

**Overseas development assistance  
programmes for tobacco control**  
*A framework for effective action*

Matthew Allen



**Overseas development assistance  
programmes for tobacco control**  
*A framework for effective action*

Matthew Allen

## Acknowledgements

The production of this publication would not have been possible without the input and advice of a large number of individuals and agencies including those who provided comment on various drafts. These included Dr Douglas Bettcher and Gemma Vestal of the World Health Organization; the New Zealand Aid Programme; Dr Harley Stanton (Gateway Health, Australia); Wardie Leppan (International Development Research Centre of Canada); Dr Ashley Bloomfield (New Zealand Ministry of Health); Judith Watt; and The International Union Against Tuberculosis and Lung Disease. The World Health Organization TFI unit in Geneva contributed partial funding support for the development of the report.

The author is, however, entirely responsible for the contents of the report.

## About the author

Matthew Allen is a Director of Allen + Clarke Policy and Regulatory Specialists, a New Zealand-based consultancy that works domestically and internationally on a wide range of policy and regulatory design, implementation and evaluation projects. Allen + Clarke works across all sectors, offering project management, research, policy, regulatory development and evaluation services.

Matthew was the project manager of the six-country overseas development project for tobacco control described in this document. He has led or contributed to tobacco control projects in many countries, including Australia, the Cook islands, Indonesia, Kiribati, the Lao People's Democratic Republic, New Zealand, Niue, Palau, Papua New Guinea, Samoa, the Solomon islands, Tokelau, Tonga, Tuvalu, Vanuatu and Viet Nam. Matthew represented New Zealand during the negotiations for the WHO Framework Convention on Tobacco Control and has been involved in a number of working groups and forums on implementation of the Convention. Earlier, he led New Zealand's National Drug Policy unit and the tobacco control portfolio for the New Zealand Ministry of Health.

**Suggested citation:** Allen M. 2012. *Overseas Development Assistance Programmes for Tobacco Control: A framework for effective action*. Wellington: Allen.

Cover art and layout by

BYTEDESIGN.CO.NZ

ISBN 978-0-473-22683-1

© 2012, Matthew Allen

# Contents

Executive summary.....	1
<b>1. Globalization of tobacco control .....</b>	<b>4</b>
1.1 Initiation of domestic action on tobacco.....	4
1.2 Initiation of international action on tobacco.....	4
1.3 The burden of tobacco-related chronic disease and the global response .....	5
1.4 The WHO Framework Convention on Tobacco Control.....	8
1.5 Article 26 of the Convention: financial resources .....	9
1.6 From developed to developing countries: rationale for assistance .....	10
1.6.1 <i>Scope of capacity-building to date</i> .....	11
1.6.2 <i>Building capacity in research on tobacco control</i> .....	12
1.7 Potential sources of assistance to developing countries .....	13
<b>2. Principles of overseas development assistance .....</b>	<b>15</b>
2.1 Existing principles for effective assistance.....	15
2.2 Comment.....	16
<b>3. Guidance on development programmes for tobacco control .....</b>	<b>17</b>
3.1 Existing principles for effective assistance.....	17
3.2 General strategies for effective tobacco control.....	18
<b>4. Case study: the Pacific region .....</b>	<b>20</b>
4.1 Profile of Pacific island countries.....	20
4.2 Agencies working in the Pacific region .....	20
4.3 Commitment of Pacific island countries to tobacco control .....	21
4.4 Influences on tobacco control in the Pacific region .....	22
4.5 New Zealand Agency for International Development-funded, six-country, 5-year, comprehensive tobacco control project.....	23
4.5.1 <i>Background</i> .....	23
4.5.2 <i>Overview of the approach</i> .....	23
4.5.3 <i>Building relations and stock-taking</i> .....	24
4.5.4 <i>Initial capacity-building</i> .....	25
4.5.5 <i>Preparing a national action plan</i> .....	27
4.5.6 <i>Continuing support and encouragement</i> .....	27
4.5.7 <i>Promoting regionalization</i> .....	28
4.5.8 <i>Conducting evaluations</i> .....	28
4.6 Lessons learnt .....	32
<b>5. A framework for development assistance projects in tobacco control.....</b>	<b>33</b>
<b>6. References.....</b>	<b>38</b>
<b>Annex: Application of principles of overseas development assistance by funders .....</b>	<b>42</b>
A1. The Paris Declaration on Aid Effectiveness .....	42
A2. Third High-level Forum on Aid Effectiveness and the Accra Agenda .....	42
A3. Development Assistance Committee of the Organisation for Economic Co-operation and Development.....	44
A4. The Millennium Development Goals.....	44
A5. Development assistance principles adopted by donors.....	45
<b>References.....</b>	<b>49</b>



## Executive summary

The purpose of this publication is to present some lessons learnt in the design, funding and implementation of overseas development assistance programmes in tobacco control. It presents a potential framework for the design and implementation of such programmes, both to encourage international discussion of best approaches and to encourage more investment in this area.

There is an unmet need in developing countries and countries with economies in transition not only for domestic action but also for international assistance to confront the tobacco epidemic. This publication summarizes how a global standard for tobacco control, as well as international agreement that tobacco control is a shared challenge and a shared commitment, has developed over recent years.

The WHO Framework Convention on Tobacco Control (WHO FCTC) established a global standard for action on tobacco control that Parties to the WHO FCTC have agreed to implement and have been encouraged to exceed.<sup>1</sup> Many developing countries will struggle to meet this standard without external technical and financial assistance, as recognized by the Conference of the Parties to the WHO FCTC, WHO and a few donors. More developed countries and international donor agencies are needed to provide the necessary assistance.

This publication sets out how and when such assistance is most likely to be effective and proposes a possible framework for drawing on when designing and implementing development assistance programmes in the area of tobacco control. Three sources of information were used to inform this publication:

- existing principles for overseas development assistance programmes, as elaborated and endorsed by international agencies such as the United Nations, WHO and the Asian Development Bank and by bilateral donor countries;
- existing strategies for effective tobacco control generally (on which a considerable amount of commentary exists) and for overseas development assistance programmes for tobacco control specifically (a limited amount of commentary exists); and
- a case study of an overseas development programme implemented between 2003 and 2007 to build the tobacco control capacity of six Pacific island states, funded by the New Zealand Agency for International Development (NZAID).

On the basis of this information, a series of principles and strategies are presented as a potential framework for development assistance projects in tobacco control. These are set out in tables, which are not intended to be exhaustive but rather to serve as a tool for agencies to use when they are considering funding or implementing overseas development assistance programmes and for evaluating existing programmes. It is hoped that the proposed framework will spark discussion and refinement of approaches to overseas development assistance in tobacco control.

The first framework table (see Table 3) identifies overarching criteria that could be used as a broad filter to exclude project proposals that fail to meet certain prerequisites for securing development assistance. These criteria include ensuring that:

- programmes are developed in line with internationally agreed best practice for overseas development assistance more broadly;
- the WHO FCTC is a focus for intervention, particularly in those countries that are Parties to the Convention;

---

<sup>1</sup> Article 2.1 of the WHO FCTC states that Parties are encouraged to implement measures beyond those required by the Convention and its protocols.

- the countries selected for assistance are those that give priority to tobacco control domestically and in their calls for international assistance;
- programmes are initiated by countries (not by donors or consultants);
- requesting countries have a demonstrated commitment to implement the proposed programme;
- the proposed programmes are based on evidence and are likely to make a difference at the population level; and
- programmes are implemented where they are likely to make the most difference (for example, in countries with high tobacco use or in countries where action is likely to generate similar action in other countries).

The second framework table (see Table 4) outlines strategic principles to guide selection by prospective funders of overseas development assistance programmes for tobacco control and which could also be used by implementing agencies as a framework for the design and implementation of such programmes. The principles include:

- overseas development assistance best practice;
- facilitation of development assistance by donors (not as prime movers);
- promoting and supporting multisectoral collaboration;
- a focus on comprehensive tobacco control programmes combined with recognition of the valuable role of ad hoc programmes in laying the groundwork for future comprehensive programmes;
- integration of any planned assistance into country planning and work programmes;
- a focus on population-level interventions;
- a focus on capacity-building (areas of recommended emphasis are outlined and include building research and organizational capacity);
- a focus on sustainable interventions;
- promotion of regional approaches, including networking and, where appropriate, setting up regional centres of excellence;
- support for leader countries as a means of generating regional action; and
- ensuring country-specific approaches.

The third framework table (see Table 5) lists tobacco control interventions for which there is some evidence that they are likely to be valuable in overseas development assistance programmes. The table also provides some guidance on how to design such interventions most effectively. The emphasis should be placed on funding programmes that support:

- the preparation of comprehensive, intersectoral, national action plans and strategies on tobacco control;
- the drafting, passage and review of comprehensive tobacco control legislation;
- the preparation and implementation of policies and legislation for substantive tax increases and other pricing measures;
- education and public awareness programmes, particularly to support implementation of population-level interventions, such as legislation and tax measures;
- smoking cessation programmes (noting that staged implementation of cessation programmes is advisable to promote sustainability);

- the sustainability of all tobacco control efforts (for example, sustainable funding);
- countries' capacity and capability to respond to challenges from the tobacco industry;
- building advocacy capacity and capability in countries;
- identifying and building the capacity of champions and leaders in tobacco control;
- devising well-structured, evaluated grant schemes; and
- including capacity-building for surveillance, research, monitoring and evaluation in programme design.

The final framework table (see Table 6) presents some models for working effectively with partner countries in implementing overseas development assistance programmes in tobacco control, and lists the characteristics of the people most suited to such work. This includes practical guidance on:

- planning and project management;
- focusing on the WHO FCTC;
- ensuring flexibility;
- implementation approaches (for example, skills transfer, type and timing of country visits, collaborative approaches and support to reinforce efforts); and
- the skills and attributes of effective project personnel.

*Note:* Many of the principles and strategies outlined in this publication for overseas development assistance programmes in tobacco control could also be considered for use in programmes for other public health issues, such as alcohol control or prevention and control of noncommunicable disease in general.

# 1. Globalization of tobacco control

An international approach to tobacco control has emerged in recent decades, not least of all through the development of the WHO FCTC (1). To be effective, an international approach must be implemented widely; however, the resources to support implementation have not been globally available. Many Parties to the WHO FCTC have called for the provision of technical and financial assistance to developing countries and countries with economies in transition that wish to comply with the WHO FCTC in implementing effective tobacco control.

## 1.1 Initiation of domestic action on tobacco

Evidence on the hazards of tobacco use accumulated in the 1930s–1950s, but public attention on the issue was captured only with the publication of two reports: that of the United Kingdom Royal College of Physicians in 1962 (2) and that of the United States Surgeon General in 1964 (3). These reports included reviews of the literature that demonstrated the significant adverse health consequences of tobacco use. The reports were instrumental in raising public and government awareness and generating action around the world.

The 1960s–1990s saw increasing domestic regulatory controls on tobacco and tobacco use and also expanding health promotion, treatment of dependence and research-based activities to encourage people to avoid or quit tobacco use. Countries drew on each other's experiences, using the introduction of measures in one jurisdiction to justify the introduction of similar or extended measures in another. International conferences and other forums enabled the sharing of experience and called for further collaboration in research and information-sharing.

At the same time, however, the sophistication of tobacco industry marketing and promotion also increased. The growing globalization in trade saw tobacco multinational companies increasing their marketing in developing countries in Asia, the Pacific region and Africa, and later in eastern Europe.

While some countries took strong action on tobacco during this period and some collaborated in certain interventions and research, it took the international community many decades to move to a collaborative stance on tobacco control.

## 1.2 Initiation of international action on tobacco

From 1970, the World Health Assembly, the highest decision-making body of WHO, started issuing resolutions calling for Member States to acknowledge the harm associated with tobacco use.<sup>2</sup> Initially tentative, these resolutions grew firmer over time. From the late 1970s to the early 1990s, Health Assembly resolutions called for Member States to implement comprehensive tobacco control programmes based on best practice, as, over the years, a significant body of literature and country experience had appeared on what worked in tobacco control.<sup>3</sup>

By the late 1990s, WHO had adopted a global approach to tobacco control, recognizing that significant global influences required action at global level if domestic tobacco control was to be successful.<sup>4</sup> Commonly cited areas of international concern included: cross-border tobacco advertising

2 Early resolutions on tobacco control included those of the Executive Board and the World Health Assembly itself. See resolutions EB45.R9, EB47.R42, EB53.R31, WHA23.32 (1970) and WHA24.48 (1971), all of which concerned the health hazards of tobacco smoking and WHO's role in limiting this 'harmful habit'.

3 Resolutions include WHA29.55 (1976), WHA31.56 (1978), WHA33.35 (1980), WHA39.14 (1986), WHA43.16 (1990) and WHA45.20 (1992). These resolutions call for implementation of comprehensive, multisectoral, long-term tobacco control strategies.

4 See resolution WHA48.11 (1995) in which WHO is requested to prepare a feasibility study on options for international instruments to control tobacco, and WHA49.17 (1996) in which WHO is requested to initiate a framework convention on tobacco control.

and promotion, the illicit trade in tobacco products, confronting the tobacco industry, research and information-sharing about how best to reduce tobacco-related harm, international disclosure and regulation of tobacco product constituents and emissions, and harmonization of tobacco labelling and tobacco taxation.

Subsequent World Health Assembly resolutions established a working group to propose draft elements for a framework convention on tobacco control and an intergovernmental negotiating body to negotiate the proposed Convention and possible related protocols.<sup>5</sup> At the same time as it was decided that a global treaty on tobacco control should be developed, WHO established a cabinet project known as the 'Tobacco Free Initiative', demonstrating its commitment to tobacco control.

Between May 1999 and June 2003, the working group and then the intergovernmental negotiating body drafted and negotiated provisions for inclusion in a treaty on tobacco control. In May 2003, the World Health Assembly unanimously adopted the WHO FCTC, which opened for signature one month later.

As of 24 August 2012, 176 countries were Parties to the WHO FCTC.

### 1.3 The burden of chronic disease and the global response

It is estimated that in 2008 36 million people died from noncommunicable diseases, principally cardiovascular disease, diabetes, cancers and chronic respiratory disease. This represented 63% of all 57 million deaths globally that year (5). Of these premature deaths, an estimated 80% occurred in developing countries, where there is less protection against the risk factors that cause these diseases.<sup>6</sup> It is projected that in 2030 noncommunicable diseases will claim the lives of 52 million people, accounting for nearly five times more deaths as communicable diseases (5).

The use of tobacco is estimated to kill nearly 6 million people each year, most deaths occurring in low- and middle-income countries, with this disparity expected to widen further over the next few decades. On the basis of current trends, tobacco use will kill more than 8 million people worldwide per annum by 2030, with 80% of those premature deaths occurring in low- and middle-income countries (6).

The financial cost of noncommunicable diseases has been well studied. For example, the report of the Secretary-General to the United Nations General Assembly high-level meeting on noncommunicable disease prevention and control in September 2011 (5) noted that losses in national income from heart disease, stroke and diabetes in 2005 had been estimated at US\$18 billion in China, US\$11 billion in the Russian Federation, US\$9 billion in India and US\$3 billion in Brazil.

Several commentaries have been published on the imbalance in the response to the increasing global burden of chronic diseases compared with that to communicable diseases, and on the lack of investment in noncommunicable diseases, particularly in developing countries and countries with economies in transition (7–10). For example, a WHO discussion paper, Noncommunicable diseases, poverty and the development agenda (11), prepared for a meeting in May 2009 on the challenge these diseases present to sustainable development in the twenty-first century, described the magnitude of the looming disease burden and the lack of an effective international response. The paper suggested that international and development agencies are 'missing in action' in relation to noncommunicable disease prevention and control. The paper also noted that of the US\$20.6

5 See resolutions WHA52.18 (1999) and WHA53.16 (2000).

6 See WHO website for the September 2011 United Nations high-level meeting on noncommunicable disease prevention and control: [http://www.who.int/nmh/events/un\\_ncd\\_summit2011/qa/qa2/en/index.html](http://www.who.int/nmh/events/un_ncd_summit2011/qa/qa2/en/index.html). Accessed 11 August 2011.

billion in official development assistance provided by 24 countries in the Organisation for Economic Co-operation and Development (OECD; see Annex A3) and the European Commission in 2006, only US\$0.1 billion was used to ensure basic nutrition, and there was no specific investment in the prevention and control of noncommunicable diseases (11).

