



WHO FRAMEWORK CONVENTION
ON TOBACCO CONTROL

S E C R E T A R I A T

GOOD PRACTICES IN DATA COLLECTION, PREPARATION AND SUBMISSION OF FCTC IMPLEMENTATION REPORTS

May 2017

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Convention Secretariat, WHO Framework Convention on Tobacco Control World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland

CONTENTS

Acknowledgements.....	5
List of Figures.....	6
Executive Summary.....	7

SECTION 1: REPORT ON GOOD PRACTICES IN FCTC REPORTING

I. BACKGROUND	9
II. METHODOLOGY	9
III. RESULTS OF ONLINE SURVEY AND KEY INFORMANT INTERVIEWS ...	10
1. GOOD PRACTICES IN FCTC REPORTING	
Good Practice 1: Establish a Functional Reporting Infrastructure	10
Good Practice 2: Build Robust Data Systems for Reporting	11
Good Practice 3: Involve Subnational Jurisdictions in Data Collection and Report Preparation	12
Good Practice 4: Develop Systems and Processes for Report Preparation.....	13
Good Practice 5: Validate Data Using Diverse Sources	16
Good Practice 6: Make Time and Human Resource Commitments	17
Good Practice 7: Familiarize Stakeholder Agencies with FCTC Meetings	17
Good Practice 8: Link FCTC Reporting with Key National Priorities	18
Good Practice 9: Disseminate FCTC Implementation Report	18
Good Practice 10: Use Country Reports for Advancing FCTC Implementation	19
Good Practice11: Involve Partners Outside the Government in Report Preparation	21
Good Practice 12: Limit and Verify Data from Tobacco Companies	22
2. OUTCOMES OF GOOD PRACTICES IN REPORTING	22
3. CHALLENGES IN FCTC REPORTING	24
4. RECOMMENDATIONS TO IMPROVE FCTC REPORTING	26

SECTION 2: PARTY CASE STUDIES

- 1. Multisectoral Meetings for Report Preparation- Bhutan's experience** (Tshering Gyeltshen)
- 2. Canada's Whole of Government Approach to FCTC Reporting** (Robert Tripp)
- 3. FCTC Reporting Practices: Ghana's Experience** (Kyei-Faried S)
- 4. Preparation Process of FCTC Implementation Report in Hungary: An Opportunity to Improve Tobacco Control** (Tibor Demjen)
- 5. The Role of National Multisectoral Coordination Mechanisms in WHO FCTC reporting: Iran's experience** (Behzad Valizadeh)
- 6. Kenya's Multisectoral Approach to FCTC Reporting** (Dorcas Jepsongol Kiptui)
- 7. Reporting Good Practices in Pakistan** (Muhammad Javed)
- 8. Palau's FCTC Report Preparation – Partners, Processes and Possibilities** (Candace Koshiba)
- 9. Panama's Best Practices in Reporting to the Conference of Parties of the WHO Framework Convention on Tobacco Control** (Reina Roa Rodríguez)
- 10. FCTC Reporting Practices: Thailand Case Study** (Vilailak Haruhanpong)
- 11. The Steps Towards Turkey's Progress in FCTC Country Reporting** (Peyman Altan)

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List of Figures

Figure 1. Good Practices in Report Preparation	14
Figure 2. Use of FCTC report for Advancing Treaty Implementation.....	20
Figure 3. Entities Contributing to Report Preparation	21
Figure 4. Outcomes of FCTC Reporting	23

Executive Summary

The WHO Framework Convention on Tobacco Control (WHO FCTC) requires Parties to submit periodic reports on treaty implementation to the Conference of Parties through the Convention Secretariat. Several Parties have developed innovative systems and practices to improve the quality and utility of the reports. This review, based on surveys and key informant interviews with 11 participating Parties, aims to describe these good practices in WHO FCTC reporting for the benefit of all Parties to the treaty. The three broad categories pertain to:

1. *Improvements in data quality:* Most Parties have initiated tobacco-specific prevalence studies, such as the Global Adult Tobacco Survey and Global Youth Tobacco Survey, to estimate tobacco use. Some have also integrated tobacco-related questions into national health, consumer and behavioural surveys.

Several parties have also inspired non-health government ministries to set up systems to collect data on tobacco agriculture, illicit trade and taxes. Some actively engage subnational jurisdictions to provide a holistic picture of treaty implementation across the country. Civil society, intergovernmental and international organizations were also reported to support the preparation and use of reports in many Parties.

2. *Developing systems and processes:* Over 80% of the respondents started preparing implementation reports a month before the WHO FCTC deadline for submission. Designated focal points in the coordinating and contributing ministries, official communication on the reporting requirements to relevant sectors, use of reporting schedules, activity sheets and data templates, and involvement of national coordination mechanisms for tobacco control are among the systems evolved by Parties to coordinate data collection and preparation of the implementation report.

Some Parties organize dedicated meetings with contributing agencies to prepare their implementation reports; one Party also facilitated exposure of relevant sectors to WHO FCTC events outside the country. All Parties stressed the importance of dedicated human and financial resources in the coordinating and contributing ministries to produce quality implementation reports. Nine of the 11 reporting Parties said the requirements take the equivalent of 15 full days of the focal point's time, and two Parties said 10 days or less.

3. *In-country use of reports:* World No Tobacco Day seems a key opportunity for Parties to disseminate the results of their reports. Some undertake media advocacy, others use it for sensitization of legislators and other sectors. One Party encourages public access to the report via the Internet, while another supplies the national report to all stakeholders in the country. In at least one party, WHO FCTC reports have consistently informed judicial action that advanced tobacco control efforts.

The reports have helped Parties in a variety of ways. These include development of data systems, policy advocacy, improvements in the national tobacco control programme, inspiring civil society advocacy, resource mobilization and improved multisectoral coordination.

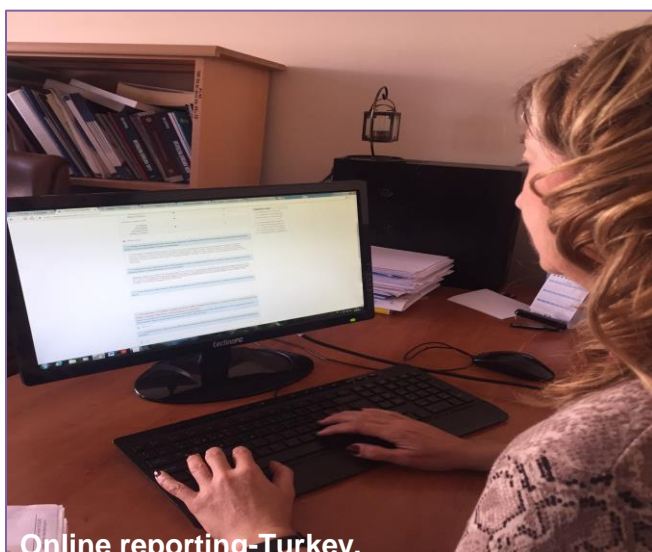
Parties face challenges in terms of linguistic barriers, online connectivity, and access to previous reports and coordination across sectors. Innovations shared between Parties and technical support from the Convention Secretariat help overcome these difficulties and produce high-quality, useful reports.

SECTION 1

REPORT ON GOOD PRACTICES IN FCTC REPORTING

I. BACKGROUND

Article 21 of the WHO Framework Convention on Tobacco Control (WHO FCTC) obligates its Parties to submit periodic reports on its implementation through the Secretariat. The first Conference of Parties (COP1) decided on the initial reporting instrument and periodicity (Decision FCTC/COP1(14)). Further, at its fourth session, the COP decided on a biennial reporting cycle synchronized with the regular COP sessions and following a revised reporting instrument (Decision FCTC/COP4(16)).



The first set of Parties started reporting in 2007 and from 2016 the Convention Secretariat provided an online instrument for reporting by the Parties. Over the first decade of treaty reporting, individual Parties have improvised their reporting systems, processes and practices to ensure timely and high-quality country implementation reports.

The workplan and budget for the financial period 2016-2017 adopted COP6 (Decision FCTC/COP6(27)), mandated the Convention Secretariat to “identify good practices in data collection and

preparation/submission of reports”. This document aims to capture key good practices that can inform data collection and preparation of official implementation reports by Parties in the coming years.

II. METHODOLOGY

Two Parties from each WHO region were initially invited to contribute to this exercise. WHO FCTC Focal Points from 11 of the invited Parties, or those assigned by them, confirmed participation as key informants in the exercise¹. This report is based on data gathered through:

- An online quantitative survey of the key informants, which aimed to identify the challenges and practices of Parties in data collection, preparation and use of the WHO FCTC reports.
- In-depth interviews of the key informants to capture the details of the systems, processes and good practices in reporting specific to each participating Party, and
- Case studies by the key informants of the participating parties describing the processes and outcomes of their reporting systems and practices.

¹Bhutan, Canada, Ghana, Hungary, Iran, Kenya, Pakistan, Palau, Panama, Thailand and Turkey.

III. RESULTS OF THE ONLINE SURVEY AND IN-DEPTH INTERVIEWS

All 11 participating Parties contributed to the survey and the interviews. The WHO FCTC focal points were the key informants from all Parties, except Thailand, which nominated an officer central to the preparation of its WHO FCTC reports for this exercise. The results of the exercise are discussed here.

1. GOOD PRACTICES IN WHO FCTC REPORTING

Good Practice 1: Establish a Functional Reporting Infrastructure

The majority of participating Parties have five or more government officials contributing to the preparation of the WHO FCTC implementation report. They are engaged in sectors whose work is relevant to the reporting questions and most frequently include the ministries of finance, revenue, commerce, justice, customs, border control, trade, agriculture, education, youth affairs, foreign affairs, communications, law enforcement, national research agencies and the government's law officers.

The ministry of health and the WHO FCTC focal point coordinate Party reporting to the Secretariat in all cases. In most countries, an officer oversees the coordination single handed. Canada has a team of three-to-five persons in Health Canada (the federal health department) responsible for the collection of data on various reporting questions. The National Coordination Mechanism (NCM) for tobacco control plays a critical role in the preparation of the report in several countries.



Iran's Health Minister Convening its National Coordination Mechanism for Tobacco Control

Role of National Coordination Mechanisms in WHO FCTC Reporting

Countries with active tobacco control coordination mechanisms engage them for a variety of WHO FCTC reporting tasks. These typically include:

- a) Coordinating communication about reporting
- b) Orientation to the reporting questionnaire
- c) Gathering data from member agencies
- d) Data validation across members
- e) Finalizing the country report

Iran's experience indicates that inclusion of WHO FCTC reporting as a responsibility in the Terms of Reference or legislation mandating the NCM help to elicit timely and quality data from its members. Iran's NCM has passed a resolution authorizing its headquarters to collect data from relevant ministries and periodically report to the country's legislature, which in turn facilitates WHO FCTC reporting. Iran's case study (Party Case Study 5) offers more detail about the role of its NCM in WHO FCTC reporting.

Similarly, one of the strategies of Thailand's National Committee for Tobacco Control is to monitor and evaluate implementation of the WHO FCTC and tobacco control measures. This enables the Office of Tobacco Control in the Ministry of Health to initiate discussion on WHO FCTC reporting in the Committee's meetings. The committee also reviews gaps identified in country reports and assigns relevant ministries to address them.

Bhutan, Ghana, Panama and Thailand also include WHO FCTC reporting in the official agenda of NCD meetings for data collection and report preparation. In a similar vein, Pakistan engages its technical working group on tobacco taxation to gather data on price and tax-related questions in the reporting questionnaire. Palau intends to utilize its recently established NCM on Noncommunicable Diseases (NCDs) for WHO FCTC reporting.

Good Practice 2: Build Robust Data Systems for Reporting

High-quality and up-to-date data is the foundation of effective reporting. Most participating parties have recognized this and have either developed or upgraded their data systems.

Almost all countries have developed capacity to have regular data on tobacco prevalence, such as through the Global Adult Tobacco Survey (GATS) or other national surveys. Some like Iran and Turkey have augmented the prevalence data in recent times to include products like smokeless tobacco and electronic cigarettes (e-cigarettes). As elaborated in Party Case Study 9, Panama has designated a government health research agency to coordinate research monitoring WHO FCTC

implementation. It is now developing a dedicated health surveillance mechanism for tobacco control.

Ministries of Health have included tobacco and WHO FCTC-related questions in national health and non-health national surveys. Ghana, for instance, has included several questions on tobacco prevalence in its 2014 national demographic and health survey.

In several Parties, non-health ministries have also expanded their data systems to gather data for WHO FCTC reporting. Kenya, Panama and Iran have required their ministries of agriculture to collect missing data on tobacco farming. Thailand has approached the National Statistical Institute to gather tobacco prevalence data in its surveys. Revenue and commerce agencies are also approached for tax and price-related data in most countries. Pakistan, for example, draws on its technical working group on tobacco taxation for data on tobacco taxes. Kenya uses the National Council for Law Reporting, the official website of Kenya Law Authority, for data on legislative measures relevant to WHO FCTC provisions and its case study (Party Case Study 6) illustrates the role of non-health ministries in building data systems for its WHO FCTC implementation report.

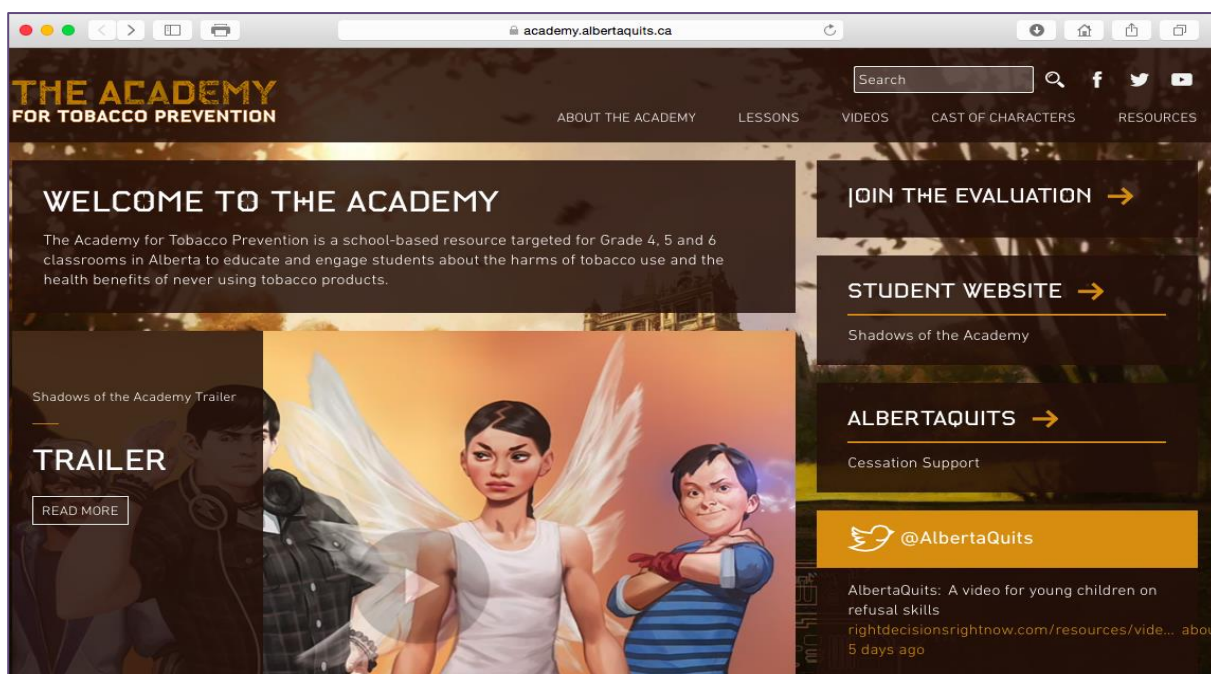
Parties have been resourceful in identifying diverse partnerships to enhance their data capacity. Palau partnered with the US Centers for Disease Control and Pacific Island Health Officers' Association to develop a hybrid survey between WHO STEPS and Behaviour Health Survey that includes tobacco-related questions (Party Case Study 8); Hungary influenced the European Health Survey to include country-specific, smoking-related questions. Ghana accessed data from the United Nations Development Programme (UNDP) to validate its data on resources for tobacco control.

Good Practice 3: Involve Subnational Jurisdictions in Data Collection and Report Preparation

It is important to ensure the participation and inputs of subnational jurisdictions in the preparation of country reports, the more so for Parties with large and diverse populations, extended geographical areas or federal structures. Thailand, for instance, finds it challenging that it does not currently have a system for data collection from the regions and provinces, which may mean that the diversity in provincial data trends is unavailable for national planning. Parties like Bhutan and Kenya rely on ministries to gather data from their respective subnational units and provide collated data to the national WHO FCTC focal point. For example, the Bhutan Narcotics Control Agency gathers data on tobacco smuggling through district offices and provides data to the Ministry of Health for WHO FCTC reporting purposes.

In the case of Canada, most of the action on cessation and smoke-free law enforcement happens in the provinces and territories. The country found it important to capture the data on subnational activities for WHO FCTC reporting. It has therefore evolved a system to actively engage subnational jurisdictions directly in its data collection for WHO FCTC reporting, such as for demand-reduction measures.

(See Canada's case study – in Party Case Study 2 – for details of this system and its benefits.)



Cessation Action in the Canadian province of Alberta (webpage)

Panama also engages with subnational units for its country report. In addition to improving the quality of the collected data, this makes subnational jurisdictions more aware of national and international tobacco control, offers a sense of ownership, a stake in the country's WHO FCTC implementation and reporting, and provides opportunities to identify priorities for future action.

Good Practice 4: Develop Systems and Processes for Report Preparation

The Parties have established a range of systems and processes to ensure timely data collection and preparation for the submission of reports. They were also designed to address some of the challenges identified in report preparation such as delays in receiving data from relevant ministries. Good examples include:

- *Designating a coordinator for WHO FCTC reporting:* All participating Parties have a designated ministry/agency and person therein to coordinate activities related to WHO FCTC reporting. Most Parties have found it practical to mandate the nodal agency and the country focal point for tobacco control/WHO FCTC implementation to coordinate their WHO FCTC reporting obligations. Ministries of health or their agencies tend to play this role. The nodal agency and the coordinator are authorized either by law (as in the case of Iran) or through executive orders, or by relevant authorities.

