries to implement the SDGs, and it engages on WHO FCTC implementation to advance not just Goal 3 but also Goals 1, 10, 16 and others. UNDP's efforts at the interface of tobacco control and development align fully with its Strategic Plan 2014-2017.[11]

With respect to Article 5.2(a) in particular, in the 11 years since the WHO FCTC came into force in 2005, there is sufficient experience to reflect on and learn from successes and challenges countries have encountered in developing effective tobacco control governance structures. This report, jointly produced by UNDP and the Convention Secretariat, identifies and discusses the key features and characteristics of tobacco control focal points and NCMs. Through examining country experiences in SSA, the report provides recommendations for policymakers to institutionalize these entities or strengthen existing ones. The report focuses on SSA because of the region's complex dynamic of widespread tobacco leaf cultivation, comparatively low (but fast-growing) levels of tobacco consumption, and relatively recent efforts among Parties in the region to implement WHO FCTC provisions. It complements an important recent related effort by the WHO Regional Office for Africa. Failing to capitalize on the opportunities for action in SSA would be an enormous setback for sustainable development progress.

11 UNDP's Strategic Plan 2014-2017 emphasizes: strengthening institutions and sectors to progressively deliver universal access to basic services; the importance of social, economic and environmental co-benefit analysis and planning; inclusive social protection; whole-of-government and whole-of-society initiatives; and addressing inequalities. All of these priorities characterize UNDP's approach to addressing the social determinants of NCDs and health outcomes more broadly, including through supporting countries to implement the WHO FCTC and its instruments.

CHAPTER 2 – FOCAL POINTS AND NATIONAL COORDINATING MECHANISMS

WHO FCTC Article 5.2(a):
Towards this end, each Party shall, in accordance with its capabilities: (a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control

Following treaty ratification, country Parties to the WHO FCTC are obliged under Article 5.2(a) to establish or reinforce and finance a focal point or national coordinating mechanism (NCM) for tobacco control. The tobacco control focal point and NCM are intended to serve different though related and mutually reinforcing functions. The focal point represents the need to establish a stable contact person or office to oversee the implementation of the provisions of the WHO FCTC within each country, and potentially to serve as the secretariat to the NCM. The NCM convenes key actors from different sectors – with the important exception of the tobacco industry and its front groups – to develop and implement effective tobacco control policies.

Box 2. Focal point and NCM defined

A **focal point** refers to a central contact person(s) or institution within government responsible for facilitating WHO FCTC implementation and communicating information about implementation within and outside the country. Even before the WHO FCTC came into force, those working in tobacco control recognized that the establishment of a national focal point was an "essential starting point for developing a nation's capacity [for tobacco control]" [14].

An **NCM** refers to the multisectoral institution established by the government to coordinate tobacco control within the country and with international entities such as the Convention Secretariat, and to oversee general governance-related issues for tobacco control. Such a mechanism should include key national and sub-national actors and stakeholders who play meaningful direct or indirect roles in tobacco control.

These are general definitions. Article 5.2(a) is sufficiently flexible to allow for differing interpretations of institutional design and structure, and there is no "correct" model. In fact, there is significant variation among WHO FCTC Parties in the design and function

of their institutional arrangements. Also, while Article 5.2(a) uses the word "or" (the article reads "…national coordinating mechanism **or** focal points…"), thus suggesting an either/or choice, experiences strongly suggest multiple benefits in a Party having *both* an NCM *and* a focal point.

Tobacco control focal points

The focal point serves as a line of communication between the international and national spheres, while coordinating domestic efforts to implement tobacco control generally and the WHO FCTC specifically. The staffing, composition, funding and role of the focal point can take many different forms and varies greatly by country. The focal point often plays a central role in an NCM, commonly in a secretariat function. Experiences throughout sub-Saharan Africa and other regions suggest that having the focal point play a central role in the NCM is an institutional best practice, as the focal point is most likely to be current on national and international tobacco control issues.

Focal points should also be an important conduit between the WHO FCTC process and a government's tobacco control efforts, and they often serve as the institutional centre and memory of these efforts. When governments include their focal points in country delegations to WHO FCTC Conference of the Parties (COP) meetings, they ensure continuity and coordination. While national focal points have increased their participation as official country delegates at COP meetings in recent years, need for improvement remains – less than half of the delegations at the sixth COP reported having the country focal point as a member [15]. High-level participation (e.g. of ministers and/or deputy ministers) in the COP process is invaluable for securing governmental commitment and broader buy-in of the WHO FCTC and tobacco control, but the active inclusion of focal points in COP delegations is essential.

"Experiences strongly suggest multiple benefits in a Party having both an NCM and a focal point."

National coordinating mechanisms

Relative to the focal point, establishing an NCM is a more elaborate approach for systematizing WHO FCTC implementation across government. NCMs are needed because tobacco control requires a whole-of-government approach and system-wide coordination. The WHO FCTC's provisions and interventions transcend many different sectors beyond health, including but not limited to: finance; foreign affairs; agriculture; education; communication; transportation; justice; environment; and trade and industry. It is therefore important for NCMs to include representatives from the different sectors of government. Among countries, the nature of NCMs varies tremendously in terms of size, inclusivity, complexity, resourcing and capacity. For example, in Laos, the NCM is small and few people are working on tobacco control issues. In neighbouring Thailand, however, the NCM is very broad and inclusive. Thailand reports that 74 government employees are part of its NCM and working meaningfully on tobacco control [16]. In Africa, most NCMs are small, but Kenya, Ghana and a growing number of governments have increasingly broad and inclusive ones. Worldwide, funding commitments for NCMs tend to be limited, but may include staff costs, training and personnel development, and participation in WHO FCTC-related events, such as COP meetings, as well as other international tobacco control events.

CHAPTER 3 – METHODOLOGY

This report's analysis and recommendations were derived from existing research, findings of needs assessment reports for Parties in WHO AFRO and related work, and dozens of hours of interviews with major stakeholders/key informants. The methodological approach consisted of four main steps.

First, WHO FCTC implementation reports since 2005 were examined. Of the 43 Parties in SSA, 34 have submitted at least one implementation report to the Convention Secretariat since 2010. Ten SSA Parties have never submitted a report (although two of these have registered a focal point with the Secretariat, suggesting some attention to tobacco control and/or the treaty). An analytical framework was developed to review the country reports. This framework included 17 data points, beginning with whether each country reported having a focal point and an NCM (see Annex 1). It then addressed the composition and funding of each of these institutions, and, where available, other institutional features such as lines of authority. To fill gaps and validate the information from the country reports, tobacco control legislation and regulations as well as related documents (e.g. legislative committee minutes, discussion papers, etc.) from individual countries were reviewed.

Second, findings from WHO FCTC needs assessment mission reports were reviewed. Between March 2010 and April 2015, the Convention Secretariat conducted 10 needs assessments in 10 Parties in Africa.[12] The reports include status, gaps and recommendations related to Article 5.2.

Third, to examine more rigorously the establishment and implementation of tobacco focal points and NCMs, a series of semi-structured key informant interviews was conducted (44 in total). Using contact information from the Convention Secretariat, requests for in-person or phone interviews were made to focal points in SSA. Focal points from 11 countries participated in interviews. Together with these focal points, the research team then identified members of NCMs and individuals from government, academic institutions and civil society for additional interviews. Identified individuals from the 11 focal point countries and an additional eight countries participated. To encourage candour, and to obtain research ethics permissions within a short time-frame, information from interviews is attributed anonymously in this report.

Fourth, lessons were drawn from related research conducted in the Philippines [17], Brazil [18], and Kenya between 2012 and 2014. These countries have established both tobacco control focal points and NCMs, with varying compositions, roles and lines of authority.

Across the three countries, more than 75 key informant interviews have been completed that address issues regarding focal points or NCMs. Generalizable lessons from this research helped to validate, inform and strengthen the sub-Saharan Africa findings.

There were some minor limitations to consider. First, 10 out of the 43 SSA Parties analysed did not submit a Party report on tobacco control to WHO. Incomplete reporting appeared to be due partly to a lack of a focal point and/or a NCM, which reinforces the importance of these entities for establishing links to the international dimension of tobacco control. From a methodological perspective, the missing reports resulted in information gaps about tobacco control efforts in these lower tobacco control performers.

Second, some countries were not reporting accurately in their report, which was revealed during the cross-referencing of the reports with validating sources. The researchers accounted for these inaccuracies in the overall analysis. Key informant interviews suggested two main explanations for the discrepancies: governments are sometimes incentivized to misrepresent progress (or the lack thereof); and reports for intergovernmental organizations are sometimes assigned to staff with insufficient knowledge to complete the reports accurately. This dynamic highlights a downside to self-reporting compared to independent, expert

12 Burkina Faso, Burundi, Congo, Gabon, Gambia, Ghana, Lesotho, Mauritius, Sierra Leone and Togo. The more recent assessments were conducted through inter-agency missions.

assessments. On the other hand, as was observed in several reports, self-reporting can provide individuals with the opportunity to report frankly on actual conditions.[13] In either case, there is a genuine need among Parties for technical support on reporting instruments to ensure reliability and consistency. Notably, at the sixth COP in October 2014, the Parties decided to establish an expert group to consider this issue and improve reporting for future COPs and in general [19].

