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Abstract

Tobacco control: a case study of development practice
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Over 2003 to 2007, NZAID funded a six country regional programme aimed at assisting the Governments of the Cook Islands, Tonga, Samoa, the Solomon Islands, Tuvalu and Vanuatu to develop and implement national tobacco control programmes. The imperative for this project arose as a result of the negotiations on the WHO Framework Convention on Tobacco Control. This Treaty, negotiated under the auspices of the World Health Organization, saw heightened focus on the need for a global, regional and national response to the tobacco epidemic, as well as increased pressure for assistance to be provided to developing countries to implement comprehensive tobacco control programmes. Pacific states took a very active role in these negotiations and immediately committed to implementation of the Treaty by their speedy ratification of it over 2004 to 2005.

The presenter will outline the imperatives that led to the design and implementation of the NZAID-funded tobacco control project, the rationale (development principles-wise) for funding projects of this nature, and lessons learned in the project that are applicable for other areas of development practice in the Pacific. In doing so, the presenter will draw on the results of an independent evaluation of the NZAID-funded Pacific tobacco control project as well as a recent publication developed for the World Health Organization on best practice principles for the design and implementation of ODA-funded tobacco control programmes.

Presentation

THE FCTC

A fortnight ago I attended the 3rd Conference of the Parties for the WHO Framework Convention on Tobacco Control (the FCTC) as part of the New Zealand delegation.

The FCTC is the only multilateral treaty negotiated to date under the auspices of the World Health Organization and the only purely public-health focused treaty in existence.

It aims to confront an epidemic of tobacco use that results in an estimated 5.3 million deaths world-wide each year.

It was negotiated over the period 2000 to 2003, it is also a treaty that has very broad support – with 160 parties to it.

The Treaty has broad support among both developed nations and developing.

Our region, the Western Pacific, has 100% ratification among member countries – including all Pacific countries, as well as China, Japan, South Korea and several other Asian countries.

The Treaty sets out a broad framework for domestic and international action on tobacco control, including:

- Tax and pricing policies
- Demand reduction strategies such as education, dependence treatment, etc
- A wide range of legislative interventions, including:
    - A comprehensive ban on tobacco advertising, promotion and sponsorship

    - Strict tobacco labelling requirements, including a requirement for large health warnings

    - Strict controls on smoking in public places, workplaces and public transport

- Supply control interventions – for example:

    - controls on the illicit trade in tobacco (eg smuggling, counterfeit products etc)

    - a ban on the sale of tobacco to minors

- Sharing of information and research between Parties

- Regular reporting to the Conference of the Parties of progress in implementation of the Treaty

- The ability to develop separate (binding) Protocols and (non-binding) Implementation Guidelines.

AND

- Article 26

CALLS FOR ASSISTANCE IN TOBACCO CONTROL

Article 26 of the FCTC calls for Parties with the resources to do so to provide financial and technical assistance to other Parties – those who are developing countries or are countries with economies in transition.

Parties are also asked to assist in helping mobilize resources from other sources, including relevant regional and international intergovernmental organizations and financial and development institutions.

As you can imagine, during the negotiations for this Treaty there were considerable calls from countries with limited resources for assistance to implement the Treaty.

RATIONALE FOR ASSISTANCE ON TOBACCO CONTROL

Tobacco control has not been seen as a core or obvious area of development assistance to date, and indeed with the exception of New Zealand (more later), no other country has funded a comprehensive assistance package – so indeed it could be seen as an area of ***peripheral concern***.

However, the focus is increasing now that the FCTC is in place and calls for assistance are mounting.

Two years ago Mayor Michael Bloomberg of New York contributed US$125 Million to tobacco control in developing countries over the past two years.

He has also recently increased that funding by a further $375 Million as well as partnering with the Gates Foundation who have pledged a further $125 Million of funding, including some funding for Africa.

However, the primary focus for this work is on a core set of 15 larger countries (eg China, India, Indonesia, Philippines).

While that is great, there are a lot of other counties who would benefit greatly from assistance.

There is a strong argument for countries such as New Zealand to provide further assistance in the area of tobacco control, including for smaller countries.

