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WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Development Planning and Tobacco Control

Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments

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ACRONYMS AND ABBREVIATIONS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COP	The Conference of the Parties to the World Health Organization Framework Convention on Tobacco Control
COP1	First Session of the COP
ECOSOC	United Nations Economic and Social Council
GDP	Gross domestic product
HICs	High-income countries
IATF	United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control
LMICs	Low- and middle-income countries
MDGs	Millennium Development Goals
NCDs	Noncommunicable diseases
NDP	National development plan
OHCHR	Office of the United Nations High Commissioner for Human Rights
PRSP	Poverty Reduction Strategy Paper
SWAp	Sector-wide approach
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHO FCTC	World Health Organization Framework Convention on Tobacco Control

EXECUTIVE SUMMARY

Tobacco use, driven by industry marketing and fuelled by social inequities, is killing 6 million people per year, inhibiting socio-economic development at household, national and global levels, exacting economic burdens on national health care systems, infringing human rights and obstructing progress towards achieving the Millennium Development Goals (MDGs). The World Health Organization (WHO) Framework Convention on Tobacco Control (WHO FCTC) is a ground-breaking international legally binding treaty that takes a comprehensive, evidence-based approach to addressing these devastating effects. The Convention acknowledges the relationship between tobacco and development and makes connections to relevant United Nations (UN) conventions that protect populations, including those on human rights, particularly the right to health. With its multisectoral approach to both the supply and demand sides of tobacco use, and a mandate for international cooperation, the treaty is a significant global public health accomplishment.

Despite the progress made, difficulties in implementation have thus far prevented the treaty from realizing its full potential to halt the tobacco epidemic. Without accelerated WHO FCTC implementation, it will be virtually impossible to meet the World Health Assembly's recently adopted target of a 25 percent reduction in premature mortality from noncommunicable diseases (NCDs) by 2025.[1] To support this much-needed progress, governments are expected to increase their domestic budget allocations for tobacco control measures, and development partners are expected to facilitate improved access to international development assistance.

The Conference of the Parties (COP) to the WHO FCTC, UN General Assembly, UN Economic and Social Council (ECOSOC) and UN Secretary-General's successive reports on the meetings of the Ad Hoc Inter-agency Task Force on Tobacco Control (IATF) have recognized the urgent need to integrate WHO FCTC implementation into countries' health and development plans and called upon the UN agencies, programmes and funds to provide coordinated support in the pursuit thereof. At the country level, the prioritization of tobacco control in national development planning would facilitate its inclusion in the UN system response as articulated through the UN Development Assistance Frameworks (UNDAFs), which are the strategic programme frameworks jointly agreed between governments and the UN system outlining priorities in national development.

Within this context, it has been proposed that the United Nations Development Programme (UNDP) take on a significant role. Among a broader division of labour within the UN regarding assistance to WHO FCTC implementation, the May 2012 report of the Secretary-General to ECOSOC on the Ad Hoc Inter-Agency Task Force on Tobacco Control notes that UNDP take into account the requirements of Article 5, in the UNDP country-level role as convener and coordinator, where appropriate and under its governance programmes. UNDP's engagement on WHO FCTC implementation aligns fully with the UNDP Strategic Plan 2014-2017, which emphasizes: strengthening institutions and sectors to progressively deliver universal access to basic services; the importance of social, economic and environmental co-benefit analysis and planning; inclusive social protection; whole-of-government and whole-of-society initiatives; and addressing inequalities. All of these priorities characterize UNDP's approach to addressing the social determinants of NCDs and health outcomes more broadly.[2]

[1] In May 2012, pursuant to an agreement at the September 2011 UN NCD Summit, 194 WHO Member States endorsed a historic target to reduce premature deaths from NCDs by 25 percent by 2025 [1]. A target of a 30 percent relative reduction in the prevalence of current tobacco use was also agreed on 7 November 2012 by a Formal Meeting of the Member States as part of the global monitoring framework later adopted at the 66th World Health Assembly [2].