The apparent lack of commitment to investing in chronic disease control, including tobacco control, is due to a number of factors. These include the apparent prominence and immediacy of communicable diseases (for example, HIV/AIDS) and limited data on the morbidity and mortality attributable to chronic disease, particularly in developing countries. There are also numerous myths about chronic diseases, including the idea that they are related to personal decisions that are difficult and expensive to change and are a problem in affluent, ageing populations, particularly among men. Many countries have inadequate funding for their entire health system, and community perceptions and opinions result in an orientation towards acute care (7–10).

Recently, a greater focus on social equity and on reducing inequities in health has given a slightly different emphasis to both domestic and international activities to improve the health of populations. For example, in 2008, WHO established the Commission on Social Determinants of Health, which recommended a focus on economic development to promote social fairness. The Commission emphasized the importance of programmes to reduce inequalities in health status within and between societies and a focus on improving overall population health (12).

Based on the escalating global burden of noncommunicable diseases over recent decades, and the inadequate international response during that period, there have been calls for a global mechanism for consistent global action on chronic disease, more recently including for chronic diseases that arise from tobacco use. Action is needed in particular in countries that are disproportionately affected by chronic diseases and are least able to respond effectively to them without external support. The Global strategy for the prevention and control of noncommunicable diseases (10) and the related action plan (4) were one such global mechanism (a 2013-2020 Global Action Plan for the prevention and Control of NCDs is under development<sup>7</sup>). Objective 5 of the action plan for the global strategy (4), for example, called on Member States, WHO, international partners and other stakeholders to promote partnerships for the prevention and control of noncommunicable diseases.

More recently, concern about the growing burden of noncommunicable diseases was escalated to the level of the United Nations General Assembly with a view to securing high-level political commitment to address noncommunicable diseases at a global level.

In 2009, a discussion paper prepared by WHO on noncommunicable diseases and the development agenda noted “there must be recognition expressed at the highest level of the United Nations that noncommunicable diseases constitute an urgent, undeniable development issue (11).” Subsequently, in May 2010, a United Nations General Assembly resolution addressed the rising impact of noncommunicable diseases and the need for international collaboration (14). The resolution noted that global health is an objective for long-term development and reaffirmed the need to strengthen international cooperation in public health, including by exchanging best practices in building capacity, providing financial assistance, establishing infrastructure and transferring technology. The resolution encouraged Member States to consider the rising incidence and the socioeconomic impact of noncommunicable diseases worldwide in their discussions at the General Assembly on the Millennium Development Goals (MDGs) in September 2010.

The resolution in May 2010 also called for a high-level meeting on noncommunicable diseases to be convened in September 2011 under the auspices of the United Nations General Assembly.

The Secretary General was requested to prepare a report for the General Assembly on the global status of noncommunicable diseases, with a focus on the challenges faced by developing countries (14). The resulting report provides a useful overview of the epidemic, noting that the health and socioeconomic toll is impeding achievement of the millennium development goals (MDGs). It recommended that United Nations agencies and other international organizations “Acknowledge the threat of the noncommunicable disease epidemics to sustainable development and integrate cost-effective preventive interventions into the development agenda and related investment programmes, including poverty reduction initiatives, in low- and middle-income countries” and “Ensure the active engagement of United Nations agencies, funds and programmes in global and regional initiatives to address the health and socio-economic impacts of non-communicable diseases (5).”

The high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases was held in New York on 19–20 September 2011. The main outcome of this meeting and of its preparatory meetings was a ‘political declaration’, which was adopted by consensus by the General Assembly (15). The declaration notes that a primary focus for preventing and controlling noncommunicable diseases should be “... developmental and other challenges and social and economic impacts, particularly for developing countries”, as the global burden and threat of noncommunicable diseases “... undermines social and economic development throughout the world, and threatens the achievement of internationally agreed development goals.” (15) Collective action by Member States and relevant international agencies was stressed, and it was stated that prevention is the cornerstone of the global response to noncommunicable diseases. The political declaration emphasizes the importance of tobacco control and implementation of the WHO FCTC, noting that price and tax measures are an important means of reducing tobacco consumption.

With regard to promoting development assistance, the political declaration states clearly that Member States should build policies and programmes for noncommunicable diseases into health planning and the national development agenda. It encourages Member States to use “... all possible means to identify and mobilize adequate, predictable and sustained financial resources and the necessary human and technical resources, and to consider support for voluntary, cost-effective, innovative approaches for a long term financing of non-communicable disease prevention and control, taking into account the Millennium Development Goals.” It supports continued inclusion of noncommunicable diseases in development cooperation agendas and initiatives and urges WHO, agencies of the United Nations system and other international organizations, including development banks, to work in a coordinated manner to support national efforts to prevent and control noncommunicable diseases.

The political declaration requests that the United Nations Secretary General, working closely with Member States and international agencies, submit options to the General Assembly by the end of 2012 for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership. A report is to be submitted on progress achieved in realizing the commitments made in the political declaration.

These recent global activities indicate significantly increased recognition of the role of noncommunicable diseases (including tobacco use as a significant risk factor) on development. It remains to be seen whether this recognition will result in significant mobilization of resources for prevention and control, including interventions for tobacco control. Promising signs include the announcement by Australia of AU\$4 million for WHO to assist developing countries in implementing the WHO action plan for the global strategy for the prevention and control of noncommunicable diseases (16). This commitment follows previous funding by Australia and New Zealand of a joint WHO/Secretariat of the Pacific Community (SPC) initiative to support Pacific countries in implementing noncommunicable disease-related initiatives (17), and a call in December 2009 for proposals from the European Commission for projects aimed at the prevention and control of these diseases in developing countries (18). Other

stakeholders have pledged support to implement the noncommunicable disease global strategy and action plan, and international agencies are hoping for further, more substantive commitments now that the political declaration has signalled an international commitment to placing noncommunicable diseases on the development agenda.

In October 2011, WHO proposed that consideration be given to establishing a ‘solidarity tobacco contribution’, whereby countries would impose a levy on tobacco products sold (19). This levy would be additional to other domestic taxes on tobacco and could be used to fund tobacco control in developing countries. The contribution would also be additional to overseas development assistance. The paper projects that a solidarity tobacco contribution could generate US\$5.5–16.0 billion in extra excise tax revenues annually. At the time this document went to press, there has been no firm commitment from countries to support establishment of such a contribution mechanism, but WHO will promote further discussion.

#### 1.4 The WHO Framework Convention on Tobacco Control

The WHO FCTC is a global approach to combat the tobacco epidemic through a range of interventions, including cooperation and assistance to countries that lack the funds or technical expertise to control the spread of the tobacco epidemic. During the negotiations for the Convention, there was considerable debate on financial and technical assistance for developing countries and countries with economies in transition. The participants in the debate considered that the value of negotiating a framework convention lay not only in the ultimate product (the WHO FCTC) but also in the ‘power of the process’ (20). It was anticipated that drawing the attention of the international community to a global approach to the tobacco epidemic would result in regional and domestic action on tobacco control.

Many documented examples show how the ‘power of the process’ delivered dividends. Some obvious examples include establishment of the Framework Convention Alliance, comprising over 350 organizations representing over 100 countries;<sup>8</sup> formation of national coalitions in countries such as Bangladesh, India and the Philippines (21); preparation of regional action plans on tobacco (22); regional meetings to build capacity, for example for participation in WHO FCTC negotiations;<sup>9</sup> and the drafting of national tobacco control legislation and action plans.

A number of Pacific island states sought assistance from WHO and other funders to start drafting tobacco control legislation and action plans, even before negotiations for the WHO FCTC were completed. Many countries used the WHO FCTC as justification for the legislation, arguing that once the treaty was in place, they would have no choice but to implement legislation and that it was better to take the required steps sooner rather than later.<sup>10</sup> Developing countries, in the face of a disproportionate burden of disease and a disproportionately small pool of financial and other resources, looked to the developed world for financial assistance to achieve results like those described above.

---

8 See [http://www.fctc.org/index.php?option=com\\_content&view=article&id=2&Itemid=277](http://www.fctc.org/index.php?option=com_content&view=article&id=2&Itemid=277), Accessed 24 August 2012.

9 See [http://ftp.who.int/gb/archive/pdf\\_files/EB107/ec30.pdf](http://ftp.who.int/gb/archive/pdf_files/EB107/ec30.pdf), which cites several inter-country meetings.

10 Author's observation while working with Pacific states in 2000–2003.

## 1.5 Article 26 of the Convention: financial resources

Article 26 (*Financial resources*) of the WHO FCTC:

- promotes the use of bilateral, regional, sub regional and other multilateral channels for funding the establishment and strengthening of comprehensive, multisectoral tobacco control programmes in developing countries and countries with economies in transition;
- requires Parties represented in relevant regional and international intergovernmental organizations and financial and development institutions to encourage these entities to provide financial assistance to developing countries and countries with economies in transition, to assist them in meeting their obligations under the WHO FCTC;
- states that all relevant potential and existing resources available for tobacco control should be mobilized and used for the benefit of all Parties, especially developing countries and countries with economies in transition, to assist them in meeting their obligations under the WHO FCTC; and
- requires the WHO FCTC Secretariat to advise developing country Parties and Parties with economies in transition, upon request, about available sources of funding to facilitate implementation of their obligations under the Convention.

Article 26 also mandated the first session of the Conference of the Parties to the WHO FCTC to review existing and potential sources and mechanisms of assistance and to consider their adequacy. This was to be based on a study conducted by the Secretariat and other relevant information. The results of the review were to be taken into account by the Conference of the Parties in determining how to enhance existing mechanisms or to establish a voluntary global fund or other appropriate financial mechanism to channel additional financial resources to developing country Parties and Parties with economies in transition.

The review showed that a comprehensive system of large donor funding for tobacco control was at an early stage. It concluded, however, that the WHO FCTC will form a “... critical part of a longer term awareness-raising process which should increase the pressure on international donors, as well as on developing countries and countries with economies in transition, to prioritise tobacco control activities” (23).

Subsequent to the review, discussions continued in the Conference of the Parties on the desirability of assisting developing countries and countries with economies in transition, for instance in the transitioning from tobacco growing and manufacture to alternative livelihoods, and in implementing their legal obligations under the WHO FCTC.

Article 26 mandates an assessment of existing assistance and raises the priority of providing technical assistance (overseas development assistance) to developing countries for tobacco control. The negotiations leading up to the adoption of Article 26 encouraged donors to at least consider whether tobacco control programmes were an appropriate area for development assistance (24), resulting in discussions at regional meetings on capacity-building needs and tobacco control priorities.<sup>11</sup> In at least one instance, it resulted in a commitment by a government (New Zealand) to provide immediate, meaningful assistance (see section 4.5). Overseas development assistance is an obvious mechanism for assisting developing countries to ‘operationalize’ the WHO FCTC.

However, a report of the FCTC Convention Secretariat at the fourth session of the Conference of the Parties in 2010 noted that although the WHO FCTC and subsequent decisions of the Conference of the Parties have called for financial and technical support to be provided to developing country

<sup>11</sup> For example, see <http://www.who.int/gb/fctc/PDF/inb4/cinb44.pdf>, Accessed 31 December 2011.

Parties and Parties with economies in transition, these provisions and decisions have “... not yet been optimally implemented”. (13) The report noted the need for increased cooperation to help release the much-needed resources required for country-level activities. It noted that undertaking country needs assessments, compiling and promoting access to internationally available resources, and promoting transfer of expertise and technology have emerged as key mechanisms of assistance in treaty implementation, along with technical and legal advice on treaty-specific matters through communication with Parties’ focal points and inter-country workshops. The report also noted an expectation that an increasing number of Parties will provide detailed information on the challenges they face during implementation and on the types of assistance they have requested or provided. This will “... inform the process of securing relevant resources and expertise.” Further resources were required for needs assessment, missions and the involvement of development partners will be a crucial factor in assisting developing country Parties to meet the needs identified under the Convention.

A further paper presented at the fourth session of the FCTC Conference of the Parties recognised three frameworks that might be utilized for strengthening coordination with international organizations and bodies with a view to supporting implementation of the WHO FCTC, particularly in developing countries and countries with economies in transition:

- the Ad Hoc Interagency Task Force on Tobacco Control – a platform for strengthening implementation of the WHO FCTC within and through the United Nations system, including through the United Nations Development Programme;
- international and regional intergovernmental organizations that are accredited as observers to the Conference of the Parties; and
- other international and regional organizations, including the OECD, regional development banks and international aid agencies (52).

It was also recommended that the WHO FCTC be integrated within the UNDAFs at a country level. (52) This is reinforced by a United Nations Economic and Social Council (ECOSOC) resolution promoting United Nations system-wide coherence on tobacco control (53).

More recently a paper from the Convention Secretariat notes, among other matters, that future work of the Secretariat might involve continued engagement with the United Nations Ad Hoc Interagency Task Force and with ECOSOC in order to develop a joint plan of action for implementation of the WHO FCTC, with options for joint programming (54).

## 1.6 From developed to developing countries: rationale for assistance

As discussed above, during negotiation of the WHO FCTC, many countries argued that they would require technical and financial assistance to implement the treaty. This was the basis for negotiations on Article 26 of the WHO FCTC. Since the Convention has come into force, however, resourcing has not been immediately forthcoming from many developed countries, even though the negotiations showed that, given the global nature of tobacco marketing and promotion and the cross-border implications of tobacco for all countries, it is in the best interests of developed countries to support developing countries and countries with economies in transition in confronting the tobacco industry and tobacco use.

Cross-border issues can only be effectively combated if countries work together. For example, in the case of tobacco advertising, promotion and sponsorship, the efforts of an entire region to reduce tobacco promotion can be undermined if one country remains a ‘safe haven’ for advertising.

The smuggling of tobacco across borders without payment of duty is another collective problem that demands collective action. While a consistent policy and regulatory approach might well be promoted by the protocol on illicit trade in tobacco,<sup>12</sup> effective implementation is essential, including a shared commitment to financial and technical assistance.

In many countries, migrant populations use tobacco at significantly higher rates than other population groups. In New Zealand, for example, the rate of smoking by Pacific peoples (estimated to be about 27%), while substantially less than that of indigenous Maori (42%), is still significantly higher than that of people of European descent (18.6%) (25). A reduction in smoking in Pacific countries might therefore help to reduce the burden of disease among Pacific communities in New Zealand and reduce the costs to the New Zealand health system for the treatment of tobacco-related disease.

There may sometimes be a moral obligation to address past wrongs. For example, some developed countries have supported the tobacco industry and its expansion into developing countries, including by financial investment in the companies, research and development grants and exerting pressure on developing country governments to open their markets. Many developed countries have implemented domestic tobacco control legislation that (intentionally or not) excludes the imposition of controls on the offshore activities of the domestic industry, such as exclusion of controls on tobacco advertising aimed at other countries and allowing the export of tobacco products in packaging bearing no or extremely limited health information, even though such packaging is unacceptable in the country of origin.

New Zealand has been a supplier and promoter of tobacco products. In 1977, the country provided funding to the Samoan Government to establish a tobacco factory, which now supplies both Samoa and neighbouring countries with tobacco products (26). In a letter to the *New Zealand Medical Journal* in 2001 (27), it was reported that, in the financial year ending June 2000, New Zealand had exported 87.3 million cigarettes to nine Pacific countries and territories. The authors of the letter estimated that that level of exports could be responsible for 75 premature deaths and 1,370 years of life lost per year. These historical activities were used by advocates to argue that New Zealand should take a more active role in regional tobacco control and to provide the kinds of assistance discussed during negotiation of Article 26 of the WHO FCTC.

An assessment of tobacco and the harm it inflicts not only on individuals' health but also, for example, on sustainable economic development, the environment, families struggling to put food on the table and on overburdened health systems, and comparison with the principles of overseas development assistance should make supporting other countries' tobacco control efforts a worthwhile investment. A number of countries have recognized tobacco control as an area for investment in the context of overseas development assistance on this basis. For example, the European Commission, in its communication *Health and poverty reduction in developing countries* (28), included tobacco control among important interventions to promote public health and reduce poverty.

The application of development assistance principles and their relevance for tobacco control are discussed further in section 2 and in the Annex to this publication.