Arguments include:

1. ***The self-interest argument***: There are significant cross border implications of tobacco control that mean that to be successful in reducing tobacco consumption, we rely on international collaboration. For example:

    a. cross border tobacco advertising through the internet, satellite TV broadcasts, magazines, video games, movies, etc

b. illicit trade in tobacco

c. confronting the actions of the multi-national tobacco companies.

This means that its within all of our interests, including we countries with effective tobacco control programmers to assist our neighbours to build up their tobacco control efforts – this will help us all.

It is also within our interests to provide assistance to smaller countries as well as larger – firstly small countries could become havens for exporting cross border advertising, illicit trade, etc – and also, smaller countries can, if supported to implement innovative interventions, be the spring board for more widespread adoption of those initiatives (for example, plain packaging of tobacco products).

2. A further self-interest argument relates to the high rate of smoking among migrant populations: in New Zealand's case, for example, a reduction in smoking in Pacific countries may help to reduce the burden of disease among Pacific communities in New Zealand, and reduce flow-on costs to the New Zealand health system from the treatment of those tobacco-related diseases.

3. The existence of a Tobacco treaty that is so focused on improving the health of populations should get tobacco control on the radar of development assistance agencies particularly if they carry out any analysis of tobacco control goals in the context of the DAC Guidelines, Paris Declaration and Millennium Development Goals: even a cursory analysis of these principles should raise tobacco control programmes as a viable area for development assistance – more about that shortly.

4. The high level of interest among developing countries for assistance in this area: it is an area where more and more requests for assistance are likely to be advanced as more countries internally prioritise this as an area of action – both in terms of meeting their international obligations under the FCTC but also health as Ministries of Health work to convince their colleagues in finance and trade ministries of the net benefit of tobacco control to economies and health systems.

5. There may also be an argument around some countries having a moral duty to right past wrongs. For example, some countries have helped develop the tobacco industry in other countries (eg NZ in Samoa). Other countries have actively pressured other countries to allow access of their industry to markets – with far more aggressive marketing and consequent surges in tobacco use as a result (eg US, UK).

NZAID PROJECT

New Zealand was the first country to step up with real assistance, with NZAID funding from 2003, before the ink was even dry on the Treaty, to provide assistance to two, and then a further four, Pacific countries to develop and implement comprehensive tobacco control programmes.

The countries in Stage 1 were the Cook Islands and Tonga.

The latter countries were the Solomon Islands, Tuvalu, Vanuatu, and to a lesser extent, Samoa.

These countries self-identified to NZAID as desiring of assistance and the value of a commitment by NZAID in this area was highlighted by the fact that the Pacific countries, as a bloc, presented a strong and unified voice on the international scene during the negotiations for the FCTC.

The Pacific consistently pushed for a strong and demanding treaty throughout the negotiations and had already started implementing initiatives on an ad hoc basis, with the assistance of the WHO while the negotiations were ongoing.

Approximately NZ$1.3 Million was committed by NZAID to the regional tobacco control project over 2003 to 2007, with the approach being as follows:

- Countries were asked to make a formal commitment to implementation of the FCTC (ie ratification, commitment of personnel resources to the project)

- There was identification of in-country leaders

- A stocktake was undertaken: usually in the form of a S.W.O.T analysis and an analysis of status of the country (legislative, policy, programme) with regard to the FCTC

- A series of capacity building visits and workshops were undertaken in a range of areas (advocacy, policy, legislation, tax and pricing policies, health promotion, cessation)

- A national plan of action on tobacco (often under their wider Non-communicable Disease Strategy if they had one) was developed

- Comprehensive legislation was developed, along with a plan for implementation

- A health promotion campaign, linked to the population level interventions, was initiated

- Assistance was provided to establish civil society action on tobacco (eg advocacy coalition development)

- There was some targeted training – eg enforcement, cessation support.

Allen & Clarke was the lead on the project team put together to assist the Pacific countries implement this project, working closely with the countries.

We also called in technical experts from the Maori Smokefree Coalition, Pacific Island Heartbeat, and others to assist.