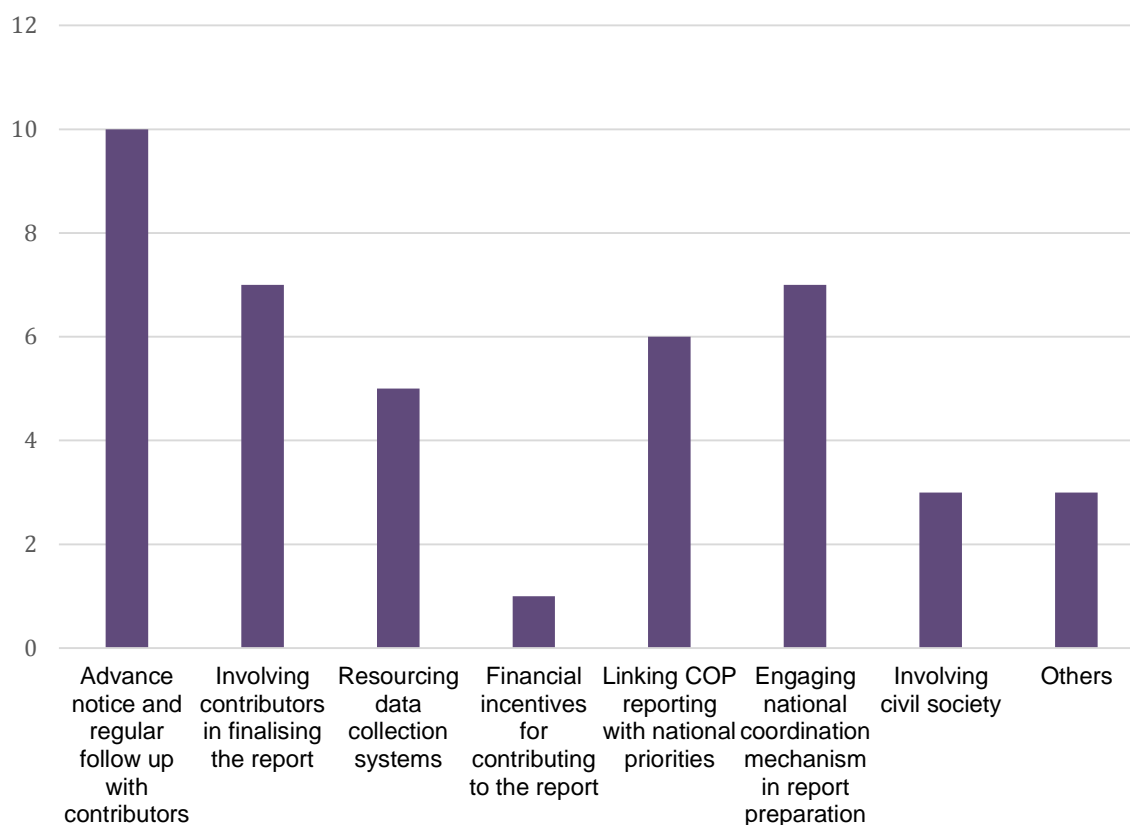
- *Early preparations:* WHO FCTC Parties report in biennial cycles. Key Informant interviews indicated that the Parties' data collection activities start early on and run throughout the reporting cycle. These early activities include coordination with stakeholder ministries to upgrade and update their respective databases, as well as collection and coordination of data from subnational units and government ministries.

The Parties can submit implementation reports to the Convention Secretariat during a four-month timeframe. For instance, the designated reporting period for 2016 was 1 January–30 April. The work of the Parties on report preparation tends to intensify in the quarter before the deadline for the designated reporting timeframe. Over 80% of survey respondents started preparing the implementation report a month before the deadline for submission. Four Parties started preparing them three months before the deadline, or even earlier. Hungary uses a formal schedule with key deadlines for contributing ministries to guide its reporting process. The schedule can be found in the case study (Party Case Study 4).

- *Authorization letters and advance notice:* Almost all Parties sent official communications from the coordinating ministry/agency to potential contributors. Typically, these letters authorize the nodal ministry to coordinate data collection and the preparation of the WHO FCTC implementation report. Additionally, the letters request the stakeholder ministries to assign a person to collaborate for data collection and preparation, as in Hungary. It has been observed that such communication is most effective when it comes from senior political authorities, such as the head of the national coordination mechanism, or the responsible ministry.

It is equally important that the official communication to contributing agencies is sent sufficiently in advance of reporting deadlines. As Figure 1 indicates, advance notice is the most reported good practice among Parties.

Figure 1. Good Practices in Report Preparation



- *Reporting activity plans:* Countries such as Hungary and Canada have developed detailed activity charts to guide the preparation of their WHO FCTC reports. Sample activity logs can be found as annexes to the respective party case studies. These charts provide step-by-step guidance on the various tasks of sectors against an agreed timeline.

The 6 Cs of WHO FCTC Report Activity Charts

The activity charts typically describe the tasks involved in the preparation of the report, identify persons responsible and fix deadlines for compliance. The broad tasks in the chart include:

- **C**ommunication of WHO FCTC reporting requirements to stakeholders
- **C**ollection of data from stakeholders
- **C**ollation of data received by the nodal ministry/agency
- **C**larification and conciliation of data received from stakeholders
- **C**onsultation of stakeholders on final report
- **C**ountry report submission to the Convention Secretariat

- *Data templates:* Several Parties have created customized templates for specific stakeholder ministries to gather data relevant to their specific mandates. For instance, Pakistan has developed a separate template for agencies that provide tax- and price-related data for WHO FCTC reporting. These templates are typically taken from the WHO FCTC reporting questionnaire. Parties prefer to receive the reporting questionnaire in Word format to allow its breakdown into elements relevant to each ministry, swift transmission across ministries and ease of compilation. This format is therefore provided by the Secretariat to Parties upon request.

- *Translations:* The reporting instrument is available in the six United Nations languages². Countries with other official languages have the additional task of translating the instrument for use by stakeholder agencies. They also translate agencies' responses back to English for the online reporting system. Turkey, for example, first translates the reporting instrument to Turkish for use by stakeholder ministries and then re-translates the data they supply to English before completing the instrument. It is important to allocate time and resources for quality translations.

- *In-country reporting system:* Given the challenges in defining and collecting data for WHO FCTC reports, Panama is developing an online surveillance system. The system would connect the databases of contributing agencies relevant to WHO FCTC reporting and enable their synthesis for Panama's WHO FCTC implementation report. Developed and managed by the Instituto Conmemorativo Gorgas de Estudios de la Salud (a national health research agency), this online tool is expected to be operational in 2017.

Thailand is also considering a national WHO FCTC surveillance system that would enable collection of data from different parts of the country for the WHO FCTC report. The plan includes workshops to orient stakeholders to the data collection system, to review and provide feedback on country reports and improve the data collection system.

- *Report preparation – stakeholder meetings:* Meetings of contributing ministries and sectors seem to be a cost-effective and time-saving strategy that Turkey, Panama, Ghana, Bhutan and Palau regularly employ to prepare country reports. Bhutan calls a one day meeting, whereas Turkey's is half a day. In Bhutan's report preparation meetings, contributing ministries bring their respective data, reconcile and validate responses to the reporting questions and review the final results for submission. The agenda of Bhutan's Tobacco Control Board meeting discussing WHO FCTC reporting can be found as an annexe to Party Case Study 1. Turkey uses the meeting both to orient stakeholder ministries to tobacco control and to gather data from contributing ministries.

- *Regular follow-up:* All key informants stressed the importance of consistent follow-up with stakeholder ministries as critical to securing quality data and producing timely reports. As seen in Figure 1, the online survey also identified regular follow up as a

² The six UN languages are Arabic, Chinese, English, French, Russian and Spanish.

key practice among participating parties. Some Parties do this through phone calls, others send emails or undertake personal visits to remind concerned agencies of the need for timely responses. Canada holds telephone conferences with partners at the subnational level to discuss reporting matters and follows-up through emails.

- *In-person visits to stakeholder ministries:* In countries like Kenya, the focal person undertakes in-person visits to ministries contributing to the WHO FCTC report. These visits are reported to enable the focal point to better inform teams working on the mobilization of data in the contributing ministries, and to develop effective working relationships.

Good Practice 5: Validate Data Using Diverse Sources

Parties check the data collected in various ways. Typically, the ministry of health, the key ministry for WHO FCTC implementation, undertakes the validation of data received from reporting agencies. In the first instance, the data is verified with that of previous reporting cycles to understand congruence or otherwise. The data is first cross-checked with other publicly available sources such as reports, press statements and announcements from concerned ministries in the intervening period. The contributing ministries are then approached to identify potential reasons for major deviation in trends and allowed time to verify the data in their own systems or with their subnational or field offices. The verified data is then entered into the online reporting instrument.

In some countries, data for reporting instrument questions, like those on illicit tobacco trade, come from diverse sources, which need to be reconciled across ministries and agencies. For instance, the WHO FCTC focal point in Turkey spends considerable time reconciling the data on the illicit tobacco trade received from agencies including the Ministry of Customs and Trade, Department of Smuggling and Organized Crime and the Gendarmerie General Command.

Tobacco price is often hard to determine. In Kenya, the Ministry of Health often verifies the price data received against actual prices in shops. Palau engages NGOs to gather retail data to verify price and sales figures.

Good Practice 6: Dedicate Time and Human Resources for Reporting

Dedicated time for coordination: Nine of the 11 participating Parties reported that the person responsible for coordinating WHO FCTC reporting spent over 15 full-time equivalent days to gather and validate data from various agencies in the country, prepare the country implementation report and submit it. The remaining two spent six-10 days.

Allocate resources for data collection: A country report is as good as the quality of available data. This calls for Parties to invest in robust data collection systems. Parties have made modest-to-significant investments in building or improving their databases for WHO FCTC reporting. This ranges from about US\$ 15 000 for one-time surveys, such as on WHO FCTC compliance, to nearly US\$ 200 000 for an in-

country WHO FCTC surveillance mechanism in the case of Panama. Several Parties reported their agriculture, finance and customs agencies spending their own resources to collect data for WHO FCTC reporting.

Apart from costs incurred for data systems, the WHO FCTC focal points incur travel, communication and meeting expenses for report coordination activities. This was pegged at around US\$ 1 500 per reporting cycle. Additionally, there are equipment and stationary costs for the unit coordinating WHO FCTC reporting and other contributing agencies.

Human resource cost: Apart from databases, Parties incur costs for the time and expertise of the personnel from the nodal and contributing ministries. While these have not been quantified, the survey and interview data indicate that minimally this takes about 15 full-time equivalent days of the coordinating person, in addition to part-time contributions from five-10 stakeholder agencies.

In the case of Canada, the coordination unit in Health Canada alone commits funds equivalent to approximately 60% of the full-time cost of the lead coordinator, 35% of a second staff member and 5-10% of a third person. Additionally, the other contributing agencies, ministries and staff from over 25 subnational jurisdictions devote part of their time to reporting tasks.

Good Practice 7: Familiarize Stakeholder Agencies with WHO FCTC meetings

Exposure of relevant ministries in the government to the WHO FCTC process and meetings can inform and inspire greater participation in treaty implementation and reporting. A case in point is the Kenya Revenue Authority (KRA). In tandem with its participation at WHO FCTC events such as the negotiations of the Protocol to Eliminate Illicit Trade in Tobacco Products, the KRA has been diligently gathering and reporting data on tobacco smuggling. Building on this experience, Kenya's delegation to the 2016 WHO FCTC COP preparatory meeting of Parties from the WHO Africa region included representatives from nine ministries/agencies of the Government – the National Treasury, Kenya Revenue Authority, Ministry of Foreign Affairs, Ministry of Health, Kenya Mission in Geneva, Kenyan Ambassador to Algeria, Parliamentary Health Committee, Kenya Bureau of Standards and the Ministry of Interior and Coordination.



Kenya's Multisectoral Delegation at the COP 7 Preparatory Meeting in Algiers

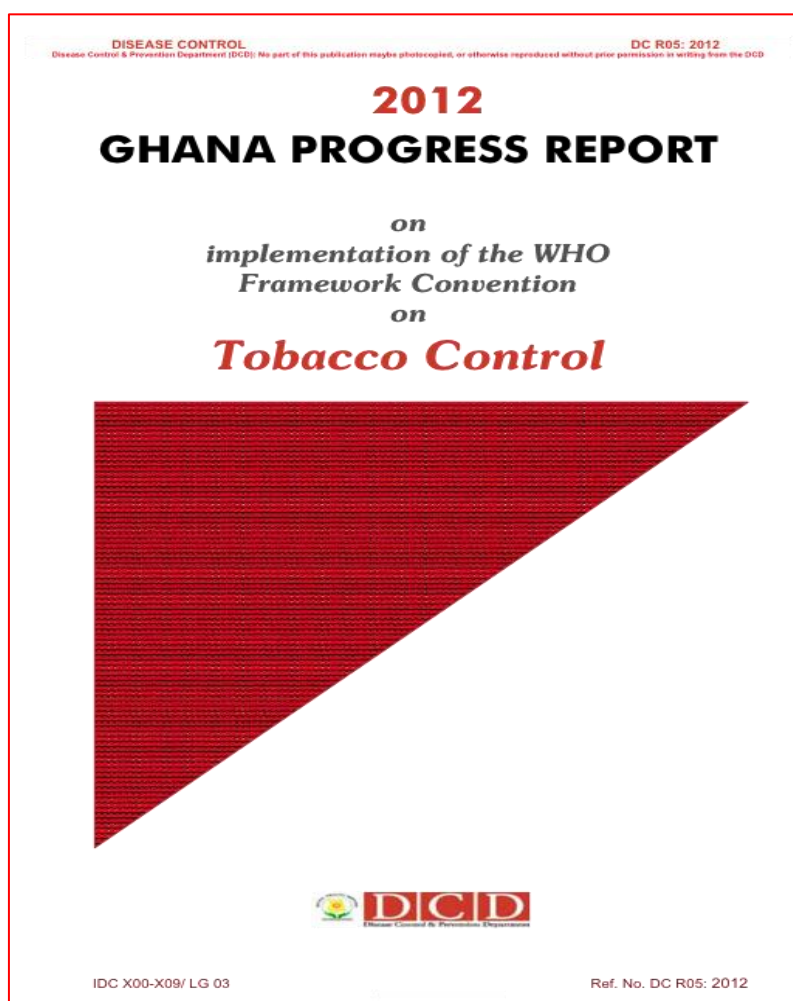
Good Practice 8: Link WHO FCTC Reporting to Key National Priorities

Parties often have the opportunity to tie WHO FCTC implementation and reporting to broader national and global priorities. The Global Action Plan on noncommunicable diseases and the Sustainable Development Goals (SDGs), adopted in 2015, provide global frameworks on which countries report regular progress. Panama has seized upon the presence of tobacco WHO FCTC-related indicators in these frameworks to include tobacco-related questions in its national reporting instruments.

Similarly, Ghana has included tobacco in its health sector programme and budget. This also provides another level of monitoring and accountability for WHO FCTC implementation and reporting across government. (See Ghana case study – Party Case Study 3 – for details).

Good Practice 9: Disseminate WHO FCTC Implementation Report

All Parties share the final country implementation report with contributing ministries and stakeholders. Most disseminate electronic copies, while some also provide hard copies. Ghana in particular produces its own WHO FCTC implementation reports – *Ghana Progress Report on implementation of the WHO Framework Convention on Tobacco Control* – and copies are made available to all interested persons. Ghana's report, modelled after the Secretariat's Global Progress Report on WHO FCTC implementation, acknowledges contributing agencies and persons by name. This acknowledgement helps to build a whole-of-government ownership and sense of responsibility among contributing partners.



Ghana's FCTC Implementation Report in form of a publication – Cover Page

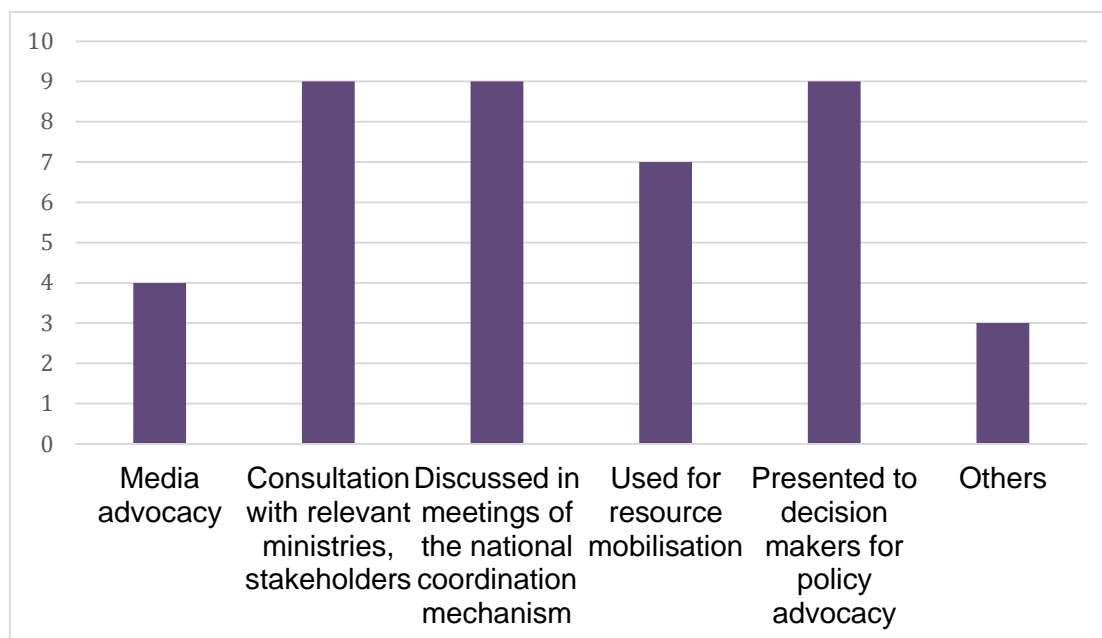
Additionally, some parties take their public accountability seriously and make country implementation reports available to citizens. Bhutan, Canada and Panama upload their reports on the websites of government agencies that are central to reporting.

Good Practice 10: Use Country Reports to Advance WHO FCTC Implementation

Figure 2 indicates that Parties use the WHO FCTC report in direct and indirect ways to advance treaty implementation. Nine of the 11 participating Parties reported stakeholder consultations to specifically address country priorities for future work. An equal number discussed it at meetings of the national coordination mechanism and presented it to decision-makers for policy advocacy.

Over half the Parties used it for resource mobilisation. Ghana in particular has been successful in using the implementation report to raise resources for treaty implementation from a variety of sources.

Figure 2. Use of WHO FCTC report to advance treaty implementation



A few Parties used implementation results for media advocacy. Panama and Bhutan used it for advocacy for tobacco control policies with their respective parliaments. In Palau, NGOs used the implementation report to highlight the country's tobacco control policy needs during the WHO FCTC's 10th anniversary celebrations.