[2] See UNDP's 2013 Discussion Paper on 'Addressing the Social Determinants of Noncommunicable Diseases' [86].

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In response to the high-level political calls to action and decisions taken by ECOSOC and the COP, UNDP and the Convention Secretariat have jointly produced this report to capture emerging lessons learned from practical experience and to provide recommendations for further action to facilitate integrating the WHO FCTC into national development plans (NDPs) and the UNDAFs that support them. In acknowledgement of the fact that accelerated implementation of the WHO FCTC requires the coordinated efforts of multiple stakeholders, the audience for this report is wide. The lessons learned, experiences and recommendations herein are meant primarily for UNDP and relevant UN agency staff, WHO FCTC focal points within government ministries, WHO, the COP, and civil society and national partners. Not all lessons, experiences and recommendations are meant to apply to all actors equally. Some actors will be more suited for some of the elements and, within each element, may have very specific contributions to make tailored to interests, mandates, capacities and available resources. Specific contributions needed from specific partners are defined where clear.

Methodology

To identify lessons and recommendations for further action on integrating the WHO FCTC into NDPs and UNDAFs, the research first reviewed the current status of such integration for the 120 countries (out of 176 Parties at the time of the data collection) that had reported on WHO FCTC activities for the 2012 cycle,[3] suggesting the need for a more robust implementation review mechanism and technical assistance under Article 5 (General Obligations). Second, 48 countries were selected for an in-depth desk analysis. Subsequently, key personnel from Ministries of Health, UNDP Country Offices and WHO were interviewed from 10 of these 48 countries, to provide a more focused case study assessment.

To supplement data collected during interviews and to provide context on the evolving landscape of development planning, a review of documentation from comparative experience was also conducted. This review included analysis of planning and guidance notes on the mainstreaming of other health and development issues, such as HIV and gender equity, as well as evaluations and reports on the UNDAF and national development planning processes.

A snapshot of WHO FCTC integration

From the sample of 48 countries it is clear that there is a low level of inclusion of tobacco in the development planning documents. About 30 percent of the NDPs retrieved support action on tobacco control, and fewer than 25 percent of the UNDAFs included any commitments to support WHO FCTC implementation or tobacco control. Just four countries were found to include commitments to tobacco control in both their NDPs and UNDAFs.

The subsequent in-depth interviews from the 10 case study countries — Bolivia, Brazil, the Gambia, Ghana, Jordan, Mauritania, Moldova, Niger, Palau and Solomon Islands — provided practical experience on the ground; a great deal of congruence was found between the data collected during these interviews and the review of documentation from comparative experience. Together these sources of data were used to compile lessons learned, key enablers and challenges, and recommendations for improving WHO FCTC integration into national development planning and UNDAFs.

[3] Convention Secretariat, '2012 Global Progress Report on implementation of the WHO Framework Convention on Tobacco Control', WHO, Geneva, 2012.

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Lessons learned, enablers and challenges

a) Emerging lessons learned were identified under three key areas: To achieve integration of WHO FCTC implementation into NDPs, the case should be made for tobacco control as a national health and development priority.

- To be included in the NDPs, tobacco control should be prioritized within national health plans and championed by the Ministry of Health.
- Strong commitment and leadership from other ministries relevant to tobacco control (e.g. Ministry of Finance and Ministry of Trade) is crucial.
- Policy advocacy should link tobacco control to economic growth and poverty reduction, using evidence on the health and economic costs of tobacco to counter the arguments of the tobacco industry and entities working to further its interests.
- Efforts should be made to link tobacco control to other development priorities such as maternal and child health, universal health coverage, gender equity and sustainable development.
- The national tobacco control strategies, targets and indicators should address the national development priorities and match the relevant planning instrument frameworks.

b) To be included in the country UNDAF, UN funds and programmes beyond WHO should recognize the relevance of tobacco control to their own objectives and plans.