### 1.6.1 Scope of capacity-building to date

Despite some obvious gaps, some countries, groups of countries and nongovernmental organizations have provided assistance for tobacco control. Although it is not the purpose of this publication to review the extent of such development assistance, it is useful to note that, broadly, capacity-building

<sup>12</sup> See [http://www.who.int/fctc/protocol/illicit\\_trade/en/](http://www.who.int/fctc/protocol/illicit_trade/en/), Accessed 24 August 2012.

assistance to date has included:

- the preparation and provision of guidance materials, such as best practice guides, legislation handbooks and guidelines for implementing specific initiatives (for example, treatment of dependence), including case studies from countries;<sup>13</sup>
- the sharing of research and resources, such as health promotion materials, whether culturally appropriate or not;
- circulation of resources for particular events from a central point, such as World No Tobacco Day kits provided by WHO, The International Union Against Lung Disease, and others;
- support for individuals in developing countries, such as training, mentoring, scholarships and attendance at conferences and other forums;
- sponsored regional and international workshops and meetings on topic-based interventions or in preparation for WHO FCTC-related meetings;
- support for country-level tobacco control stock-takes and needs assessments;
- ad hoc responses to requests for assistance, including in drafting legislation, facilitating workshops and undertaking research projects or surveys;
- grant schemes and other assistance provided by philanthropic trusts or other funding agencies;
- regional or international projects designed to collect standardized data, including surveillance programmes such as STEPwise, the Global Youth Tobacco Survey and the Global Adult Tobacco Survey;<sup>14</sup>
- bilateral and regional programmes for implementation of comprehensive tobacco control programmes in countries or groups of countries;
- programmes or ad hoc support to build research capacity in developing countries, including North–South and South–South programmes; and
- collaboration between research groups and individual researchers to build the capacity of research institutions in developing countries.

These approaches are valuable in certain contexts, but certain characteristics help to ensure that programmes are successful. Assistance programmes must be sustainable and coordinated with donor countries as well as with regional programmes and legislation. The funding of ad hoc programmes should be consistent with existing or proposed programmes, otherwise they will not make a lasting contribution to building capacity and capability in the countries that can benefit most. Later sections of this publication explore some of these issues in detail.

## 1.6.2 Building capacity in research on tobacco control

Building capacity in tobacco control research in developing countries is a core component of development assistance. Wipfli et al. (29), for example, identified significant barriers to effective tobacco control in many countries. They proposed an agenda for domestic action that includes a focus on research and building national leadership and international networking in order to increase information exchange, technical assistance and mentoring relationships. Such links could help tobacco control researchers and policy advocates in developing countries to maximize use of their scarce resources.

---

<sup>13</sup> See, for example, WHO resources available at <http://www.who.int/tobacco/training/en/>. Accessed 31 December 2011.

<sup>14</sup> See, for example, <http://www.who.int/tobacco/surveillance/en/index.html>. Accessed 31 December 2011.

There is obvious value in using local data to form the basis and support for local actions, and to challenge tobacco industry claims is obvious. Maziak et al. (30) commented on the value and benefits of supporting local research rather than supporting work by external parties. The answers to local questions are best found in credible research conducted by people in the local environment and culture. This approach can also build the capacity of local research institutions and researchers for further studies, not only on tobacco control but on public health more broadly.

An example of local capacity-building was presented by Stillman et al. (31), who described the capacity-building and research programmes of the Johns Hopkins Bloomberg School of Public Health Institute for Global Tobacco Control in several developing countries. The model combines research skills development and mentoring with obtaining national data for implementation of relevant tobacco control policies and programmes. The model serves as a guide for programme development and implementation, with three priorities: skills and tools development, building networks and leadership and collecting local empirical data.

A further model for the development of research capacity and skills among researchers in developing countries is the 'research assistance matching project' (32), an online programme to facilitate tobacco control research by connecting researchers. The purpose of this project was to enhance the spread and quality of tobacco control research in developing countries by improving the access of researchers to the expertise and experience of the international tobacco control research community and by helping international colleagues to identify partners in developing countries. This project appears to have languished recently, however such an approach may have merit as a means of encouraging collaboration and capacity building.

These are some forms of research-related development assistance that can have benefits beyond simply the recipient and the donor country. Shared knowledge can result in consistent approaches, regionally and globally, can help reduce cross-border issues and, more generally, can achieve the aims of the WHO FCTC.

Targeted technical assistance for researchers can be complemented by support for institutional capacity development, such as by sustainable funding, management of funds and the formation of networks.

## 1.7 Potential sources of assistance to developing countries

A range of funding options exist for developing countries and countries with economies in transition that wish to implement comprehensive tobacco control programmes in line with the WHO FCTC. These include:

- domestic funding, by appropriations from a national, regional or local government consolidated fund or another usual funding mechanism;
- use of dedicated taxes or surcharges on tobacco taxes to fund tobacco control, with options ranging from stand-alone health promotion foundations or similar bodies to the simple assignment of a portion of revenue from tobacco taxes or levies to a fund held by a state entity for allocation to tobacco control programmes;
- domestic funding from businesses or philanthropic organizations;
- development assistance funds from bilateral, sub-regional, regional or international donor agencies, or governments;
- grants from international philanthropic organizations or individuals; and
- technical assistance or advice from regional or global research or health agencies (for example, cancer research agencies).

Donors often expect countries to consider domestic sources of funding for tobacco control first. WHO's World Health Report, 1999 (33), for example, commented that the financial resources for health are overwhelmingly within countries (see Annex A5). As discussed above, however, tobacco control is often overshadowed by apparently more pressing priorities in developing countries. Even when budgets are secured, they are often under threat of diversion to other priorities.

WHO and other international agencies with a tobacco control focus are promoting the use of longer-term domestic funding mechanisms (for example, health promotion foundations, dedicated tobacco taxes or levies) as a sustainable approach for funding domestic tobacco control and other noncommunicable disease programmes. Regrettably, such funding mechanisms face significant opposition in many countries, not just from the tobacco industry but also from domestic finance ministries, which consider that they will undermine the state's ability to allocate resources according to priorities. While the number of countries that have established health promotion foundations and dedicated taxes or surcharges on tobacco taxes has increased,<sup>15</sup> developing countries and countries with economies in transition often require outside assistance (technical and financial) to establish such mechanisms, including in building domestic support for such an initiative.

Philanthropic bodies have made more funds available to countries. For example, New York Mayor Michael Bloomberg in 2006 committed to provide US\$125 million over 2 years to developing countries with the greatest tobacco use. This provided a much-needed boost to those countries' domestic capacity to respond to the tobacco epidemic. The focus of this fund on countries with the largest number of tobacco users has resulted, however, in more applications for assistance than there are funds available.

Subsequently, Michael Bloomberg announced a commitment of a further US\$375 million over 4 years, and the Bill & Melinda Gates Foundation contributed a grant of US\$24 million to the Bloomberg Initiative, in addition to a complementary investment of US\$101 million over 5 years towards tobacco control in China and India and help to combat the tobacco epidemic in Africa (no African countries had been included in the countries targeted by the Bloomberg initiative countries) (34). In 2009, TFI received US\$10 million over 5 years to advance tobacco control in Africa. The intention was that TFI would not only provide technical assistance to the countries identified but would also establish a resource centre within Makerere University School of Public Health in Kampala, Uganda, known as the Centre for Tobacco Control in Africa, which will work with WHO teams to build local capacity and sustain the tobacco control initiative (35). In March 2012 Bloomberg announced a further \$220 Million for the Bloomberg Initiative.<sup>16</sup>

In 2005, other funders, including the American Cancer Society, Cancer Research UK, the Open Society Institute and the International Development Research Centre, established an informal 'international tobacco control funders forum', which met ad hoc. The forum was subsequently joined by partner agencies of the Bloomberg Initiative and the Gates Foundation to share experiences and promote collaboration among funding agencies. The forum is discussed in section 3.1.

15 See <http://www.hpfoundations.net>, Accessed 31 December 2011 and <http://www.who.int/healthpromotion/areas/foundations/en/index.html>, Accessed 31 December 2011 for information on the International Network of Health Promotion Foundations.

16 See <http://www.cdcfoundation.org/pr/2012/bloomberg-philanthropies-announces-additional-220-million-fight-global-tobacco-use>, Accessed 30 August 2012.

## 2. Principles of overseas development assistance

Development assistance is generally based on principles that development agencies are encouraged to observe and apply in designing and implementing policies and programmes. Application of these principles helps to ensure (but does not guarantee) sustainable, effective development assistance policies and programmes.

### 2.1 Existing principles for effective assistance

The elements of effective overseas development assistance have been defined more clearly in recent years. The principles defined by international donors, against which proposals for development assistance are to be assessed, are summarized below.

Widely agreed upon principles for effective development assistance are based on those of the Paris Declaration on Aid Effectiveness, the Development Assistance Committee of the OECD, the MDGs and certain international donors.<sup>17</sup> Table 1 presents preliminary conclusions, based on more detailed assessments contained in sections A1, A3 and A4 of the Annex to this report.

Table 1. Principles of overseas development assistance	
Principle	Description
Ownership	Countries should manage their own systems for development, using their own institutions. This includes leading and owning the design and implementation of projects.
Mutual responsibility and accountability	Donors and receivers of overseas development assistance should be mutually responsible for the outcomes.
Focus on results	The desired development outcomes should be results-focused.
Monitoring and evaluation	Monitoring and evaluation should be integrated into the programme, with local systems.
Relevance	Programmes must be adapted to the needs of individual countries.
Pro-poor sustainable economic growth	Poverty alleviation and reduction should be a focus of all overseas development assistance.
Good governance, anti-corruption	Improving governance and combating corruption should be a focus of overseas development assistance.
Harmonization	Development assistance strategies should be harmonized and coordinated between donors.
Gender equality	Promotion of equality should be integrated into development assistance programmes.
The environment	The environment and promotion of sustainability should be core considerations in all development activities.
Millennium Development Goals	The MDGs should be considered in setting development assistance priorities.
Health and social equity	Assistance programmes that support a framework of social determinants of health for domestic planning (to reduce inequities in health status within the society) should be promoted.
Like-minded partnerships	Focus on countries with a shared vision and commitment
Prioritization	Assistance should be given for the priorities identified by partner countries, where those priorities cannot be met within their existing systems.
Impact	Focus on areas in which assistance can have the most impact and development agencies can add value.
Integration	Ensure that projects are integrated within the work programmes and national plans of the partner country. This includes, where applicable, within the country's UNDAF.*

<sup>17</sup> The Accra Agenda for Action 'refreshed' the drive for consistent, effective development assistance. The Agenda is intended to respond to the main technical, institutional and political challenges to full implementation of the Paris principles (see section A2 of the Annex).

\* The UNDAF is an agreed programme of action between a government and a United Nations Country Team. It sets out the agreed shared strategies and interventions by United Nations agencies to promote national development priorities. UNDAFs typically run for three years. See: [http://www.un.org/special-rep/ohrlls/ohrlls/cca\\_undaf\\_prsp.htm](http://www.un.org/special-rep/ohrlls/ohrlls/cca_undaf_prsp.htm), Accessed 30 August 2012.

This report proposes a further principle, consistent with the discussion in section 1.6 on the past policies of some governments to promote expansion of their domestic tobacco industry into other markets or to support investment in the tobacco industry in developing countries:

Principle	Description
Consistent cross-government policy	Ensure overseas development assistance policy and programmes are not undermined by conflicting policies of other domestic agencies.

Funders must also be aware that potential conflicts in the policies of overseas development assistance funders could undermine their efforts. For example, some funders require that the national interests of the donor country be considered in decisions about overseas development assistance (such as where funding should or even should not be spent). This could raise a conflict, for example, if one overseas development assistance funder promotes tobacco cultivation or manufacture as an economic development project in a country where other agencies are attempting to confront the health and social consequences of tobacco use. No separate principle is proposed; however, several of the principles listed in Table 1 are directly relevant, including harmonization, pro-poor sustainable development, the environment and the MDGs.

Tobacco control agencies have been debating for some years the appropriateness of accepting funds from the tobacco industry for tobacco control development projects or for humanitarian purposes. There is now spirited debate on the appropriateness of accepting funding from agencies in which people in leadership positions are either currently or have previously been associated with the tobacco industry or who are directors or employees of such companies (36). The guidelines adopted by the Conference of the Parties for implementation of Article 5.3 of the WHO FCTC are explicit: Parties should not accept "... political, social, financial, educational, community, or other contributions from the tobacco industry or from those working to further their interests, except for compensations due to legal settlements or mandated by law or legally binding and enforceable agreements" (37). A guiding principle of the Article 5.3 guidelines is "There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests."

Accordingly, a further principle is proposed:

Principle	Description
Exclusion of tobacco industry partnerships	Overseas development assistance for tobacco control should exclude any tobacco industry involvement, including in the design, funding, delivery or evaluation of programmes.

## 2.2 Comment

While the above principles are useful for guiding the design and implementation of development assistance projects, they are unlikely by themselves to guide the design and implementation of overseas development assistance projects for tobacco control. The following sections of this publication therefore outline existing knowledge about effective overseas development assistance programmes for tobacco control and effective tobacco control more generally. A case study of a recent project in the Pacific is used as a basis for a framework for designing and implementing overseas development assistance programmes for tobacco control.

### 3. Guidance on development programmes for tobacco control

This section summarizes commentaries on successful development assistance for tobacco control and more extensive guidance on effective domestic tobacco control programmes. Analysis of this information and the case study in section 4 has led to a number of proposed principles for future implementation of development assistance projects for tobacco control.

#### 3.1 Existing principles for effective assistance

Few commentaries address best practice in funding development assistance projects specifically for tobacco control. A review of existing and potential funding sources for tobacco control, prepared by the WHO FCTC interim Secretariat for the first session of the Conference of the Parties (23), noted that models for best practice by donors to poverty reduction partnerships had been described in a report by the OECD Development Assistance Committee in 2005 (38). The report of the Conference of the Parties considered that those general principles were generally transferrable to the provision of development assistance for tobacco control at country level (23). The following principles were identified: using the partner country's poverty reduction strategy and national budget as frameworks for providing assistance; clarifying the roles and responsibilities of partners, including government, civil society, international organizations and the private sector; investing in mechanisms for coordination; and promoting joint work, including data collection and evaluation.

The Conference of the Parties acknowledged that the principles of partnership, ownership and participation are central to appropriate sustainable development assistance by donor countries and concluded that "The relevance of these principles clearly extends to donor assistance for tobacco initiatives" (23). Their report also noted that tobacco control should be considered a fundamental part of the MDGs and concluded that donor countries should be the 'facilitators' rather than the 'prime movers' of development assistance.

The report of the Conference of the Parties also confirmed that donors expected developing countries and countries with economies in transition to initiate dialogue about tobacco control development assistance. Donors were unlikely to see their role as encouraging countries to submit requests for assistance; rather, countries should make tobacco control a priority in their strategies and initiate dialogue with donors. A paper written for the second session of the Conference of the Parties (39) summarized one key finding:

*Some potential donors indicated that eligibility criteria to receive tobacco control funding would include a serious commitment at the national level to strengthen tobacco control and to fund part of the costs incurred by the project or activity. Some donors expressed their readiness to fund tobacco control, if it was a stated priority of the Party, if it fit with the national health priorities, if the activities met the objectives of the WHO Framework Convention and if the demands came from within the Party, instead of being imposed from the outside.*

The WHO FCTC interim Secretariat suggested on the basis of feedback from prospective Party donors that countries interested in obtaining assistance should first undertake a needs assessment and gave advice on how to do so (39).

An informal grouping of funders of tobacco control development assistance projects was established in 2005 and met ad hoc to share experiences and explore common interests in order to increase the impact of their grants. In 2006, this group prepared a brief paper based on shared experience and

outlining the conclusions of participating agencies about effective funding of international tobacco control (33):

- Focus on promotion of policy change: Interventions based on proven policy at country level, undertaken by leading national organizations, are the most powerful, cost-effective, sustainable interventions.
- Help countries to resist opposition from the tobacco industry: Build political will, support advocates and promote multisectoral responses to tobacco control.
- Research is the foundation of successful tobacco control interventions: Support policy-relevant research and speedy incorporation of research into advocacy campaigns so that advocacy is based on evidence.
- Champions are essential: Identify, recruit, train and retain (for example, with grants) competent leaders in tobacco control, and invest in the tobacco control workforce.
- Technical assistance must be consistent, sustained and effective: Useful approaches include: accurate assessment of needs; building capacity; developing personal relationships; facilitating strategic planning; helping maintain momentum; ensuring consistency among advisers; ensuring face-to-face contact through well-timed site visits, as well as desk-based support; and providing specific assistance in tobacco control issues, production of effective advocacy materials, research capacity, developing and maintaining regional and global tobacco control networks, effective policy campaign skills and organizational capacity (for example, fund-raising and staff development).
- Use regional centres of excellence in tobacco control: These can build capacity and overcome linguistic and cultural challenges.
- Support precedents in countries that are policy leaders: They can demonstrate to other countries that particular interventions work.
- Specialized grants, for example for rapid response, seed grants and strategic planning, can have a major impact.
- Strengthen the communications infrastructure of the tobacco control movement.
- Ensure collaboration among international tobacco control funders: This is important to avoid duplication of effort and ensure efficient use of resources.