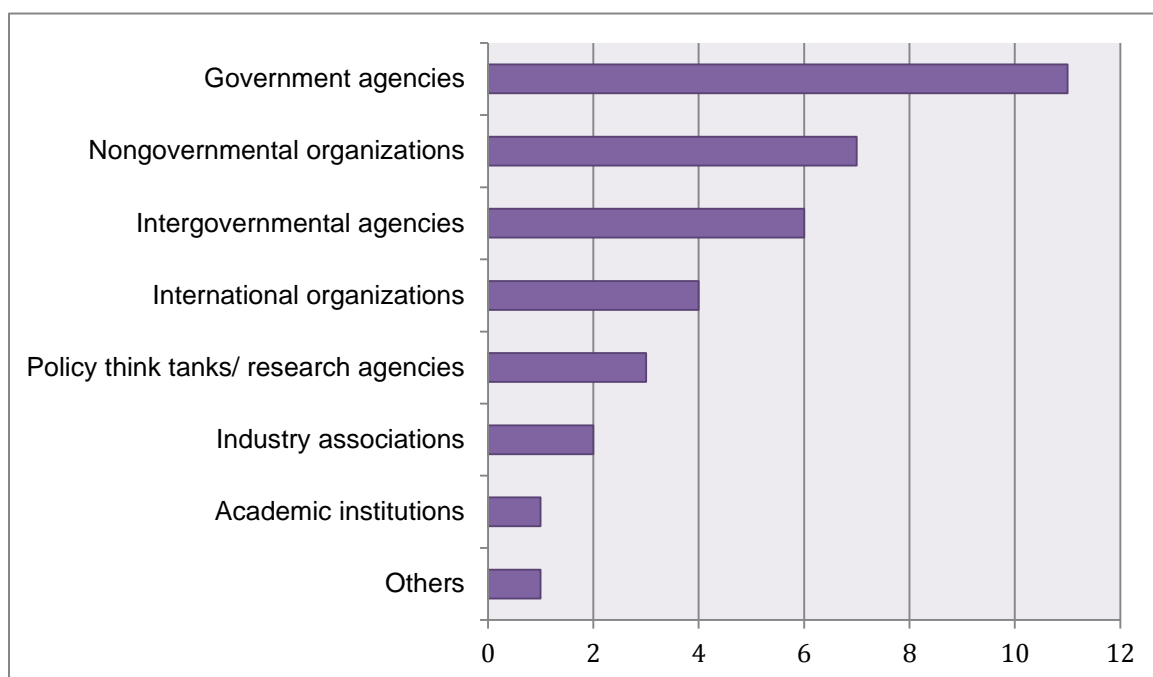
Panama's WHO FCTC Focal Point Sharing treaty plans and progress with the media

It may be noted that, with the exception of Thailand, most Parties have not published the results of their implementation reports in journals. While most key informants were interested in doing so, lack of time and competing commitments were cited as impediments. In Thailand, the involvement of academic institutions in report preparation ensured publication in scientific journals.

Good Practice 11: Involve Partners outside the Government in Report Preparation

As Figure 3 shows, government agencies are the primary source of data for the WHO FCTC implementation reports. Additionally, intergovernmental organizations (IGOs) and nongovernmental organizations (NGOs) are invited to provide data on some sections of the questionnaire.

Figure 3. Entities Contributing to Report Preparation



NGOs provide data most often on WHO FCTC Article 12 (Education, communication, training and public awareness). NGOs also report information on tobacco industry interference in treaty implementation. Parties often commission civil society to undertake research on tobacco prevalence and policy compliance for WHO FCTC reporting purposes. Most Parties include relevant NGOs and IGOs in the report preparation consultations. NGOs, in particular, were said to have offered on-the-ground information on compliance with tobacco control laws and treaty implementation.

In Canada, civil society consults on the country report and prepares shadow reports. NGOs recently prepared a shadow report on the country's implementation of Article 5.3 to inform government policy-making in this area.

Pakistani civil society has been using the country implementation report in multiple ways to advance domestic treaty implementation. Based on the country report, they litigate for better treaty implementation and produce shadow reports, which identify gaps in treaty implementation. The government and civil society have worked synergistically to address these gaps and Pakistan's case study (Party Case Study 7) highlights this.

Among IGOs, Parties seem to draw most on WHO inputs. This is mainly in developing tobacco control prevalence data at the country level, such as through the Global Adult Tobacco Survey, Global Youth Tobacco Survey and STEPS. In Ghana, UNDP also provided data on domestic financing of tobacco control.

The scope for IGOs to provide data on tobacco-related expenditure, taxes, agriculture, illicit trade, advertising and trade for the implementation reports appear to

be under-explored, and this also seems to be the case with international organizations. Pakistan involves the World Bank (a multilateral agency) in its technical group on tobacco taxes, which in turn supplies data for the country's WHO FCTC report. Some parties also engage Bloomberg Initiative partners in meetings on report preparation.

Research agencies and academic institutions are engaged by Panama and Thailand. These entities reportedly assist Parties in both data collection and dissemination, particularly through academic publications.

Good Practice 12: Limit and Verify Data from Tobacco Companies

Survey participants generally reported that they had not received data directly from tobacco companies or farming groups (See Figure 3 above). The two parties that mentioned industry associations explained that this referred to shops selling tobacco, from which tobacco price and brand data is obtained.

In some countries, tobacco companies are required by law to report their price and sales data to ministries like commerce or industry. Companies also often find it in their interest to track and report data on counterfeit seizures. Most participating Parties have limited the data received from tobacco industry sources to those received through government agencies under statutory provisions or court orders. Iran, for example, has educated its contributing agencies to decrease their reliance on industry reported data and replace this with governmental surveys.

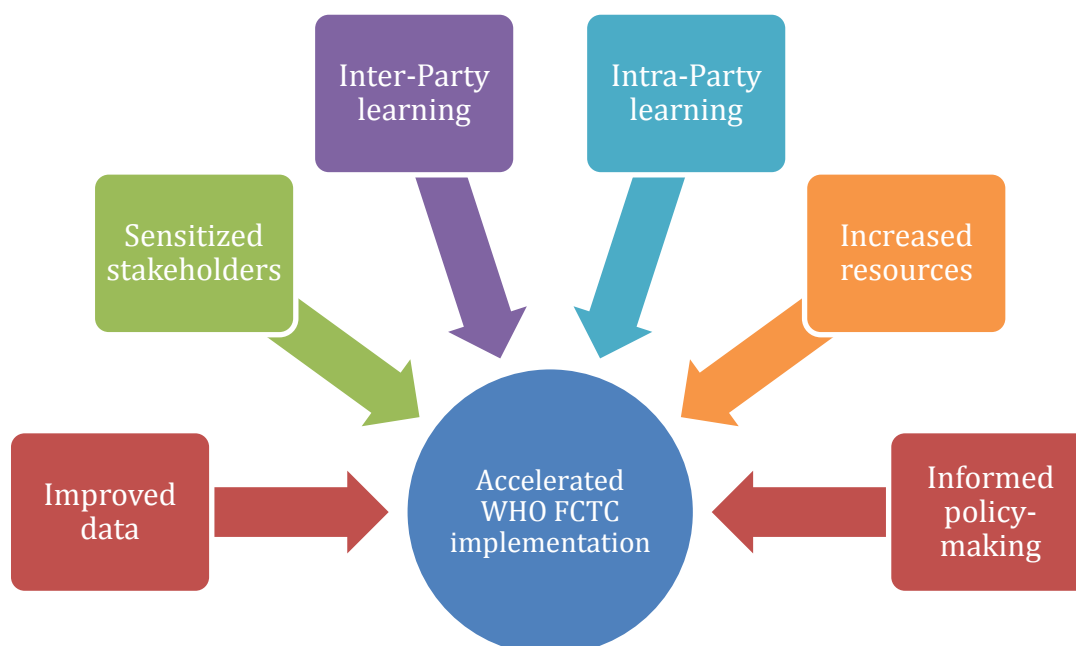
2. OUTCOMES OF GOOD REPORTING PRACTICES

The Parties reported a range of outcomes from both the process of reporting and the country reports (Figure 4). These include:

1. Improved Tobacco Data: The reporting obligation presented an opportunity for most Parties to review and develop or upgrade their health and non-health data systems. This has led to the generation of tobacco-related data relevant across various provisions of the WHO FCTC and sections of the reporting questionnaire in countries like Palau and Iran. Tobacco prevalence, taxes and farming are among the areas that have witnessed new or updated data.

2. Sensitized Stakeholders: Meetings and interactions for data collection and report preparation afforded opportunities for ministries of health to orient their counterparts in other stakeholder ministries to tobacco control in general and the treaty in particular. Hungary, for instance, found the professional reporting network built up across ministries helpful in securing stakeholder support for tobacco control policy-making. Bhutan found similar partnerships helpful in improving enforcement of its tobacco control policies.

Figure 4. Outcomes of WHO FCTC Reporting



3. Inter-Party Learning: The implementation database and the WHO FCTC Global Progress Report that are developed on the basis of country reports provide a platform for Parties to compare treaty compliance with those of other Parties. It also enables them to learn of good practices in treaty implementation and exchange lessons. Pakistan, for instance, used the information on tobacco pictorial warnings from neighbouring countries to advance its tobacco packaging regulations.

4. Intra-Party Learning: Reporting also creates opportunities for jurisdictions within Parties to learn from each other. For instance, the north eastern provinces of Canada made great strides in tobacco control such as through smoke-free car initiatives. The reporting exercise created the platform for other provinces to recognize and learn from this experience.

5. Increased Resources: The reporting process as well as the report itself has enabled many Parties to identify gaps in resources for treaty implementation. Based on implementation reports, Panama and Thailand advocated the earmarking of some tobacco tax revenue for tobacco control, which is also being ploughed back into WHO FCTC data systems. The discussions on Ghana's WHO FCTC report enabled the country to include tobacco control in its health sector programme and budget.

6. Informed Policymaking: The most significant outcome of reporting has been the development of policies and programmes. Country reports serve as a great tool in identifying the gaps in WHO FCTC implementation and developing and advocating policy responses. Kenya, for instance, developed several policies to control illicit tobacco trade that had been highlighted by the country report. In Turkey, the report informed the development of the second phase of its national tobacco control programme (See Party Case Study 11). The country report helped Canada to

recognize that more action is needed on the implementation of WHO FCTC Article 5.3. Following the review of gaps identified in the implementation report, Thailand's Ministry of Education began strict enforcement of smoke-free policies in educational institutions, while the Ministry of Information and Broadcasting initiated monitoring of websites promoting and selling tobacco. Party Case Study 10 provides details of the improvements in enforcement of Thailand's tobacco control policies.

3. CHALLENGES IN WHO FCTC REPORTING

While Parties expressed increasing ease in reporting over the years, the key informants identified a few challenges to effective reporting. These relate to:

1. Data

Several parties mentioned difficulties in finding price- and brand-related data. This makes it hard to report on the price of the most widely consumed tobacco brands as required in the reporting questionnaire (Section 2.9). This has either been due to a lack of official data, or the inability of concerned ministries to provide the data because of business privacy laws.

Prevalence of emerging products like smokeless tobacco and electronic cigarettes, and data on tobacco growing and the illicit tobacco trade are among the areas where accurate and up-to-date information is yet to emerge in most Parties.

Resources for tobacco control are an area where information is scattered. For instance, it is often difficult to find information on civil society resources for tobacco control.

2. Reporting Instrument

Most Parties welcomed the introduction of online reporting for the instrument. Several commented on orientation webinars and assistance from the Secretariat in familiarizing with the reporting instrument.

However, Internet connectivity remains a problem for Parties where network coverage is weak, such as for some island nations. They will need to either email completed hard copies to the Secretariat or travel to places with better connectivity to submit the online data.

It was also a challenge to share the online reporting instrument for input from contributing ministries. Most Parties circumvented this problem by securing a Word version of the questionnaire from the Secretariat and sharing relevant parts with the ministries concerned. This however, creates additional work for the focal points to transfer data received from multiple ministries to the online instrument. See below a recommendation to address this challenge.

Lack of access to the data from previous years also makes updating difficult for the focal points and contributing ministries. It also inhibits comparison of data across reporting cycles and limits its use for in-country advocacy.

The language of the reporting instrument raises linguistic difficulties for those Parties with official languages other than those of the UN. This leads to additional work for focal points both to translate the questionnaire into the official language of their country and translating the information received from multiple agencies back to English before inputting to the online instrument.

Reporting data was difficult in the earlier questionnaires. However, the descriptive nature of the revised questionnaire has addressed this challenge.

3. Communication

Several parties faced challenges in communication regarding the reporting process. It begins with delays in receiving the initial *note verbale* from the Convention Secretariat conveying the reporting requirements and deadline. The document typically passes through multiple entities – the Geneva Mission of the Party, the offices of the Ministry of Foreign Affairs and the Ministry of Health – before reaching the country's WHO FCTC focal point.

Likewise, it has often been difficult to get timely acknowledgements from the Secretariat on submission of the report. Some reported receiving reminders for a report even after its submission. This causes confusion among focal points and ministries of foreign affairs.

4. Submission Process

Often there is mismatch between the country requirements for submission of reports to treaty secretariats and the requirements of the WHO FCTC. For example, in the case of WHO FCTC, reports are to be submitted online by the technical focal point officially communicated by the Party to the Convention Secretariat. Usually, the focal point is based in the nodal ministry for WHO FCTC implementation, i.e. the ministry of health. However, some Parties require all their treaty reports to be submitted via the ministry of foreign affairs. This requires the WHO FCTC focal points to additionally submit a copy of the report through the ministry of foreign affairs to the Secretariat, often causing confusion about the final report among all concerned.

Similarly, it is mandatory in some countries to submit the cover note accompanying a country report signed in hand by the authorized signatory, along with a hard copy of the report to the treaty secretariat. The WHO FCTC reporting instrument provides only for only electronic signatures. Once again, this implies additional hard copy submission and resultant confusion.

4. RECOMMENDATIONS FOR IMPROVED REPORTING

The Parties participating in this exercise had nearly a decade of experience implementing the WHO FCTC and reporting on their progress. Based on this experience, they made key recommendations to improve the WHO FCTC reporting process.

1. Create multi-level access to the online reporting instrument: The mechanism could provide certain minimal access for Parties' contributing agencies to input data directly into the online system and a higher level of access to the WHO FCTC focal point to review, modify and finalize the country report. Such a system could reduce wastage of time and resources through manual entry and transfer of data, while improving efficiency and coordination in the preparation of the report.

2. Include WHO FCTC focal points in official reporting communications: This could be achieved by either a single email regarding the reporting *note verbales* for all WHO FCTC focal points, or by copying them on the communication to Geneva missions.

3. Acknowledge report submissions: The Convention Secretariat can issue a formal, preliminary acknowledgement on the submission of a country report through the online system. This would help avoid confusion among concerned entities.

4. Involve the WHO country office in follow up: As WHO country offices are close to the ground, they are well placed to follow up with the country WHO FCTC focal points regarding submission of the implementation report.

5. Request input from intergovernmental organizations: IGOs often have information relevant to WHO FCTC reporting such as on tobacco revenue, resources for tobacco control, trade, farming and employment. The COP may invite IGOs to provide information available with them in support of treaty reporting.

SECTION 2

PARTY CASE STUDIES

1. Bhutan
2. Canada
3. Ghana
4. Hungary
5. Iran
6. Kenya
7. Pakistan
8. Palau
9. Panama
10. Thailand
11. Turkey

ANNEX 1: BHUTAN

Multisectoral Meetings for Report Preparation: Bhutan's experience

Mr Tshering Gyeltshen
Senior Communication Officer
Health Promotion Division, Department of Public Health, Ministry of Health
FCTC Focal Point

The reporting infrastructure

Bhutan ratified the WHO Framework Convention on Tobacco Control (WHO FCTC) on 23 August 2004. The country implements the WHO FCTC primarily through the Tobacco Control Act 2010, along with Tobacco Control Rules and Regulations 2014, which banned the cultivation, production, distribution and sale of all tobacco products and restricted smoking in public places. A high customs duty is levied on the limited quantity of tobacco products that can be brought into the country for personal use.

Figure 1. Health Minister informing parliamentarians about WHO FCTC and Tobacco Control Bill in 2009.



Bhutan's Tobacco Control Act not only provides a legal framework for enforcement but also provides official mechanisms for coordinated action among different sectors. Thus, the Government formed the Tobacco Control Board (TCB) and assigned the Bhutan Narcotic Control Authority (BNCA) to manage its Tobacco Control Office (as per Chapter 8 of the Act). The BNCA coordinates the development and implementation of tobacco control policies and also the country's reporting on WHO FCTC implementation. The law stipulates specific roles and responsibilities for its enforcement to the Department of Trade in the Ministry of Economic Affairs and the Department of

Customs in the Ministry of Finance and the Royal Bhutan Police, with the BNCA coordinating the overall tobacco control effort in the country.

Since the ratification of the WHO FCTC, the country has been proactive in the preparation, submission and use of its implementation reports and thus complying with its reporting obligations under the treaty. Bhutan has its own administrative processes for WHO FCTC reporting. It involves a broad range of governmental agencies including Trade, Customs, BNCA and the Royal Bhutan Police in the preparation of the WHO FCTC report. While the Ministry of Health coordinates the preparation of the report, the Ministry of Foreign Affairs is central to its communication and submission.

On ratification of the WHO FCTC, Bhutan's Ministry of Health informed other government ministries and agencies relevant to tobacco control about the provisions and obligations under the treaty. In the early years of WHO FCTC reporting, the country gathered data in an informal manner. The focal point for WHO FCTC implementation in the Ministry of Health approached relevant agencies individually through informal phone calls and meetings. Over the years, the process of report preparation has been streamlined with the country adopting a more inclusive and systematic approach to reporting.

WHO FCTC reporting practices

The reporting process in Bhutan starts with the request from the WHO FCTC secretariat. The Convention Secretariat's *note verbale* details the reporting requirements via the WHO Country Office to Bhutan's Ministry of Foreign Affairs, which in turn informs the country's Ministry of Health. The focal person in the Ministry of Health plays a pivotal role in the preparation and submission of reports to the Convention. As WHO FCTC implementation involves multisectoral action, the focal point involves relevant stakeholders in the process of reporting. The issue of WHO FCTC reporting is therefore placed on the official agenda of the meeting of the country's tobacco control board, which consists of stakeholder ministries. The meeting takes stock of the treaty's implementation status and provides policy guidance and future policy for tobacco control in the country. See Annex 1 for the agenda of the meeting on reporting discussions.

The Ministry of Health then sends a formal letter requesting information for WHO FCTC reporting from the relevant agencies. The letter identifies the specific data anticipated from each sector in order to answer questions in the reporting questionnaire. It further invites the agencies to attend a day-long working group meeting dedicated to the preparation of the report. The date, time and objectives of the meeting are detailed in the invitation. Agencies are requested to bring the data relating to their area of competence to the meeting. The questions are apportioned to agencies based on their mandates and expertise. For instance, the questions about illicit trade of tobacco products are passed to the official who looks after the enforcement of those provisions in the Tobacco Control Act. The agencies respond in writing and nominate an officer handling the enforcement of the tobacco control law to attend the meeting.