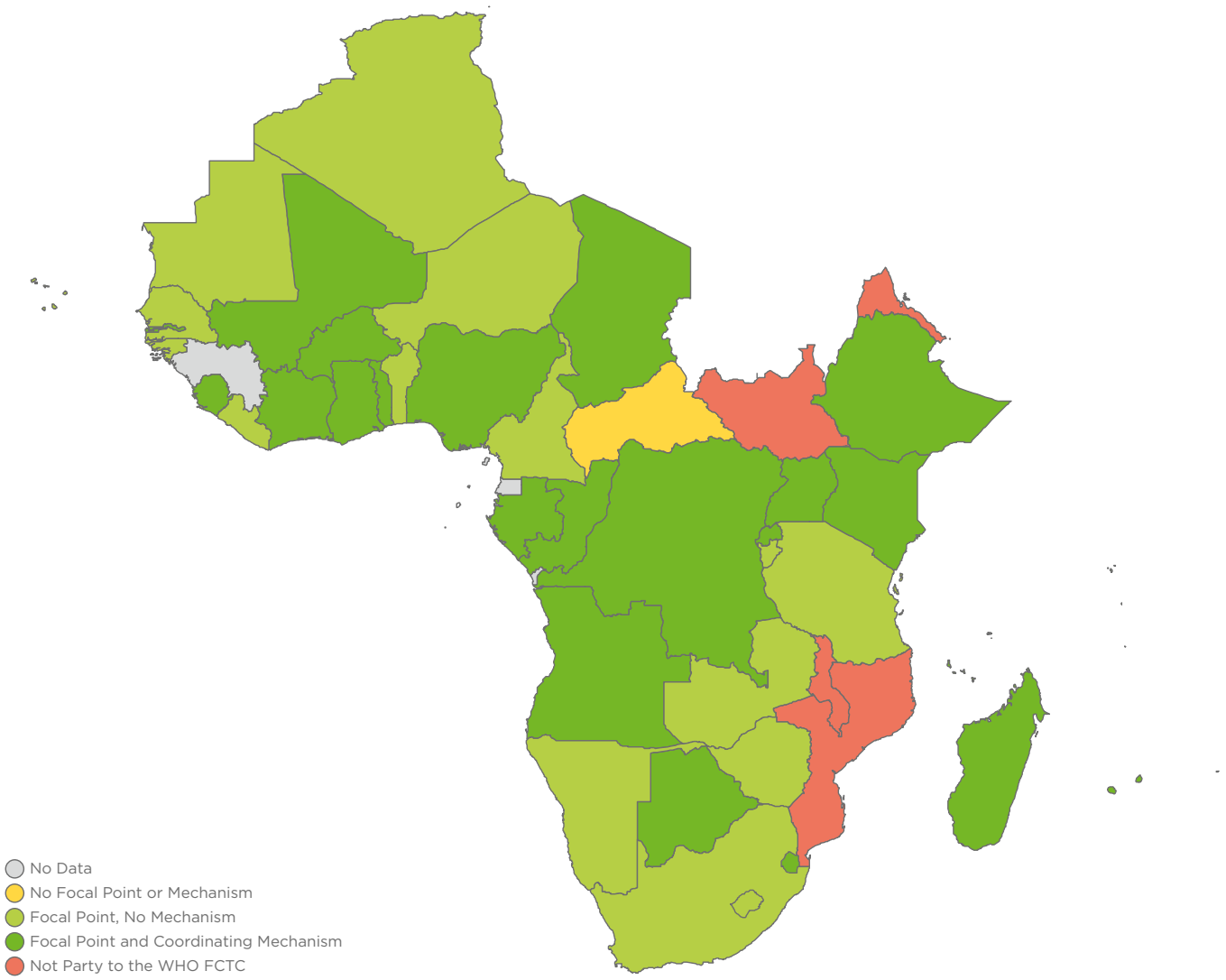
Finally, the key informant interviewing process was limited by time constraints and the potential reticence of some focal points to discuss certain topics. Only 11 focal points agreed to be interviewed and it was difficult to discern if there was sample selection bias as a result. Most focal points were well informed about the WHO FCTC and tobacco control, so it is possible that the less informed focal points did not want to be interviewed. The collected data might therefore be slightly biased toward the experiences of more engaged officials, if focal points who are less informed reflect differently on the dynamics of either/both of the roles of focal points and NCMs.

13 For example, several reports criticize their own governments for not funding focal points and NCMs (see Chapter 4).

CHAPTER 4 – FINDINGS AND DISCUSSION

More than 90 percent of sub-Saharan African Parties have a tobacco control focal point and 53 percent have an NCM in place. A total of 39 out of 43 SSA Parties have a focal point in some form. Of the 34 SSA Parties that reported on whether they established an NCM, 23 reported having an NCM in place by late 2015 Assuming that non-reporting Parties do not have an NCM (which is likely), the percentage of Parties in the region with an NCM (53 percent) falls below the 67 percent global rate reported in the 2014 Global Progress Report

Figure 1. Focal Points and National Coordinating Mechanisms in the WHO AFRO Region (As of November 2015)



Countries in sub-Saharan Africa require support in their efforts to implement Article 5.2(a), in particular to engage and coordinate non-health sectors in their tobacco control efforts. This Chapter discusses in detail the key principles underlying calls for greater intersectoral coordination and cooperation for tobacco control, the lessons learned from countries that have established focal points and NCMs, and six key domains for governments to consider with respect to focal points and in the design of their national coordinating mechanism. These are:

(1) Leadership;

(2) Composition;

(3) Lines of authority and statutory power;

(4) Funding;

(5) International linkages; and

(6) Fitting into the broader NCD agenda.

(1) Leadership

a. Institutional and individual leadership characteristics

Historically, successes in tobacco control have often resulted from strong advocacy efforts by informal networks of individual champions. Over the years, this advocacy has consolidated into institutional mechanisms that continue to develop, implement and enforce strong tobacco control legislation [20]. Individual leadership and institutional design are complementary and necessary features of successful WHO FCTC implementation.

The location of the focal point and corresponding NCM within government is critical. Because tobacco is a major threat to health, it is natural for tobacco control to be situated within health ministries and/or associated agencies. The challenge for governments, however, is to situate leadership within the health sector while ensuring that this does not isolate tobacco control from other relevant sectors.

For meaningful policy change and corresponding enforcement of provisions, the health sector must make tobacco control a priority. This cannot be assumed, and other priorities will inevitably compete for attention. Tobacco control, however, advances many other health and development priorities. It is a "best buy" investment in terms of saving lives and generating healthy, productive societies. The WHO FCTC, meanwhile, is a legally binding commitment. Even in countries that have already started tobacco control efforts, this framing still needs promotion. There is not yet a country in the world that is finished with tobacco control.

Countries can have more than one tobacco control focal point. Brazil, for example, has focal points within three different institutions: (1) the Ministry of Health (covering surveillance and final political decisions around major tobacco control issues); (2) the National Cancer Institute (INCA), which is also the Secretariat to the National Commission for the Implementation of the FCTC (CONICQ)); and (3) the Brazilian Health Surveillance Agency (ANVISA; covering product regulation and enforcement). Brazil has one of the world's more advanced tobacco control arrangements. When a country is in the nascent stages of tobacco control, having just one focal point arguably makes the process more cohesive and consistent. When countries have made progress, Brazil's more comprehensive structure might be a good model.

The location of leadership is also important for the success of NCMs. Because the NCM is likely to include representatives from across government, there will likely be differing perspectives on WHO FCTC commitments vis-à-vis other government policies. A discourse within intersectoral bodies that consistently challenges tobacco control legislation efforts is the protection of private commercial interests. A false notion is commonly perpetuated that tobacco control only benefits health and, as such, must be balanced against the economic benefits from preserving tobacco industry interests, industry-created employment and other perceived benefits. Departments of trade and industry, for example, often view the tobacco industry like any other legal industry whose activities they work to protect or even facilitate.

Box 3. Leadership lessons from the Philippines, Brazil and Kenya

In the Philippines, the Inter-Agency Committee – Tobacco (IAC-T) is chaired by the Department of Trade and Industry, with the Department of Health as co-chair. This location of leadership has created difficulties for the Department of Health in moving the Philippines towards WHO FCTC-compliant legislation [21]. In many other countries, such as Brazil and Kenya, conflicts also continue between the tobacco control perspectives of the health sector and those of the industry sector (including agribusiness). This points to the importance of establishing legislation that confers authority to and situates leadership within the health ministry, without compromising the multisectoral nature of the governance mechanism, while mandating that other sectors of government work together to achieve the objectives of tobacco control.

It is important for the health sector to make the economic case [22] – not just the public health case – for tobacco control and WHO FCTC implementation. Departments of trade, industry, agribusiness and other potentially reluctant actors must be shown that addressing the social, environmental and economic consequences of tobacco can advance rather than impede their core objectives. Situating leadership within the health ministry and making the economic case for tobacco control by no means guarantee the protection of tobacco control efforts from competing interests. But they are two important elements – one institutional and the other advocacy-focused – of a multi-faceted approach to optimal WHO FCTC implementation.

Leadership is particularly important when governments are navigating the complexities around international negotiations related to the WHO FCTC, such as in the COP process. Typically, country delegations comprise representatives from multiple sectors, including trade and industry, which frequently speak to, or even for, the interests of the tobacco industry. This is especially the case if the country has a state-owned tobacco monopoly. Moreover, because the WHO FCTC is a treaty that entails international negotiation, the ministry of foreign affairs or its equivalent usually leads delegations to the COPs and other international meetings. Foreign affairs ministries often seek to broker compromises among the different ministries to accommodate both health and trade/industry. The role of the focal point is to steer pre-negotiation discussions firmly toward a strong health position, laying the foundation for the foreign affairs delegation leaders to guide strong health-focused decisions. These pre-negotiation discussions should take place within the NCM so that they are substantive and transparent, and so that the different actors can together develop appropriate positions to facilitate full implementation of the WHO FCTC, rather than diluted versions of key provisions. If the foreign affairs leaders shift from strong health positions during the actual negotiation process, the health representatives – particularly the focal point, if present – must guide the foreign affairs team back toward strong tobacco control.