### 3.2 General strategies for effective tobacco control

The WHO FCTC outlines measures for controlling supply and reducing demand that Parties to the treaty are required or encouraged to implement as the basis of any domestic tobacco control programme. Article 2.1 of the WHO FCTC also encourages Parties to "... implement measures beyond those required by this Convention and its protocols ...". Many international and national publications discuss effective strategies for tobacco control, including:

- The WHO report on the global tobacco epidemic 2011 (6), also known as the WHO MPOWER report, outlines six evidence-based tobacco control measures that are proven to reduce tobacco use and save lives:
  - Monitor tobacco use and prevention policies;
  - Protect people from tobacco smoke;
  - Offer help to quit tobacco use;
  - Warn about the dangers of tobacco;
  - Enforce bans on tobacco advertising, promotion and sponsorship.

- Raise taxes on tobacco.
- The World Bank report, *Curbing the epidemic, governments and the economics of tobacco control*, in 1999 outlines effective tobacco control strategies from an economic perspective (40).
- *Tobacco control in developing countries* (41) published in 2000 contains background papers for the above publication.
- The WHO *Guidelines for controlling and monitoring the tobacco epidemic* (42) published in 1998 outlines effective policies for curbing tobacco use and emphasizes the need for surveillance, research, monitoring and evaluation.

These reports and many others are consistent with the provisions of the WHO FCTC, the main interventions of which are:

- tax and pricing policies to increase the cost of tobacco to the consumer;
- tobacco control legislation, especially bans on tobacco advertising, promotion and sponsorship; bans on smoking in public places, workplaces and public transport; and placing health warnings on tobacco packaging;
- education, training and public awareness programmes to discourage tobacco use and to protect people from exposure to second-hand smoke;
- support for people wishing to quit tobacco use; and
- research, surveillance and evaluation programmes.

These interventions are widely accepted as effective in tobacco control, and this has tended to influence funding by donors, including grant schemes, which have tended to focus on such high-impact, population-level initiatives more recently. Partner agencies in the Bloomberg initiative (43), for example, focus on large populations and give priority to projects that lead to sustainable improvements in tobacco control laws, regulations, policies and programmes at national or sub national level.

The principles and strategies presented in section 5 of this publication for use as a framework for development assistance projects are based on the above principles and guidance.

## 4. Case study: the Pacific region

This section presents a case study of an overseas development assistance programme for tobacco control funded by the New Zealand Agency for International Development (NZAID; now known as the New Zealand Aid Programme (NZAP), managed by the International Development Group of the New Zealand Ministry of Foreign Affairs and Trade) in 2003–2007 in six Pacific island countries. It outlines the project design, how the project was implemented and the results of an independent evaluation. Lessons learnt from this case study are presented.

Care should be taken in generalizing all the findings of this case study to future overseas development assistance programmes in tobacco control. Later sections emphasize the importance of flexibility in the approach and of tailoring programmes to regional and national contexts.

### 4.1 Profile of Pacific island countries

Pacific island countries are highly diverse culturally, socially and economically. They tend to be geographically small and isolated, with small populations, ranging from less than 2000 in countries such as Niue and Tokelau to 5.8 million in Papua New Guinea (44). With the exception of Fiji, Papua New Guinea and the Solomon islands, all these countries have populations of less than 300 000.

Most comprise multiple islands, or atolls, spread over many hundreds or thousands of nautical miles, making administration and the provision of basic infrastructural services difficult. The Cook islands exclusive economic zone, for example, is estimated to cover nearly 2 million km<sup>2</sup>, but the Cook islands itself has a land area of only 240 km<sup>2</sup>, spread over 15 islands.

Many Pacific island countries have experienced colonization or external administration. Their economies tend to be based largely on agriculture, tourism or fishing, and many are significantly dependent on donor aid and on remittances from citizens living elsewhere. The benefits of natural resources (for example, fish stocks) often flow out of the region.

A number of regional donors provide development assistance, including funding for basic infrastructure. Some such aid has conditions attached.

Yach et al. (8) noted that economic factors significantly influence the risk for chronic disease. They suggested that important drivers are urbanization, foreign investment and promotional marketing: “More open conditions for trade and foreign investment can bring economic benefits, but also encourage unhealthful behaviour risks.” This is certainly the experience in many Pacific island countries. Since the Second World War, many have become more dependent on imported foods and other goods. Traditional agricultural economies are changing to cash economies, and, as a result, access to and use of tobacco, alcohol and unhealthy foods has significantly increased. Imported products are now a sign of status, and trade liberalization is arguably increasing dependence on such products. These countries are rapidly becoming more urbanized.

### 4.2 Agencies working in the Pacific region

A number of agencies work in the Pacific region within the Pacific Plan<sup>18</sup> and other regional plans for economic and social development. The Pacific Plan was endorsed by leaders at the Pacific islands Forum in October 2005. The Plan was intended to be a ‘living document’, to form the basis for

strengthening regional cooperation and integration for “the benefit of the people of the Pacific”. It is intended to bring together various regional policies and programmes, including those offered by regional and bilateral donors. Its goal is to “enhance and stimulate economic growth, sustainable development, good governance, and security for Pacific countries through regionalism” in a series of objectives and many initiatives. The objectives include reduced poverty, improved natural resource and environmental management, improved health, and improved education and training. It is intended that all bodies interested in improving the health of Pacific peoples will operate within the Plan.

In the area of health policy and programmes, agencies working in the Pacific include WHO, the SPC and bilateral donors such as the NZAP and the Australian Agency for International Development (AusAID). The SPC is an international organization that provides technical assistance, policy advice, training and research services to 22 Pacific island countries and territories in areas such as health, human development, agriculture, forestry and fisheries.

Other bilateral donors in the Pacific region include China, Japan and the United States of America; however, the main funders or facilitators of tobacco control assistance in 2000–2008 were WHO, SPC, NZAID (now NZAP) and AusAID.

In the past, the efforts of these agencies were fragmented. An attempt has subsequently been made to coordinate funding and programmes under the umbrella of the *Pacific framework for the prevention and control of non-communicable diseases* (45), prepared by WHO and SPC. This paper stated those agencies’ commitment to work jointly on noncommunicable disease prevention and control in the Pacific island region. AusAID and NZAP have also committed themselves to work closely with WHO and SPC in this area, and it is expected that funds for noncommunicable disease prevention and control, including tobacco control, will be combined and coordinated in the future.

### 4.3 Commitment of Pacific island countries to tobacco control

During negotiation of the WHO FCTC, Pacific island countries worked as a bloc to seek a strong, demanding treaty. The bloc coalesced as part of the ‘power of the process’, with regional and sub regional meetings of groups of countries that agreed on common positions on tobacco control and presented that view during the negotiations (see section 1.4).

Since the WHO FCTC came into force, these countries have shown that they are not only willing to advocate for a strong tobacco control treaty but are also committed to implementing it. Many have taken bold steps to bring their domestic tobacco control programmes into line with the WHO FCTC. With the assistance of regional funders, some have prepared national tobacco control strategies, comprehensive tobacco control legislation, new tax policies, and programmes for education, training and public awareness, advocacy and cessation of tobacco use.

During the past few years, for example, the Cook islands, the Solomon islands, Tonga, Tuvalu and Vanuatu have passed comprehensive legislation that is largely consistent with the WHO FCTC (local circumstances have influenced the scope of the legislation in some areas). This legislation provides for comprehensive bans on tobacco advertising, promotion and sponsorship; bans on smoking in all workplaces and public places (including restaurants and bars); and strong health warnings on all tobacco products. Several other countries, including Niue, Kiribati, Papua New Guinea and Tokelau have drafted legislation.

Several countries are considering sustainable funding mechanisms for their national tobacco control programmes. In 2007, Tonga passed legislation establishing a health promotion foundation (46).

The Cook islands, Papua New Guinea, Solomon islands and Vanuatu are considering the use of tobacco taxation as funding for tobacco control programmes and establishing sustainable health promotion mechanisms.

#### 4.4 Influences on tobacco control in the Pacific region

A number of factors make Pacific island countries a good choice for overseas development assistance in the area of chronic disease prevention and mitigation, including tobacco control:

- In countries with small populations, usually only one level of government sets legislation and policy, there is no decentralization of services and it is easier to access and influence decision-makers.
- A hierarchical culture of chiefs and village elders makes institution of programmes easier (for example, smoke-free villages, support for national interventions), provided these leaders can be convinced. Influential church leaders can be strong allies.
- Where village life persists, there is often a greater sense of community. It may therefore be easier to achieve engagement and feedback on topics of significance to the community (for example, health, issues relating to youth).
- Urbanization and globalization have contributed to a rapid increase in the incidence of noncommunicable diseases; this is an issue of concern throughout the Pacific and has encouraged countries to seize opportunities to confront the epidemic.

The threats to and limitations on tobacco control in the Pacific region include:

- Limited capacity and leadership: There are effective leaders and champions in tobacco control in some Pacific island countries. Given the relatively small workforce available for tobacco control, these leaders are often stretched to do all they would like to.
- Limited domestic resources: There is a lack of sustainable funding for tobacco control programmes in almost all Pacific island countries, largely because of small national budgets and other, more immediate funding needs.
- Influence of the tobacco industry: There are tobacco factories in Fiji, Papua New Guinea, Samoa, the Solomon islands and Tonga. The companies' strong endorsement of what they call 'sensible regulation' tends to resonate with decision-makers in the Pacific. Industry allegations of catastrophic economic loss should tobacco control measures be put in place raise the concern of ministries of finance and tourism.
- Some continued acceptance of tobacco use: In many countries, acceptance of tobacco use remains, sometimes culturally (even though tobacco was introduced relatively recently). While this is changing, it still influences some decision-makers.
- Lack of a domestic evidence base: Some decision-makers argue against tobacco control measures on the basis that their effectiveness has not been proven in their country. One example is tax policy: business groups (and sometimes even ministries of finance) reject World Bank advice and argue that their country would not react positively to an increase in the price of tobacco.
- The illicit trade in tobacco: Illicit trade in tobacco, including counterfeit tobacco products from other countries, continues to pose a threat to effective tobacco control, although this is often not widely recognized in some Pacific island countries.
- Economic and trade liberalization: The advent of the Pacific Islands Countries Trade Agreement could result in increased, less-regulated trade in tobacco and alcohol. At a meeting in Vanuatu in 2007, Pacific trade ministers agreed to defer a decision on whether to remove tariffs from tobacco products under the Agreement for a further 2 years (no decision has been made to date). Many commentators argue that tobacco and alcohol consumption will increase as a result of trade liberalization, because

of reduced prices, increased competition and increased advertising and branding (47). Countries are being encouraged to implement domestic excise taxes and use other mechanisms to counter liberalization in the trade of tobacco, should that happen (48).

## 4.5 New Zealand Agency for International Development-funded six-country, 5-year, comprehensive tobacco control project

### 4.5.1 Background

In 2003, NZAID agreed to fund a project to provide support to two small Pacific Polynesian nations: the Cook islands and Tonga. Both having actively engaged in negotiation of the WHO FCTC, these two countries had asked NZAID for assistance to meet their anticipated obligations under the treaty. During 2003–2004, a consortium of tobacco control experts, led by Allen + Clarke Policy and Regulatory Specialists Ltd, a New Zealand-based company, helped the two governments to design and initiate comprehensive tobacco control programmes consistent with the WHO FCTC and best practice. Allen + Clarke provided expertise on policy and preparation of legislation and implementation (including enforcement), assisted by agencies and individuals with expertise in tax policy, advocacy, health promotion and smoking cessation.

At the end of 2004, after significant progress had been shown in the two countries, NZAID agreed to extend the project (Stage 2) to an additional four Pacific countries that had similarly asked NZAID for assistance. All had been actively involved in the WHO FCTC negotiations and had shown willingness and commitment to WHO FCTC-compliant policies and programmes. The countries selected for the project were two Melanesian countries (the Solomon islands and Vanuatu) and two further Polynesian countries (Samoa and Tuvalu). The countries were at varying stages of tobacco control and had secured varying levels of domestic political commitment for the project.

Allen + Clarke and its partners continued the project with personnel from the New Zealand National Heart Foundation's Pacific island Heartbeat Unit and representatives from the Cook islands and Tonga who could provide input from their experience during 2003 and 2004.

Note: At the request of Samoa, work in that country was deferred until late 2007. Accordingly, the following discussion relates to the Cook islands, the Solomon islands, Tonga, Tuvalu and Vanuatu).

### 4.5.2 Overview of the approach

The goal, objectives and stated outputs of the Tobacco Control in the Pacific project are summarized in Figure 1 below.

The focus of the project was building capacity. NZAID and the implementing agencies tried to ensure that the project would be:

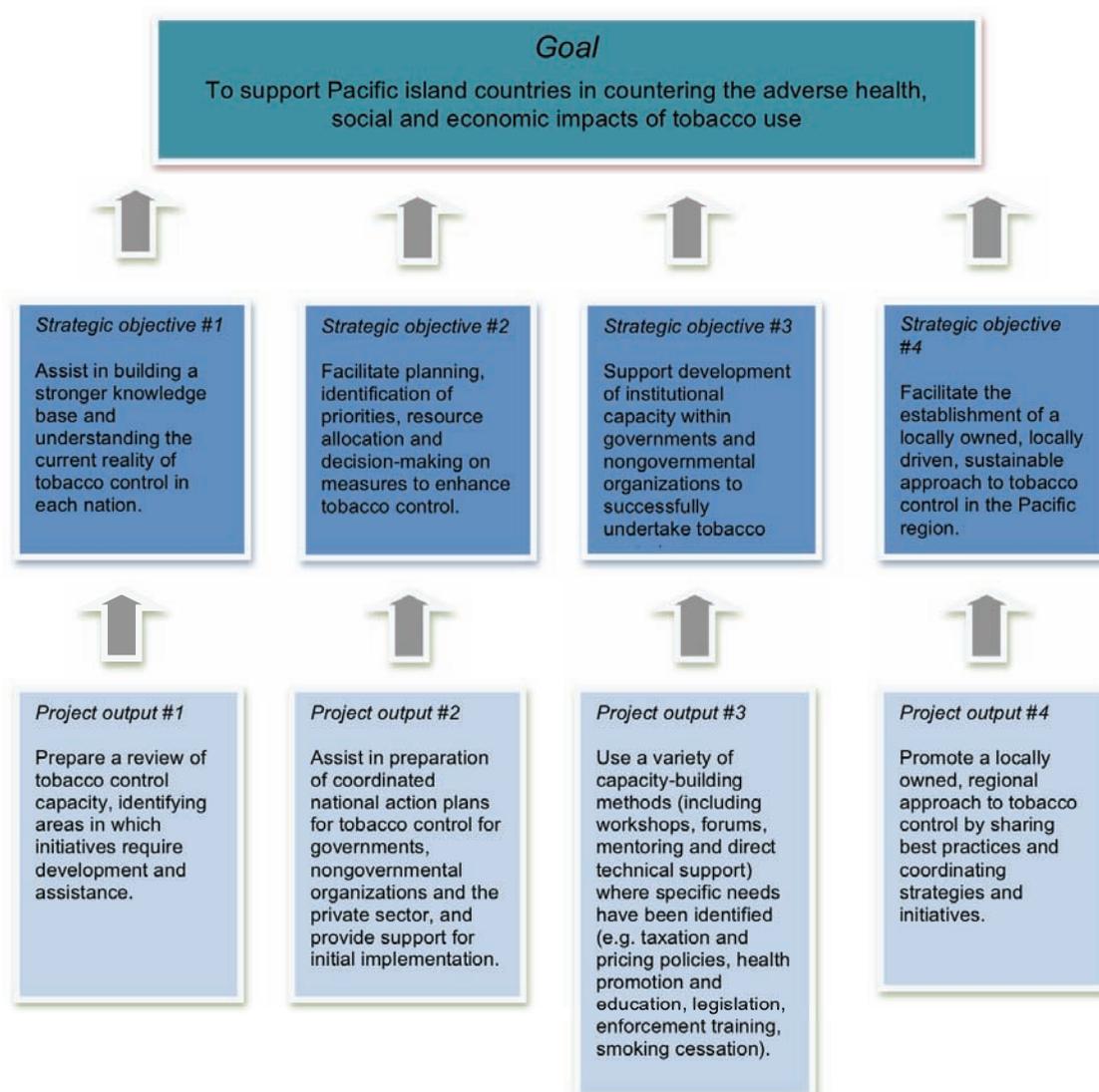
- owned by the countries;
- managed and implemented in close partnership with the countries;
- focused on developing capacity in the countries, particularly for population-level interventions (i.e. strategic interventions);
- strongly linked with other donor activities; and
- cognizant of the key NZAID principles of poverty elimination, gender equality and good governance.