The working group meeting is organized as a retreat in a district away from the usual workplace of the participating agencies. This helps participants to focus fully on report preparation, removed from the demands of their regular work. Participating agencies collect the required data from their respective district units and furnish it at the meeting. At the meeting, the participants go through the questions in the reporting questionnaire in detail. Officers discuss and finalize the data brought from their respective agencies. The final reports are sent by the Ministry of Health to the WHO Country office through the Ministry of Foreign Affairs for onward submission to the Convention Secretariat.

The Royal Government of Bhutan spends approximately Bhutanese Ngultrum 134 000 (US\$ 2 000) as operational costs for WHO FCTC data compilation.

Outcomes

Timely coordination from the nodal agency and cooperation of the relevant agencies have helped the country to gather quality data. The stakeholders' meeting creates the opportunity to gather, cross-check and validate data all at the same time. For example, given Bhutan's ban on all tobacco products, it is important to reconcile the tobacco seizure figures with sales tax and customs duty. The meeting allows all the concerned enforcement agencies to compare and validate their data before finalization. These meetings have also given the nodal agency an opportunity to inform relevant agencies about Bhutan's obligations under the WHO FCTC.

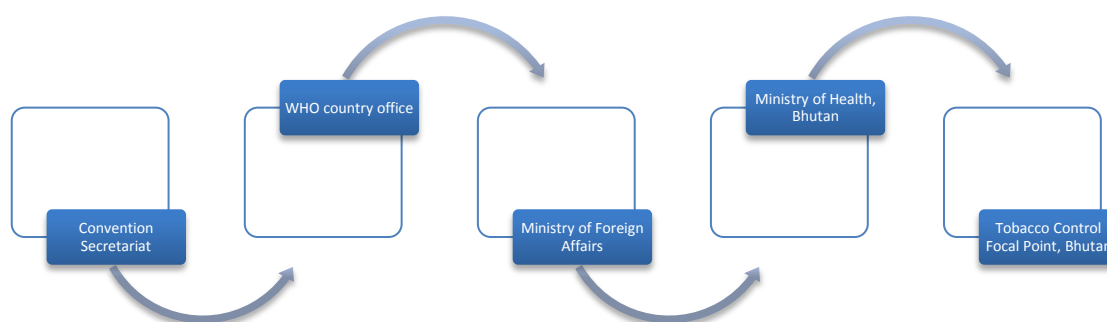
The WHO FCTC report has been used as a resource for advocacy with policy-makers for overall tobacco control measures in the country. The Ministry of Health presented results of the global and regional country implementation reports to parliamentarians while tabling the Tobacco Control Bill in parliament. This helped in the drafting and passage of the tobacco control law and its regulations by the Royal Government of Bhutan.

Over the years, WHO FCTC reports have informed the development of the country's annual work plans for tobacco control. The gaps identified in the implementation reports help determine the future priorities for tobacco control in the country.

Challenges in WHO FCTC Reporting

The circuitous route taken by the *note verbale* on WHO FCTC reporting from the Convention Secretariat delays its arrival at the Ministry of Health. The report's preparation is thus missed from the regular work plan of the nodal ministry and stakeholder ministries and comes to be perceived as an ad-hoc activity. This makes it challenging to give sufficient importance and attention to report preparation.

Fig 1. The journey of the reporting *note verbale*



At times, the report is delayed due to the non-availability of staff in stakeholder agencies due to interagency transfers or out-station travel. This calls for additional follow up work by the nodal ministry. In a similar vein, the reporting procedure consumes time as it requires multiple agencies to gather data from their field units on implementation of the tobacco control law. Human resource constraints and coordination often poses challenges for timely reporting.

However, the Ministry of Health has introduced the concept of Health in All Policies (HiAP) over the years. The HiAP approach is premised on the idea that policies of sectors other than health have a significant impact on the determinants of health and the people's health, including tobacco use. The health sector alone cannot address issues related to tobacco as most of the determinants that affect health related to tobacco lie in other sectors such as environment, education, agriculture, trade and governance. Tobacco is therefore a broader concern.

Bhutanese policy-makers and planners believe that the HiAP approach is a potential tool to bridge gaps in health inequities, including tobacco consumption. Therefore, government officials consider it important to integrate health concerns including tobacco into the policies of relevant sectors. Thus, the HiAP method is useful in initiating intersectoral action for tobacco control as well, encouraging sectors to cooperate and exchange information through formal means such as meetings of relevant stakeholders for reporting purposes.

Annex 1/1

**Meeting of Tobacco Control Board
Bhutan Narcotic Control Authority
Venue: Minister's chamber, Ministry of Health
Date: 14 August, 2015**

AGENDA

TIME	PROGRAMMES
09:30 A.M	Opening remarks by Chairperson
09:40 A.M	Confirmation and endorsement of minutes of 7th TCB meeting
09:50 A.M	Achievements of Tobacco Control Programme including FCTC and its reporting
10:15 A.M	Discussions
<i>Healthy Breaks</i>	
11:15 A.M	Enforcement of Tobacco Control Act 2010 and discuss its issues and challenges
01:00 P.M	Discussions
<i>Lunch</i>	
02:00 P.M	Appraisal on Tobacco Control Rules and Regulations 2015 and seeking guidance on few implementation issues
<i>Discussions and way forward</i>	
04:30 P.M	Closing remarks

ANNEX 2: CANADA

Canada's Whole-of-Government Approach to WHO FCTC Reporting

Mr Robert Tripp
Policy Analyst
Tobacco Control Directorate
Healthy Environments and Consumer Safety Branch
Health Canada

Background

Canada recognizes reporting under Article 21 of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) as a valuable tool to track and advance progress on the domestic implementation of the treaty, while reinforcing the idea that the treaty applies to all sectors and levels of government.

Canada ratified the WHO FCTC in 2004 and has been reporting on its implementation since 2007. In the initial phase of reporting, Canada focused primarily on activities within the federal health ministry. However, recognizing the significant contributions of subnational partners as well as non-health actors in advancing tobacco control measures, Canada now regularly consults with sectors outside the health ministry to gather data for the WHO FCTC report. Key partners engaged in the reporting process include Canada's 13 provinces and territories, in addition to various Government of Canada ministries and agencies such as Health Canada, Public Safety Canada, Finance Canada, the Canada Revenue Agency and the Canada Border Services Agency.

General Reporting Practices

Two analysts from the Tobacco Control Directorate in Health Canada lead the country's reporting, supported by a team of approximately 25 persons across subnational jurisdictions and other federal departments and agencies.

Work plan for report preparation

The team leading the reporting exercise has developed a detailed work plan for preparing the report. The work plan includes details such as communications plans; consultation schedules with internal and external partners who provide data; data collection tracking; as well as analysis and approval timelines. The work plan is tied to the reporting cycle of the WHO FCTC, with activities commencing in September of the year before reporting and ending with submission of the final report the following March. A generic template of Canada's reporting work plan and sample activity sheet are at Annex 1 and 2 respectively.

The completion of Canada's WHO FCTC report is an important internal policy indicator for the Tobacco Control Directorate's yearly Performance Report on the Federal Tobacco Control Strategy (FTCS). Once finalised and published, the WHO FCTC reports are used to inform bilateral conversations with internal and external tobacco control partners, domestically and regionally. The report identifies gains in the national and subnational implementation of tobacco control activities, as well as areas where the Government can expand its policy influence. It raises awareness of best practices that can be disseminated through subnational networks, and reinforces Canada's engagement with like-minded countries to identify global trends and opportunities as a means to strengthen domestic programmes.

Canada's FCTC reports are also used by domestic non-governmental organizations (NGOs) in their efforts to advocate increased governmental efforts in tobacco control. NGOs consult Canada's report to gauge progress in implementing the WHO FCTC. "Shadow" reports are developed by domestic tobacco control advocates following the report's publication, and in September 2016, a coalition of Canadian tobacco control organizations released a report on Canada's Implementation of WHO FCTC Article 5.3. Following the review of Canada's WHO FCTC reports, civil society organizations called for increased federal government efforts to implement Article 5.3. The report is available [here](#).

UNIQUE GOOD PRACTICE: THE WHOLE-OF-GOVERNMENT APPROACH TO WHO FCTC REPORTING

Strategies

Canada has implemented a whole-of-government approach to tobacco control involving subnational authorities and multiple ministries. Canada implements a similar approach for the collection and validation of WHO FCTC reporting data, although treaty reporting is not strictly defined in their work descriptions. The domestic and global benefit from the collection and reporting on tobacco activities through a whole-of-government approach is acknowledged across jurisdictions. Specifically:

- 1) Health Canada engages subnational authorities and multiple ministries through emails, regular meetings and conference calls. A preliminary call informs them of the purpose of the reporting process and the upcoming reporting period.
- 2) Subsequent calls assist in seeking data to populate the reporting instrument. Each jurisdiction responds to those sections of the WHO FCTC reporting instrument that fall within their mandate. As the reporting process evolved, Health Canada now only seeks validation of their previous responses and collects data on new activities since the previous reporting period.
- 3) On receiving the information, Health Canada collates and adjusts the data as required for national reporting purposes, while effectively capturing subnational and other government department tobacco control activities.

- 4) Once completed, Canada's report is shared with all partners for concurrence and to ensure that it accurately reflects Canada's whole-of-government approach with the implementation of the WHO FCTC. Discussions are also held to determine how the country report will be used to inform domestic and global policies and programmes.

Outcomes

Engaging multijurisdictional partners has enabled Canada to provide a report giving a comprehensive picture of tobacco control across all jurisdictions, while also being a vehicle through which partners can share their achievements.

Through engagement with federal and provincial partners in the WHO FCTC reporting process, Canada supports and nurtures a collaborative network of tobacco control authorities. This network has allowed individual partners to become aware of activities in other sectors and has fostered greater synergy and understanding between tobacco control authorities. This further supports Canada's ability to identify areas that could benefit from additional effort.

Synergies resulting from ongoing dialogue and effective reporting mechanisms have contributed to an increasingly countrywide approach to tobacco control. Early movement in some subnational jurisdictions in areas such as smoke-free spaces provided the template and support for others to follow. A similar situation is currently taking shape with the regulation of vaping-free spaces.

Canada's WHO FCTC reports are also used internally to measure Canada's domestic performance in tobacco control. Canada has successfully implemented many policies supporting WHO FCTC implementation; however, the reporting process defined a need for increased domestic action to support the principles of Article 5.3. Canada acknowledged this in the 2016 reporting cycle and will be engaging domestic and global partners in the development of a national approach supporting enhanced implementation of Article 5.3.

A responsive WHO FCTC reporting system

The prescriptive nature of the initial reporting instrument did not allow the presentation of data from subnational activities, and as such was not an accurate representation of Canada's whole-of-government approach in tobacco control. Some of Canada's tobacco control activities are delivered outside the federal health ministry. For instance, while Canada had exhaustive smoke-free coverage, it was predominately within provincial and territorial jurisdiction and not captured under reporting of any national activity.

Responding to such challenges, Parties and the Convention Secretariat revised the reporting instrument to provide for subnational reporting, as well as open-ended questions supporting activities not covered in the instrument. These improvements have helped to generate a more comprehensive national report.

Canada's WHO FCTC Reporting Workplan

Critical Path WHO FCTC Reporting
<p>The WHO FCTC requires that Parties submit to the Conference of the Parties (COP), through the Convention Secretariat, periodic reports on the implementation of the Convention.</p> <p>At its fifth session, held in Seoul, the COP agreed to make minor updates to the data collection initiatives in the area of tobacco control, to develop an Indicator Compendium, and to develop a voluntary reporting instrument on the implementation of WHO FCTC guidelines.</p> <p>Canada's reporting cycle requires the submission of the WHO FCTC reporting instrument to the Convention Secretariat.</p> <p>The Office of Policy and Strategic Planning (OPSP) leads the reporting process, with input from internal and external data sources, specifically TCD, PHAC, IAD, CRA, CBSA, RCMP, PSC, AAFC and members of the TCLC.</p> <p>Legal Affairs and Communications is consulted for review and the development of communication lines as required/appropriate.</p> <p>The Critical Path follows the following approach:</p> <ul style="list-style-type: none">• Project preparation• Data collection• Analysis• Data verification• Consultation• FCTC DG validation• TCD executive approval and data submission

List of Acronyms

AAFC	Agriculture and Agri-Food Canada
ADM	Assistant Deputy Minister
ADMO	Assistant Deputy Minister's Office
BN	Briefing Note
CBSA	Canada Border Service Agency
CRA	Canada Revenue Agency
DG	Director General
DGO	Director General's Office
IAD	International Affairs Directorate
FCTC	Framework Convention on Tobacco Control
FTCS	Federal Tobacco Control Strategy
PHAC	Public Health Agency of Canada
PSC	Public Safety Canada
RCMP	Royal Canadian Mounted Police
TCD	Tobacco Control Liaison Committee (Subnational jurisdictions)

Preparation	Task/Activity	Lead	Target Date	Status
	Access and review reporting templates and step-by-step instructions from WHO FCTC.		October 16	
	Develop Critical Path.		October 24	
	Needs assessment on reporting timelines and data sources.		October 24	
	Create activity log to record data collection and track external submissions.		October 25	
	Create files on L-drive to support 2012 reporting process		October 30	
	Briefing to management on work plan		Nov 1	
	Briefing on work plan and activities to Director/DGO		Nov 4	

Data collection	Task/Activity	Lead	Target Date	Status
	Input report from Group 2 data – populate report from previous input of TFI and WHO FCTC Group 2 Reports		Nov 4	
	Email to partners on reporting requirement and instructions for validation of data		Nov 8	
	Email to TCLC members (TCLC call – speaking notes)		Nov 8	
	Follow-up with TCLC members for validation of previous reports		Nov 18	
	Follow-up within TCD, RAPB		Nov 18	
	Follow-up with CRA, CBSA, RCMP		Nov 18	
	Follow-up with all members for collection of data		Nov 21	
	Confirmation of data collection (accurate and applicable for report)		Nov 25-29	
	Follow-up as required for data collection		Dec 2-6	

Data Analysis	Task/Activity	Lead	Target Date	Status
	Data analysis and input for collective report		Dec 9-13	
	Briefing to Management		Dec 13	Ongoing
	Amendments to report data as required		Dec 16-18	
	Preparation of collective report for distribution to working members		Dec 18	

Data Verification	Task/Activity	Lead	Target Date	Status
	Report to working team members and TCLC for final review and sign-off		Dec 20	
	Amendments to report as required following final review		Jan 6-10	
	Briefing with Director OPSP (DGO as appropriate)		Jan 13	
	Preparation of final version for external consultation and sign off		Jan 13-15	

Consultation	Task/Activity	Lead	Target Date	Status
	Forward report to Legal for review and comment		Jan 15	
	Forward report to Communications for review, comment and media lines		Jan 15	
	Brief to DGO in preparation of DG verification		Jan 15	
	Insert into Head Up		Dec 16	

DG Sign off	Task/Activity	Lead	Target Date	Status
	E-text from TCD DG to DGs to DGO for approval of final report		Jan 20	
	Final report forwarded by TCD DG to DGs for sign-off		Jan 22	
	Confirmation of DG concurrence		Jan 31	
	Thank you notes to DGs for participation		Feb 7	

Executive Approvals and Submission	Task/Activity	Lead	Target Date	Status
	Final Report to DGO for final review		Feb 7	
	Finalize cover letter to WHO		Feb 7	
	Raise BN to ADMO		Feb 12	
	ADM briefing		Feb 17-19	
	Preparation of final documentation (Covering letter to WHO, media lines, Question Period, note update)		Feb 20	
	Float time as required		Feb 20-27	
	PDF of final report and submission to WHO		Feb 27	
	Letters of appreciation from DG TCD to working team members		Feb 27	
	File storage		Mar 5-6	

Annex 2/2 – Sample FCTC Reporting Activity Sheet

Activity Log (Sample only)

Report Activity		Source							
A	Origin of the Report	OPSP	Officer concerned	Email	Phone	Sent	Received	Completed	Final sign off
A1	Name of contracting party	OPSP				15-Nov	15-Nov		
A2	National reporting contact	OPSP				15-Nov	15-Nov		
A3	Official contact	OPSP				15-Nov	14-Mar		
A4	Period of reporting	OPSP				15-Nov	14-Mar		
B Tobacco Consumption									
B1	Prevalence	ORS					14-Mar		
B2	Exposure to Smoke	ORS					14-Mar		
B3	Mortality	ORS					14-Mar		
B4	Tobacco Related Costs (Direct and indirect health care costs)	ORS					14-Mar		
B5	Supply of tobacco products	TPRO							
B6	Seizures of illicit tobacco products	RCMP, CBSA,							
		CBSA							
B7	Tobacco Growing (No. of workers by gender and GDP)	Agriculture Canada					14-Mar		
B8	Taxation	Canada Revenue Agency					03-Feb		
B9	Price of Product	TPRO							
C Legislation, regulations and policies									
C1	General Obligations	TPRO/OPSP							
C12	Protection of health policies from industry	OPSP				21-Dec			

C2	Measures relating to the reduction of demand for tobacco	OPSP/TCLC	21-Dec
C22	Protection from exposure to tobacco smoke	OPSP/TCLC	21-Dec
C23	Regulation of the contents of tobacco products	TPRO	21-Dec
C24	Regulation of product disclosures	TPRO	
C25	Packaging and labelling	TPRO	
C26	Education, communication and public awareness	TCLC	
C27	Advertising, promotion and sponsorship	TPRO	
C28	Demand reduction on tobacco dependence measures and cessation	TCLC	21-Dec
C3	Reduction of supply	OPSP	
C31	Illicit trade	PSC, CRA, RCMP,CBSA	
C32	Sales to minors	TCLC/TPRO	21-Dec
C33	Support for economically viable alternatives	Agriculture Canada	14-Mar
C4	Other Measures	OPSP	
C41	Protection of the environment and health of persons	OPSP	21-Dec
C42	Liability	OPSP	21-Dec
C43	Research, surveillance and exchange of information	ORS	

D International Cooperation and Assistance TPRO/OPSP/IAD/IDRC/FNIHB/CHIR

E Priorities and comments OPSP

Acronyms

OPSP	Office of Policy and Strategic Planning
ORS	Office of Research and Surveillance
TPRO	Tobacco Products and Regulatory Products
RCMP	Royal Canadian Mounted Police
CRA	Canada Revenue Agency
CBSA	Canada Border Serviced Agency
TCLC	Tobacco Control Liaison Committee
IAD	International Affairs Directorate
IDRC	International Development Research Centre
CHIR	Canadian Institutes of Health Research
FNIHB	First Nations and Inuit Health Branch

ANNEX 3: GHANA

WHO FCTC Reporting Practices: Ghana's Experience

Dr Kyei-Faried S.

Deputy Director, Public Health & Head of Department

Disease Control & Prevention Department

Focal Point, Tobacco Control

Ghana Health Service, Ministry of Health

BACKGROUND

WHO FCTC reporting enables information sharing, facilitates public discourse, ensures transparency, identifies issues for research and helps in resource mobilization for treaty implementation. Therefore, the Government of Ghana considers effective WHO FCTC implementation reporting to be a priority and the Ministry of Health and its agencies take it very seriously.