International complexity around WHO FCTC implementation is another reason why Parties should assign the tobacco control focal point a leadership role on the NCM. The NCM's international connections would be strengthened through the focal point's connections to the Convention Secretariat and the broader WHO FCTC process. Such assignation would also provide at least three additional benefits. It would: (1) help ensure that the needs and goals of both the NCM and focal point are aligned; (2) provide the focal point with readier access to other sectors through the NCM; and (3) reinforce to the focal point that tobacco

control generally and WHO FCTC implementation specifically are multisectoral undertakings.

b. Leadership process

Each sector of government will have a particular perspective on tobacco control within the broader context of public policy. The NCM leadership must become familiar with the different policy preferences held by its members, to develop agreeable positions that respect the spirit of the WHO FCTC. This is a continuing challenge.

Three logical scenarios can result from differing policy preferences within an NCM. Firstly, members see differences in policy preferences as intractable. For example, a department of industry or investment authority may be providing investment incentives to transnational tobacco companies to stimulate the national economy, while the agricultural ministry may simultaneously be implementing crop substitution programmes for tobacco farmers in order to decrease tobacco production. Intractable differences can lead to the dissociation of the different sectors from the NCM and policy fragmentation.

In the second scenario, one or two members of the NCM establish policy positions for the entire mechanism. This scenario may be particularly appealing in situations where the health sector perceives a lack of commitment to tobacco control, or active opposition, among other sectors. However, the ultimate goal of an intersectoral coordinating mechanism is to create a forum in which active cooperation and engagement can occur across the different sectors. Elevating short-term policy gains over long-term system strengthening is not ideal, and may result in lack of buy-in among, or the withdrawal of, representatives from other sectors.

Parties should strive for a third scenario in which consultation and cooperation are fostered among members from different sectors to construct and implement initiatives that align with the provisions of the WHO FCTC. Given the many barriers to coordination and cooperation across sectors, governments must commit – financially and otherwise – to building the capacity of different sectors to engage in tobacco control. The Convention Secretariat, intergovernmental organizations including WHO and UNDP, non-governmental organizations (NGOs), and individual governments have all worked toward this end. For example, they have conducted needs and/or capacity assessments as well as organized workshops with different sectors of government on areas such as tobacco industry interference, tobacco taxation, trade, and illicit trade. Some of these efforts have particularly sought to foster South-South interactions, wherein LMICs can learn from the experiences of other LMICs that are confronting similar challenges around WHO FCTC implementation.[14] These types of initiatives will continue to be important in orienting different sectors around the best available evidence.

In addition to committing to understand the responsibilities and perspectives of the different sectors, NCM leadership should also support representatives from these sectors to implement WHO FCTC provisions. Many ministries in SSA still view the WHO FCTC as an issue for the health sector exclusively. This perspective may provide cover for the economic, trade or agribusiness sectors to continue acting in contravention of treaty obligations. However, it may also be a case of different sectors legitimately perceiving tobacco control as residing outside their portfolio.

NCM leadership must help these sectors to understand that the WHO FCTC is a commitment made by the entire government. The United Nations (UN) resident coordinator mechanism, led by UNDP, plays a very important role in this respect [see 23 and 24].

The foundation for the third scenario is for the leadership to engage with the different sectors, advocate a whole-of-government approach to WHO FCTC implementation, and promote the alignment of domestic policy with Convention obligations. In the absence of this, a misaligned policy environment is likely to result. For example, Zambia's Department of Industry and the Zambian Development Agency do not restrict the provision of investment incentives to increase tobacco manufacturing and treat tobacco companies like any other industry [25]. This approach

14 Most recently, from 29 September–1 October 2015 in Uruguay, UNDP and the Convention Secretariat convened representatives from the governments of 22 Parties to chart out how they can apply South-South and Triangular cooperation to accelerate tobacco control. These efforts are in line with Decision FCTC/COP4(19), which calls for the promotion of South-South cooperation for WHO FCTC implementation [*see* 37]. They are also in line with the treaty itself. Article 5.2(b) of the Convention, for example, calls in part for countries to cooperate with other Parties in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke [*see* 12].

breaches Article 5 and directly contradicts Principle 4 of the adopted guidelines for implementation of Article 5.3, which states, "Because their products are lethal, the tobacco industry should not be granted incentives to establish or run their businesses" [26].

Such policy incoherence and fragmentation is not specific to the countries discussed in this report; it is a global phenomenon relevant to all WHO FCTC Parties. The reasons for fragmentation are many, ranging from conscious antagonism between sectors, to systemic misalignment between health and commercial objectives, to sectors not knowing the international commitments of the Convention. Filling information gaps and informing all sectors of the government's legal commitment to WHO FCTC implementation is essential.

Creative engagement strategies can help leaders of the NCMs forge and sustain relationships with representatives from other agencies. The generation of evidence-informed counter-narratives to established pro-industry arguments is fundamental, including that the tobacco industry is: (1) a stakeholder in health policy; (2) a necessary source of public revenue; and (3) a necessary source of employment. In the context of inaction, well-nurtured and ongoing intersectoral relationships can disentangle such positions from information gaps and other legitimate obstacles. In sum, leaders of the NCMs must at once be sensitive to, and seek to uncover the origins of, differing policy preferences across sectors while striving to forge relationships among sectors to establish policy coherence.

(2) Composition

a. Size

There is no guidance in Article 5.2(a) on the suggested size of an NCM. Parties, within their contexts, must weigh the risks and opportunities of broader versus more selective membership in the NCM. Greater inclusion would likely produce a wider variety of viewpoints, but this can also make collective action more difficult, possibly causing gridlock if actors cannot agree.[15] A perceived benefit

"Not including key actors on the NCM – especially those thought to oppose tobacco control – could limit the discussion and reduce the opportunity to secure buy-in from key constituents."

of selective membership might be to include only or mostly members who are known to be receptive and supportive of tobacco control. However, not including key actors on the NCM – especially those thought to oppose tobacco control measures – would likely be detrimental because discussion of legitimate opinions and concerns would be limited, thus reducing the opportunity to secure buy-in from key constituents and to achieve better policy coherence across sectors. Although discussions could prove difficult in an inclusive environment where participants adopt strong positions, the often painstaking work of securing consent typically produces tobacco control policies that are widely accepted and more durable. The less inclusive alternative will typically lead to a failure of policy, policy change and/or implementation.

15 In some countries, such as Kenya, the ministry of agriculture is supportive of tobacco control and works closely with the health sector. In other countries it is antagonistic to and/or sceptical of tobacco control [17]. Support can also be divided within a ministry of agriculture, in situations where agribusiness works closely with tobacco industry stakeholders even though agrarian development aligns with the health sector [18].

In general, key informants agreed that it is better to err on the side of larger and more comprehensive membership, because that breadth of opinion makes discussions richer and more meaningful. Even if certain sectors are not supportive of tobacco control, including them in the process provides important opportunities to raise convincing arguments about the broad benefits of tobacco control as well as to reinforce the entire government's legal commitment to the WHO FCTC. A number of officials noted that tobacco control is fundamentally multisectoral and by its nature requires the participation of officials from across ministries and agencies. Without widespread buy-in, effective tobacco control is unlikely.

b. Membership

As with size, Article 5.2(a) is vague about the composition of an NCM. Indeed, the variation in membership across sub-Saharan Africa is considerable (Table 1).

Table 1. Range of agencies on existing NCMs in SSA

Ministry of Health	**Food and drugs regulatory agency**	**Ministry of Finance**	**Ministry of Foreign Affairs**	**Ministry of Justice**
Revenue Authority	**Customs Authority**	**Planning Authority**	**Ministry of Agriculture**	**Ministry of Agrarian Development**
Ministry of Agribusiness	**Ministry of Labour**	**Environmental Authority**	**Media Authority**	**Ministry responsible for gender issues**
Ministry responsible for children/youth issues	**Ministry of Education**	**Standards Authority**	**Tourism Authority**	

There is a wide range of ministries and agencies for Parties to consider including on their NCM, while giving full consideration to Article 5.3 and its guidelines. Critically, composition must advance the policy objectives of tobacco control, specifically the overarching objective of implementing the provisions of the WHO FCTC through national legislation, corresponding regulations and national, and in some cases sub-national, programmes. In considering inclusion, current and former tobacco focal points identify three general (not prescriptive) categories of ministries and agencies: (1) essential (2) recommended/strongly considered; and (3) optional/important to consider (Table 1).[16]

If a ministry or agency is involved meaningfully in any aspect of WHO FCTC implementation, it should be included on the NCM. Moreover, depending on context, some ministries or agencies on the NCM may need to assume a more integral role than others. Conversely, some ministries or agencies play only a very minor role in tobacco control and including them on the NCM might be unnecessary or even unrealistic. In these instances, it is still important for the focal point and other active members of the NCM to engage these actors as the needs of WHO FCTC implementation warrant.

Category 1: Essential ministries and agencies

Health. The NCM should include those sectors with mandates that directly cover or address some aspect of the WHO FCTC. These sectors will likely be most incentivized to assist in the establishment, implementation and enforcement of tobacco control measures. The health ministry is the obvious example. It or its equivalent must take the leading

16 In Table 1, green indicates ministries and agencies that are essential to be on the NCM in any context, blue denotes ministries and agencies that should nearly always be included, and orange represents the ministries and agencies that are less obvious for tobacco control but should still be given due consideration based on context.

role in the NCM. While this might seem self-evident, the Philippines example demonstrates that the principal health authority does not always lead the coordinating body (Box 3).

Food and Drugs. In some countries, there is more than one entity that monitors and/or regulates health. For example, in Ghana, there is an autonomous food and drugs authority with a specific regulatory mandate separate from the health ministry. In Ghana, as elsewhere, it plays a specific role in tobacco control, for example by monitoring ingredients or by developing and/or implementing labelling requirements. Such agencies – in addition to the main health ministry – must be included in an NCM.