In addition, the consultants, with NZAID support, expressed a strong commitment to an intervention project that would be:

- evidence based, in terms of its technical inputs and outputs;
- implemented in a culturally sensitive way, with careful consideration of social, economic and other contextual issues that affect a country's ability to implement effective interventions; and
- sustainable in the long term.

Accordingly, the project consisted of six steps: building relations and stock-taking; initial capacity-building; preparing a national action plan; providing continuing support and encouragement; promoting regionalization; and conducting evaluations. Each of these is outlined briefly in Figure 1.

Figure 1. Framework of the Tobacco Control in the Pacific project



#### 4.5.3 Building relations and stock-taking

Consultants visited each country to agree with partners on the scope of the project and respective roles and responsibilities and to establish a commitment to flexibility in implementation. They emphasized that the project belonged to the country partners, who could direct the project team as they saw fit. A local leader, appointed at the outset, provided direction on all aspects of the project. Over the course of the project, a partnership developed.

During the initial visits to each country, stock was taken by ‘SWOT’ (strengths, weaknesses, opportunities, threats) analysis. The visits were made by a policy and legal expert, a health promoter and, during Stage 2, a smoking cessation expert. In most cases, the stock-taking was done during one team visit. The expertise of country partners, usually during an initial workshop and meetings, was used to identify:

- current programmes that could be built upon or extended and the lessons learnt from them (for example, World No Tobacco Day celebrations and activities);
- strong leaders and agencies that could serve as partners (for example, churches and church ministers, political leaders, umbrella advocacy organizations);
- where efforts should be focused for maximum effect (for example, effective interventions that were likely to be supported, financially viable, culturally appropriate and consistent with the cultural norms in the Pacific region and in each country);
- gaps in resources, personnel and commitment, with a view to identifying possible ways of filling those gaps, either by building the capacity of country partners or by providing technical expertise and funding (for example, identifying any workshops required and any technical drafting required for policy or legislation);
- any specific threats to effective tobacco control (such as the existence of tobacco factories, tobacco growing, lobbyists, strong relationships between tobacco importers and decision-makers or apathy or lack of knowledge about, or commitment to, tobacco control in some sectors); and
- any upcoming events or other opportunities that could be used to promote strong tobacco control (for example, new legislation, the WHO FCTC itself, regional meetings of ministers and officials or release of local statistics stressing the need for action).

The stock-taking visits included a formal assessment of compliance with the WHO FCTC on a template that was completed and reviewed by the countries. The template was prepared with input from relevant government departments (for example, health, education, justice, customs, foreign affairs, trade, youth and economic development).

The stock-taking visits usually resulted in agreement on the scope of the assistance required, including the priority to be given to various interventions; a schedule of visits for technical assistance, including an outline of the workshops that would be held; and the best strategies for gaining support for various interventions (for example, tobacco legislation, workshops for parliamentarians and other decision-makers).

As governments changed periodically in some countries and there were various troubles, such as the breakdown of law and order in the Solomon islands in 2006, the team had to be flexible in implementing the project and responsive to the countries’ capacity to implement projects at the same time as other domestic priorities. As a result, the post-stock-taking agreements were informal and reviewed regularly by the team and the countries.

#### 4.5.4 Initial capacity-building

After the stock-taking visits, the consultants went to each country, at times agreed on with country personnel. The countries assisted in logistics, such as arranging workshops, booking venues, inviting attendees and, in some cases, co-facilitating workshops. The workshop topics chosen by country partners and the project team were:

- *WHO FCTC*: Workshops were held to outline the requirements of the WHO FCTC, the country’s current compliance with the treaty and means for ensuring fuller compliance. These workshops,

usually attended mainly by representatives of government agencies, also covered best practices in tobacco control to focus on health rather than simply complying with an international treaty. Discussions usually addressed the priorities for action in the country and by whom the priorities would best be implemented.

- *Strategy and policy*: Workshops were held in each country to design or agree on the elements of a national action plan for tobacco control. Workshops were attended by representatives of a range of government agencies and civil society organizations, including nongovernmental organizations, church leaders, sports bodies, youth bodies and women's groups. They agreed on the actions that were required to ensure implementation of a comprehensive tobacco control programme, assigning responsibilities and building momentum by establishing an intersectoral committee to take ownership of the plan. In Tonga and Tuvalu, it was decided that the tobacco control action plan should be integrated within a wider noncommunicable disease strategy and implementation plan. The consultants subsequently facilitated this process.
- *Taxation and pricing policies*: Short workshops were held in several countries for government departments interested in tobacco taxation. Evidence was presented for the effectiveness of this strategy for reducing tobacco use and for securing funding for programmes to combat noncommunicable disease risk factors.
- *Health promotion capacity-building and strategy development*: The project provided a budget for each country to fund a health promotion campaign, with whatever campaign elements the country decided were appropriate. One or more workshops were held in each country to build capacity in health promotion and to agree on a strategy comprising health promotion messages, target groups, campaign approach, evaluation approach and an implementation and funding plan. These campaigns were intended to support strategic interventions such as legislation. The final decision on content and focus was left to each country.
- *Advocacy capacity-building*: Two advocacy workshops were held in most countries, usually spaced at least 1 year apart. These were designed to bring together nongovernmental organizations and people with an interest in tobacco and health to facilitate groupings or coalitions in each country. None of the countries had a dedicated tobacco control advocacy organization at the start of the project. The role of the coalitions was to assist in identification of advocacy opportunities, to provide training on advocacy and to assist in grant applications to international funders, in order to make the groups effective advocates for tobacco control and public health policy in general.
- *Preparation of legislation*: This workshop, often held in conjunction with the workshop on strategy and policy, was held to identify priorities for tobacco control legislation in each country, any barriers to passage of legislation and strategies for achieving passage of legislation and its effective implementation.
- *Enforcement training*: A trained investigator facilitated 3–5-day workshops in several countries to build the capacity of enforcement staff to undertake effective investigations and gather evidence for successful prosecutions. Given the scope of the project, the focus of these workshops was tobacco control; however, they were designed to build the capacity of the officers to take effective enforcement action in any area of compliance with legislation. The workshop included a session on enforcement policies for jurisdictions, covering such matters as identifying priorities for immediate and longer-term enforcement.
- *Smoking cessation train-the-trainers workshops and short intervention workshops*: These workshops built the capacity of health workers to intervene with smokers. Interventions included short interventions in which smokers are advised of the risks and asked whether they want to quit and training for health professionals in counselling smokers and training other health workers on effective brief interventions. In several countries, the participants designed cessation strategies to be included in the national tobacco control action plan, with specific interventions that might be implemented, subject to funding and commitment.

#### 4.5.5 Preparing a national action plan

National tobacco control action plans were prepared by the consultants and the country partners on the basis of the stock-taking, the assessments of compliance with the WHO FCTC, the workshops and follow-up discussions with agencies and individuals in each country.

The planning was based on the WHO STEPwise approach to interventions against risk factors for noncommunicable diseases, with a matrix of actions based on phased levels of commitment and resourcing at population, community and individual levels (49). The WHO STEPwise approach is a simple, standardized method for collecting, analysing and disseminating data in WHO Member States. It has been adapted for the design and implementation of systematic staged interventions to address noncommunicable disease risk factors.

The resulting plans listed actions to be taken on various priorities in:

- core initiatives, which could be implemented immediately, with existing resources;
- expanded initiatives, with a medium-term implementation time frame (2–5 years), which might require additional resources; and
- optimal initiatives, which would be implemented in the longer term and subject to securing longer-term funding (5–10 years).

The status of the action plans differed by country. In the Cook islands, for example, the action plan was formally launched by the Minister of Health. In Vanuatu, it was prepared for use as a Ministry of Health planning document under the country's existing, overarching national noncommunicable disease strategy. All the plans included a formal mechanism for implementation and evaluation, most proposing establishment of an intersectoral committee consisting of representatives of various government, and in some cases civil society, agencies charged with implementation and monitoring.

#### 4.5.6 Continuing support and encouragement

Much of the assistance to country partners was desk-based, project personnel acting as a source of information and advice at the end of a telephone or via e-mail throughout the project. Project personnel made sure they were available when required and also made contact periodically to check progress. Further visits were made as required to provide support, such as to launch a health promotion strategy or at key stages of legislation drafting and passage.

Project personnel assisted in drafting a wide range of documentation. Efforts were made to do this in partnership, but some documents were written by project personnel in consultation with country partners, rather than the other way around. The documentation included:

- workshop reports;
- action plans and strategies resulting from the outcomes of the workshops;
- legislation, including secondary legislation such as regulations;
- policy papers seeking support for passage of legislation and implementation of other initiatives;
- briefings for community groups, government agencies, ministers and parliaments;
- constitutions and terms of reference for advocacy groups;
- technical input on health promotion materials;
- funding applications for advocacy groups;

- papers proposing increased tobacco taxation and the establishment of sustainable funding mechanisms for health promotion; and
- supporting papers for officials, for example, for responding to approaches by tobacco companies.

#### 4.5.7 Promoting regionalization

The NZAID-funded project was regional and was therefore expected to have a regional focus. While Stage 1 of the project (the Cook islands and Tonga) did not explicitly promote regionalization of tobacco control or collaboration between project teams and funders, the Allen + Clarke team and the SPC-led, AusAID-funded Pacific Action for Health Project in Kiribati, Tonga and Vanuatu did work in a regional, collaborative manner (50).

As a result of Allen + Clarke's internal evaluation of Stage 1 (see below), Stage 2 focused explicitly on closer collaboration between the project team and other regional initiatives to control tobacco use and noncommunicable diseases and also between countries. The project consultants also promoted, in liaison with WHO, SPC and Australian agencies, the concept of a regional network for tobacco control in Pacific island countries, and supported informal networking among countries during the project. After the close of the project, a regional coordinator was funded by the Framework Convention Alliance to promote networking on tobacco control.

Project consultants also supported attendance of Pacific representatives at regional forums and contributed funding to a WHO-hosted Pacific tobacco control workshop in Fiji in 2006.

#### 4.5.8 Conducting evaluations

Stage 1 of the project (the Cook islands and Tonga) underwent an interim internal evaluation by Allen + Clarke, while NZAID commissioned an independent evaluation towards the end of Stage 2 (45).

##### *Internal evaluation of Stage 1*

The internal evaluation, while not independent, highlighted some methodological issues, which were taken into account in implementing Stage 2. While the aim of the evaluation was mainly to satisfy the project team and NZAID that all the outputs in the contract had been achieved, other conclusions could be drawn:

- The project method was fundamentally sound, achieving a good balance between theory (the evidence base) and practical application of the evidence to respond to local circumstances.
- The country partners showed a high level of commitment and satisfaction.
- Country visits were particularly effective. In recipient countries with low capacity, more and longer country visits might be considered rather than desk-based support.
- The project imposed a considerable burden on local partners, who had other work responsibilities. Development assistance partners must be sensitive and ensure in advance that projects are built into the work plans of partner countries.
- It was difficult to measure whether the project had achieved the desired outcomes in the short term and especially in the medium-to-longer term.
- There was good inter-donor collaboration during the project.

NZAID was sufficiently satisfied with the outcome of Stage 1 to agree to extension in Stage 2 to four additional countries from 2005.

### *Independent evaluation of Stages 1 and 2*

NZAID commissioned an independent evaluation of the project by a specialist in public health medicine with experience in development assistance. The purpose of the evaluation, conducted at the end of 2007 when the project was near completion, was to determine how the project team performed, what the countries achieved and what they were likely to achieve over the longer term (51). The evaluation therefore determined the extent to which the project achieved its goal and objectives, the lessons learnt and the implications for future NZAID programming.

The conclusion of the evaluation was that range of evidence-based interventions had been implemented successfully and had strengthened capacity in the partner countries. It was concluded that the medium- to long-term consequences of the project should be improved health and social outcomes.

Some of the findings are useful for assessing what makes overseas development assistance programmes for tobacco control effective. Table 2 presents relevant findings, with a framework that could be used in such a programme.

<b>Table 2. Lessons from the NZAID-funded project: Guidance for future overseas development assistance programmes in tobacco control</b>		
	<b>Findings of independent evaluation</b>	<b>Implications for design and implementation of programmes</b>
Timing	The intervention was the right intervention at the right time.  The intervention was requested by countries and was focused on their needs and what would work to control tobacco use.	Initiated by partner country.  Commitment by the country a prerequisite.  Based on evidence.
Leadership	Individual leadership (e.g. by a health minister) increases the chance of success.  Mentoring and other support by local leaders were important elements in the success of the project.	Identification and training of respected individuals to be leaders and sponsors of the programme.
Flexibility	Much was achieved on various technical issues in all countries, despite some constraints in areas outside the control of the consultants.	Flexibility of project and consultants.  Flexibility in programme design and implementation.  Flexibility in response to changing circumstances.
Approaches	Consultant approaches valued by country partners included the: <ul style="list-style-type: none"> <li>• collaborative approach</li> <li>• quality of technical advisers</li> <li>• strong support of country staff with new skills and knowledge</li> <li>• professionalism and commitment</li> <li>• responsiveness to country needs</li> <li>• phasing of work to build necessary capacity</li> </ul>	Project owned and directed by countries.  Collaboration in implementation.  Respect for local customs.  Focus on capacity-building.  Appropriate consultants (technical competence, flexibility, humility,

**Table 2. Lessons from the NZAID-funded project:  
Guidance for future overseas development assistance programmes in tobacco control**

	<b>Findings of independent evaluation</b>	<b>Implications for design and implementation of programmes</b>
Approaches (continued)	<ul style="list-style-type: none"> <li>• acceptance of local constraints, flexibility</li> <li>• willingness to undertake drafting when partner lacked resources</li> <li>• receptiveness and respect for local players, willingness to listen, supportive but not intrusive engagement</li> <li>• efficient responses to requests</li> <li>• continuity of advisers.</li> </ul> <p>Short, sharp inputs (possibly more frequent) favoured over prolonged stays, in order to minimize burden on local partners.</p>	<p>cultural sensitivity, respect, skills transfer, facilitation, networking, personal commitment, responsiveness and professionalism).</p> <p>Flexibility in timing (time frame and duration of project, phasing of work, timing and frequency of visits).</p> <p>Continuity of personnel.</p> <p>Immediate response to requests.</p>
Support	<p>Support for community advocacy groups was pivotal; when this did not exist, the programme was slowed.</p> <p>Support from other government agencies is important in achieving policy; if other agencies are not engaged, it is difficult to reform policy.</p>	<p>Support establishment and work of advocacy and intergovernmental groups as a priority in programme assistance.</p> <p>Integrate work of advocacy and intergovernmental groups into the project or ensure links.</p>
Funding	<p>Tobacco control programme budgets are limited, and sustainable funding is required to consolidate technical capacity and commitment.</p>	<p>Identify sustainable funding mechanisms.</p> <p>Build tobacco control into core government work programmes.</p>
Planning	<p>Facilitating the preparation of national tobacco action plans focused attention, as few resources had been committed to plans or formal reporting.</p> <p>Programmes must be rationalized to meet core needs and be planned at the behest of those who use them.</p> <p>Action plans should clearly define priority groups and address capacity to reach rural and remote populations.</p>	<p>Wide engagement in planning.</p> <p>Integration of tobacco control planning into wider planning.</p> <p>Secure commitment to real monitoring of and reporting on implementation of plan.</p> <p>Focus on sustainable funding to ensure viability of plans.</p> <p>Emphasize community interventions in any action plan.</p> <p>Avoid duplicate planning.</p>
Targets	<p>Most interventions were (intentionally) directed to national decision-makers, with consequent limited reach to rural and remote populations.</p>	<p>Population-level interventions must be cost effective.</p> <p>Include community-based interventions in action plans.</p>
Workshops	<p>Workshops are useful if they are integrated into the wider programme and supported by interventions.</p>	<p>Ensure integrated project design.</p> <p>Support learning with continual support and capacity-building (e.g. desk-based support).</p>
Research, monitoring, evaluation	<p>The project design limited support for research, surveillance, monitoring, evaluation and capacity-building in response to the countries' stated priorities and resources for the project and because some of these activities were supported by other sources. The consequence was limited documentation of achievements or refining of plans during the project.</p>	<p>Inclusion of surveillance, research, monitoring, evaluation and capacity-building in programme design.</p> <p>Alternatively, closer integration with other projects in this regard.</p>

**Table 2. Lessons from the NZAID-funded project:  
Guidance for future overseas development assistance programmes in tobacco control**

	<b>Findings of independent evaluation</b>	<b>Implications for design and implementation of programmes</b>
Cooperation	Coordination with activities of other donors to avoid duplication and extended programme support, particularly in the cooperative relationship with PAHP* and a link between Allen + Clarke, WHO and the Secretariat of the Pacific Community in establishing the regional approach.	Close collaboration and information-sharing with other donors and programme managers.  Promote resource sharing or transfer between projects for efficiency.
Capacity-building	Specific technical components were valued, capacity was built, and desired outputs were achieved, including in: <ul style="list-style-type: none"> <li>• health promotion campaign planning and implementation</li> <li>• legislation (focus on this was useful)</li> <li>• review of compliance with the WHO FCTC</li> <li>• tax and funding mechanisms, identification of sustainable funding options</li> <li>• technical responses to industry lobbying</li> <li>• preparing an action plan</li> <li>• capacity-building workshops</li> <li>• desk-based support.</li> </ul>	Focus on population-level interventions.  Comprehensive tobacco control approach.  Focus on capacity-building.  Identify means of ensuring sustainability.  Avoid unsustainable interventions.
Cessation services	Knowledge and skills were transferred for cessation activity. Countries found difficulty in implementing programmes (limited demand, lack of clinical space, absence of pharmaceuticals). Further integration into clinical programmes is needed.	Staging: avoid investment in unsupported, costly cessation interventions* too early.  Consider awareness-raising and training for health professionals as a first step, with inclusion of quit messages in population health promotion campaigns.  Integrate within health services.
Country focus	While a regional approach can be useful (e.g. shared resources, facility to support technical input, networking opportunities), regional programmes must remain country-specific. Allen + Clarke's approach was based on this focus in both design and implementation, with deliberate support to meet the needs of each country.	Programme design should be country-specific, even for regional programmes.  Close collaboration between development partners.  Promote networking opportunities between countries.
Continuing support	Allen + Clarke has continued low-level support and mentoring after completion of the contract (e.g. for implementation of legislation); this is highly valued by the countries.	Consider means of providing continuing low-level support regionally.
WHO FCTC focus	Tobacco programmes have benefited from the focus on the WHO FCTC.  With limited resources for tobacco and other public health programmes, integration of tobacco control programmes into wider noncommunicable disease programmes, as proposed for the future, might lose the strong focus on tobacco and the FCTC.  Targeted achievements in tobacco control are needed in order not to lose focus.	Identify and prioritize discrete tobacco control interventions within any regional approach to noncommunicable diseases.  A regional approach should include country-specific interventions.  Avoid a generic approach to country support.