A key source of national data for WHO FCTC reporting in the country is the Ghana Demographic and Health Survey (GDHS). It is conducted by the Ghana Statistical Service (GSS) in collaboration with the Ministry of Health (MOH), Ghana Health Service (GHS) and other key stakeholders. Started in 2008, the survey collects data on adult tobacco use every four years. In addition to smoking trends among males and females, the data also includes other forms of tobacco use such as chewing, sniffing and the use of "Bonto". The prevalence of smokeless tobacco use in the adult population is unknown while the use of Shisha (water pipes) is gaining popularity and proving to be challenging.

As GDHS is conducted every four years, the government documents activities and programmes that describe the processes leading to change in prevalence and the emerging challenges in the intervening years.

REPORTING PRACTICES

Initially, Ghana's WHO FCTC reporting was based on prevalence studies and information on specific programmes and activities. These only covered World No Tobacco Days (WNTDs), Global Youth Tobacco Surveys (GYTS) results, Quit-and-Win programmes and results of a needs assessment. They did not help in assessing the progress in treaty implementation.

In 2012, country reporting was therefore improved to develop a report based on the WHO FCTC articles akin to the Convention Secretariat's Global Progress Report. The latter gave insights into additional areas that could be included in comparison to Ghana's earlier WHO FCTC reports. The content of the country report was further refined by the requirements in the obligatory and optional parts in the reporting questionnaire and the requirements of the Global Tobacco Control Report (GTCR).

On completing the WHO FCTC online questionnaire, Ghana uses that information to produce a user-friendly report that provides a snapshot of treaty implementation.

Table 1. Ghana Progress Report 2012: Contents	
CHAPTER 1	Introduction
CHAPTER 2	Progress in implementation of the convention
CHAPTER 3	Implementation of the convention by provision
CHAPTER 4	Prevention of tobacco use and tobacco-related mortality
CHAPTER 5	Logistics and finance
CHAPTER 6	Implementation challenges and 2013 priorities
CHAPTER 7	Conclusion

WHO FCTC implementation is multisectoral and therefore contributions to reporting come from sectors such as the Ghana Revenue Authority (GRA), Immigration Service, Attorney General's (AG) Department, Food and Drug Authority (FDA), Civil Society Organizations (CSOs), Ministry of Finance (MOF), Ghana Education Service (GES) and the Ministry of Health, among others. This is achieved by making WHO FCTC reporting part of the agenda of the Tobacco Control Inter Agency Coordinating Committee (TC IACC) meeting.

At the meeting, members are informed of the data expected of each agency and the content thoroughly discussed. Agency-specific requirements are defined and expected "must do" action (Annex 1) shared with contact persons. Agencies then submit their reports to the MOH. The tobacco task force discusses the WHO FCTC reporting cycle and reports from the contributing agencies in greater detail. A sample agenda of the task force meeting is at Annex 2. The final country implementation report is coordinated and prepared by the WHO FCTC Focal Point in the Ministry of Health.

Figure 1. Tobacco Control Inter-Agency Coordinating Committee meeting chaired by Chief Director, MOH



The report includes a detailed list of contributors, with the names of individuals, agencies and specific areas of expertise. This acknowledges their contribution to the previous report, while inspiring participation in the next. The list includes all the contributing agencies of the Government and the WHO FCTC Secretariat, WHO AFRO and WHO Ghana Office.

A complete section is now devoted to the contribution of civil society organizations. This showcases their specific contributions and collaborative efforts with the government towards WHO FCTC implementation.

The final report is discussed at TC IACC meetings. This has helped to increase stakeholder participation in contributing to subsequent reporting and in-country studies.

USE OF WHO FCTC IMPLEMENTATION REPORTS

WHO FCTC implementation reporting has been useful to Ghana in many ways. It presents Party achievements, contributions of key stakeholders, trends in certain intervention outputs, key challenges and recommendations to address gaps.

Ghana has been able to use the WHO FCTC implementation report for advocacy with various agencies. One such effort led to the inclusion of tobacco control measures in the five-year Health Sector Medium-Term Development Plans of the Ministry of Health for 2010-2013 and 2014-2017. Similarly, tobacco control also appears in the Ministry of Health Sector Programmes of Work (POW) for 2015 and 2016, with specific budget lines.

Figure 2: WHO FCTC Implementation captured in MOH HSMTD Plan 2014-2017

OBJECTIVE	PROGRAMME	SUB PROGRAMME	OPERATIONS	MAIN OUTPUTS
			<ul style="list-style-type: none"> Intensify efforts for the certification of eradication of guinea worm and polio Implement recommendations of Framework Convention for Tobacco Control (FCTC) 	Number of guinea worm cases seen Non Polio AFP rate Number of tobacco control (TC) IACC meetings held Availability of TC reports including surveys
		2.3 Institutional-based Services	<ul style="list-style-type: none"> Strengthen accident and emergency services including referral Strengthen QA/QI and patient safety systems 	Number of hospitals with their emergency care teams trained Number of regions that conducted clinical care peer review

Ghana has a Public Health Act with nine parts. Part 6 of the Act concerns “Tobacco Control Measures”- the only part in the law to have developed regulations. This has given Ghana its “Tobacco Control Regulation”. The use of the Ghana WHO FCTC Implementation Report in advocacy and as reference material have contributed significantly to the development and passage of this Regulation.

OUTCOMES

Good WHO FCTC implementation reporting has helped in achieving the following:

1. Improved the work of the TC IACC subcommittees, particularly the Finance Subcommittee. This subcommittee has held two meetings in 2016 and the information on tobacco economics is helping it to negotiate the review of excise taxes, with the Ad Valorem rate currently at 175% (an increase from 150% at 2015 Budget Statement).
2. Helped the government to partner with UNDP to initiate a process to undertake Tobacco Economic Burden Analysis to make the case for introducing Specific Excise Taxation.
3. Improved advocacy enabling the inclusion of WHO FCTC implementation in the MOH Sector Medium Term Strategy and the Ghana Health Service Programme of Work.
4. Created greater transparency between MOH and other stakeholders, thus leading to VALD, a CSO, supporting WNTD 2016 and a tobacco control strategic planning meeting.
5. Improved mobilization of technical and financial support from WHO regional and country offices and the Convention Secretariat for implementation of the WHO FCTC. For example, the Ghana Implementation Report 2012 identified

inadequate funding to implement planned activities, lack of educational materials and weak guidance in cessation interventions as a key challenge to treaty implementation. On sharing the report with WHO in Geneva, Ghana received financial support to implement Article 12 and reached out to schools and the public. Similarly, WHO Office for Africa provided technical support by way of tobacco cessation training and in the development of tobacco cessation guidelines.

6. Enhanced lobbying that facilitated the passage of Tobacco Regulation.
7. Better understanding and influence of tobacco control efforts on the teaching in health training institutions and colleges.

CHALLENGES

The main challenge faced in 2012 was to develop a format for the report that would meet both the country needs (GTCR, FCTC and POW) and WHO FCTC needs (FCTC Obligatory and Optional questions). The Party addressed this by including indicators required by Country POW, FCTC Secretariat and GTCR in the country report and modelling its table of contents on the WHO FCTC Secretariat's Global Progress Report.

Another challenge was in obtaining data from key stakeholders. Many of the relevant agencies had never reported on WHO FCTC implementation and did not know what to report on, how to report and when to report. This caused significant delays in finalizing the report and it took more than six months to gather the required data. Active engagement of these agencies with due acknowledgement has helped improve the situation.

At the moment, the 2013-2014 report is ready but there is difficulty securing funding for printing hard copies for domestic distribution. Similarly, the 2015-2016 report is nearly complete, but funding for its printing is uncertain.

REFERENCES

1. Ghana Demographic and Health Survey 2014, p270
2. In-country Civil Society Organization (CSO) report, 2012 Ghana Progress Report, p.27, sub section 2.3.
3. MOH Medium Term Health Sector Development Plan, 2014-2017
4. Ghana Health Service 2015 Programme of Work, MOH p20
5. Ghana Health Service Website
6. Public Health Act 2012, (ACT 851)
7. Tobacco Control Regulation, 2016 (L.I. 2247)

ANNEXES

Annex 3/1 MULTI STAKEHOLDER “MUST DO” ACTIONS

No	Agency	“Must Do” Action
1	MOH/ GHS	-Data on Prevalence of Tobacco use -Data on NCDs Morbidity & Mortality -FCTC implementation activities, WNTD -Write Tobacco Control Report
2	MOF	-Data on Excise Taxation -Data on Volume of Tobacco Products Imports -Revenue from Tobacco Taxation
3	Customs	-Illicit trade in Tobacco Products -Seizure of Tobacco products
4	CSO	-CSO activities report -VALD Report -Special activities report
5	AG	-Legislation and Regulation formulation report
6	FDA	-Public sensitization report -Tobacco Control Regulation activities report

Annex 3/2

TOBACCO CONTROL TASK FORCE MEETING MOH CONFERENCE ROOM, 5TH NOVEMBER 2014, AGENDA

TIME	AGENDA
09:30 A.M	Opening remarks
09:40 A.M	Objectives of the meeting
09:50 A.M	Implementation status of Tobacco Control programme including FCTC and its reporting cycle
10:30 A.M	Report by RBP
<i>Healthy Breaks</i>	
11:30 A.M	Report by Ghana Revenue Authority and Customs
11:40 A.M	Report by Road Safety Transport Authority
11:50 A.M	Presentation on Tobacco and its ill effect
12:00 A.M	Discussions

ANNEX 4: HUNGARY

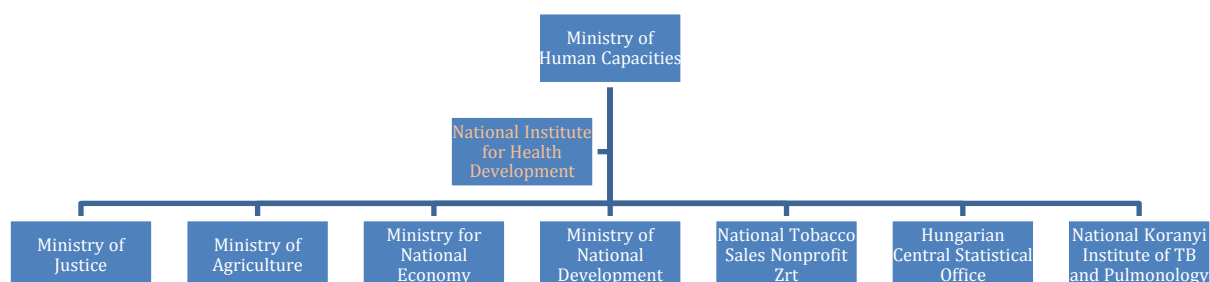
Preparation Process of WHO FCTC Implementation Report in Hungary: An Opportunity to Improve Tobacco Control

Mr Tibor Demjen
Focal Point for Tobacco Control
National Institute for Health Development
Ministry of Human Capacities, Hungary.

Background

Institutional

The Ministry of Human Capacities³ is responsible for WHO FCTC implementation and reporting, while the National Institute for Health Development is an important associated subsidiary institution in which Mr Tibor Demjén is the head of Focal Point for Tobacco Control. This is a unit with four full-time professionals dedicated to work on tobacco control and smoking prevention-related matters. Furthermore, the Focal Point for Tobacco Control is officially appointed to coordinate work related to the WHO FCTC report with various agencies, including other ministries:



Reporting

Hungary ratified the WHO FCTC on 7 April 2004 and the treaty entered into force for the country on 27 February 2005. Hungary began reporting on the implementation of the convention in 2007. Since then, four more reports were submitted biennially in 2010, 2012, 2014 and 2016. Until 2016, the reporting instrument had to be completed in a Word file and sent electronically to the Secretariat.

The reporting process is efficient because participating agencies are requested to cooperate, and the key person leading the Hungarian country report preparation is an accepted and well-known professional who has worked in smoking prevention and tobacco control for 26 years. Moreover, there is strong cooperation between the above-mentioned agencies in many other fields such as preparations for proposed new legislation.

³ Formerly the Ministry of Human Resources

Report preparation practices

Each reporting year the Focal Point for Tobacco Control is officially appointed to coordinate work related to the report in cooperation with agencies from the public sector. A schedule (see Annex 1) has been developed and shared to guide contributing ministries through the preparation process. This schedule is designed to break down the complex process of actions and deadlines so that each participant exactly understands their task. Agencies have to name a responsible contact and declare the questions in which they are competent (See Annex 2). Once the participants understand and have used this system, the previous year's process-related documents just need to be updated. Once personnel and tasks are defined, work on answering the questions can begin. Even though the reporting is in English, the Hungarian government approves discussion materials only in the country's national language, so contributing parties are asked to send answers in Hungarian and English.

Filing system to organize data inputs

A filing catalogue system has been developed to help coordinate and organize data inputs from various ministries. File names are identified as follows:

Elements of the file name	Example
• Abbreviation of institution submitting (in lowercase)	Emmi
• the number of the report (updated as per reporting cycle)	who_fctc_5th_report
• English or Hungarian	Hu
• Date file was filled	20160215

The full file name, for example, would therefore read:

e.g.: emmi_who_fctc_5th_report_hu_20160215.docx

e.g.: emmi_who_fctc_5th_report_en_20160215.docx

When necessary, contacts are reminded via phone or e-mail to ensure timely responses. Once all parties have provided their input, which are organized in the reporting format, the agencies have an opportunity to review the final document and seek changes if needed. The Ministry of Human Capacities sends it for public administration consultation (Administrative State Secretary meeting). Once approved through a Government Decree⁴, the report can be submitted to the WHO FCTC Secretariat.

Challenges and strategies

In 2016, the new reporting instrument's question numbers had changed from the last reporting cycle, resulting in some problems matching the questions and answers to competent agencies. There are also occasional delays in contributions from ministries because of staff changes. Sometimes data for the report is insufficient, as

⁴ The Government can issue a decree with the Prime Minister's signature, which is then published in the Official Gazette.

there are no new data on a specific field. For example, the impact assessment on the implementation of the Amendment to Act XLII of 1999 on the protection of non-smokers of 26 April 2011. A survey was made in 2012 when the amendment was effective and again in 2013. This provided the data to respond in the next reporting cycle. As for new data, the Focal Point for Tobacco Control asked the Ministry of Human Capacities to finance an adult smoking preference public opinion survey which is yet to be supported.

According to the official government decree published in the Official Gazette, in the near future it is expected that, after restructuring of institutions, the Focal Point for Tobacco Control will become a part of the Ministry of Human Capacities. Although, this would help with contacting other ministries, on the other hand internal processes may become more time-consuming.

Outcomes of reporting practices

Expanding tobacco control network: Cooperation during the reporting period develops an intersectoral network, which can collaborate even after the report is submitted, for the exchange of information and knowledge.

Non-governmental organizations are also informed about the report and access to it. It could also help to inform the media about the current development of ideas. There are plans for a summary to be presented at a press conference, to achieve more publicity.

Based on the WHO FCTC report, the EU Tobacco Product Directive transposition of the results can also be monitored, as for example, changes in the consumption and packaging of tobacco products are subject to biannual follow-up reports.

Resource mobilisation: As there were no new data on adolescent smoking prevalence, in 2015 the Focal Point for Tobacco Control requested the Ministry of Human Capacities to support implementation of the Global Youth Tobacco Survey (GYTS). A public opinion company was entrusted with the fieldwork and the Focal Point for Tobacco Control was responsible for the questionnaire and data analysis in 2016.

Similarly, in the case of European Health Interview Survey in 2014, the Focal Point for Tobacco Control successfully negotiated with the Hungarian Country Office of WHO to support the Hungarian Central Statistical Office to add more questions – about smoking in Hungary – besides the standardized questionnaire used throughout the European Union⁵. The professional work related to additional questions – such as information on e-cigarette usage – was carried out in cooperation with Focal Point for Tobacco Control and the Centre for Disease Control.

⁵ 28 European countries

Annex 4/1

Sample Schedule for Report Preparation

Under the Article 21 of the WHO FCTC, preparation timetable for the fifth country report.

Information about the country's fifth report

Parties are required to report every two years, not later than six months before the next Party Conference of the Parties. Reports on the implementation of the Framework Convention next due in 2016.

The questionnaires are filled out online, to which only the ministry has access, so the two questionnaires (Country Report and Additional Questionnaire) as a Word document is delivered to those concerned.

Instructions for filling in the questionnaire available at the following link:
http://www.who.int/fctc/reporting/reporting_instrument/en/

Deadlines

1. The Ministry of Human Capacities asks the participating government agencies to appoint contact persons	10/12/2015
2. Written reply letter from contact persons about their opinion on the assignment of tasks and the timetable	11/02/2015
3. The appointed contact persons electronically send the completed questionnaire to the coordinator of Focal Point for Tobacco Control in two separate files in English and Hungarian	01/15/2016
4. Replies are put together and participants have the opportunity to review	02/01/2016
5. The designated contacts send their opinion back about report	02/10/2016.
6. Finalization of the answers	02/24/2016
7. Public administration consultation	02/29/2016
8. Approved with Government Decree	03/23/2016
9. Report submitted to the WHO FCTC Secretariat.	04/15/2016.

Annex 4/2

Chart of Data Contributing Agencies by Questions (Sample Only)

	Responsible Agency	Contributor	Appointed for responsible/ contributor approved /disapproved
1. Origin of the report	Ministry of Human Capacities		
2. Tobacco consumption and related indicators	National Institute for Health Development		
2.1 Prevalence of tobacco use			
1. Smoking prevalence in adult population	National Institute for Health Development		
2 Smoking prevalence in the adult population (by age groups)	National Institute for Health Development		
3. Smokeless tobacco – adult population	National Institute for Health Development		
4. Smokeless tobacco – adult population by age groups	National Institute for Health Development		
5. Tobacco use by ethnic groups	National Institute for Health Development		
6. Tobacco use by young persons	National Institute for Health Development		
2.2 Exposure to tobacco smoke	National Institute for Health Development		
2.3 Tobacco related mortality	National Institute for Health Development		
2.4 Tobacco related costs	National Institute for Health Development		
2. 5 Supply	Ministry for National Economy		
2. 6. Seizures of illicit tobacco	Ministry for National Economy		
2.7 Tobacco-growing	Ministry of Agriculture		
2.8 Taxation	Ministry for National Economy		
2. 9 Price of tobacco	Ministry for National		

products	Economy		
3. Legislation, regulation and policies			
3.1. General obligations	Ministry of Human Capacities		
3.1.2 Protection of public health policies from commercial and vested interests of the tobacco industry	Ministry of Human Capacities		
3.2. Demand reduction			
3.2.1. Price and tax measures	Ministry for National Economy		
3.2.2. Protection from exposure to tobacco smoke	Ministry of Human Capacities		
3.2.3. Contents of tobacco products	Ministry of Agriculture		
3.2.4. Tobacco product disclosures	Ministry of Agriculture		
3.2.5. Packaging and labelling	Ministry of Human Capacities		
3.2.6 Education, communication, training and public awareness	Ministry of Human Capacities		
3.2.7 Tobacco advertising, promotion and sponsorship	Ministry for National Economy		
3.2.8 Demand reduction measures concerning tobacco dependence and cessation	Ministry of Human Capacities		
3.3 Supply reduction	Ministry for National Economy		
3.3.1 Illicit trade	Ministry for National Economy		
3.3.2 Sales to and by minors	Ministry of Human Capacities		
3.3.3 Support for economically viable alternative activities	Ministry of Agriculture		
3.4 Other measures and policies			
3.4.1 Protection of the	Ministry of Agriculture		

environment and the health of persons			
3.4.2 Liability	Ministry of Human Capacities		
3.4.3 Research, surveillance and exchange of information	Ministry of Human Capacities		
4. International cooperation and assistance	Ministry of Human Capacities		
5. Priorities and comments	All		

ANNEX 5:

The Role of National Multisectoral Coordination Mechanisms in WHO FCTC reporting – Iran’s experience

Behzad Valizadeh

Senior Expert, National Tobacco Control Secretariat
National FCTC Technical Focal Point
Environmental and Occupational Health Department
Ministry of Health and Medical Education
Islamic Republic of Iran

Background

The Islamic Republic of Iran (IRI) ratified the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2005. The Government promptly followed up on its implementation by enacting the Comprehensive Act on National Control and Campaign against Tobacco (hereinafter referred to as the Act) in 2006 and its Executive Bylaw (hereinafter referred as the Bylaw) in 2007.