Finance. Tobacco control has cost implications, as governments pay for certain programmes or enforcement of regulations. Also, finance authorities should understand the enormous direct and indirect costs that tobacco use inflicts on national economies and societies. In addition to medical treatment costs, tobacco also results in significant indirect costs in the form of lost workforce productivity. When working-age people suddenly cannot work, work less, or work less well, their economic contribution diminishes or even becomes negative. This, in turn, impedes the economic development sought in particular by finance ministers. It is therefore essential that ministries of finance accurately weigh the short-term benefits of tobacco-related revenue against the longer-term financial consequences of tobacco-related disease. In addition, the tobacco control policy that is now widely accepted as the most cost-effective and arguably most effective overall – uniformly high tobacco excise taxation – generates immediate revenue and is clearly the direct responsibility of finance authorities.

Foreign affairs. The foreign affairs ministry is central to WHO FCTC negotiations, including in serving as the usual head of delegation at COPs. A well-informed and engaged foreign affairs ministry can be instrumental in supporting successful and vigorous participation in the COP process, by bringing together disparate members of the delegation and promoting a solid public health position.

Justice. This includes the justice ministry, the attorney-general's office, or equivalent institutions. At some point, the institution that vets the legality and/or constitutionality of laws and regulations must scrutinize or, more typically, approve proposed tobacco control policies. Involving this entity early on enables the modification of legislation or regulation.

Category 2: Ministries and agencies that should nearly always be included

Revenue and customs. These agencies often report directly to the finance ministry. In the case of revenue authorities, not only are they responsible for enforcement of revenue collection (e.g. tax), but they can also play a direct role in developing revenue-related policies, including taxation. Customs authorities are not only responsible for collecting tariffs on imported goods, but are often part of the official apparatus responsible for combatting illicit trade. Illicit trade in tobacco products is a challenge in some African countries – though the magnitude of this challenge varies enormously [27]. As such, it is critical that the customs authority is directly involved in tobacco control policy, especially in light of the 2013 Protocol to Eliminate Illicit Trade in Tobacco Products [see 28 for a copy of the Protocol].

Planning. Some countries have a separate planning ministry, and tobacco control is or should be part of their strategy. In countries that grow large amounts of tobacco leaf, this sector must be on the NCM. The tobacco industry consistently cites the livelihoods of tobacco farmers as a reason for stifling tobacco control efforts. This argument, like the industry's other arguments, is illusory. Tobacco production is in fact associated with harmful societal and individual consequences, such as unlawful or exploitative labour, including child labour, environmental degradation, and nicotine poisoning amongst those harvesting tobacco leaves [see 38]. Moreover, because demand for tobacco is global, tobacco control efforts and reduced demand for tobacco within one country are unlikely to affect that country's tobacco farmers in the short- and medium-term. The timeline for achieving a significant decline in global demand for tobacco leaf will likely be long, so governments will have years to transition their workforce toward alternative economic activities

without major cost to these farmers – though support and preparation for this should begin immediately. Planning ministries must be an integral part of discussions to move tobacco farmers towards other viable crops or new economic activities. Historically, planning ministries have played indirect roles in tackling health-related challenges by contributing to population-level solutions. Tobacco certainly qualifies, and should be a central concern of those involved in development planning.

Agriculture and environment. Ministries that address agricultural issues should be an integral part of the NCM, and this is certainly the case in tobacco-growing countries. Where governments have separate ministries for agribusiness and/or agrarian development, all relevant agricultural agencies must be included. Developing economically sustainable alternatives to tobacco growing is the *raison d'etre* of Articles 17 and 18 of the WHO FCTC as well as their adopted policy options and recommendations. Serious government participation in these efforts is needed. Since tobacco is a legal crop, better aligning a government's agricultural framework with the health goals of the WHO FCTC is not possible without the genuine efforts of agricultural authorities. The environmental authority similarly needs to be on the NCM, particularly in countries where tobacco is cultivated. Because tobacco farming is land-intensive and frequently utilizes large amounts of fertilizer, herbicide and pesticide, it has enormous implications for the environment. In tobacco-growing countries that require flue-curing (usually with wood), sustainable forestry management is also jeopardized.

Labour. Tobacco's negative implications for livelihoods extend beyond tobacco growing to tobacco manufacturing and broader labour issues. In countries with tobacco manufacturing, the labour ministry should be on the NCM. This can help assure the labour ministry that tobacco control does not, overall, affect employment adversely. Indeed, research suggests that most changes in tobacco manufacturing have little or nothing to do with tobacco control efforts; they are much more connected with industry attempts to maximize efficiency and profit in its operations [see 29]. In countries with sizeable hospitality sectors, these industries will need to work with the labour ministry to demonstrate that policies like smoke-free areas do not adversely affect business revenues, and can even reap rewards for businesses, again contrary to the myths propagated by the tobacco industry and its allies [see e.g. 39].

Media. Considering that WHO FCTC Article 13 strives to ban all tobacco advertising, promotion and sponsorship, it is vital to have the principal media regulation authority or authorities engaged in tobacco control efforts. Where jurisdiction over media falls across a number of sectors, efforts should be made toward broad-based, meaningful engagement of these sectors in the NCM.

Youth, gender and education. Tobacco control is widely accepted as a concerning issue for and to children and young people. It also has important gender dimensions. In many sub-Saharan African countries, tobacco use among women and girls is increasing dramatically.[17] The tobacco industry is aggressively targeting these potential new consumers with multiple marketing efforts, often using duplicitous tactics that link smoking with gender equality [30]. A recent International Tobacco Control Policy Evaluation Project (ITC) report from Zambia (2014) indicates that, in Zambia, girls are now more likely to use tobacco than boys[18] [31]. Importantly, young people should be a key part of the solution in terms of engagement with efforts to promote healthy living, for example as central participants in government-sponsored mass and social media campaigns against tobacco use (Article 12). Similarly, education ministries should be engaged because anti-tobacco messages must be a part of the national health education curriculum at all levels of education. In many countries, health and education authorities already work closely on these and other related issues.

Category 3: Non-obvious ministries that should be given strong consideration

Standards. Particularly if a country manufactures tobacco, it may be reasonable to include an agency

17 This is consistent with global trends. WHO states that, globally, smoking prevalence is about five times higher among men (37 percent) than among women (7 percent) [46]. Recent evidence, however, suggests that the sex gap may be closing, with women taking up smoking at alarming rates, and men's rates expected to remain steady or decline [*see* 6]. The proportion of female smokers is expected to rise from 12 percent in 2010 to 20 percent by 2025 [47].

18 The report cited the national-level WHO Global Youth Tobacco Survey conducted in Zambia in 2011, which found that one-quarter (25.6 percent) of students currently use any form of tobacco, with girls edging out boys for the first time (25.8 percent compared to 24.9 percent) [*see* 48 and 31].

responsible for establishing and maintaining standards. This can be complex as the mandates of standards agencies often have little to do with the health aspects of tobacco products. In Kenya, for example, the standards bureau does not govern the health aspects of tobacco products but does govern the size, weight and design of such products. This has led to a troubling dynamic in Kenya, where some smokers have reported seeking the "stamp of approval" from the standards bureau because they are under the impression that approved cigarettes are safe or at least safer. More worrying are situations where the standards agency has strong ties to the tobacco industry. In such cases, the NCM would need to ensure that all actors are strictly adhering to Article 5.3 and its guidelines.

Tourism. Implementing measures such as smoke-free restaurants, hotels, and bars will require the cooperation of the tourism authority. For example, tourism authorities often need to be introduced to the overwhelming evidence that smoke-free tourist facilities generally increase revenues – not the opposite as the tobacco industry consistently claims [32].

c. Representation

A conceptual issue considered by the key informants was appropriate ministry and agency representation on the NCM. Several officials with more tobacco control experience noted that many ministries send representatives who are too junior and/or officials who do not have any requisite knowledge. Similarly, it was noted that some ministries send officials who are not engaged seriously in tobacco control. Key informants related anecdotes of meeting participants who were not only passive but in fact openly prioritized other activities during NCM meetings. Most egregious is when representatives use the NCM to openly defend or even promote the interests of the tobacco industry. The commonly cited justification for such action is that some official institutions must, by their mandate, serve all their constituents, even when the tobacco industry is one of them. However, opposing WHO FCTC provisions on the industry's behalf contradicts the fact that entire governments – not just ministries of health – have signed the WHO FCTC and are therefore legally obligated to implement its provisions. It is incumbent upon sectors to reconcile contradictions and find common ground within the parameters of their mandates and the WHO FCTC. Developing a clear terms of reference for participation in an NCM that clearly delineates responsibilities will help mitigate these challenges.

Identifying the appropriate level of representative to the NCM is difficult. In practice, the greater the ministry's support to tobacco control, the more senior the representative is likely to be. In some cases, ministers or deputy ministers – usually from the health ministry – have opened NCM meetings, but an individual at the director or lower level more typically chairs. Beyond the health representation, the rank of the officials attending the meeting is less important than having consistent representation by the same official at multiple meetings. Personnel changes at ministries and agencies was a repeated point of frustration among officials who are actively trying to lead or push tobacco control. New representatives tend to lack institutional memory or knowledge about tobacco control. Discussions cannot progress when new members are incapable of meaningful participation in the NCM. For NCMs to coordinate

WHO FCTC implementation successfully, system-wide representation should be stable over time, ideally with civil servants who are present across political cycles.

Having a group of NCM representatives who are sensitized to tobacco's damaging impacts across sectors, and to the steps that governments can take to mitigate these impacts, is among the greatest benefits of bringing together the same group on a consistent and frequent basis.

While educating NCM representatives about the WHO FCTC was cited consistently as a continuing challenge,[19] motivating these individuals to care about tobacco control was mentioned as perhaps an even greater (though related) task. In terms of representatives' basic knowledge of the Convention, focal points reported widespread lack of understanding, or significant misunderstanding, of treaty obligations. Often, non-health officials believe that only the health ministry has an obligation to the WHO FCTC.

Even after educating representatives about the health and development issues around tobacco, and the role of tobacco control and the WHO FCTC, scepticism commonly remained. Focal points observed that many non-health officials – and even some health officials – were: (1) simply not interested in tobacco control or the WHO FCTC; and/or (2) maintained that tobacco control should be within the sole purview of health officials.