\* Pacific Action for Health Project, a development assistance programme for noncommunicable diseases funded by AusAID and facilitated by the Secretariat of the Pacific Community in Kiribati, Tonga and Vanuatu

\* 'Cessation interventions' are clinical interventions: individual engagement to encourage people to quit.

## 4.6 Lessons learnt

The case study and the evaluation of the project on which it was based validate many of the preliminary conclusions on principles for and approaches to overseas development assistance projects in tobacco control. The following conclusions were the most consistent:

- support for comprehensive interventions;
- initiation of requests for assistance by partner countries;
- integration of programmes within country planning;
- focus on population-level interventions;
- use of evidence-based interventions;
- use of a multisectoral approach for interventions;
- incorporation of research, surveillance, monitoring and evaluation;
- focus on advocacy and multisectoral responses,
- identification and support of local champions;
- use of regional approaches that are country-specific and focus on tobacco control;
- emphasis on capacity-building;
- building sustainable programmes;
- collaboration among funders; and
- use of various modes of delivering overseas development assistance.

Section 5 presents a framework for overseas development assistance programmes in tobacco control, which is based on the principles for such assistance described in section 2 and Table 1 and the results of the evaluation of the Tobacco Control in the Pacific project described in section 4 and Table 2.

## 5. A framework for development assistance projects in tobacco control

The principles and approaches discussed above can be drawn on in the design, implementation and evaluation of development assistance projects in tobacco control. A possible framework for focussing and guiding future action in this area is presented below in the form of a series of tables. It is intended to be a starting-point for discussion among international, regional and national agencies.

Table 3 lists some overarching criteria that could be used to exclude project proposals that fail to incorporate certain prerequisites for securing development assistance. Table 4 presents strategic principles for selecting programmes for funding, which could also be used by implementing agencies as a guide for designing and implementing programmes. Table 5 lists tobacco control interventions that have been shown to be valuable in these programmes and provides guidance on effective design of these interventions. Table 6 gives guidance on modes of working with partner countries in implementing overseas development assistance programmes in tobacco control and characterizes the individuals most suited to such work.

The principles and guidance in tables 3–6 are not intended to be all encompassing. Rather, it is hoped that they will help agencies that are considering funding or implementing tobacco control programmes. Compliance with the WHO FCTC must be the centre of attention, as an international convention that requires its Parties to meet certain standards is an obvious starting-point for the design, implementation and evaluation of overseas development assistance for tobacco control.

Table 3. Prerequisites for funding overseas development assistance for tobacco control	
Best practice	Consider the consistency of the project design with identified best practice in overseas development assistance programmes (see Table 1).
Focus on WHO FCTC	Include a focus on compliance with the WHO FCTC, especially in countries that are Parties to the Convention.
Prioritization	Countries should prioritize tobacco control domestically, specifically in requests for development assistance.  Countries should consider domestic funding options before seeking assistance.  Priority should be given to assisting those countries that are willing to contribute domestic resources to the programme.
Initiation	Programmes should be initiated by country partners.
Commitment	Country commitment should be a prerequisite for donor assistance, as demonstrated by a willingness to assign local resources (staff, organizational) to the project and the level of political and government agency support.
Evidence based	Programmes for which investment is sought should be based on evidence and be likely to have an effect at population level.
Effectiveness	The donor should consider where investment will be most effective (e.g. which country, which sector), not only in countries with high rates of tobacco use but also in those in which success may encourage action in others.
Exclusion of tobacco industry partnerships	The tobacco industry must not be involved or fund, directly or indirectly, overseas development assistance programmes for tobacco control.

**Table 4. Strategic principles for selection and guidance for implementation of overseas development assistance programmes for tobacco control**

Best practice	Consider the project design in terms of identified principles of best practice in overseas development assistance programmes (see Table 1).
Facilitation	Donor countries should be the facilitators, not the prime movers, of development assistance.
Multisectoral	Promote and support multisectoral collaboration; draw in a wide range of government and civil society players, international organizations and the private sector.
Comprehensive approach	Support comprehensive tobacco control programmes, including those that promote compliance with the WHO FCTC (recognizing that ad hoc projects may be all that can be achieved initially and that well-managed, targeted ad hoc projects can build support for future comprehensive action).
Integration	Ensure that both comprehensive programmes and projects funded ad hoc are well integrated within country programmes, including development assistance plans and the country's plans and strategies (including agency work plans).
Population focus	Focus on effective population-level interventions, which include: <ul style="list-style-type: none"> <li>• legislation (especially bans on advertising, protection from second-hand smoke and tobacco pack warnings)</li> <li>• taxation and pricing policies</li> <li>• education and public awareness.</li> </ul>
Capacity-building	Focus on projects that build the capacity of country partners rather than deliver a finished product to the country. Emphasize: <ul style="list-style-type: none"> <li>• technical aspects of best practice in interventions</li> <li>• effective advocacy and campaign skills</li> <li>• research capacity</li> <li>• establishing and maintaining networks</li> <li>• ensuring organizational capacity (including for research, monitoring and evaluation).</li> </ul>
Sustainability	Support interventions that can be sustained and built on by the country after the project is completed.
Regionalization	Depending on the readiness of countries, consider setting up regional centres of excellence, promote regional networking and North–South or South–South technical assistance, strengthen communications between countries and champions, and promote networking opportunities between countries.
Regional leaders	Invest in and support 'leader' countries to generate regional action.
Country-specific focus	Programmes, even for regional programmes, should be designed for specific countries. Avoid a blanket approach to implementation, in terms of both the interventions selected and how they are implemented.

**Table 5. Types of tobacco control interventions that should be priorities in overseas development assistance programmes**

Preparation of national action plans and strategies for tobacco control	<p>Preparation of comprehensive strategies and action plans to focus efforts, promote multisectoral collaboration, assign tasks and time frames and organize continuous monitoring. In particular:</p> <ul style="list-style-type: none"> <li>• Encourage use of the WHO FCTC as a basis for intervention, while supporting countries to exceed obligations under the treaty when appropriate</li> <li>• Promote wide engagement in preparation of the strategy or plan</li> <li>• Integrate tobacco control into wider planning</li> <li>• Ensure sustainable funding to make plans viable</li> <li>• Emphasize population-level interventions in areas of tobacco control shown to be most effective</li> <li>• Consider adoption of the STEPwise approach to planning</li> <li>• Avoid duplicate planning</li> <li>• Include community-based interventions in action plans</li> <li>• Secure commitment to real monitoring and reporting of implementation of plans.</li> </ul>
Legislation	<p>Support the drafting and passage of comprehensive tobacco control legislation. In particular:</p> <ul style="list-style-type: none"> <li>• Ensure that legislation is consistent with the WHO FCTC and the guidelines for implementation of articles of the Convention adopted by the Conference of the Parties</li> <li>• Include comprehensive bans on tobacco advertising, promotion and sponsorship</li> <li>• Include bans on smoking in public places, workplaces and public transport</li> <li>• Include provisions relating to tobacco package labelling and warnings</li> <li>• Support implementation of legislation, including training in enforcement, enforcement policy, public awareness, education of affected parties and businesses and, when possible, review the impact.</li> </ul> <p>Avoid short assignments to simply draft legislation; build in some follow-up support for passage and implementation.</p>
Tax and pricing policies	Support the drafting and implementation of policies and legislation for substantive tax increases and other pricing measures to increase the price of tobacco to the consumer.
Education and public awareness	<p>Focus on:</p> <ul style="list-style-type: none"> <li>• building the capacity of countries to implement their own programmes</li> <li>• funding programmes to support population-level interventions (e.g. legislation, tax policies).</li> </ul>
Cessation	<p>Consider awareness-raising and training for health professionals, with quit messages in population-level health promotion campaigns.</p> <p>Consider clinical programmes and pharmacological interventions once there is demand for cessation support and when sustainable funding is secured.</p> <p>Ensure that cessation services are integrated into existing health services.</p>
Sustainability	<p>Support sustainable funding initiatives (e.g. health promotion foundations, dedicated taxes or surcharges on tobacco taxes).</p> <p>In all projects, ensure that any initiative will be sustainable and can be built on by the country partner.</p>
Industry response	Support countries in responding to tobacco industry challenges of initiatives.
Advocacy	<p>Support the establishment and work of advocacy and intergovernmental groups as a priority in programme assistance.</p> <p>Integrate the work of advocacy and intergovernmental groups into the work of the project.</p>
Champions	Identify, recruit, train and retain champions; help respected individuals to become leaders or sponsors of the programme.

**Table 5. Types of tobacco control interventions that should be priorities in overseas development assistance programmes**

Grant schemes	<p>Consider establishing special grants, including for rapid response, seed projects and strategic planning.</p> <p>Ensure that grant schemes are easy to apply for, and support applicants.</p> <p>Provide clear criteria and priorities for any scheme.</p> <p>Ensure transparency.</p> <p>Provide for monitoring and reporting of progress, including feedback on appropriateness of delivery.</p>
Research and surveillance	<p>Include surveillance, research, monitoring and evaluation of capacity-building in programme design. Alternatively, ensure close integration with other projects and funders in this regard.</p> <p>Support quantification of the disease burden resulting from tobacco use as a means of building domestic support for action.</p>

**Table 6. Effective implementation of overseas development assistance programmes for tobacco control**

Planning and project management	<p>Appoint an effective project manager.</p> <p>Agree to goals and objectives at the outset.</p> <p>Secure agreement in principle to the scope of the project (interventions, modes of working, time frames, deliverables).</p> <p>For comprehensive interventions, plan:</p> <ul style="list-style-type: none"> <li>• establishment of relationships</li> <li>• assessment of needs in a SWOT<sup>1</sup> analysis</li> <li>• scope of project</li> <li>• capacity-building in identified areas</li> <li>• continual support</li> <li>• evaluation.</li> </ul>
Focus on the WHO FCTC	<p>Use the WHO FCTC as a basis and driver for action, but consider interventions that build on and exceed obligations under the Convention.</p>
Flexibility	<p>Flexible project and consultants.</p> <p>Flexible programme design and implementation (time frame and duration of project, phasing of work, scope of interventions).</p> <p>Ability to respond to changing circumstances.</p>
Approaches	<p>Provide for:</p> <ul style="list-style-type: none"> <li>• full collaboration on all aspects of implementation between the country and the implementing agency</li> <li>• well-timed country visits, at a frequency and duration consistent with the countries' preferences and ability to support</li> <li>• locally appropriate skills transfer (through workshops, focus groups, direct training, training trainers, Internet-based support, printed materials)</li> <li>• continual support and capacity-building (e.g. desk-based)</li> <li>• integration with other programmes and work plans.</li> </ul> <p>Consider means of providing continuing low-level support, including capacity-building (through regional networks or a resource person for peer review or mentoring) after completion of the project.</p>

**Table 6. Effective implementation of overseas development assistance programmes for tobacco control**

<p>Personnel skills and attitudes</p>	<p>In countries, select personnel who:</p> <ul style="list-style-type: none"> <li>• are good project managers and planners, who can focus on both the overall project and detailed implementation</li> <li>• are good at forming relationships and networking</li> <li>• take direction and are respectful</li> <li>• are flexible</li> <li>• respect other cultures and customs</li> <li>• are skilled in capacity-building and sharing skills and knowledge</li> <li>• are technically knowledgeable in tobacco control</li> <li>• are professional</li> <li>• can develop rapport and modes of working that are appropriate to the country partners</li> <li>• are good facilitators and presenters</li> <li>• have a personal commitment to tobacco control and public health</li> <li>• can be involved in the project throughout its life (continuity).</li> </ul>
---------------------------------------	--

\* Strengths, weaknesses, opportunities, threats

## References

1. *WHO Framework Convention on Tobacco Control*. Geneva, World Health Organization ([http://www.who.int/fctc/text\\_download/en/index.html](http://www.who.int/fctc/text_download/en/index.html), Accessed 29 December 2011).
2. Royal College of Physicians. *Smoking and health. A report of the Royal College of Physicians on smoking in relation to cancer of the lung and other diseases*. London, Pitman Medical Publishing Co Ltd, 1962.
3. United States Surgeon General's Advisory Committee on Smoking and Health. *Smoking and health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*. Washington DC, United States Public Health Service, 1964 (<http://profiles.nlm.nih.gov/NN/B/C/X/B/>, Accessed 29 December 2011).
4. *2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases*. Geneva, World Health Organization, 2008 (<http://www.who.int/nmh/Actionplan-PC-NCD-2008.pdf>, Accessed 29 December 2011).
5. *Prevention and control of non-communicable diseases. Report of the Secretary-General: report to the United Nations General Assembly*. 19 May 2011. A/66/83. ([http://www.un.org/ga/search/view\\_doc.asp?symbol=A/66/83&Lang=E](http://www.un.org/ga/search/view_doc.asp?symbol=A/66/83&Lang=E), Accessed 11 August 2011).
6. *WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco*. 2011. Geneva: World Health Organization, 2011 ([http://whqlibdoc.who.int/publications/2011/9789240687813\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789240687813_eng.pdf), Accessed 11 August 2011).
7. Beaglehole R, Yach D. Globalization and the prevention and control of non-communicable diseases: the neglected chronic diseases of adults. *Lancet*, 2003, 362:903–908.
8. Yach D et al. The global burden of chronic diseases: overcoming impediments to prevention and control. *Journal of the American Medical Association*, 2004, 291:2616–2622.
9. Horton R. The neglected epidemic of chronic disease. *Lancet*, 2005, 366:1514.
10. *Global strategy for the prevention and control of noncommunicable diseases*. In: *2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases*. Geneva, World Health Organization, 2008 (<http://www.who.int/nmh/Actionplan-PC-NCD-2008.pdf>, Accessed 29 December 2011).
11. *Noncommunicable diseases, poverty and the development agenda*. World Health Organization discussion paper, 5 May 2009 for the ECOSOC/UNESCWA/WHO Western Asia Ministerial Meeting, *Addressing noncommunicable diseases and injuries: major challenges to sustainable development in the 21st century*, Doha, 10–11 May 2009. Geneva, World Health Organization, 2009.
12. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008 ([http://whqlibdoc.who.int/publications/2008/9789241563703\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf), Accessed 29 December 2011).
13. Conference of the Parties to the WHO Framework Convention on Tobacco Control. *Financial resources and mechanisms of assistance: report by the Convention Secretariat*. Geneva, World Health Organization, 2010 (A/FCTC/COP/4/16) ([http://apps.who.int/gb/fctc/PDF/cop4/FCTC\\_COP4\\_16-en.pdf](http://apps.who.int/gb/fctc/PDF/cop4/FCTC_COP4_16-en.pdf), Accessed 24 August 2012).