Article 21 of the WHO FCTC on reporting obligations of Parties provided a stimulus for Iran’s implementation of the WHO FCTC, by way of tobacco use and monitoring prevention policies, generating relevant data and reporting on the progress of implementation to the Convention Secretariat and to domestic authorities.

Timely reporting

Iran has been very punctual in its WHO FCTC reporting. The first report (after two years of the treaty’s entry into force for the country) was submitted in April 2007, second report (at the five-year mark) in October 2012 and the third and fourth rounds of reports in 2014 and 2016 respectively.

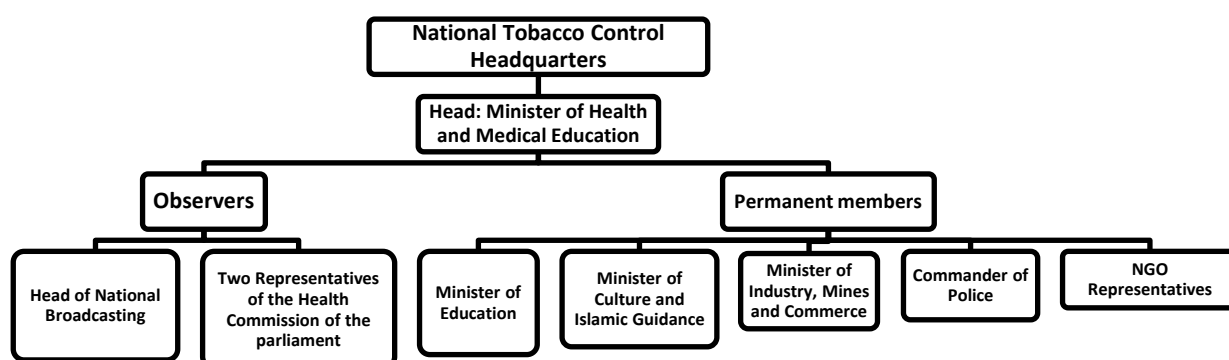
In the initial years after the treaty’s entry into force, efforts were focused on informing relevant government agencies about the country’s treaty reporting obligations and building the legal infrastructure of the Act and its Bylaw to facilitate their data contributions.

The infrastructure and process for preparing WHO FCTC reports

The very first Article of the Act, along with its Bylaw, established the National Headquarters for Tobacco Control (hereinafter referred as the HQ) to coordinate Iran’s tobacco control activities. The Minister of Health and Medical Education heads the HQ, which includes Ministers of other relevant Ministries (Education, Industry, Mines and Commerce, Culture and Islamic Guidance), the Commander of Police and a representative of nongovernmental organizations (NGOs) that are active in tobacco control. Two representatives from the Health Commission of the parliament and the

head of IRI Broadcasting are observers to the HQ. The Ministry of Health and Medical Education serves as the secretariat of the HQ (Fig 1).

Figure 1. Organogram of National Tobacco Control Headquarters



The HQ functions as a Multisectoral Coordination Mechanism (MCM) for tobacco control. Note 2 of the Act requires the HQ to submit a six-monthly performance report to the Cabinet and Health Commission of the Islamic Consultative Assembly. Additionally, under Article 25 of the Bylaw, HQ is to submit reports to the parliament. The first session of the HQ in 2009 therefore passed a resolution authorizing its secretariat to coordinate the collection of data from relevant agencies for reporting to both the national authorities and to the WHO FCTC Convention Secretariat. The President of the Republic approved this resolution, thus making it enforceable.

At the start of each WHO FCTC reporting cycle, the national WHO FCTC focal point in the Secretariat of the HQ requests the Convention Secretariat to provide a soft copy of the reporting instrument. The questions are translated, when required, into Persian. The questionnaire is then sent to partner ministries along with a formal notification from the HQ requesting their response to relevant questions within a fixed timeframe. The focal point in the HQ secretariat follows up and supports these ministries till finalization of the report.

By and large, the reports for the domestic agencies reflect the activities and performance of the HQ and address implementation of key elements of the WHO FCTC such as Articles 5, 6, 8, 12, 13 and 15. The Ministry of Health reports the data related to WHO FCTC Articles 11 and 14 and other ministries and organizations, with the respective mandate, report on the rest of the treaty articles. Based on the input formally received from other agencies, the secretariat of the HQ prepares and submits the country WHO FCTC implementation report to the Convention Secretariat.

Challenges in reporting WHO FCTC and strategies to address them

Lack of timely availability of data and resistance from tobacco companies in submitting data to the Ministry of Industry poses challenges to the preparation of the report. In some cases, there is difficulty comprehending and responding to the English reporting questionnaire. This requires additional time and work by the focal point person in the HQ, who then arranges for translation of the relevant questions into Persian and the responses back to English. These challenges often lead to delays in the preparation of the report. The secretariat of the HQ overcome them by starting preparations early, through the investment of additional time and consistent follow up in gathering the data.

The role and authority of the HQ as a national multisectoral coordination mechanism for tobacco control has been particularly helpful in addressing these challenges. The inclusion of the reporting requirements in the national law and resolutions of the HQ enables the secretariat of the HQ in the Ministry of Health to get all relevant agencies to report relevant data. All relevant stakeholders are obligated by law to prepare and submit their reports upon request of the HQ secretariat. This has not only created an enabling environment fostering cooperation between key Ministries in the reporting process, but also put WHO FCTC implementation on their agenda and so aligns with the HQ's strategy on the issue.

The legislative mandate for WHO FCTC reporting, coupled with the resolution of the national coordination body and presidential assent, gives political force to timely contributions from relevant agencies and helps to prepare an up-to-date country report.

The HQ secretariat coordinates with relevant agencies to identify solutions and resources to bridge emerging gaps in reporting data. Where infrastructure such as surveillance systems is available, the preferred action is to integrate questions relating to missing data in existing surveys. STEPs is a case in point, where questions relating to other forms or patterns of tobacco consumption, such as smokeless tobacco, has been incorporated to address data gaps pertaining to Section 2 (Prevalence of tobacco use) in the WHO FCTC reporting instrument. For data gaps requiring new infrastructure, as for WHO FCTC Articles 9 & 10, the Ministry of Health allocated resources to establish a tobacco laboratory.

The Ministry of Health is the responsible agency for implementation of the WHO FCTC and as head of the HQ, usually identifies such gaps in data and mobilizes other relevant agencies to bridge any gaps using their own resources. For instance, the Ministry of Economy (Tax Administration Organization) was induced to require the Ministry of Industry to provide data regarding the price of tobacco products to report on Article 6 of the Convention.

Impact of reporting exercise in accelerating treaty implementation at national level

The universality of the reporting system under the WHO FCTC and the potential comparability of data among Parties make the reports and data effective when advocating to bridge the gaps in treaty implementation. The experience of countries with advanced tobacco control can inspire other Parties. The MCM, focal point or other coordination structure can use the country report to highlight gaps in treaty implementation to policy-makers and persuade them to address such issues by strengthening the national tobacco programme. The aggregated data from Parties' reports showcase best practices in the implementation of the Convention at the national level. Iran has been able to utilize such comparative data, for instance, in its deliberations on increased tobacco taxes and plain packaging for tobacco packs.

Figure 2. The HQ Meeting on Tobacco Taxes, 2016.



Conclusions

The legislative obligation to implement the WHO FCTC, its reporting and the national coordination mechanism, help Iran enormously in improving the involvement of relevant agencies in the reporting exercise. Besides legislative obligations, reporting calls for consistent follow-up by the nodal agency. The role of focal point in this process is therefore very important. The knowledge and experience of the focal point in collecting information and providing timely feedback to relevant agencies when there is incomplete reporting or irrelevant data goes a long way to ensuring quality and completeness of the data collected.

ANNEX 6: KENYA

Kenya's Multisectoral Approach to WHO FCTC Reporting

Dorcas Jepsongol Kiptui
Head, Tobacco Control Unit
Division of Noncommunicable Diseases
Department of Preventive and Promotive Health Services
Ministry of Health, Kenya

BACKGROUND

In the early years of reporting on the WHO Framework Convention on Tobacco Control (WHO FCTC), the WHO FCTC focal point at Kenya's Ministry of Health (MOH) would visit the relevant sectors in person to collect data and compile the country's report for submission to the Convention Secretariat. In the absence of any formal communication, this approach often met with a slow-to-no response. The challenges arose largely due to lack of awareness about the obligatory nature of reporting for the whole Government and the responsibilities of specific sectors in collecting and submitting relevant data to the MOH.

The Health Ministry therefore initiated a strategy whereby the Government's WHO FCTC reporting obligation is officially communicated to the Principal Secretaries of other sectors. These sectors are also requested to officially nominate a focal person to liaise with the Tobacco Control Focal Point at the MOH for collection of timely and accurate data. In agencies with a designated focal point, a copy of the letter is emailed directly to the person concerned to make an early start on data collection. An information brief accompanies these letters. The brief contains both general information on the tobacco epidemic and the reporting obligations of the Government under the treaty, and a tailored communication on the data requirements from each sector. This approach has helped to inform senior officials about the roles and responsibilities of their respective sector in WHO FCTC implementation, reporting and evaluation. The Kenya Revenue Authority (KRA), Kenya Bureau of Standards (KEBS) and Ministries of Finance and Agriculture, for instance, now lend much political support and leadership to WHO FCTC implementation and reporting.

An official letter signed by the Principal Secretary of the Ministry of Health is now hand delivered to the Principal Secretaries of other Ministries and heads of relevant agencies, requesting sectoral data and the nomination of a focal point.

Following this strategy, each participating ministry and agency now officially submits its report to the Ministry of Health through its highest accountable office. In addition

to improving overall access to data, this has also led to the collection of new data. For example, the country did not have official data on tobacco growing for submission to the WHO FCTC Secretariat. Following regular interaction and capacity building by the Ministry of Health, the Division of Crops in the Agriculture Ministry requested its agricultural officers in tobacco growing regions/counties to gather this data. The focal person at the Ministry of Agriculture now compiles the data along with updates on its latest policies and initiatives, and submits them formally to the Health Ministry focal point. Sometimes the sectors initially share a draft report with the Health Ministry focal point, which in turn seeks clarification or provides feedback on its

completeness. A final report containing the feedback is then formally submitted to the Health Ministry.

WHO FCTC reporting demands time and resource commitments of Parties, particularly from the coordinating ministry and its focal point. Some of the regular resources, over and above those required for data generation, are indicated in Table 1. Kenya addresses these needs through resource sharing between the contributing ministries contributing.

Table 1. Reporting Costs	
Major Heads	Components
Ministry of Health	Communication – phone, internet Stationery Venue for meetings Refreshments for meetings Transport for orientation & feedback to other ministries
Non-health ministries	Communication – phone, internet Stationary Transport for data collection & stakeholder meetings
Data collection	Compliance observation visits Purchase of tobacco products for pricing data Photography and documentation keeping
Stationary	Official letters to stakeholder ministries Reporting tool copies for stakeholder ministries Feedback meeting stationery
Equipment for data collection/compilation	Computers Projectors Printers Photocopier Voice recorders Telephones Camera

Why WHO FCTC reporting is important to Kenya

The WHO FCTC requires Parties to report on treaty implementation. Reporting has helped Kenya to:

- monitor and evaluate implementation of the treaty and the country's Tobacco Control Act (TCA)
- inform relevant sectors and stakeholders about their roles and responsibilities under the Convention and national law
- present initiatives, challenges and opportunities for sectors to improve implementation
- improve ownership of treaty implementation by various sectors
- share good practices in treaty implementation with other Parties and learn from their experiences.

REPORTING GOOD PRACTICES

Kenya undertakes a series of cross-sectoral measures that have improved its reporting and subsequent use of the report for better WHO FCTC implementation. Some of these measures include:

1. In-person orientation for data collection

Ahead of data collection, the WHO FCTC focal point at the Ministry of Health holds face-to-face meetings with the nominated focal points in other sectors. This includes the Ministries of Agriculture, Foreign Affairs, Planning and Devolution, Finance, Kenya Revenue Authority, Environment and Natural Resources, National Environment Management Agency, Kenya National Bureau of Statistics, Kenya Bureau of Standards and the Attorney General's Office among others.

2. Ongoing sectoral support and sensitization

During the data collection phase, the focal point at Ministry of Health is available for formal and informal consultation. This is strengthened by continuous communication beyond the reporting period and engagement with focal points of other sectors in regular tobacco control activities. These contacts have facilitated teamwork among the sectors, including sharing of information pertaining to tobacco industry interference at the sectoral/institutional level. Several non-health sectors not only supply data for reporting, but also actively seek feedback on their performance as per national indicators and by comparison with other countries. This includes, in particular, the Finance sectors on tax and illicit trade matters and the office of the Attorney General and Ministry of Foreign Affairs on matters of treaty compliance.

3. Engaging Technical Working Groups for Reporting

Kenya has multisectoral technical working groups involving government ministries, civil society groups and academic experts led by key ministries for the implementation of various articles of the WHO FCTC. A case in point is the group working on WHO FCTC's Article 6 and 15, led by the Ministry of Finance in collaboration with the Kenya Revenue Authority (KRA). These lead teams have collected and shared the data required for reporting on WHO FCTC implementation which has enabled the Ministry of Health to use it for policy advocacy and legislation.

The joint planning and implementation of FCTC provisions have strengthened the collaboration among sectors to collect data and report on their progress and achievements.

Similarly, the Kenya National Bureau of Statistics (KNBS) has been the lead agency for national household tobacco-related surveys and research, such as the Global Adult Tobacco (GATS) and the STEPS Surveys in Kenya. The research team was oriented to tobacco control and the need for data to track and document progress and trends. The KNBS has since included tobacco questions in key national household surveys, economic surveys and the multiple indicator cluster survey.

Multisectoral collaboration has reduced the time and resources required for data collection. It has also increased the demand for updates on the progress and performance of the sectors, because participants are keen to share their experiences and successes at subregional (East African Community), regional and global forums.

4. Exposure to WHO FCTC meetings

The participation of experts from non-health sectors of the Government in WHO FCTC meetings and related workshops has fostered interaction and experience-sharing with counterparts among other Parties to the treaty. This has helped build the capacity of these sectors and better implement the treaty. Some of these ministries now directly support the participation of their focal points at the WHO FCTC Conference of Parties, motivating them further to align and work jointly as a tobacco control team. This enthusiasm has translated to the collection and supply of data for treaty reporting and its use to implement policy change within sectors. The KRA, Foreign Affairs, Treasury, Kenya Bureau of Standards, Ministries of Agriculture, Trade, Kenya Agricultural Research Institution, academic experts and civil society representatives have participated in such meetings. Such involvement and capacity building has generated interest to document and share achievements, challenges and experiences with other Parties through WHO FCTC implementation reports.

5. Cross sectoral and jurisdictional networks

In addition to close work with focal points of other sectors, Kenyan reporting systems identify and use personnel at the subnational level for prompt data collection. It also enlists input from civil society organizations and academia in the development and use of WHO FCTC implementation reports. The data collected is also shared through subregional (East Africa Community) forums for joint action.

6. Use of the report for internal advocacy

The final WHO FCTC report is used to draw the attention of relevant Ministries/agencies of the government and other stakeholders to the challenges, gaps and opportunities for improved treaty implementation. This is currently being done informally between the focal person at the Ministry of Health and the representatives of the relevant sectors. The Ministry of Health disseminates the results of the report in a formal, multisectoral forum hosted around World No Tobacco Day (31 May). This is usually done as an update on WHO FCTC and Tobacco Control Act implementation. Kenya intends to develop a more formal feedback mechanism on WHO FCTC reporting and implementation to draw a roadmap for concerted action. The mechanism is envisaged as providing feedback to individual sectors as well as to organize a joint forum where all stakeholders can offer critiques and mutual lessons.

The reports have been used to call on sectors and tobacco control civil society for closer tobacco industry monitoring and to initiate research to address gaps in data. Its results have been broadly discussed in World No Tobacco Day newsletters. The reports have also triggered official letters to various ministries for improved treaty implementation and funding to address the identified challenges and gaps.

OUTCOMES OF KENYA'S REPORTING PRACTICES

The Kenyan multisectoral approach has:

- improved sectoral ownership of roles and responsibilities under the WHO FCTC including the reporting requirement.
- reduced response times for data collection.
- established focal points in relevant sectors
- enhanced data quality in terms of content, completeness, accuracy and additional insights
- improved treaty implementation and reporting
- strengthened coordination between sectors.

CONCLUSIONS

The involvement of stakeholder sectors in WHO FCTC reporting has helped improve the quality of its reports and treaty implementation in Kenya. It could be further strengthened through a monitoring and evaluation tool, feedback mechanism and data from civil society organizations. The country is making efforts to get partners interested in building these mechanisms to enhance its treaty reporting. The proposed work of the Reporting mechanism review committee established by the seventh session of the Conference of Parties in 2016 is expected to assist Kenya in further improving its WHO FCTC reporting.

ANNEX 7:

Reporting Good Practices in Pakistan

Mr Muhammad Javed
Project Manager, Tobacco Control Cell
Ministry of National Health Services,
Regulations and Coordination (M/o NHSRC), Pakistan

BACKGROUND

Pakistan ratified the WHO Framework Convention on Tobacco Control (WHO FCTC) on 3 November 2004 and submitted the first WHO FCTC implementation report in February 2009. In the early years, the country reporting was rather informal – the report template was filled offline with available data and emailed to the Convention Secretariat.