In efforts to involve NCM representatives more meaningfully, focal points reported trying to develop concrete expectations. Such terms of reference could help government officials to identify easily what is required of them, including the need to learn about the WHO FCTC, consider how the treaty's provisions might affect their ministry's mandate and goals, and consult with senior officials in their ministries about policy preferences.

d. Industry exclusion

Compliance with Article 5.3 of the WHO FCTC should be upheld in the composition and activities of the NCM and focal point. Specifically, there should be no tobacco industry representation in any form, i.e. all industry interests such as industry organizations, associations, institutes, foundations and front groups. Commercial and other vested interests must be excluded because of their determination to preserve the commercial interests of the tobacco industry, usually through outright attempts to block industry regulation and stifle its implementation, and through the promotion of legislation and regulations that favour the preservation of commercial activity.

Parties and their NCMs must be able to navigate the complexities surrounding inclusion and exclusion decisions. Articles 17 and 18 of the WHO FCTC, on economically sustainable alternatives to tobacco growing, are a case in point. In composing their NCM, Parties must distinguish between the tobacco industry and its interests (i.e. tobacco manufacturers, wholesale distributors and importers of tobacco products) and tobacco growers (i.e. individual farmers who grow tobacco crops). The former must be excluded, while it is the responsibility of governments to assist tobacco farmers in finding alternative livelihoods to

19 A focal point from one country was considering a mandatory introductory course for new NCM representatives about tobacco control, the WHO FCTC and the country's relevant public health laws and system. The idea, however, had not gained wide support, even within the focal point's ministry.

tobacco growing.[20] But, with the tobacco industry's use of front groups, the line between the tobacco industry and individual farmers is not always clear. The tobacco industry has frequently used tobacco growers' associations to represent its interests, such as the tobacco industry-supported 'International Tobacco Growers' Association', which the tobacco industry has used for many years to subvert local growers' groups to promote industry goals, not growers' actual concerns [33]. Each country must carefully examine the nature of organizations that claim to represent the interests of growers.

The challenge in implementing Article 5.3 is that certain economic sectors of government such as trade and industry often see themselves as accountable to the tobacco industry. They view the tobacco industry as a legitimate stakeholder in public policy simply because it is a legal entity. While a particular ministry might have some responsibility to address specific needs of the tobacco industry, for example, mitigating illicit trade in tobacco products, these responsibilities never supersede the government's broader obligations to the WHO FCTC. Economic sectors may also consider tobacco to be a revenue-generating product because they do not account for the direct and indirect costs of tobacco use. The tobacco industry continues to exploit lax standards in industry-government relationships to influence public policy. It is an ongoing challenge for tobacco control proponents to work with the economic sectors of government, and secure their commitment without undermining tobacco control objectives. Tobacco control focal points and NCMs are crucial in this respect given their ability to engender a coordinated whole-of-government approach to tobacco control that is supported by national and international law. In lieu of (or in addition to) such legislation, the NCM can play a pivotal role in establishing and promoting norms of government-industry relations that adhere to Article 5.3 (Box 4).

"While a particular ministry might have some responsibility to address specific needs of the tobacco industry, these responsibilities never supersede the government's broader obligations to the WHO FCTC."

Box 4. Protecting against industry interference in Brazil and the Philippines

Brazil's NCM (CONICQ) has established ethical guidelines that provide tangible instructions to prevent undue interaction between government departments and tobacco industry interests, and standards to follow if such interactions must take place. It is instrumental critical for NCMs to serve in this norm-setting role as they work to create a culture within government that situates tobacco principally as a health-harming risk factor rather than an economic good. The Philippines has taken a somewhat different approach by seeking to enshrine these guidelines in a broader civil service code of conduct [see 34].

e. Civil society representation

Civil society organization (CSO) activity on tobacco control has changed significantly over the past three decades. In the early stages of the tobacco control movement, CSOs were few in number and generally focused on de-normalizing tobacco use and pushing for the creation of national tobacco control legislation to combat tobacco industry influence. Since this early era of tobacco control, the number of CSOs working on tobacco control has grown enormously. Intersecting with and propelling this growth is a recent influx of resources from large

20 As noted, it important to include on the NCM the government sectors that can facilitate this process. Though much of the discussion on alternative activities has focused narrowly on alternative crops, Article 17 uses the broader term "activities". This terminology means that the NCM should think broadly and creatively about how to assist tobacco growers. Alternative *crops* would fall under the purview of the ministry of agriculture, whereas alternative *economic activities* can involve a host of sectors, including labour, social development and public works.

donors and development agencies. Immediately prior to the drafting and negotiation of the WHO FCTC, CSOs began to consolidate their efforts through the establishment of global networks. These networks have supported and strengthened civil society activity around the world. They are now targeting governments to implement the provisions of the Convention.

Some Parties in SSA have responded to this civil society movement by establishing informal and formal relationships with CSOs around tobacco control issues. Fifteen of the 18 sub-Saharan African countries that completed the CSO representation question in their 2014 country report noted having established at least some type of relationship with health-oriented CSOs in their tobacco-control efforts. The nature of these relationships was not specified in the reports. Interviews with key informants revealed that government-CSO relationships range from formal inclusion of CSO representatives on the NCM, as in Ghana, Kenya and Mauritius, to informal and periodic contact between the tobacco control focal point and tobacco control CSOs operating in the country, as in Zambia.

Given the relative infancy of institutional arrangements in Africa, governments can consider what type of formal arrangement to seek with CSOs, and under what conditions formalization will strengthen efforts to implement the WHO FCTC. Firstly, it is important for governments to understand the landscape of CSO activity in their country. What are the CSOs, what are they working on, and, if there is more than one CSO engaged in tobacco control, are efforts coordinated? While governments map civil society activity on tobacco control, CSOs can push for inclusion and ensure that their potential contribution is known by government. In one study country, one of the main tobacco control CSOs provides material support to the health authorities on tobacco control, including research and links to international organizations. Partly as a result, it is represented on the NCM.

In Mauritius, after some criticism from civil society, the government has taken measures to be more inclusive of CSOs. As of 2014, representatives from three different CSOs are on the NCM.

> **WHO FCTC Article 5.3:** In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law

The second consideration is how many CSOs to include on the NCM. A number of governments in sub-Saharan Africa include one CSO representative, often selected by the health ministry. It might be preferable to engage with and/or include a range of relevant CSOs on the NCM to leverage the diversity of CSOs within a country to advance tobacco control. Different CSOs may specialize, for instance in health education and promotion, farmers' livelihoods, human rights and fiscal measures. Broad inclusion or regular consultation with existing CSOs will give the NCM access to the diversity of perspectives without alienating CSOs that are working towards goals of WHO FCTC implementation. It will also further two other important goals: (1) ensuring that the human and financial resources of the CSOs are best utilized to support WHO FCTC implementation through the NCM; and (2) aligning CSO efforts to country-specific priority tobacco control measures.

Another important consideration is the selection process for which CSOs, and which representatives from these, should participate. Several representatives from major tobacco control-focused CSOs noted that, while their governments mandated inclusion of civil society on the NCM, they did not openly seek input from civil society as to which specific organizations and/or individuals should be included. As a result, in several countries in SSA, CSOs with few or even no links to tobacco control are the representatives of civil society on the NCM. In one country, a government official who was part of the selection process suggested that the inclusion of the CSO representative was motivated by their desire to solicit "new viewpoints" on tobacco control. In contrast, an official in another government admitted that civil society can often ask uncomfortable questions and/or raise accountability to a level that the government

is not prepared to accommodate. These comments help to explain unusual civil society appointments to NCMs.

(3) Lines of authority and statutory power

Almost without exception, tobacco focal points and NCMs in SSA do not possess any meaningful statutory or other legal power. Focal points are typically in charge of day-to-day tobacco control efforts, usually within and representing the health ministry (often including organizing or helping to organize the NCM, if it exists). In essence, the tobacco focal point's 'authority' lies with the minister to whom it reports. Typically, an NCM only makes recommendations. Most commonly, it reports to and/or advises the health ministry, usually the minister or a high-ranking official in the minister's executive office, though it will often make recommendations to other ministries on issues relevant to them (e.g. advice on taxation to the finance ministry).

Some tobacco control proponents lamented in their interviews the lack of authority for NCMs, while others conceptualized the advisory role more realistically and/or positively. In practice, it is highly unusual for an inter-agency body to have much, if any, statutory power. If a ministry were suddenly getting instructions from an NCM, rather than from the executive branch to which it reports, opposition toward the NCM's very existence could quickly develop. The NCM should have a strong connection to high levels of the executive branch, to ensure that the necessary directives flow from the top down to the responsible ministries. This dynamic is not necessarily easy to promote, particularly where the executive branch provides weak support for tobacco control.

Regarding the relationship between the focal point and the NCM, there is logic to assigning the focal point a leadership role on the NCM. Stakeholders identified two weaknesses in this structure. First, even if they have strong knowledge of the tobacco control issues facing government and society, focal points are not always high-ranking officials and may therefore lack the institutional stature to convene an inter-agency body. Second, effectively chairing complex entities like an NCM requires significant energy and political acuity. One focal point who did not chair their government's NCM commented that it was easier for them to concentrate on and support the NCM's chair (in this case, a high-level official from the health ministry with more political, rather than technical tobacco control, expertise). This set-up enabled the focal point to focus on substantive issues, which would not have been possible in a chairing function. Thus, while participation of the focal point on the NCM is always crucial to the NCM's success, assigning the focal point a leadership role is not always necessary or even desirable.

Whatever the lines of authority, several key informants underscored the importance of transparency. Informants, including two current focal points who are on their countries' NCMs, emphasized that regular reporting of the NCM's activities was crucial to its utility. They argued strongly that, even if the NCM is not successful at fostering policy consensus, required and transparent reporting of the NCM's discussions is instrumental for making clear the positions of key actors. In some countries, such reports have helped to identify government agencies that appear to be acting in close association with the tobacco industry, and have helped to hold such institutions more accountable.