14. United Nations. *Prevention and control of non-communicable diseases*. Resolution 64/265 of the General Assembly. New York, 2010 (<http://esango.un.org/event/documents/ARES64265.pdf>, Accessed 31 December 2011).
15. United Nations General Assembly. *Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*. New York, 2011 (Document A/66/L.1)([http://www.un.org/ga/search/view\\_doc.asp?symbol=A%2F66%2FL.1&Lang=E](http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL.1&Lang=E), Accessed 31 December 2011).
16. Australian Government. *New global commitment to tackle non-communicable diseases*. Canberra, 2011. ([http://www.ausaid.gov.au/hottopics/topic.cfm?ID=4192\\_2973\\_9096\\_8707\\_7049&From=HT](http://www.ausaid.gov.au/hottopics/topic.cfm?ID=4192_2973_9096_8707_7049&From=HT), Accessed 26 October 2011).
17. Secretariat of the Pacific Community. *Healthy Pacific lifestyles—2-1-22 Programme* ([http://www.spc.int/hpl/index.php?option=com\\_content&task=blogcategory&id=21&Itemid=49](http://www.spc.int/hpl/index.php?option=com_content&task=blogcategory&id=21&Itemid=49), Accessed 29 December 2011).
18. *Supporting prevention and control of non-communicable diseases in developing countries: Call for proposals*. 2009, Brussels, European Commission ([http://www.enpi-info.eu/maineast.php?id=18552&id\\_type=4](http://www.enpi-info.eu/maineast.php?id=18552&id_type=4), Accessed 29 December 2011).
19. Ross A, Bettcher D. *STC: The solidarity tobacco contribution. A new international health-financing concept prepared by the World Health Organization*. Geneva, World Health Organization ([http://www.who.int/nmh/events/un\\_ncd\\_summit2011/ncds\\_stc.pdf](http://www.who.int/nmh/events/un_ncd_summit2011/ncds_stc.pdf), Accessed 29 December 2011).
20. *The Framework Convention on Tobacco Control: a primer*. Geneva, World Health Organization, 2003 (WHO/NCD/TFI/99.8 Rev.7) ([http://whqlibdoc.who.int/hq/2003/WHO\\_NCD\\_TFI\\_99.8\\_Rev.7.pdf](http://whqlibdoc.who.int/hq/2003/WHO_NCD_TFI_99.8_Rev.7.pdf), Accessed 29 December 2011).
21. Hammond R, Assunta M. The Framework Convention on Tobacco Control: promising start, uncertain future. *Tobacco Control*, 2003, 12:241–242.
22. *First action plan for tobacco control—years 2000 to 2004*. New Delhi, WHO Regional Office for South-East Asia, 2000.
23. Conference of the Parties to the WHO Framework Convention on Tobacco Control. *Review of existing and potential sources and mechanisms of assistance: note by the Secretariat*. Geneva, World Health Organization, 2006 (A/FCTC/COP1/4) ([http://www.who.int/gb/fctc/PDF/cop1/FCTC\\_COP1\\_4-en.pdf](http://www.who.int/gb/fctc/PDF/cop1/FCTC_COP1_4-en.pdf), Accessed 29 December 2011).
24. *Tobacco control in EC development policy: a background paper for the High Level Round Table on Tobacco Control and Development Policy*. Brussels, European Commission, 3–4 February 2003 ([http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/Documents/030129ec\\_paper\\_com\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/030129ec_paper_com_en.pdf), Accessed 29 December 2011).
25. *A portrait of health: key results of the 2006/07 New Zealand Health Survey*. Wellington, Ministry of Health, 2008 (<http://www.health.govt.nz/publication/portrait-health-key-results-2006-07-new-zealand-health-survey>, Accessed 31 December 2011).
26. Anon. Cigarette factory draws criticism. *New Zealand Herald*, 25 July 1978:1.
27. Wilson N, Thomson G. Pacific peoples killed by New Zealand tobacco industry exports. *New Zealand Medical Journal*, 2001, 114:49–50.

28. *Communication from the Commission to the Council and the European Parliament: Health and poverty reduction in developing countries*. Brussels, European Commission, 2002 ([http://eur-lex.europa.eu/smartapi/cgi/sga\\_doc?smartapi!celexplus!prod!DocNumber&lg=en&type\\_doc=COMfinal&an\\_doc=2002&nu\\_doc=129](http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexplus!prod!DocNumber&lg=en&type_doc=COMfinal&an_doc=2002&nu_doc=129), Accessed 29 December 2011).
29. Wipfli H et al. Achieving the Framework Convention on Tobacco Control's potential by investing in national capacity. *Tobacco Control*, 2004, 13:433–437.
30. Maziak W et al. On the gains of seeding tobacco research in developing countries. *Tobacco Control*, 2006, 15:3–4.
31. Stillman F et al. Building capacity for tobacco control research and policy. *Tobacco Control*, 2006, 15:18–23.
32. Maziak W, Wipfli H. Research assistance matching (RAM) project. *Tobacco Control*, 2005, 14:15.
33. *World Health Report, 1999: making a difference*. Geneva, World Health Organization, 1999 ([http://www.who.int/whr/1999/en/whr99\\_ch6\\_en.pdf](http://www.who.int/whr/1999/en/whr99_ch6_en.pdf), Accessed 29 December 2011).
34. *Michael Bloomberg and Bill Gates join to combat global tobacco epidemic* (press release). Bloomberg Philanthropies, Bill and Melinda Gates Foundation, 23 July 2008 (<http://www.tobaccofreecenter.org/files/pdfs/en/Bloomberg-GatesReleaseFinal.pdf>, Accessed 29 December 2011).
35. *WHO launches new tobacco control effort in Africa* (media release). Geneva, World Health Organization, 4 December 2009 ([http://www.who.int/mediacentre/news/notes/2009/tobacco\\_20091204/en/](http://www.who.int/mediacentre/news/notes/2009/tobacco_20091204/en/), Accessed 29 December 2011).
36. Simpson D. News analysis: Africa/Canada: BAT director on aid board spurs boycott. *Tobacco Control* 2010, 19:175–178.
37. *WHO Framework Convention on Tobacco Control: guidelines for implementation Article 5.3; Article 8; Article 11; Article 13*. World Health Organization, Geneva, 2009 (<http://www.who.int/fctc/protocol/guidelines/adopted/en/>, Accessed 29 December 2011).
38. Organisation for Economic Co-operation and Development. *Managing aid: practices of DAC member countries*. Paris, 2009.
39. Conference of the Parties to the WHO Framework Convention on Tobacco Control. *Matters identified in decisions taken by the Conference of the Parties that call for action in the period between its first and second sessions*. Geneva, World Health Organization, 2007 (A/FCTC/COP/2/5) ([http://www.who.int/gb/fctc/PDF/cop2/FCTC\\_COP2\\_5-en.pdf](http://www.who.int/gb/fctc/PDF/cop2/FCTC_COP2_5-en.pdf), Accessed 31 December 2011).
40. World Bank. *Curbing the epidemic, governments and the economics of tobacco control*. Washington DC, 1999.
41. Jha P, Chaloupka F, eds. *Tobacco control in developing countries*. Washington DC, World Bank, 2000 (<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTETC/0,,contentMDK:20226973~menuPK:478900~pagePK:148956~piPK:216618~theSitePK:376601,00.html>, Accessed 31 December 2011).
42. *Guidelines for controlling and monitoring the tobacco epidemic*. Geneva, World Health Organization, 1998.
43. Bloomberg Initiative. *Bloomberg initiative to reduce tobacco use grants program*. New York, 2010 (<http://tobaccocontrolgrants.org/Pages/27/Common-Questions>, Accessed 29 December 2011).

44. Central Intelligence Agency. *CIA World Factbook*. Washington DC, 2008 (<https://www.cia.gov/library/publications/the-world-factbook/index.html>, Accessed 29 December 2011).
45. World Health Organization, Secretariat for the Pacific Community. *Pacific framework for the prevention and control of non-communicable diseases*. Manila, WHO Regional Office for the Western Pacific ([http://www.spc.int/hpl/index.php?option=com\\_content&task=blogcategory&id=21&Itemid=49](http://www.spc.int/hpl/index.php?option=com_content&task=blogcategory&id=21&Itemid=49), Accessed 31 December 2011).
46. Parliament of Tonga. *Health Promotion Foundation Act 2007, Act No. 2 of 2007*. Nuku'alofa 14 August 2007 (<http://legislation.to/Tonga/DATA/PRIN/2007-002/HealthPromotionFoundationAct2007.pdf>, Accessed 29 December 2011).
47. Taylor A et al. The impact of trade liberalization on tobacco consumption. In: Jha P, Chaloupka FJ, eds. *Tobacco control in developing countries*. Oxford, Oxford University Press, 2000.
48. Secretariat of the Pacific Community. *Tobacco and alcohol in the Pacific island Countries Trade Agreement: impacts on population health: a report commissioned by the Secretariat of the Pacific Community for use by governments and administrations in the Pacific*. Noumea, 2005 (<http://web.idrc.ca/uploads/user-S/12109511571001726-051-FINALReport-PICTA.pdf>, Accessed 31 December 2011).
49. Epping-Jordan JE et al. Preventing chronic diseases: taking stepwise action. *Lancet*, 2005, 366:1667–1671.
50. Secretariat of the Pacific Community. Pacific Action for Health Project (<http://www.spc.int/en/pacific-action-for-health-project-pahp/152-pacific-action-for-health-project-pahp.html>, Accessed 23 December 2011).
51. Douglas M. *Tobacco control in the Pacific: evaluation of program support phase 1 (2003–2004) and phase 2 (2005–2008)*. Wellington, New Zealand Agency for International Development, 2008. (<http://www.aid.govt.nz/about-aid-programme/measuring-results/evaluation/activity-reports/2008-review-and-evaluation-reports/evaluation-build>, Accessed 24 August 2012).
52. Conference of the Parties to the WHO Framework Convention on Tobacco Control. *Cooperation with international organizations and bodies for strengthening implementation of the Convention: report by the Convention Secretariat*. Geneva, World Health Organization, 2010 (A/FCTC/COP/4/17) (<http://apps.who.int/gb/fctc/PDF/cop4/FCTC COP4 17-en.pdf>, Accessed 24 August 2012).
53. ECOSOC. *United Nations system-wide coherence on tobacco control*. E/2012/L.18. 20 July 2012 ([http://www.who.int/nmh/events/2012/ecosoc\\_20120727.pdf](http://www.who.int/nmh/events/2012/ecosoc_20120727.pdf), Accessed 30 August 2012).
54. Conference of the Parties to the WHO Framework Convention on Tobacco Control. *Cooperation with international organizations and bodies for strengthening implementation of the Convention: report by the Convention Secretariat*. Geneva, World Health Organization, 2012 (A/FCTC/COP/5/16) (<http://apps.who.int/gb/fctc/PDF/cop5/FCTC COP5 16-en.pdf>, Accessed 30 September 2012).

# Annex: Application of principles of overseas development assistance by funders

## A1. The Paris Declaration on Aid Effectiveness

The Paris Declaration of 2005 (1) contains a “practical, action-oriented roadmap to improve the quality of aid and its impact on development”. The aim of the Declaration is to ensure international cooperation, harmonization and alignment in development assistance. It emphasizes working within the institutions and systems of developing countries to achieve development goals and provides an agreed set of indicators and targets with which to monitor the effectiveness of aid. Over 100 countries and many development agencies have agreed to adhere to the Paris Declaration.<sup>19</sup> The principles of development assistance according to the Declaration are:

- Developing countries must exercise strong and effective leadership over development policies and strategies and coordinate development actions.
- Countries receiving aid should strengthen their development capacity with the support of donor countries.
- The institutions of developing countries should be used in giving aid.
- Development assistance should be adapted and applied to the situation in each country.
- Indicators, timetable and targets should be specified.
- Implementation should be monitored and evaluated by appropriate national mechanisms.
- Funding should be linked to a single framework of conditions or a manageable set of indicators derived from the national development strategy.
- The effectiveness of aid must be monitored on the basis of 12 indicators of progress and aid effectiveness.<sup>20</sup>
- Donor countries must cooperate and harmonize their development assistance.
- There should be a focus on results-oriented development assistance.
- Donors and partners should be held mutually accountable for development results.

## A2. Third and Fourth High-level Fora on Aid Effectiveness and the Accra Agenda

The Third Forum was hosted by the Government of Ghana in September 2008 and was attended by representatives from developing and donor countries, United Nations and multilateral institutions, global funds, foundations and civil society organizations.

The Forum reviewed progress on implementation of the Paris Declaration on the basis of evidence collected in a survey conducted in 54 countries and an evaluation of how a subset of recipient and donor countries were implementing the Paris principles.<sup>21</sup>

The Accra Agenda for Action was adopted at the Forum (2). It was intended to reflect an international commitment to support the reforms required to accelerate effective application of development assistance and to help ensure achievement of the MDGs (see below) by 2015. The Agenda addresses

<sup>19</sup> A list of countries and international agencies that are committed to adhering to the Paris Declaration is available at: [http://www.oecd.org/document/22/0,3343,en\\_2649\\_3236398\\_36074966\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/22/0,3343,en_2649_3236398_36074966_1_1_1_1,00.html), Accessed 10 July 2012.

<sup>20</sup> The 12 indicators are available at: <http://www.oecd.org/dataoecd/57/60/36080258.pdf>, Accessed 10 July 2010.

<sup>21</sup> See monitoring and evaluation documentation prepared in relation to the Paris Declaration: <http://www.oecd.org/dataoecd/59/0/41202112.pdf>, Accessed 10 July 2012.

aid effectiveness by responding to the main technical, institutional and political challenges to full implementation of the Paris principles.

The key points in the Accra Agenda for Action are:

- *Predictability*: Developing countries will strengthen the links between public expenditure and results, and donors will state how much aid they are planning to give to partner countries by 2015.
- *Ownership*: Developing country governments will engage more with their parliaments and civil society organizations.
- *Country systems*: The first option for aid in partner countries is their own systems, rather than donor systems, and donors will share plans for increasing the use of country systems.
- *Conditionality*: Donors will no longer prescribe the conditions under which aid money is spent but will base it on the country's development objectives.
- *Untying*: Donors will make further plans to avoid limiting their aid.
- *Aid fragmentation*: Donors will avoid creating new aid channels, and donors and recipient countries will work on a division of labour at country level.
- *Partnerships*: All actors are encouraged to use the principles of the Paris Declaration, and South-South cooperation is welcomed.
- *Transparency*: Donors and countries will increase efforts to have mutual assessment reviews in place by 2010. These will involve stronger engagement of parliaments and citizens and will be complemented with credible, independent evidence (3).

In November 2011, members of the global community reunited in Busan, South Korea, for the Fourth High-Level Forum on Aid Effectiveness. The purpose of this Forum was to review global progress in improving the impact and value for money of aid efforts, and for delegates to make new commitments to further ensure that aid supports progress in meeting the Millennium Development Goals. In particular, delegates discussed progress towards implementing the Paris Declaration principles, and in meeting the targets of the Accra Agenda for Action.

The finding was that though significant progress has been made, donors and developing countries have fallen short of the targets set at the Third Forum to be achieved by 2010. The OECD explained that “although the Accra Agenda for Action was adopted in 2008 to accelerate progress with a call for heightened focus on country ownership, more inclusive partnerships, and increased accountability for and transparency about development results, progress in 2010 was still lagging on the majority of the Paris Declaration commitments.”<sup>22</sup>

The Forum culminated in the Busan Partnership for Effective Development cCooperation, which was signed by representatives of developed and developing nations. This agreement established an agreed framework for development cooperation, including traditional donors, South-South co-operators, the BRICS, civil society organisations and private funders.

---

22 Progress towards more effective aid: What does the evidence show? Talaat Abdel-Malek and Bert Koenders, Co-Chairs, Working Party on Aid Effectiveness, October 2011. <http://www.oecd.org/dataoecd/39/19/48966414.pdf> (Accessed 17 July 2012).