After the Conference of the Parties (COP) mandated online reporting at its fourth session (FCTC/COP4 (16)), Pakistan began to undertake formal reporting. The online data collection instrument and guidance from the Secretariat helped to improve the country reporting. Now, the questionnaire is filled and submitted online. Reporting provides the country with the opportunity to assess progress in the implementation of the Convention and to take action to bridge the gaps.

GOOD PRACTICES IN WHO FCTC IMPLEMENTATION REPORTING

The Ministry of National Health Services, Regulations and Coordination (M/o NHSRC) is the nodal ministry responsible for the reporting process in Pakistan. After the development of the online reporting instrument by the WHO FCTC Secretariat, the country adopted a systematic and structured approach to reporting. The M/o NHSRC developed customized templates for relevant ministries to report data under certain articles of the WHO FCTC, such as on Article 6 pertaining to price and tax measures.

The Ministry also holds regular meetings with relevant ministries, agencies and tobacco-related working groups to ensure timely input to the report. For instance, the ministry has formed a technical working group on tobacco taxation involving experts from Federal Board of Revenue (FBR), Tobacco Control Cell, WHO, International Union Against Tuberculosis and Lung Disease and the World Bank. Meetings of this working group have facilitated international agencies like WHO and the World Bank to provide prevalence data and national tobacco tax and price trends. Similarly, the FBR supplies tax and production-related data. Some reports by civil society organizations (CSOs) are also used in the country reports.



Figure 1. WHO FCTC Report Preparation Meeting at NHSRC Pakistan

UNIQUE GOOD PRACTICE: USE OF IMPLEMENTATION REPORTS FOR SYNERGISTIC ACTION BY THE GOVERNMENT AND CIVIL SOCIETY FOR IMPROVED TREATY IMPLEMENTATION

A major challenge

In the early years of reporting, the WHO FCTC implementation report was not optimally used for policy advocacy within the country. While reports were developed and submitted biennially, they were seldom used for advocacy with legislators and policy-makers to address gaps in treaty implementation. There was little substantial tobacco control policy forthcoming at the start of this decade and there was no plan of action by the Government or CSOs to address gaps in treaty implementation. This raised questions about the report's benefits and its role in treaty implementation.

Strategies to address the challenge

In Pakistan, the Government and CSOs have been able to use WHO FCTC implementation reports to advocate comprehensive Tobacco Advertising, Promotion and Sponsorship (TAPS bans), larger pictorial health warnings and increased tobacco taxes. CSOs have demonstrated the need and demand for improved policies, and the Government has been able to introduce new legislation that bridges the gap between national legislation and WHO FCTC requirements.

A case in point is the TAPS law. The WHO FCTC implementation report inspired a civil society organization to develop a shadow report in 2016, which highlighted the gaps in Pakistan's tobacco advertising regulations. Based on the shadow report, the NGO asked senators to introduce a private member's Bill calling for a comprehensive ban on tobacco advertising, promotion and sponsorship in July 2016. This provided the M/o NHSRC with the opportunity to draw on data from the WHO FCTC implementation report, identify the gaps in Pakistan's advertising laws and propose a

legislation complaint referencing the WHO FCTC provisions. This also enabled the ministry to inform senators on the need for WHO FCTC-complaint legislation. This in turn has led to the Senate Standing Committee discussing for prospects the legislation with the M/o NHSRC in August, 2016.

Similarly, civil society filed a petition in Islamabad High Court against the recommendations of Inter-Ministerial Committee on pictorial health warning (PHW) on cigarette packs in 2015. In order to bridge the gaps, the Government of Pakistan enhanced the size of PHWs from 40% to 85% of the packs. Even as

Synergistic action between the Government and civil society has facilitated optimal use of the country report to accelerate Pakistan's WHO FCTC implementation.

the larger warnings were to be implemented from 30 March 2015, an Inter-Ministerial Committee (IMC) was appointed by the Finance Minister to review the impact of pictorial health warnings on revenue and smuggling and consult stakeholders on implementation concerns, and the implementation date was extended by M/o NHSRC.

The Committee recommended a phased approach to the PHWs, suggesting a 10% increase to the warning size every year. The M/o NHSRC presented its case to the IMC, quoting data on regional trends in PHWs from WHO FCTC implementation reports. The NGO petitioned against the decision of the IMC and asked that the government be directed to implement 85% PHW in line with regional and international trends. The court is currently hearing various parties on the case. Parallel to these, the WHO FCTC implementation report also led NGOs and other groups to undertake media advocacy in support of large tobacco warnings.

Based on the gaps in the implementation of the Convention, one of the NGOs also became a party in the Suo Moto case on the "Tobacco Epidemic in Pakistan" in the Supreme Court of Pakistan in 2016. Citing the country's tobacco epidemiological data, the NGO argued that the Government of Pakistan was not fulfilling its obligations under the WHO FCTC and sought a direction that the government take urgent rectifying measures. The M/o NHSRC agreed in court that the current law is not fully compliant with WHO FCTC provisions and assured the Court of all efforts to implement the Convention's provisions. Similarly, there have been questions on Pakistan's WHO FCTC implementation in the National Assembly. The response to this can be found in Annex 1.

OUTCOMES OF PAKISTAN'S GOOD REPORTING PRACTICES

The above strategies showcase synergistic use of the WHO FCTC Implementation Report and Civil Society Shadow Report for media and policy advocacy in Pakistan. These advocacy efforts have generated parliamentary debates on gaps in the country's current laws and ways to make them better compliant with the WHO FCTC.

As a result, WHO FCTC compliant-draft laws have been presented to parliament and discussions are underway in the Senate Standing Committee.

In addition to this, gaps that were brought to light based on the implementation reports have led to the generation of authentic data for reporting. Several pieces of research, such as the health cost study and illicit tobacco trade survey, have been planned by specialized government organizations.

The Supreme Court's direction for Governmental action against lethal tobacco products in the Suo Moto Case has led to Pakistan's ban on the import of sheesha (tobacco and non-tobacco forms) and similar products into the country. Additional measures are being taken to ban local production. One of the Provincial Governments has also banned sheesha smoking, sale of mainpuri and gutka (chewing tobacco products).

The reporting process itself has strengthened the partnership between the Health Ministry, revenue department, and international organizations to generate authentic data for reporting. The WHO FCTC implementation database has also provided the opportunity to analyse regional trends in treaty implementation, which then informs policy decisions.

STARRED NATIONAL ASSEMBLY QUESTION NO. 237, 30 SEPTEMBER 2016

Question moved by: Ms Shagufta Jumani, Member of National Assembly	Reply by Ms. Saira Afzal Tarar, Minister of State for National Health Services, Regulations and Coordination
<p>Will the Minister for National Health Services, Regulations and Coordination be pleased to state;</p> <p>a) Whether the existing Anti- Tobacco laws are adequate to meet the obligations made under the WHO Framework Convention on Tobacco Control; if so, the details; if not, the reasons thereof?</p>	<p>The existing Anti-tobacco laws are not adequate to meet the obligations made under the WHO Framework Convention on Tobacco Control (FCTC). Following are the major reasons:</p> <p>a) Pakistan's major tobacco control law titled "Prohibition of Smoking and Protection of Non-Smoker's Health Ordinance, 2002" was promulgated in 2002, while the Government of Pakistan signed the Framework Convention on Tobacco Control (FCTC) in May, 2004 and ratified it in the same year.</p> <p>b) Since then, this Ministry is taking steps to make existing laws compliant to the FCTC obligations. Following are major legislative steps taken in this regard:</p> <ol style="list-style-type: none"> i. Under Article 5.2 of FCTC, Tobacco Control Cell was created in 2007 which is national coordination mechanism for multi-sectoral coordination of tobacco control efforts. ii. Under Article 6, Pakistan is taking price and tax measures to reduce demand of tobacco products. Resultantly, 33% FED was increased cigarette packs since last two years. iii. Under Article 8, Pakistan has declared all places of public work or use 100% smoke-free. iv. Under Article 11, Pakistan introduced Pictorial Health Warning (PHW) on cigarette packets and outers in 2010. v. Under Article 13 of FCTC, Pakistan has imposed ban on tobacco and tobacco product advertisements in Print, Electronic and Outdoor media. vi. Complying Article 16, Pakistan's prohibited sale of tobacco products to persons under 18. Pakistan has also banned offering free samples, cash rebates, discounts

	and sponsorship of events. This ban includes manufacture or offer for sale sweets, snacks, or toys in the form of cigarettes. There is also ban on manufacturing and sale of cigarettes packs having less than 20 cigarette sticks.
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ANNEX 8: PALAU

Preparation of the WHO FCTC Report – Partners, Processes and Possibilities

Ms Candace Koshiba
Palau FCTC Focal Point
Prevention Unit Program Manager
Behavioral Health Division
Ministry of Health, Palau.

Background

Palau ratified the WHO Framework Convention on Tobacco Control (WHO FCTC) on 12 February 2004 and the treaty entered into force for the country on 27 February 2005. Since then, Palau has submitted five implementation reports (2007, 2010, 2012, 2014 and 2016).

Palau considers reporting on the WHO FCTC to be of paramount importance in updating the community, partners and stakeholders about its implementation status. It also creates opportunities to share the lessons learnt from its implementation, successes and challenges and to identify ways to improve the health of its people.

The country's approach to reporting has changed over the years. Initially, the report had to be filled manually, and was long and complicated. It was challenging to bring other stakeholder ministries together to work on its preparation. The new online reporting system has improved preparations, making data collection easier, as well as entry and navigation through the questionnaire.

Report preparation process

The Ministry of Health is the nodal ministry for WHO FCTC reporting in Palau. The WHO FCTC focal person in the Health Ministry (hereafter referred to as the focal person) coordinates any research required to generate reporting data, gathers information from various sources and compiles the WHO FCTC report. The focal person also facilitates communication among contributing agencies, such as through meetings, phone calls and emails. This communication helps ensure that all contributing agencies are aware of the requirements of reporting, the data needed to complete the report and the timeline for preparation.

A team of stakeholder agencies works to prepare the report. The focal person sends an initial email notifying those who are in a position to find or collect the information required for various sections in the reporting questionnaire, along with the reporting questionnaire itself. Participating agencies then assign a member of staff to liaise with the focal person and gather data. Most of the time, the directors or supervisors of bureaus from various agencies are involved in this process.

The WHO FCTC focal person conducts meetings and phone calls with contributors. The various sections of the reporting questionnaire are then assigned to programme staff, governmental agencies who have been contacted and community members from non-governmental organizations for data collection. About two weeks are given for data collection. The focal person then reviews the information and starts compiling

the report. If there are comments or questions about the data, the focal person consults the person or agency responsible. The focal person then shares the final draft report with stakeholders who assisted in collecting the information for final review and consent, whereafter the report is readied for submission. The final report is emailed to all contributors.

Figure 1. Some members of Palau's Tobacco Control Working Group in action



Data generation for treaty reporting

Over the years, Palau detected a lack of data on prevalence of tobacco use among adults. This was due to the absence of surveys or assessments in recent times. This prevented the country from providing an accurate and up-to-date picture of tobacco consumption and affected treaty implementation, as there was no credible data to defend interventions.

To address this challenge, Palau devised a hybrid survey – a combination of WHO STEPS survey and Behavioral Health Survey in 2016. The US Centers of Disease and Prevention (CDC), US Substance Abuse and Mental Health Administration (SAMSHA), WHO and other partners and agencies supported the Palau Hybrid Survey. The survey team from the Palau Ministry of Health, partner agencies and NGOs undertook the planning, development, design and data collection of the survey.

The Hybrid Survey is an adult (18 years and above), population-based, prevalence survey on noncommunicable diseases, mental health, and related risk factors such as tobacco and alcohol consumption, diet/nutrition, and physical activity. Tobacco-related questions in the survey include 30-day use, age at initiation, type of tobacco products used, exposure to tobacco smoke and interest in quitting, and chewing of betel nut with tobacco among others.

The survey results will establish a baseline for the tobacco control programme. It will also help to improve existing interventions, identify new priorities to meet emerging community needs and develop effective population-targeted interventions. In addition, the results will be used to monitor trends/changes and evaluate the effectiveness of existing programmes and services.

Multisectoral engagement for WHO FCTC report preparation

Palau established the National Coordinating Mechanism for NCDs (CM) in 2015. This includes the Tobacco Control Working Group, which consists of representatives of government, semi-government and nongovernmental organizations (NGOs). This working group is expected to be involved in the preparation of the WHO FCTC report in the coming years. Given the reach the CM offers to diverse partners, future WHO FCTC reports will be shared with all its members via email and a power point presentation with its highlights presented at its meetings.

Role of NGOs in WHO FCTC reporting

NGOs or community partners play an important role in the preparation of the report. They help bridge the shortage of staff required to support the focal point. These community partners assist by gathering data, compiling, reviewing and disseminating the report. They also make good use of the implementation report for advocacy. For instance, they facilitated information sharing, assistance and learning about effective implementation during the 10th anniversary celebrations of the treaty's entry into force in 2005. They also assist the Government to overcome its technological challenges around submission of the report, by lending their services and facilities.

Some of the NGOs that are members of the CM have assisted the Government in the reporting process over the years. Their support is anticipated to continue in the newly established CM and its tobacco control working group, including for the preparation of the report.

Challenges and strategies

The diverse priorities of the contributing agencies cause occasional delays in the preparation of the report. Staff shortages to support the focal person also pose difficulties. Nongovernmental partners have stepped in to address these challenges to a great extent.

The mismatch between data required for reporting and what is locally relevant and available also presents challenges for reporting. For example, the questionnaire seeks data on seizures of illicit tobacco

The regular communications, through emails, phone calls, and meetings with partner agencies, ministries and stakeholders have smoothed gathering of data and information across all sections.

products. In the case of Palau, while the Bureau of Customs Office (under Ministry of Finance) has data to this effect, the tobacco products seized by them mostly result from non-payment of customs duty by visitors to the country at the ports of entry, either because they refused or could not pay the requisite amount. In other words, Palau's seizure data does not reflect tobacco products brought illegally for use or distribution in the country as envisaged in the reporting instrument.

Meetings and communication with the Customs Office has helped to clarify the scenario and identify solutions. The Customs Office now seeks to distinguish between seizures of illegal products and non-payment of customs duty by tourists.

Conclusions

The effective and continuous communication between the health and other governmental agencies, community organizations, and other partners has made Palau's report preparation smoother and enabled timely submission of its WHO FCTC reports. The National Coordination mechanism for NCDs is expected to make it even more effective and engaging in the future.

ANNEX 9: PANAMA

BEST PRACTICES IMPLEMENTED BY PANAMA FOR REPORTING TO THE CONFERENCE OF THE PARTIES OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL (WHO FCTC)

Dr Reina Roa Rodríguez MD. MPH

Planning Director, Ministry of Health

Focal Point for Tobacco Control

Ministry of Health

BACKGROUND

Panama ratified the WHO FCTC in 2004 and started reporting on treaty obligations from its first reporting cycle in 2007. The WHO FCTC report facilitates organization and synthesis of data through exchange of information within government and with civil society to assess country compliance with WHO FCTC implementation. It also enables Panama to fulfil reporting obligations under Article 21 of the treaty.

Panama's initial reports included content of a general nature obtained mainly from available data sources. Today, the report contains results from research specifically carried out to characterize the smoking epidemic in the country. It also includes an assessment of compliance with WHO FCTC demand and supply control measures. It further helps the country to determine gaps in treaty implementation guidelines and to be more effective in protecting the health of its citizens.

WHO FCTC REPORTING PRACTICES IN PANAMA

Coordination among relevant ministries and stakeholders

The Ministry of Health (MINSA) is responsible for the implementation of the WHO FCTC in Panama. It coordinates the country's accountability to the WHO FCTC Conference of the Parties through the country implementation reports. Despite Panama's enactment of several tobacco control policies, its collection of data for the reports was initially complicated, poorly organized and officials found the report structure difficult to manage.

In order to address these challenges, MINSA established close communication with several key sectors and government agencies. These included the National Institute of Statistics and Census (INEC), the National Customs Authority (ANA), and the Ministries of Education, Economy and Finance. It also succeeded in making tobacco supply and demand a research priority in the mandate of the Gorgas Commemorative Institute, a government health research agency.

The preparation of Panama's fifth country report commenced with a communication from the National Tobacco Control Commission of MINSA requesting information on each subsection of the WHO FCTC reporting instrument from responsible entities. The Commission Coordinator at the Ministry of Health analysed the data provided by the information systems of the various entities and prepared the first draft of the report. This draft was presented, consulted and agreed upon over two meetings between the Commission and participating governmental entities. The meeting

validated the data received from diverse sources for relevance, quality and consistency. The Panamanian Coalition Against Tobacco Use (COPACET) and the Pan American Health Organization (PAHO/WHO) participated and contributed to the discussions at this meeting.

Improving databases

Over the years, Panama has established several measures to improve the quality of information for reporting. Tobacco-related variables and indicators were included in various national surveys.

- Given Panama's relatively small tobacco farming, the National Agricultural Census did not originally gather data. INEC subsequently included this variable in the agricultural census to meet the requirements of the WHO FCTC report.
- The 2013 Global Adult Tobacco Use Survey included questions on assessing illicit trade in tobacco products, as the country information on illegal tobacco trade up until that year was limited to seizure statistics.
- In 2014, the MINSA and Social Security Administration Electronic Records System made it mandatory to keep tobacco use records of patients accessing health care.
- In preparation for the next (sixth) country WHO FCTC report, the 2017 National Health Survey includes questions about the prevalence of tobacco use and exposure to tobacco smoke.

Figure 1. Data collection for Global Adult Tobacco Survey



Additionally, Panama undertakes implementation assessment research to address gaps in data for WHO FCTC reporting. For instance, it conducted market research on compliance with the country's prohibition of advertising, promotion and sponsorship of tobacco products.

Improved public accountability through WHO FCTC reports

Panama view WHO FCTC reporting as a tool for public accountability. To this end, the report and its annexes are uploaded to the Tobacco Observatory via the website of the Gorgas Commemorative Institute⁶ (<http://www.gorgas.gob.pa/SitioWebTabaco/Inicio.htm>).

Figure 2. Web access to Panama's FCTC reports



Innovating country surveillance and reporting system for WHO FCTC implementation

Panama is currently developing a new tobacco control surveillance system to improve the feasibility and sustainability of the reporting process. This effort aims to produce a more comprehensive, far-reaching and timely country report, which will also be easier to prepare than the current one. An Internet-based tool will facilitate health and non-health entities to upload their data on relevant WHO FCTC implementation matters and enable effective multisectoral coordination for information exchange. When fully operational, it will provide timely and quality data that indicates the advances, follow-up, monitoring and evaluation of WHO FCTC implementation as an international treaty. At an investment of around US\$ 200 000, this web tool is anticipated to be functional by mid-2017.