(4) Funding

Article 5.2(a) does not just oblige Parties to establish or reinforce focal points and NCMs for tobacco control – it also obliges Parties to finance them. The survey of SSA Parties revealed three common funding scenarios: (1) a dedicated source of funding; (2) *ad hoc* funding through the ministry in which the focal point is housed (almost always health); and (3) no funding.

A very limited number of countries indicated scenario one – that there is discrete funding allocated towards the focal point and/or the NCM. Several countries reported being well-resourced, though this was the exception. The second scenario of *ad hoc* funding was most common. Focal points observed that funding varied from year-to-year and was often highly dependent on the particular minister or the composition of government more broadly. Although the health ministry typically assigns a regular salaried ministry employee to act as the tobacco control focal point, this individual is often also charged with other important and sizeable tasks, such as being the focal point for other health issues, for example alcohol, another key NCD risk factor, or even all NCDs.

In a number of SSA countries, the focal point and/or NCM appear to have no obvious direct funding.

This scenario was particularly common for NCMs. Even where the focal point has a clear funding mechanism, the NCM has not been incorporated into the government budget in a transparent and consistent manner. In more than one country, private foundations were donating the money to host NCM meetings. This is neither sustainable nor what the framers of the WHO FCTC envisioned as 'finance.' Four countries explicitly reported in their WHO FCTC status reports that a lack of sufficient funding was a major obstacle to fulfilling even basic functions.

(5) International linkages

Ideally, the tobacco control focal point acts as a central liaison to the international tobacco control community, including the COP process and the Convention Secretariat directly. A representative of the foreign affairs ministry often leads a country's COP delegation despite often having limited expertise. The focal point, and preferably several other key members of the NCM, should help to fill out the delegation such that domestic tobacco control policymaking is tightly and meaningfully linked with the international dynamic. It is also critical that the focal point establishes a strong relationship with the Convention Secretariat at multiple levels. The Convention Secretariat provides the precise support needed to develop and implement necessary policies and regulations. Focal points can also serve as the bridge between other key actors in their country – such as tax or trade officials – and the Convention Secretariat. The Convention Secretariat can then help to provide these other actors with the necessary support, either directly or indirectly. If the focal point is integrated meaningfully into the NCM he or she is well-positioned to also act as liaison between the WHO FCTC process and the NCM. The focal point should also establish connections with both the COP Bureau and the regional coordinator elected to represent their region in the WHO FCTC process.

(6) Fitting into the broader NCD agenda

A number of African governments are considering whether to nest tobacco control focal points within NCD departments, keep them separate, or create focal points for NCDs broadly (rather than for tobacco

control specifically). As of mid-2015, some African Parties have placed their tobacco control focal points within broader NCD departments, while in other Parties focal points are responsible for all NCD-related issues, including tobacco control. Given that tobacco is one of the leading NCD risk factors,[21] there is a compelling logic to merging tobacco control with NCD prevention and control. Further, many of the strategies that governments and societies use in combatting tobacco and its consequences can also be employed against other common NCD risk factors, such as harmful use of alcohol and over-consumption of foods high in saturated fats, salts and processed sugars.

Many key informants acknowledged the general trend towards a holistic view of NCD prevention and control, as opposed to discrete components such as tobacco control. Of particular concern amongst informants working in the lower-income countries was the ability to attract support from external sources. To appeal to external funders at a time of resourcing constraints, most officials agreed that it was important to engage in the growing movement to address NCDs, while placing tobacco control explicitly and coherently within this agenda.[22]

A number of key informants raised major concerns over a combined tobacco-NCD strategy. First, given the range of modifiable NCD risk factors, an NCD mandate is very wide. There is a real risk that a focal point working on all NCD issues will be overwhelmed, both in terms of what they need to know and the scope of what/whom they need to coordinate. As one official lamented, "I am trying to address every single major risk factor to non-communicable diseases and there is just one of me…" Second, tobacco is arguably the NCD risk factor that is most amenable to global action. It is the only NCD risk factor with a formal, well-developed and internationally agreed framework to address it – the WHO FCTC. It is also the only behavioural NCD risk factor that is not safe at any level of consumption. Some officials noted that when tobacco control is subsumed within a broader NCD mandate, many proven, effective and low-cost strategies/interventions for tobacco control can be overlooked or less likely to succeed. For example, rather than address tobacco taxation specifically, there might be an emphasis on both tobacco and alcohol taxes (in several cases, finance ministries were also including food in the broader plan). If successful, such a comprehensive strategy would likely be the better opportunity for positive public policy change. But the scope and magnitude of broader change efforts might lead to political gridlock, including because potential opponents of change – particularly powerful, private economic interests – could mobilize to stifle it. This is not to say that such a scenario could only occur if tobacco control focal points take on a broader NCD agenda, or if governance structures are combined. The same scenario is also possible where tobacco control focal points and those working on NCD prevention and control operate in silos. In any scenario, there must be coordination between actors to weigh the risks of a selective versus comprehensive approach, and to identify not just the most cost-effective interventions but also the most politically feasible ones.[23]

Ultimately, there is no clear-cut recommendation, and context is all-important. However, the countries that link tobacco control directly to the broader NCD agenda but still have a dedicated tobacco control focal point with sufficient resources appear to have significant success. This may be a good model for contemplating the broader NCD agenda, and remaining engaged with it, while still keeping the Party committed to its legal obligations under the WHO FCTC.

21 Recent estimates suggest that 16 percent of NCD-related deaths are attributable to tobacco [*See* 35].

22 NCD prevention and control efforts continue to be under-funded. Despite their overwhelming contribution to disease burden and their development dimensions, NCDs receive the smallest amount of donor funding of all major global health areas [only 1.23 percent of all donor assistance for health in 2011]. Contrary to the perception amongst key informants, donor funding for tobacco control specifically has, to date, been higher than for NCDs more broadly. A 2015 WHO Policy Paper on NCD financing cited as possible reasons: the strong call for tobacco reduction articulated in and through the WHO FCTC, powerful advocacy from cancer control organizations, and the existence of WHO MPOWER - an agreed set of clear and measurable tobacco control interventions that are in line with the WHO FCTC [51]. While increased external funding for NCDs is sorely needed, governments cannot afford to rely on or wait for this. They must continue to pursue innovative strategies for financing national NCD responses domestically. This includes tobacco taxation, a financing for development strategy highlighted in *Paragraph 32* of the 'Addis Ababa Action Agenda of the Third International Conference on Financing for Development' [52].

23 Within some countries there may be greater cross-sectoral and political support for addressing tobacco, while in others there may be greater cross-sectoral and political support for addressing other NCD risk factors. A reasonable strategy is to leverage the area with more support as the entry point for expanding efforts to the areas with less support.

CHAPTER 5 – RECOMMENDATIONS

The recommendations are most applicable to countries in SSA, as they were derived from an analysis primarily focused on these countries. However, many recommendations are generalizable to any WHO FCTC Party that is serious about strengthening its tobacco control governance. The recommendations are mutually reinforcing and organized around three main categories: recommendations for tobacco control focal points; recommendations for NCMs; and general recommendations for both.

Recommendations for tobacco control focal points

1. **The tobacco control focal point should be part of the health ministry or its equivalent.** Tobacco control is a core health issue, and multisectoral tobacco control activities always have essential health protection and promotion elements. The health minister should appoint the focal point and ensure a direct reporting line.
2. **The tobacco control focal point must have the requisite technical expertise.** A health policy background, even if not in tobacco control specifically, is critical. Experience in public health areas – such as health promotion – permits the focal point to initiate and promote active and effective policy development and implementation.
3. **The focal point must dedicate most of their working time solely to tobacco control-related tasks and activities.** As the national steward of tobacco control, a focal point's tasks are by their nature broad and require great effort. One of the biggest challenges faced by focal points in SSA is being overburdened by an unwieldy portfolio of responsibilities in addition to tobacco control.
4. **Governments must develop a reliable funding mechanism for the focal point.** Considering the huge body of evidence on the direct and indirect costs of tobacco, it is a sound investment for governments to have a clear line item in the health ministry budget providing sufficient resources for the focal point to fulfil basic tasks. Governments might earmark revenue from tobacco excise taxes to fund the focal point specifically.
5. **The focal point must have sufficient institutional stature to convene both non-health sector and non-governmental actors, and to represent the government internationally.** It is paramount that the focal point has enough stature to bring together the necessary actors from different sectors. Typically, this stature is imbued indirectly on the focal point when a higher-level official – such as the health minister – makes it clear and widely known that the focal point is their direct representative. An executive prerogative (e.g. a decree), legislative effort, or national regulation may be needed. Beyond the domestic sphere, the focal point must also be able to speak as the representative of the government on tobacco control within inter-governmental settings.
6. **Consider placing tobacco control focal points within a broader NCD-focused mandate.** While it should be ensured that the focal point is not overwhelmed (Recommendation 3), Parties should consider placing the focal point within the country's broader NCD prevention and control agenda. Many of the strategies employed in tobacco control are transferable to other NCD-related interventions. Strengthened WHO FCTC implementation (SDG target 3.a) will reduce premature mortality from NCDs (target 3.4).

Recommendations for national coordinating mechanisms

1. **The highest levels of a government's executive branch should officially establish and announce the NCM.** The NCM must have initial and sustained legitimacy. A clear demonstration of support from the executive branch (ideally, the president and the health minister) would confer importance to the NCM within and beyond the government.
2. **Ensure that a high-ranking official chairs the NCM**. It is critical that the chair has the stature to effectively lead a group of officials – some of them

potentially high-ranking – from across many parts of government. While the chair is often an official in the health ministry or its equivalent – preferably someone with the ability to communicate directly with the minister – it is also possible that other high-ranking non-health officials (e.g. from the executive branch) could play this role effectively. While health knowledge is a requisite, the ability to motivate members of the NCM toward tobacco control is arguably more important.