- The UNDAF is intended to be a tool for aligning the UN system's country-level activities with national priorities, and thus the inclusion of tobacco control in the country UNDAF will push forward its integration into national health plans and NDPs.[4]
- The UNDAF is also an evolving tool for coordinating and harmonizing UN agencies' plans and activities; therefore, for it to be included, more than one agency should specify plans for supporting WHO FCTC implementation. To achieve this, additional efforts will be required, possibly by UNDP, the WHO FCTC Secretariat and/or civil society, to sensitize UN agencies beyond WHO[5] to the relevance of tobacco control to their mandates, and their responsibilities towards implementing the WHO FCTC.
- Equally important are assessments of the macroeconomic impacts of tobacco use and stakeholders' assessments in terms of their role in response and country-level planning.

c) WHO FCTC implementation is a multisectoral endeavour requiring a whole-of-government approach to planning, operational activities and accountability.

- The establishment of a multisectoral coordinating committee at national and municipal levels for tobacco control is not just widely seen as vital for implementing the WHO FCTC and integrating it into broader government planning and accountability; such a committee is an obligation to Parties under Article 5 of the WHO FCTC.
- The national development planning process should be used as an opportunity to sensitize other ministries — particularly those responsible for finance and economy — to the multisectoral impacts of tobacco use and ministry responsibilities for tobacco control.

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[4] In this document, national development plans are taken to include Poverty Reduction Strategy Papers (PRSPs).

[5] WHO also agrees multi-year country cooperation strategies directly with national governments to detail their support for national health strategies.

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- Key elements of WHO FCTC implementation require multisectoral action: drafting and passing treaty-compliant tobacco control legislation and subsequent legislative instruments require working with parliamentarians; effective implementation and subsequent enforcement of legislation require the sensitization of non-health ministries, including those of finance and revenue, justice, trade, tourism and education; this in turn requires supportive communication and training provided down to the district and community level.
- Developing a tobacco taxation strategy (Article 6) that will help reduce the prevalence of tobacco use and increase government revenue requires close cooperation with the Ministry of Finance and building a shared understanding of the evidence and issues.
- Specific intersectoral collaboration is demanded regarding the implementation of Article 8 (Protection from exposure to tobacco smoke: enforcement authorities in general and the legal system in particular); Article 11 (Packaging and labelling of tobacco products: Ministry of Trade/Commerce); Article 12 (Education, communication, training and public awareness: Ministries of Education and Communication); Article 13 (Tobacco advertising, promotion and sponsorship; Ministry of Communication and broadcasting authorities); Article 15 (Illicit trade in tobacco products; with the Ministries of Finance, Law Enforcement and Customs) and Articles 17 and 18 (Provision of support for economically viable alternative activities and protection of the environment and the health of persons, with Ministries of Agriculture and the Environment).

Enabling factors that support the integration of WHO FCTC implementation into NDPs and UNDAFs include: high-level government leadership; WHO FCTC Needs Assessments supported by the Convention Secretariat; WHO support to the Ministry of Health; the accountability required by the legally binding international obligations of the WHO FCTC; anticipation by Ministries of Health, civil society and UN partners of typical tactics employed by the tobacco industry to interfere with policymaking; civil society advocacy and top-level UN recognition of the socio-economic threat posed by NCDs and their risk factors, including better understanding of country-specific complexities related to tobacco production and distribution. This latter factor includes the related global media coverage that has raised awareness of the imperative for action at the national level.

The main challenges to effective integration include: a lack of financial and human resources; failures to align plans and budgets where tobacco control units were not under the same line management as relevant disease control departments; widespread lack of awareness of tobacco use as a pressing health and development issue; absence of tobacco control from development partners' funding priorities; interference by the tobacco industry; lack of national data on the prevalence of tobacco use and related morbidity and mortality; and cost estimates of action and inaction — all of which are needed to counter the fears of negative economic impacts and make a case for inclusion of tobacco control in the NDP and UNDAF as well as to decrease the influence of the tobacco industry.