USE OF WHO FCTC IMPLEMENTATION REPORTS

For awareness, advocacy and defence of WHO FCTC implementation

Strategically, the country WHO FCTC report is shared with media via educational sessions, interviews and press conferences. It is also used to defend existing tobacco control measures or inform decisions on new policies. For instance, the tobacco industry has filed six legal suits against Panama's tobacco control measures. The MINSA used information from the WHO FCTC reports and research complementing the reports, to defend its positions before the Panamanian Supreme Court of Justice.

Informing contributing ministries

Overall, the modifications in the process of preparation of the country report over time has included face-to-face meetings, email and telephone exchanges, visits to

⁶ The Gorgas Institute analyses national mortality data and organizes research on tobacco, among other issues.

governmental agencies and consensus-seeking meetings. These consultations have resulted in greater awareness among key ministries, including ministers and director generals of decentralized institutions, about the importance of the WHO FCTC report and of the binding nature of the treaty for the whole government.

Prioritizing the WHO FCTC in national health and development plans

The findings of the WHO FCTC country report and related tobacco control research also inform tobacco control intervention and decision-making pertaining to other risk factors for noncommunicable diseases. Tobacco indicators are included in the National Health Plan, environmental indicators system and in the analysis of country indicators in the follow-up process for the Sustainable Development Goals. Please see Annex 1 for tobacco-specific indicators in the national health and development plan assessments.

Figure 3. Health Commission of Panama Assembly Debating Tobacco Control Law, 2015



HUMAN AND FINANCIAL INVESTMENTS IN REPORTING

Members of the National Tobacco Control Commission spend a significant time on data collection, preparation of the report and data management. The personnel and logistics expenses for meetings and working sessions of governmental entities and NGOs would total several thousand dollars. While there has been no concrete estimate of the human and financial costs incurred during the entire process of preparation of the country WHO FCTC report, the major human resource commitments in Panama are described here.

Coordination of the Commission for Tobacco Control for the development of the initial draft of the WHO FCTC implementation report in Panama requires the equivalent of about 30 full workdays of its Coordinator. The 12 members of the Commission can spend about four hours each to provide information on specific reporting questions to the initial draft.

The draft is reviewed collectively by members of the commission with the participation of two officials each from INEC, ANA and two representatives of civil society through COPACET. This step collectively takes about 40 hours.

The expenses incurred in undertaking research related to tobacco control as prioritized by MINSA and the Gorgas also needs to be considered. In general, the short research could cost around US\$ 15 000, and the population-level studies such as the GATS are estimated to cost around US\$ 700 000. The research is financed by funds collected by the dedicated tax on tobacco products, which is allocated to MINSA.

Annex 9/1

Key Tobacco Indicators in the National Health Plan, in the System of Environmental Indicators, in the Five Year Tobacco Control Plan and Development Plans

1. Prevalence of tobacco consumption by type of product, age and sex
2. Proportion of Proportional Mortality Attributable to Consumption of Tobacco Products
3. Mortality rates due to diseases associated with tobacco consumption
4. Number of premature deaths due to NCDs and risk factors
5. Rate of incidence of malignant tumours associated with tobacco consumption
6. Annual amount of tax collection through selective tax on tobacco consumption
7. Percentage of tobacco control establishments (ict) inspected
8. Percentage of establishments that violate the prohibition of advertising, promotion and sponsorship of tobacco products in entertainment media (national television, cable, written media, radio, film, internet and social networks)
9. Percentage of tobacco product outlets inspected in compliance with current tobacco warning standards and pictograms.
10. Percentage of brands of cigarettes and other tobacco products and other non-compliant health warnings.
11. Number of packages of cigarettes and other tobacco products by type, seized at points of sale, for lack of health warning
12. Number of seizures of electronic and similar cigars, by the National Customs Authority (ANA)
13. Number of sanctions for violation of the current norms of tobacco control, applied to natural or legal person.
14. Number of bales or units of tobacco products per type seized by the ANA, which are in violation of tobacco control regulations
15. Percentages of establishments that do not comply with current regulations on tobacco control and have not used a self-adhesive ticket.
16. Percentage of establishments selling tobacco products, which comply with the ban on tobacco products and their derivatives in dispensers and on shelves.
17. Percentage of establishments selling tobacco products that comply with the prohibition of advertising, promotion and sponsorship of tobacco products on packs and inside cartons.
18. Percentage of establishments with price list by brand and type of tobacco product, which comply with the regulations
19. Number of tobacco farms
20. Percentage of complaints handled by the hotline of the Ministry of Health, reported to 311, by Internet or other mechanism.

ANNEX 10: THAILAND

WHO FCTC Reporting Practices: Thailand Case Study

Mrs. Vilailak Haruhanpong
Public Health Technical Officer – Professional Level & FCTC Focal Point
Deputy Director of Bureau of Tobacco Control
Department of Disease Control, Ministry of Public Health

Background

Thailand has introduced a number of strong policy measures implementing the WHO Framework Convention on Tobacco Control (WHO FCTC) to address its tobacco epidemic. As a result, the prevalence of smoking among the Thai population appears to be decreasing over time. Reporting under the WHO FCTC is important to the country in more than one way. On the one hand, the report reflects the country's efforts to control tobacco consumption and the efficacy of such work. On the other, the recommendations and feedback of the report help the Government to develop new policies and guidelines to address gaps in efforts.

Sources of data for WHO FCTC Reporting

The national surveys conducted by the National Statistical Office constitute the major source of information for Thailand's WHO FCTC implementation report. Additionally, a significant part of the information is collected from a multisectoral group, which consists of other government ministries and NGOs such as Action on Smoking or Health Foundation- Thailand (ASH Thailand), the Southeast Asia Tobacco Control Alliance (SEATCA) and the Thai Health Professionals Network Against Tobacco.

4Ps Survey for WHO FCTC reporting

The 4Ps survey provides valuable information for Thailand's WHO FCTC reporting. This annual, sentinel survey covers the marketing strategies of tobacco businesses by way of: Price, Place, Product and Promotion (the 4Ps). It analyses the sales and promotional strategies of tobacco businesses in motivating customers to greater cigarette use. The survey has brought to light unlawful practices engaged by agents, wholesalers and retail outlets to describe products and discuss prices.

Table 1. Data sources for WHO FCTC reporting

Source of data	Data provided
National Statistical Office <i>The Smoking and Drinking Behaviour Survey</i>	Prevalence of tobacco use, Exposure to tobacco smoke
Institute for Population and Social Research, Mahidol University <i>Six waves of The International Tobacco Control Policy Surveys</i>	Tobacco use by young persons
Bureau of Tobacco Control Department of Disease Control,	Tobacco use among youth

Ministry of Public Health <i>Thailand youth survey (GYTS)</i>	
National Burden of Disease Programme, International Health Policy Programme <i>Economic Burden from Smoking Related Diseases in Thailand, 2009. Updated by National Burden of Disease Study, 2015.</i>	Tobacco related mortality, tobacco related costs
Ministry of Finance	Taxes on cigarettes and other tobacco products, tobacco products supply, imports and seizures of illicit tobacco products
Department of Revenue <i>Notification of retail price</i>	Price of tobacco products
The Office of the Royal Thai Police	Prevention and control of cigarette smuggling and enforcement of tobacco control law
The Department of Special Investigation, Ministry of Justice	Legal action against smuggling and evasion of customs duty in violation of customs legislation
The Tobacco Control Research and Knowledge Management Centre (briefly called TRC) supported by ThaiHealth	Database for monitoring and surveillance of tobacco control, supporting research activities and evaluating tobacco control programmes and projects
ASH Thailand	Media campaigns against tobacco, particularly in the areas of smoke-free environments, empowering young people and providing helpline support for tobacco cessation
Thai Health Professional Alliance Against Tobacco	Advocacy for tobacco policy and law, information to the general public about the strategies of the tobacco industry
SEATCA	Thai tobacco control experience shared with other countries. Technical assistance for policy change, monitoring of tobacco industry, research, study tours, sharing of best practices, regional/country workshops, fellowships, and seed grants for national capacity building

The National Strategic Plan Framework for WHO FCTC Reporting

Thailand's National Strategic Plan for Tobacco Control not only provides a mechanism to guide its tobacco control, but also helps to coordinate reporting on WHO FCTC implementation. The plan has been introduced through an overarching National Committee for the Control of Tobacco Use (NCCTU) and subcommittees to address each of its six strategies. Under the strategic plan, the Cabinet assigned the Ministry of Public Health as the nodal ministry and various non-health ministries as contributors to the committees set up for its implementation. The committees are responsible for implementing the National Strategic Plan through action plans and integrating them as a part of their regular tasks. They also monitor and report on the operational results and the challenges to implementation to improve the next year's action plan.

The National Strategic Plan for Tobacco Control provides the institutional framework for the preparation of Thailand's WHO FCTC implementation report.

WHO FCTC report preparation begins with a formal letter from the Ministry of Public Health requesting relevant information from the concerned agencies in the committees. This is sent together with the WHO FCTC reporting questionnaire. The follow-up on data collection for WHO FCTC reporting is coordinated through the committees. For instance, WHO FCTC reporting is placed on the agenda of the meeting of the NCCTU around January of the reporting year. Similarly, the subcommittees convene regularly in order to report on the progress of specific plans for tobacco control. These reports and meetings feed into the preparation of Thailand's WHO FCTC report. The Ministry of Public Health follows up with contributing agencies such as the National Statistical Office for clarification and details.

Figure 1. The Strategy 1 subcommittee discussing the WHO FCTC country report



Prior to reporting to the Convention Secretariat, the data collected from relevant ministries and agencies is presented to the Strategy 1 subcommittee of the national plan. This strategy aims to strengthen and develop competency in national tobacco control. The Strategy 1 subcommittee, chaired by the Deputy Director of Department of Disease Control, reviews and approves the data for WHO FCTC reporting. The integration of WHO FCTC reporting in the national strategic plan framework and seeking input via its subcommittees have enabled smooth gathering of data.

Use of WHO FCTC reports on treaty implementation

Thailand's last WHO FCTC report identified a lack of effective provincial action on several tobacco control concerns as a challenge to treaty implementation. Recognizing this gap, the NCCTU supported all 77 provinces of the country to strengthen and develop competency for tobacco control at the local level in 2016.

1. Improved implementation of smoke-free environments: One of the gaps identified in treaty implementation was the enforcement of Thailand's smoking ban. The Smokefree School Project was initiated to address this gap. A memorandum of understanding was signed between the Ministry of Public Health, Office of Basic Education Commission and ASH Thailand to increase awareness and prevent young people from tobacco use initiation. Following this, the Smokefree Schools guidelines developed by the Teachers Network were disseminated for implementation in educational institutions.

Similarly, a Smoke-free Province Project was initiated in 2012 to strengthen and expand the coverage of smoke-free environments in 14 provinces. Following the WHO FCTC report review, this has been expanded to cover 30 provinces in 2014. In 2016, the Ministry of Public Health issued a further policy expanding the initiative to cover all 77 provinces in the country.

2. Enhanced monitoring of tobacco promotion: The country WHO FCTC report indicated the need to monitor websites promoting tobacco sales in contravention of Thai law. The Ministry of Public Health has forged cooperation with the Ministry of Digital Economy and Society, excise department, customs department and police to address this challenge. The group identified short- and long-term measures to prevent and control the advertising and promotion of tobacco products through electronic and computer networks. The Ministry of Digital Economy and Society has since regulated websites advertising and selling tobacco products.

3. Report dissemination among key stakeholders: Thailand disseminates its WHO FCTC report quite broadly, with information shared both at national and international levels. These information exchanges include meetings among policy-makers, technical officers and personnel working on tobacco control.

The report is also distributed at the annual National Conference on Tobacco or Health. The conference brings together nearly 1 000 participants from academia, research institutes, medical professionals, educators, public and private agencies, local government officials, civil society and the general public to exchange information on tobacco control. The Conference includes expert presentations on WHO FCTC implementation that facilitates collective review of what has worked in tobacco control in a given year and development of future plans and conference recommendations.

Information from the implementation report is also used in press statements, and press conferences by the Government and civil society.

Challenges to reporting

Thailand's major challenge is the lack of updated national and regional data, as the national surveys are not conducted every year. The quality of data in terms of the level of detail is also a challenge. For example, previous national surveys did not classify tobacco prevalence data by province. The committee addressing Strategy 1 of the Strategic Plan has since taken steps to update questions regarding tobacco use and also to gather and classify data by province. The country is planning to integrate tobacco control into the national surveillance system to ensure nationally representative data for future reporting. Sentinel surveys are under consideration to address areas where data is lacking. Plans are also afoot to organize workshops with agencies that contribute to the country WHO FCTC report with a view to providing feedback on the data, reporting processes and improve data collection systems.

Delays in receiving data from various agencies poses challenges for timely submission of the country report. The relevant ministries and agencies are now being approached to respond to the reporting questionnaire at least three months before the reporting deadline to the Convention Secretariat. Showcasing the success of tobacco control efforts by other ministries and agencies at conferences also help in motivating them to provide timely responses to the questionnaire.

Resources for reporting

The major, direct investment in WHO FCTC reporting relates to the human resources used to conduct and organize meetings to collect all relevant data, information and report from the relevant sectors.

ANNEX 11: TURKEY

The Steps towards Turkey's Progress in WHO FCTC Country Reporting

Dr Peyman Altan

Head of Unit & Tobacco Control Focal Point
Department of Tobacco and Other Addictive Substances Control
Ministry of Health, Turkey

Background

Turkey ratified the WHO FCTC in 2004 and the law implementing its provisions (No. 5727) was enacted in the Grand National Assembly in 2008. The law sought to protect individuals and future generations from the harm of tobacco and tobacco products and to ensure clean air. While enforcing the Smoke-free Air Law, the National Tobacco Control Programme 2008-2012, its action plan, strategies and related activities was determined by the National Tobacco Control Committee through comprehensive collaboration among related government and academic institutions, and civil society.

Turkey is also committed to the implementation of the WHO FCTC, including Article 21, regarding the reporting and exchange of information. The country has therefore been making timely submission of its WHO FCTC implementation reports since 2007 to the WHO FCTC Secretariat.

Preparatory steps of WHO FCTC reporting

The Ministry of Health (MOH) is the coordinating body for all tobacco control activities, including reporting. Two people in the Ministry of Health are involved in coordinating WHO FCTC reporting in the country. The MOH spends roughly the equivalent of seven full working days on treaty reporting. The data is collected from related ministries and institutions. Altogether, six ministries, four agencies and non-governmental partners, and about 17 people are involved in the preparation of Turkey's WHO FCTC implementation report.

Since questions in the WHO FCTC report are not in Turkish, a good translation of the questions is needed to reduce the workload of focal points of contributing ministries. The translation is done in-house by the Ministry of Health and takes up to two full working days.

Orientation of contributing ministries

Close collaboration and coordination among focal points of relevant ministries is essential to the preparation of a comprehensive report. New focal points in these ministries also need orientation to WHO FCTC reporting from time to time. These are achieved through an orientation meeting at the Ministry of Health. As the meeting is dedicated to reporting, the focal points of institutions contributing to the country report are invited to it.

Figure 1. Key government agencies contributing to Turkey's WHO FCTC report



In addition to orienting contributing ministries to WHO FCTC reporting, this meeting increases participant awareness of tobacco control and the treaty. The meeting starts with a round of participant introduction followed by elaboration of the aim of the meeting, information on the importance of tobacco control and the WHO FCTC, the tobacco control situation in Turkey and internationally. The meeting then discusses in detail the country's WHO FCTC reporting and the reporting instrument by sections and questions. It also addresses sector specific questions about the reporting instrument and agrees timelines for data collection.

Orientation meetings were organized in February of the reporting year in the previous three reporting cycles to allow sufficient time for collation of data before the submission deadline in April. The Ministry of Health usually organizes a second meeting to share and discuss the data collected. The orientation meeting was not required during the preparation of the last report as most focal points of relevant ministries are by now familiar with WHO FCTC country reporting requirements.

Data collection from focal points

Alongside the invitation to the orientation meeting, the letter from the Minister of Health provides the relevant parts of the reporting instrument to each of the contributing ministries. Additionally, the questionnaire in Turkish is provided with a firm deadline to the focal points at the orientation meeting. Post-orientation, the Ministry of Health follows up with contributors by phone. The calls help not only to track the progress of data collection, but also to clarify questions or concerns among the contributors. For instance, coordination between Ministry of Education and Ministry of Health would be key to report on educational activities under Article 12 of the treaty, as both would be undertaking them.

While deciding the timelines for data inputs from other ministries, it is important to consider the varying processes for the collection, analysis and cleaning of data. For instance, some ministries might have the systems to transfer official data

electronically from subunits to headquarters, while others might need to post hard copies. It is therefore important to encourage the contributing ministries to start data collection two-to-four months before the reporting deadline.

Coordination and reconciliation of data across ministries

There are several questions in the reporting questionnaire that need a collaborative approach to finalize the data. This demands the full attention of the MOH focal point. Question 2.6 in the reporting questionnaire dealing with seizures of illicit trade of tobacco products is a case in point. The data for this comes from a host of agencies including the Ministry of Customs and Trade, Coast Guard Command, Smuggling and Organized Crimes Department and Gendarmerie General Command. The data from each of these agencies need to be cross-checked and tallied before entry into the questionnaire.

The reporting process does not end with the collection of data. The MOH focal point checks quality, consistency and relevance by comparing them with previous reports, official statements and briefings. The finalized data is then translated to English for the online reporting questionnaire.

Submission procedures

The official procedure for submission of Turkey's WHO FCTC implementation report requires the hard copy to be officially signed and approved by the Minister of Health. Thereafter, the report is submitted online and the signed copy sent by email to the WHO FCTC Secretariat.

Outcomes of Turkey's reporting practices

- ***Motivation for WHO FCTC reporting among stakeholders***

The WHO FCTC country implementation report captures outcomes from the work of the dedicated activities of the National Tobacco Control Committee. It provides an opportunity for the committee's work to be showcased internationally. This encourages further work on WHO FCTC implementation.

- ***Increased public education about the WHO FCTC***

Turkey's successful implementation of the WHO FCTC, as reflected in the country's report to the COP, is emphasized in ministerial statements on World No Tobacco Day and international meetings like the World Conference on Tobacco or Health (WCTOH) 2013 and 2015. These have helped to earn media coverage and provided reach to the whole population.

- ***Improvements to the National Tobacco Control Programme***

The report helped to identify the progress and lessons from Turkey's first National Tobacco Control Action Programme and its plan. It identified progress in the implementation of WHO FCTC Articles 6, 8, 9 and 10, 12, 14, 17 and 18. Questions on implementation of the WHO FCTC guidelines proved useful in considering new steps in tobacco control, such as developing new regulations on the ingredients of

tobacco products in line with Articles 9 and 10. These have also helped to expand the scope of the implementation of Article 8. The country's tobacco control plan was revised based on country data as reflected in the WHO FCTC country report.