3. **Seek broad representation from across government sectors**. The NCM must be inclusive. Even if inclusion appears to cause gridlock, it is still better to use the NCM as a discussion forum and to log preferences and opinions. In this light, inclusion absolutely means engaging ministries and agencies that interact directly with the tobacco industry, for example trade and agricultural ministries.
4. **Maintain wide consultation with or consider formally including representatives from civil society**. In most countries, civil society plays a key role in tobacco control, including mobilizing evidence and public support for tobacco control efforts, exposing industry practices and facilitating the implementation of tobacco control measures. Civil society can play an important advisory role to government and should therefore be a regular partner in implementing the treaty provisions. If a government chooses to include civil society formally on the NCM, it must ensure that the selection process generates the participation of a broad range of public health-oriented CSOs that represent a wide range of viewpoints. NCMs must also establish explicit inclusion criteria to ensure that CSOs are not front groups of the tobacco industry.
5. **Ensure significant continuity in membership and participation.** As much as possible, the same representatives from each ministry/agency/department should participate in NCM meetings. This would leverage existing capacities and help provide continuity in a context of informed discussion and debate. Otherwise, members will likely fail to engage and the body will have to expend limited resources on sensitizing new members repeatedly.
6. **Develop explicit terms of reference or similar guidelines for NCM representatives**. Some or even many of the assigned officials will have limited knowledge of tobacco control. A terms of reference or similar guidelines can ensure that NCM representatives understand at minimum the following key elements: their role on the NCM; the social and economic harms of tobacco; the goals of tobacco control; how their particular sector interacts with and contributes to tobacco control; their country's tobacco control legislation and regulations; WHO FCTC obligations; and their role in communicating these goals and commitments to their ministry. In most cases, it will be necessary for the ministry that chairs the NCM to develop a curriculum to ensure that each member is properly informed.
7. **Develop an explicit code of behaviour for how all members of the NCM interact with industry representatives**. In light of Recommendation 3, it is imperative that all members of the NCM understand the limitations of, and restrictions on, their relationship with industry representatives, even – or perhaps especially – if the industry is a direct constituent of the ministry or agency. It is crucial to emphasize total transparency of communication and to emphasize that the industry cannot participate in the generation of health-related tobacco policies.
8. **Develop rules of procedure for NCM meetings**. Rules of procedure can help systematize NCM functioning. Participants need to know what NCM meetings will entail, including topics for discussion and decisions that need to be reached. The rules should be made available to participants a minimum of 14 days in advance. The rules should also obligate the generation of minutes from each meeting, with the intention of communicating these minutes to the minister responsible for the NCM (typically, health) and sharing them with all participating ministries. To achieve greater public accountability it is important to link the NCM to a standing legislative committee or a similar body, where possible. Finally, it is encouraged to invite representatives from intergovernmental

organizations that can provide substantive support, including and especially WHO and UNDP.

General recommendations for focal points and national coordinating mechanisms

1. **Make the tobacco focal point a central member of the NCM.** Making the tobacco focal point a central member of the NCM – for example, as Secretary or a similar position – can help develop and synchronize efforts to implement the WHO FCTC and/or other tobacco-control efforts. Leadership of the NCM, however, is best assigned to a higher-ranking official.
2. **Prioritize transparency.** Parties should ensure transparent, regular and frequent reporting of decisions, discussions and activities to the NCM members, the legislature (e.g. the standing committee on health), relevant government agencies, civil society, and where discretion permits, the general public. Specific steps should be taken to protect against industry interference in policymaking.
3. **Report comprehensively and accurately.** The focal point and NCM should each produce comprehensive reports, at least biennially, that synthesize tobacco control efforts in a holistic manner.

In the context of the SDGs, UNDP is scaling up its support to countries in meeting their Article 5.2(a) obligations, in collaboration with the Convention Secretariat. Within its organization approach to supporting implementation of the SDGs, which centres on mainstreaming, acceleration and policy support, UNDP's tobacco control efforts will include: planning and costing support to governments on WHO FCTC implementation, including through helping countries to make the investment case for tobacco control; participation in combined needs assessment missions on the WHO FCTC and NCDs, to build multisectoral capacity across government and UNCTs; and ensuring that WHO FCTC Article 5 implementation efforts are integrated with countries' other development priorities and represented in their planning frameworks for the SDGs. Given the interconnectivities of the SDGs, UNDP will more than ever work across its portfolio to operationalize cross-practice linkages. UNDP's work on innovative financing[24] and its strong institutional competencies in South-South information exchange[25], including on anti-corruption, offer two major opportunities for programmatic and technical harmonization with tobacco control efforts. UNDP can also support governments to navigate the political risks of tobacco control (real or perceived), including with the NCD-specific institutional and context assessment tool that it has developed and piloted.

24 With the Addis Ababa Action Agenda highlighting tobacco taxation as a revenue stream for development, not just health, UNDP will ensure that its policy instruments and technical capacities around innovative financing are embedded within its tobacco– and NCD-specific delivery platforms – and vice versa.

25 FCTC COP Decision 4(18) proposed that the Convention Secretariat shall: "actively engage with UNDP and the Special Unit for South–South Cooperation in order to explore the possibility of utilizing the existing United Nations institutional framework for South–South cooperation, including under the 'One United Nations' initiative and 'Delivering as One' at the country level."

CONCLUSION

Sub-Saharan Africa is at a major crossroads in tobacco control. Unlike other regions, most countries in SSA are in the early stages of the tobacco epidemic. However, tobacco use is rising dramatically in SSA, in large part due to the tobacco industry's aggressive efforts to expand its markets. If these efforts go unchecked, and if current projections come to fruition, many of the region's hard-won health and development gains will be in serious jeopardy. This situation presents both an urgent need and enormous opportunity for countries to prevent and control the tobacco-related death, disease and developmental consequences that have plagued other regions.

Effective tobacco control and strengthened WHO FCTC implementation require governance arrangements that can facilitate multisectoral coordination and cooperation, while protecting against tobacco industry interference in policymaking. Strong tobacco control governance depends considerably on whether Parties have a well-functioning and reliably financed tobacco-control focal point and NCM, in line with WHO FCTC Article 5.2(a) obligations. The exact form of these entities can and should vary based on country context. Both entities should be established or reinforced with: clear and significant legitimacy; sufficient technical expertise in tobacco control; and the ability to coordinate and engage with key stakeholders, some of which may be antagonistic to tobacco control. Also, both entities must prioritize transparent, comprehensive and accurate reporting. Their functions, roles and responsibilities must at all times preserve public health integrity and advance the policy objectives of the WHO FCTC. UNDP's established methodologies for capacity development, public administration reform and anti-corruption efforts can be applied to strengthen the governance of national tobacco control efforts.

The tenth anniversary of when the WHO FCTC came into force coincided with Member States making a clear statement, in the SDGs, that current tobacco trends and sustainable development cannot coexist. It is an especially opportune time for Parties to accelerate these mutually reinforcing tobacco control commitments. Well-functioning NCMs and reliably financed focal points are not a magic bullet for addressing the social, economic and environmental costs of tobacco, but investing in both can facilitate the cooperation, coordination and governmental commitment needed for strengthened WHO FCTC implementation.

Annex 1. Data points for analysing WHO FCTC Party reports

1. FOCAL POINT (Y/N)
2. FOCAL POINT – INDIVIDUAL OR GROUP?
3. FUNDING FOR FOCAL POINT?
4. NCM (Y/N)
5. IS NCM INTERSECTORAL?
6. FUNDING FOR NCM?
7. COMPOSITION OF NCM
8. CIVIL SOCIETY REPRESENTATION
9. INDUSTRY (OR PROXY) REPRESENTATION
10. TOBACCO GROWERS
11. NCM LEADERSHIP (E.G. MOH)
12. TO WHOM DOES THE NCM REPORT?
13. STATUTORY POWER (E.G. ADVISORY, IMPLEMENTING, ENFORCING)
14. SEPARATE TECHNICAL WORKING GROUP (Y/N)
15. IF YES TO #14, DESCRIBE
16. NATIONAL ACTION PLAN (Y/N)
17. OMNIBUS TOBACCO CONTROL LEGISLATION (Y/N)

REFERENCES

1. Global Burden of Disease 2013 Risk Factors Collaborators (2015). "Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." *Lancet, Published Online September 10, 2015* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2900128-2/abstract
2. Global Burden of Disease 2013 Mortality and Causes of Death Collaborators (2015). "Global, regional, and national age–sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." *Lancet*; 385: 117–71, Published Online December 18, 2014 http://dx.doi.org/10.1016/S0140-6736(14)61682-2
3. GF/B33/11. Global Fund support for co-infections and co-morbidities.
4. From Burden to "Best Buys": reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries. Geneva: World Economic Forum (WEF) and World Health Organization (WHO). 2011.
5. Eriksen M, Mackay J, Ross H: The Tobacco Atlas: Fourth Edition. American Cancer Society and World Lung Foundation; 2012.
6. WHO. The Millennium Development Goals and Tobacco Control: An Opportunity for Global Partnership. WHO, 2004. Available at: http://www.who.int/tobacco/publications/mdg_final_for_web.pdf
7. NCD Alliance. The Millennium Development Goals and Non-Communicable Diseases. Available at: http://ncdalliance.org/sites/default/files/rfiles/The%20MDGs%20and%20NCDs_0.pdf
8. Framework Convention Alliance (2015). "Tobacco: a barrier to sustainable development." Available at: http://www.fctc.org/images/stories/Tobacco_sustainable_development_190315.pdf
9. Méndez, D, Alshanqeety, O, and Warner, K (2013). "The potential impact of smoking control policies on future global smoking trends." *Tob Control*, 22(1): 46-51 doi: 10.1136/tobaccocontrol-2011-050147
10. Bilano, V, et al. (2015). "Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control." *Lancet*, 385(9972): 966-976.
11. Blecher, E, and Ross, H (2013). *Tobacco Use in Africa: Tobacco Control through Prevention*. Atlanta, USA: American Cancer Society. Available at: http://www.cancer.org/acs/groups/content/@internationalaffairs/documents/document/acspc-041294.pdf
12. WHO Regional Office for Africa. 2015. *National Coordination Mechanism for Tobacco Control: A Model for the African Region*. Brazzaville: WHO Regional Office for Africa.
13. World Health Organization, 'WHO Framework Convention on Tobacco Control', A56/8, WHO, Geneva, 2003, http://whqlibdoc.who.int/publications/2003/9241591013.pdf
14. WHO (2012). *2012 GLOBAL PROGRESS REPORT on Implementation of the WHO Framework Convention on Tobacco Control*. Available at: http://www.who.int/fctc/reporting/2012_global_progress_report_en.pdf
15. Blanke, D, and da Costa e Silva, VL (Eds.)(2004). *Tools for Advancing Tobacco Control in the 21st Century - Tobacco Control Legislation: An Introductory Guide*. Available at: http://www.who.int/tobacco/research/legislation/Tobacco%20Control%20Legislation.pdf; see also WHO (2004). *Building Blocks for Tobacco Control: A Handbook*. Geneva. Available at: http://whqlibdoc.who.int/publications/2004/9241546581_eng.pdf?ua=1
16. Plotnikova, E, Hill, SE and Collin, J (2012). "The diverse, dynamic new world of global tobacco control? An analysis of participation in the Conference of the Parties to the WHO