However, the ownership and leadership of the project remained entirely with the countries concerned and implementation timeframes, focus of the project, and means of implementation were different in each country.

EVALUATION

Late last year an independent evaluation of the project was commissioned by NZAID. The evaluation found that the intervention was:

- Desired and thus supported by the countries
- Well targeted in that it was based on need, best practice, and the FCTC.

The evaluation found that there was an array of achievements in a range of areas that it was expected would be sustained and would lead to health gains over time.

The collaborative approach, capacity building focus and flexibility of approach – both between countries, but in implementation within countries – was also highly valued by the countries concerned.

Some other key findings perhaps of interest to other development assistance practitioners included that:

- Short, sharp inputs (and possibly more frequent) were favored over prolonged stays in order to minimize the burden on local partners – the on call desk support (by phone, email, etc) facilitated this working

- The establishment of civil society coalitions was seen as a crucial and effective part of the program, as was engagement of cross-departmental support

- A strong regional focus of the project, including coordination of funding and activities with other donors, and cross-country sharing of ideas was seen as a significant advantage of the project

- However, although it was a regional project, it was implemented in a somewhat bilateral fashion, ensuring that each country had ownership and the project was tailored to that country – this was highly valued

- Low level post-project support was also seen as a benefit as too often projects can end abruptly without the ability of countries being able to call for brief advice or mentoring once the project is over – we have continued to provide that low level support a year later and this is highly valued

- (And no surprises) best practice overseas experience and guidelines was highly valued, but the tailoring to local circumstances ensured buy-in by the countries.

The evaluation also highlighted a couple of areas for improvement – for example:

- The project design limited the level of support for research, surveillance, monitoring and evaluation capacity building. This was in response to countries' priorities. However, this was a disadvantage

- There was limited formal integration of national action plans on tobacco control within country wider plans and budgets in several countries, despite our best efforts.

However, overall the evaluation was very positive and it will shortly be released by NZAID.

I know there are several countries, as well as a number of development agencies very interested in seeing it and I am hopeful that it will help mobilize further resources for developing countries.

BEST PRACTICE ODA GUIDELINES

Allen & Clarke has recently been contracted by the World Health Organization to develop a best practice guide to overseas development assistance in tobacco control.

The WHO intends to publish this and circulate it among development assistance agencies as a way of encouraging further support for tobacco control in developing countries. This document:

- Assesses best practice principles in ODA (eg DAC Guidelines, Paris Declaration, MDGs)

- Assesses best practice in the area of tobacco control

- Presents the case study of the NZAID-funded regional tobacco control project I have described today …

And, based on these, presents a series of principles and recommendations on:

- overarching criteria that could be used as a broad filter to exclude ODA project proposals that fail certain pre-requisites for securing development assistance

- some strategic principles to inform selection by prospective funders of ODA tobacco control programs, and that could also be used by implementing agencies as guidance in both the design and implementation of ODA tobacco control programs

- tobacco control interventions for which there is evidence on value in their inclusion in ODA tobacco control programs, and some guidance in relation to how to most effectively design such interventions
- modes of working with partner countries in implementing ODA programs in tobacco control and characteristics of those individuals most suited to such work.

This will be published, I hope, early in the New Year.

I hope it will be useful more broadly (beyond just tobacco control, that is). If anyone is interested in obtaining a copy of the document when published, let me know and I will provide copies.

GOING FORWARD

The FCTC Conference of the Parties in Durban a fortnight ago confirmed the adoption of three sets of guidelines on:

- Limiting engagement with the tobacco industry
- How to implement a comprehensive ban on tobacco advertising, promotion and sponsorship
- How to implement effective tobacco labeling and health warnings.

It also received and accepted a progress report on separate negotiations underway on the development of a separate Treaty (a Protocol under the FCTC) on clamping down on the illicit trade in tobacco.

All these require or encourage further action by Parties to the FCTC – and in the case of developing countries who still struggle with limited resources, can only spark more requests for assistance.

New Zealand actively called on the meeting floor for countries to contribute funds to these efforts.

It is my hope that countries will stump up with the assistance required.

ENDS