### A3. Development Assistance Committee of the Organisation for Economic Co-operation and Development

The OECD Development Assistance Committee is a forum in which donor governments and multilateral organizations like the World Bank and the United Nations meet to increase the effectiveness of their aid and coordinate their development efforts. The main principles of the Committee for development assistance are (4):

- pro-poor economic growth;
- cooperation and harmonization between overseas development assistance donors to share information, simplify procedures and prevent duplication;
- reviewing and evaluating development assistance systems, policies and outcomes (on the basis of the 12 indicators of the Paris Declaration);
- including gender equality as part of development;
- ownership: “Developing countries set their own strategies for poverty reduction, improve their institutions, and tackle corruption.” Improving governance by reforming security systems (to secure peace and stability) and fighting corruption; and
- making the environment a core consideration in all development activities.

### A4. The Millennium Development Goals

In September 2000 at the United Nations Millennium Summit, world leaders agreed to time-bound, measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. While the MDGs are not strictly principles for overseas development assistance, they provide a focal point for the support of developing countries and countries with economies in transition (5). The eight MDGs are:

- Goal 1: Eradicate extreme poverty and hunger.
- Goal 2: Achieve universal primary education.
- Goal 3: Promote gender equality and empower women.
- Goal 4: Reduce child mortality.
- Goal 5: Improve maternal health.
- Goal 6: Combat HIV/AIDS, malaria and other diseases.
- Goal 7: Ensure environmental sustainability.
- Goal 8: Develop a global partnership for development.

Commentators have analysed how each MDG can be linked to tobacco use and how tobacco control can be integrated into programmes for achieving the MDGs (6–8). For example, in relation to poverty elimination, spending on tobacco undermines household incomes. Spending on tobacco also limits spending on education, and engagement of children in tobacco production limits their opportunities. The increase in smoking among women threatens advances in their economic and maternal health, while tobacco use by pregnant women and exposure of their children to second-hand smoke can undermine efforts to reduce child mortality. Tobacco use promotes the onset and outcome of tuberculosis. Tobacco growing has a significant adverse impact on the environment.

There have been calls for the MDGs to be updated to incorporate measures to address the increasing impact of noncommunicable diseases. In 2009, for example, WHO noted (6) that the World

Economic Forum had ranked those diseases as the global risk that was the third most likely to occur and the fourth most severe in its impact if it did. It was stated that failure to address noncommunicable diseases will hinder achievement of the MDGs.

## A5. Development assistance principles adopted by donors

Preparation of this publication included a review of policies and guidelines on development assistance and capacity-building from several agencies, including WHO, the United Nations, SPC, the New Zealand Aid Programme, AusAID, the Asian Development Bank and the European Commission. These agencies were considered to be relevant to the Pacific states included in the case study described in section 4. A report by the WHO-sponsored Commission on Social Determinants of Health is also relevant to setting aid policy for reducing the burden of chronic diseases in developing countries. All these agencies take into account to varying degrees the MDGs, the Paris Declaration and the guidelines of the OECD Development Assistance Committee in determining their priorities and modes of operation.

### *World Health Organization*

The Paris Declaration and the MDGs are central elements in WHO's health and aid policies. The Paris Declaration is used as the framework for assessing aid effectiveness in health: "... the Paris Declaration is a key point of reference for improvements in health aid", and the health-related MDGs are explicitly incorporated in WHO's objectives (9).

*The World Health Report 1999* (10) summarized the areas in which WHO (and other agencies) should use their limited resources to provide assistance to countries:

- In order to enhance impact, concentrate technical assistance on countries with a shared strategic vision.
- Outsiders should avoid imposing their own perspectives; rather, they should support projects and policies to which recipient governments are committed.
- Concentrating resources on poor countries or vulnerable groups without alternative sources of finance will amplify impact.
- The international community should avoid using its resources for activities that countries can perform for themselves; international resources should, instead, be concentrated on functions for which collective international action is required.

In 2005, WHO established the Commission on Social Determinants of Health to examine the evidence on actions to promote health equity and to foster a global movement to achieve it. The Commission's report (6), released in 2008, noted that action on the social determinants of health must involve all sectors of government and must take into account the fact that economic development and growth without appropriate social policies to promote fairness in the distribution of resources do little to improve health equity.

The Commission's report recognized the value of overseas development assistance, stating that the main value of aid was as a mechanism for the "... reasonable distribution of resources in the common endeavour of social development". It called for increased aid as well as increased quality of aid, endorsing the Paris Declaration, while calling for donors to consider channelling most of their aid through a single multilateral mechanism. The Commission called for poverty reduction planning at national and local levels in recipient countries to adopt a social-determinants-of-health framework to promote coherent, cross-sectoral financing. This, it was suggested, could help to demonstrate

how aid is allocated and the impact it has. The Commission called on the United Nations to make health equity a global development goal and to adopt a social-determinants-of-health framework to strengthen multilateral action on development.

### *United Nations*

In 2009 the United Nations reviewed its guidelines for its country teams, which build capacity in countries to pursue poverty elimination, sustained economic growth, peace-building and human rights (11). The guidelines affirm the United Nations' commitment to "...working with governments and civil society partners to achieve the agenda endorsed by the 2005 World Summit, the Millennium Declaration, and the Millennium Development Goals and other internationally agreed treaty obligations and development goals". The country team guidelines emphasize:

- national ownership at all stages of development assistance;
- exploiting comparative advantage, by focusing efforts where United Nations country teams can provide leadership and make the greatest difference; and
- maximizing effectiveness and accountability, whereby performance is measurable and accountability clarified, so that the system can deliver effectively.

The document also lists five interrelated principles to be applied at country level: a human rights-based approach, gender equality, environmental sustainability, results-based management and capacity development.

The action plan of the United Nations Development Group for implementation of the Paris Declaration states specific commitments to increase effectiveness (12).

### *Secretariat of the Pacific Community*

For the SPC, the MDGs are central international agreements on which to base its work (13), although the SPC's objectives and activities are broader than the MDGs, aimed at meeting the specific needs of the Pacific Region. The guiding principles include:

- a focus on members' priorities;
- response to needs;
- alleviation of poverty and promotion of sustainable development;
- promotion of gender, environmental and cultural sensitivity;
- provision of excellent service;
- emphasis on results and accountability; and
- transparent operation.

### *New Zealand Aid Programme*

The MDGs and the Paris Declaration are stated as sources of the New Zealand Aid Programme policy direction in development assistance. Aspects of the New Zealand Aid Programme approach to improving the effectiveness of aid include (14):

- close alignment with partner country needs and with sectoral or national plans of partner countries;
- a focus on mutual accountability for results;

- the pursuit of concrete, measurable development results;
- support for fewer, larger, longer-term comprehensive initiatives;
- coordination with other donors, especially Australia;
- a focus on effectiveness and cost efficiency of initiatives;
- the promotion of partnerships with governments, the private sector, multilateral and regional agencies, NGOs and other civil society organisations;
- robust monitoring and evaluation;
- consistency of development assistance with NZ foreign policy; and
- programmes reflecting and encouraging recognised values such as transparency, accountability, democratic governance, gender equity and the rule of law.

### *AusAID*

Australia has stated it is committed to the implementation of both the MDGs and the Paris Declaration on Aid Effectiveness. AusAID's objectives are guided by five core strategic goals, consistent with the MDGs:

- saving lives;
- opportunities for all;
- sustainable economic development;
- effective governance; and
- humanitarian and disaster response" (16).

Principles of AusAID that are similar to those of the Paris Declaration and the OECD Development Assistance Committee include: ownership (17), assessing the effectiveness of aid (18), harmonizing and aligning with partners and other donors (19), combating corruption (20), and recognizing gender equality as integral to growth, governance and stability (20).

### *Asian Development Bank*

The Asian Development Bank lists three 'pillars' for effective, socially inclusive development: pro-poor sustainable economic growth, good governance and social development (21). These three pillars form the basis for the Bank's poverty reduction policy. The principles of development assistance are (21,22):

- economic cooperation within the region;
- economic development accompanied by social development;
- pro-poor sustainable economic growth based on policies and programmes that facilitate employment and income generation for the poor;
- good governance: anticorruption, fiscal discipline, transparent use of public funds, sound macroeconomic management, and adequate allocations for basic education, primary health care and other public services;
- infrastructure development;
- promotion of private sector-led growth; and
- replacement of market-distorting interventions by sound macroeconomic management.

### *European Commission*

The European Commission's report *Health and poverty reduction in developing countries* (23) includes discussion on principles for effective development assistance in health, including:

- poverty reduction as a central goal of assistance;
- noting the commitment to the MDGs by most governments and international organizations;
- increased ownership, good governance and stewardship at country level as prerequisites for development effectiveness and efficiency;
- promotion, at global level, of coherence in international development policies and institutions;
- use of sector-wide approaches, including harmonization of donor policies and procedures, to increase the effectiveness of aid;
- a focus on coordinated and pro-poor health policies;
- promotion of a healthy environment;
- encouragement of corporate responsibility;
- recognition of the importance of global public goods (such as research); and
- consideration of public–private partnerships (such as, with philanthropists).

The paper *Tobacco control in EC development policy* also highlighted poverty reduction as the overarching objective of the EC development policy and noted three cross-cutting principles for development assistance: human rights, gender equality, and the environment (24).

## References

1. *Paris Declaration on Aid Effectiveness*. Paris, Organisation for Economic Co-operation and Development, 2005 (<http://www.oecd.org/dataoecd/11/41/34428351.pdf>, Accessed 17 July 2012).
2. *The Paris Declaration on Aid Effectiveness and Accra Agenda for Action. Product of the Third High-level Forum on Aid Effectiveness*, Accra, 2008 ([http://www.oecd.org/document/3/0,3746,en\\_2649\\_3236398\\_41297219\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/3/0,3746,en_2649_3236398_41297219_1_1_1_1,00.html), Accessed 17 July 2012).
3. *Accra Agenda for Action, Product of the Third High-level Forum on Aid Effectiveness*, Accra, 2008 (<http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER-FINAL-16h00.pdf>, Accessed 9 August 2012).
4. *Development Assistance Committee ... where governments come together to make aid work*. Paris, Office for Economic Co-operation and Development, 2007 (<http://www.oecd.org/dataoecd/39/58/39218438.pdf>, Accessed 17 July 2012).
5. *End Poverty 2015: Make it happen. Millennium Development Goals*. New York, United Nations, 2000 (<http://www.un.org/millenniumgoals/>, Accessed 17 July 2012).
6. *Noncommunicable diseases, poverty and the development agenda*. Geneva, World Health Organization. Discussion paper, 5 May 2009 for the ECOSOC/UNESCWA/WHO Western Asia Ministerial Meeting, *Addressing noncommunicable diseases and injuries: major challenges to sustainable development in the 21st century, Doha, 10–11 May 2009*. Geneva, World Health Organization, 2009.
7. *The Millennium Development Goals and Tobacco Control*. Tobacco Control Center website ([http://global.tobaccofreekids.org/files/pdfs/en/MDGs\\_en.pdf](http://global.tobaccofreekids.org/files/pdfs/en/MDGs_en.pdf), Accessed 17 July 2012).
8. *The Millennium Development Goals and tobacco control: an opportunity for global partnership*. Geneva, World Health Organization, 2004 ([http://www.who.int/tobacco/publications/mdg\\_final\\_for\\_web.pdf](http://www.who.int/tobacco/publications/mdg_final_for_web.pdf), Accessed 17 July 2012).
9. *Aid effectiveness and health: working paper no. 9*. Geneva, World Health Organization, 2007 (WHO/HSS/healthsystems/2007.2) (<http://www.who.int/management/workingpaper9.pdf>, Accessed 17 July 2012).
10. *World Health Report, 1999: making a difference*. Geneva, World Health Organization, 1999 ([http://www.who.int/whr/1999/en/whr99\\_ch6\\_en.pdf](http://www.who.int/whr/1999/en/whr99_ch6_en.pdf), Accessed 17 July 2012).
11. *Common country assessment and United Nations development assistance framework: guidelines for UN country teams on preparing a CCA and UNDAF*. New York, United Nations Development Group, 2007 (updated 2009) (<http://www.undg.org/?P=16>, Accessed 17 December 2012).
12. *Beyond the Paris High-level Forum on Aid Effectiveness: action plan of the UN Development Group*. 2005. New York, United Nations Development Group ([http://www.searo.who.int/LinkFiles/Strategic\\_Alliance\\_and\\_Partnerships\\_5c\\_Action\\_Plan.pdf](http://www.searo.who.int/LinkFiles/Strategic_Alliance_and_Partnerships_5c_Action_Plan.pdf), Accessed 17 July 2012).
13. *Corporate plan 2003–2005*. Noumea, Secretariat of the Pacific Community, 2003.
14. *International Development Policy Statement: Supporting sustainable development*. Wellington, New Zealand Aid Programme Ministry of Foreign Affairs and Trade, March 2011 ([http://www.aid.govt.nz/webfm\\_send/3](http://www.aid.govt.nz/webfm_send/3), Accessed 17 July 2012).

15. *Empowering women reduces poverty*. Wellington, New Zealand Agency for International Development, undated ([http://cdwi.net/uploads/library/nzaid/2008/45\\_NZAID2008.pdf](http://cdwi.net/uploads/library/nzaid/2008/45_NZAID2008.pdf), Accessed 31 December 2011).
16. *Australian Aid*, Canberra, Australian Agency for International Development 2011 (<http://www.ausaid.gov.au/Publications/Documents/australian-aid-brochure.pdf>, Accessed 17 July 2012).
17. *Australian aid: promoting growth and stability. A white paper on the Australia Government's overseas aid program*. Canberra, Australian Agency for International Development, 2006 ([http://www.AusAID.gov.au/publications/pubout.cfm?Id=6184\\_6346\\_7334\\_4045\\_8043](http://www.AusAID.gov.au/publications/pubout.cfm?Id=6184_6346_7334_4045_8043), Accessed 29 December 2011).
18. *Annual Review of Development Effectiveness 2008*. Canberra, Australian Agency for International Development, 2008 ([http://www.ode.ausaid.gov.au/publications/pdf/arde\\_report-2008.pdf](http://www.ode.ausaid.gov.au/publications/pdf/arde_report-2008.pdf), Accessed 17 July 2012).
19. *AusGuide—a guide to program management*. Canberra, Australian Agency for International Development, 2005 (<http://www.ausaid.gov.au/ausguide/default.cfm>, Accessed 29 December 2011).
20. *Promoting opportunities for all: Gender equality and women's empowerment. Thematic strategy November 2011*. Canberra, Australian Agency for International Development, November 2011 (<http://www.ausaid.gov.au/aidissues/Documents/thematic-strategies/gender-equality-strategy.pdf>, Accessed 17 July 2012).
21. *Enhancing the Fight Against Poverty in Asia and the Pacific: The Poverty Reduction Strategy of the Asian Development Bank*. Manila, Asian Development Bank, 2004 (<http://www.adb.org/documents/enhancing-fight-against-poverty-asia-and-pacific-poverty-reduction-strategy-asian-developm>, Accessed 17 July 2012).
22. *Philippines: Private Sector Development: Challenges and Possible Ways to Go*. Manila, Asian Development Bank, August 2011 (<http://www.adb.org/publications/philippines-private-sector-development-challenges-and-possible-ways-go>, Accessed 17 July 2012).
23. *Communication from the Commission to the Council and the European Parliament: Health and poverty reduction in developing countries*. Brussels, European Commission, 2002 ([http://eur-lex.europa.eu/smartapi/cgi/sga\\_doc?smartapi!celexplus!prod!DocNumber&lg=en&type\\_doc=COMfinal&an\\_doc=2002&nu\\_doc=129](http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexplus!prod!DocNumber&lg=en&type_doc=COMfinal&an_doc=2002&nu_doc=129), Accessed 17 July 2012).
24. *Tobacco control in EC development policy: a background paper for the High Level Round Table on Tobacco Control and Development Policy*. Brussels, European Commission, 3–4 February 2003 ([http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/Documents/030129ec\\_paper\\_com\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/030129ec_paper_com_en.pdf), Accessed 17 July 2012).







*Overseas development assistance programmes for tobacco control: a framework for action* explores commentary on development assistance principles both generally and in the tobacco control area. It also presents a case study of a tobacco control development assistance programme implemented in six Pacific island states between 2003 and 2007 and draws out lessons from this experience. A potential framework for developing, implementing and evaluating development assistance programmes in the area of tobacco control is presented with a view to consolidating and encouraging application of key lessons for future assistance programmes.

It is hoped that the report will promote further discussion and refinement of approaches to overseas development assistance in tobacco control, as well as encourage governments and development funding agencies to invest further in this area. It will be a useful resource for agencies who are considering funding, implementing or evaluating overseas development assistance programmes including, but not limited to the area of tobacco control.