Framework Convention on Tobacco Control." *Tob Control*, doi:10.1136/tobaccocontrol-2012-050849

17. Southeast Asia Tobacco Control Alliance (2013). *The ASEAN Tobacco Control Report, 2013*. Bangkok, Thailand. Available at: http://seatca.org/dmdocuments/asean%20tobacco%20control%20report%20card%202013.pdf
18. Chavez JJ, Drope, J, Lencucha, R, and McGrady, B (2014). *The Political Economy of Tobacco Control in the Philippines: Trade, Foreign Direct Investment and Taxation*. Quezon City: Action for Economic Reforms and Atlanta: American Cancer Society. Available at: https://www.law.georgetown.edu/oneillinstitute/documents/2014-Political-Economy-Tobacco-Control-Philippines.pdf
19. Bialous S, et al. (2014). *The Political Economy of Tobacco Control in Brazil: Protecting Public Health in a Complex Policy Environment*. Rio de Janeiro: Centro de Estudos sobre Tabaco e Saúde/Escola Nactional de Saúde Publica and Atlanta: American Cancer Society. Available at: http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-044951.pdf
20. See Convention Secretariat, 'FCTC/COP6(15) Decision. Reporting arrangements and analysis of implementation of the WHO FCTC.' Available at: http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6(15)-en.pdf
21. Mamudu, HM, and Glantz, SA (2009). "Civil society and the negotiation of the Framework Convention on Tobacco Control." *Glob Public Health*, 4(2): 150-68 doi: 10.1080/17441690802095355; Lencucha, R, Kothari, A and Labonté, R (2010). "The role of non-governmental organizations in global health diplomacy." *Health Policy Plan*, 26(5): 405-12 doi: 10.1093/heapol/czq072.
22. Lencucha, R, Drope, J, and Chavez, JJ (2014). "Whole-of-government approaches to NCDs: the case of the Phillipines Interagency Committee - Tobacco." *Health Policy Plan*, 30(7): 844-52 *doi: 10.1093/heapol/czu085*.
23. Convention Secretariat, 'FCTC/COP6(17) Decision. Sustainable measures to strengthen implementation of the WHO FCTC.' Available at: http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6%2817%29-en.pdf
24. UNDP and WHO FCTC Secretariat (2014). *Development Planning and Tobacco Control: Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments*. New York, USA. Available at: http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/development-planning-and-tobacco-control--integrating-the-who-fr.html
25. WHO and UNDP (2015). *Guidance Note on the Integration of Noncommunicable Diseases into the United Nations Development Assistance Framework*. Geneva, Switzerland. Available at: http://www.who.int/nmh/ncd-task-force/guidance-note.pdf
26. Lencucha, R, et al. "Investment Incentives and the Implementation of the Framework Convention on Tobacco Control: Evidence from Zambia." 2015. *Tobacco Control*. Available online at: http://tobaccocontrol.bmj.com/content/early/2015/07/01/tobaccocontrol-2015-052250.abstract
27. *WHO (2008). Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control*. Geneva, Switzerland.
28. See Euromonitor International (2013). *Illicit Trade in Tobacco Products 2013*. Available at: http://www.euromonitor.com/illicit-trade-in-tobacco-products-2013/report
29. WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products (2013). Available at: http://apps.who.int/iris/bitstream/10665/80873/1/9789241505246_eng.pdf?ua=1
30. See Holden, C. et al. (2010). "The impact of regional trade integration on firm organization and strategy: British American Tobacco in the Andean Pact." *Business and Politics*, 12(4): Article 3; see also Holden, C, and Lee, K (2011) "'A major lobbying effort to change and unify the excise structure in six Central American countries': How British American Tobacco influenced tax and tariff rates in the Central American Common Market." *Globalization and Health*, 7(15): doi:10.1186/1744-8603-7-15

31. Bettcher, D. on behalf of WHO (2010). *Official comments from World No Tobacco Day.*

32. *International Tobacco Control Policy Evaluation Project (2014). ITC Zambia National Report.* Available at: http://www.itcproject.org/files/ITC_ZambiaNR-ENG-FINAL-web_May2014.pdf

33. Borland et al. Support for and reported compliance with smoke-free restaurants and bars by smokers in four countries: findings from the International Tobacco Control (ITC) Four Country Survey. 2006. *Tobacco Control* 15:iii34-iii41.

34. Bettcher, D, and Yach, D (2000). "Globalisation of tobacco industry influence and new global responses." *Tob Control*, 9(2): 206-216 doi:10.1136/tc.9.2.206

35. Philippines Civil Service Commission at http://excell.csc.gov.ph/cscweb/RA6713.html

36. IHME (2014). *Global Burden of Disease (GBD) Statistics.* Available at: http://www.healthdata.org/gbd. Last accessed 15 Oct. 2015.

37. A/RES/70/1. Resolution adopted by the General Assembly on 25 September 2015. Transforming our world: the 2030 Agenda for Sustainable Development. Available at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

38. Convention Secretariat, 'DECISIONS', FCTC/COP/4/DIV/6, Conference of the Parties to the WHO Framework Convention on Tobacco Control, Fourth session, Punta del Este, Uruguay, 2010, available at: http://apps.who.int/gb/fctc/PDF/cop4/FCTC_COP4_DIV6-en.pdf

39. Hu, T and Lee, A. 2015. "Tobacco Control and Tobacco Farming in African Countries." *J Public Health Policy*, 36(1): 41-51.

40. Glantz, SA, and Smith, LR. 1997. "The effect of ordinances requiring smoke-free restaurants and bars on revenues: a follow-up." *American Journal of Public Health*, 87(10): 1687-1693.

41. Basu, S, et al. 2011. "Projected effects of tobacco smoking on worldwide tuberculosis control: mathematical modelling analysis." *BMJ*, 343, *doi:* http://dx.doi.org/10.1136/bmj.d5506

42. Yen, Y-F, et al. 2014. "Smoking increases risk of recurrence after successful anti-tuberculosis treatment: a population-based study." *The International Journal of Tuberculosis and Lung Disease*, 18(4): 492-498.

43. Putting noncommunicable diseases on the global agenda: NCD Alliance briefing paper: NCDs, Tobacco control, and the FCTC. NCD Alliance; 2011. Available at: http://www.ncdalliance.org/sites/default/files/rfiles/NCD%20Alliance%20Briefing%20Paper%20NCDs%20%20Tobacco%20Control%20and%20the%20FCTC_0.pdf

44. Geneau, R, and Hallen, G. 2012. "Toward a systemic research agenda for addressing the joint epidemics of HIV/AIDS and noncommunicable diseases." *AIDS*, 26: S7-S10.

45. Global atlas on cardiovascular disease prevention and control. Edited by Mendis S, Puska P, Norrving B. Geneva: World Health Organization in collaboration with the World Heart Federation and the World Stroke Organization; 2011

46. Non-communicable diseases: A priority for women's health and development. NCD Alliance; 2011. Available at: http://www.ncdalliance.org/sites/default/files/resource_files/Non%20Communicable%20Diseases%20A%20priority%20for%20womens's%20health%20and%20development.pdf

47. WHO. 2015. Global Status Report on Noncommunicable Diseases 2014. Available at: http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1

48. WHO. 2010. Empower Women: Combatting Industry Marketing in the WHO European Region. Available at: http://www.euro.who.int/__data/assets/pdf_file/0014/128120/e93852.pdf

49. World Health Organization. (2011). Global Youth Tobacco Survey, Available at: http://apps.nccd.cdc.gov/gtssdata/Ancillary/DataReports.aspx?CAID=1

50. John, R. et al. 2011. "Counting 15 million more poor in India, thanks to tobacco." *Tob Control*, doi:10.1136/tc.2010.040089

51. Sorensen, G, Gupta, PC and Pednekar, MS. 2005. "Social disparities in tobacco use in Mumbai, India: the roles of occupation, education and gender." *Am J Public Health*, 95(6): 1003-1008.

52. WHO. 2015. WHO Global Coordination Mechanism on the Prevention and Control of Non-communicable Diseases. Working Group on how to realize governments' commitment to provide financing for NCDs. Geneva, 23-24 February 2015. Available at: file:///C:/Users/roy.small/Desktop/Policybrief5.2docx.pdf

53. A/RES/69/313. Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda). Resolution Adopted by the General Assembly on 27 July 2015. Available at: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/313

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