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**FCTC**  
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
COP <sub>1</sub>	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.<sup>1</sup> 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.<sup>2</sup>

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<sup>1</sup> 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 66<sup>th</sup> World Health Assembly [2].

<sup>2</sup> 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,<sup>3</sup> 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.

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<sup>3</sup> Convention Secretariat, '2012 Global Progress Report on implementation of the WHO Framework Convention on Tobacco Control', WHO, Geneva, 2012.

## 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.<sup>4</sup>
  - 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<sup>5</sup> 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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<sup>4</sup> In this document, national development plans are taken to include Poverty Reduction Strategy Papers (PRSPs).

<sup>5</sup> 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.

### Recommendations

To benefit from the enablers and overcome the challenges identified, this report makes the following recommendations for further action and investment:

- International development partners, civil society, the UN system and Parties themselves should continue advocacy efforts at the international and national levels to make the case for tobacco control as an issue that should be integrated as a priority into development planning.
- The UN system should support country-specific stakeholder analysis to identify the governance and leadership structures best suited for mobilizing multisectoral engagement and resources. This includes developing a better

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understanding between Ministries of Health and other relevant ministries to leverage their comparative strengths for a multisectoral response.

- The UN system and the Convention Secretariat should resource and deliver a capacity-building strategy to support the integration of WHO FCTC implementation into country-level development planning processes and UNDAFs. It would apply to such a strategy relevant and applicable lessons learned, keeping in mind similarities and differences between HIV and tobacco, from the UNDP/UNAIDS programme to mainstream HIV.
- WHO, the wider UN system, the World Bank and Parties should all invest in generating disaggregated data and analysis that provide evidence of tobacco use trends as well as the impact of tobacco use on socio-economic development; this evidence should be used to support the argument for integrating tobacco control into development priorities and planning processes.
- Parties should make the promotion of Article 5.3 of the WHO FCTC, to protect public health from interference by the tobacco industry, an integral component of any multisectoral discussion on tobacco control. Due to the history of the tobacco industry's interference in public health policymaking through other ministries, Parties should safeguard multisectoral approaches to implementing the WHO FCTC by developing firewalls and codes of conduct.
- The UN system and Parties should adopt a more proactive approach to integrating the WHO FCTC into UNDAFs, which would be to view support for WHO FCTC integration, at the very least, as an international obligation that the UN is mandated to support in respect to the implementation of the WHO FCTC by States Parties. This would allow supporting the integration of the WHO FCTC into UNDAFs without any precondition of activities first being included in the NDPs.

### Structure and additional resources

Chapter 1 provides a synopsis of the developments on the global health and development agenda that have supported accelerated implementation of the WHO FCTC. Chapter 2 outlines the research methodology applied, and Chapter 3 provides a snapshot of the current status of WHO FCTC integration into national planning instruments and UNDAFs from desk research carried out for a sample of 48 countries. Chapter 4 captures the good practice guidance from interviews with key contacts in 10 case study countries, and extrapolated from a review of the documentation of comparative experience across efforts to mainstream other issues and activities of the United Nations Development Group (UNDG). Chapter 5 makes recommendations for further action based on the key enablers and challenges identified in Chapter 4.

There are three annexes to this report. Annex 1 examines in-depth the links between tobacco, health and development. Annex 2 provides a visual representation of countries whose UNDAF mentions tobacco control or the WHO FCTC. Annex 3 is a comprehensive Resource Guide that includes key decisions, declarations, reports, guidance and articles relevant to tobacco control. The Resource Guide is intended to provide evidence and tools to help WHO FCTC Parties and institutions providing technical support to put the guidance and recommendations in this report into practice.

# CHAPTER 1: THE DEMAND FOR ACCELERATED IMPLEMENTATION OF THE WHO FCTC

This chapter provides a brief overview of the WHO FCTC as well as the barriers to implementation. It also chronicles the calls for accelerated implementation of the WHO FCTC made by the international community and the COP; calls that led to this jointly produced UNDP and Convention Secretariat report. Further context on the health and development challenges posed by tobacco is provided in Annex 1: Tobacco, health and development.

## 1.1. The WHO Framework Convention on Tobacco Control

The WHO FCTC, a ground-breaking international legally binding treaty negotiated under the auspices of WHO, takes a comprehensive approach to preventing the 6 million annual deaths caused by tobacco use. Addressing both the demand- and supply-side aspects of tobacco use, as well as overarching governance elements, the WHO FCTC requires a multisectoral approach that goes beyond the health sector to encompass, for example, trade, tax, education, justice and law enforcement, environment and agriculture. Also required are a national coordinating mechanism and focal points for tobacco control (Article 5.2),<sup>6</sup> as well as protection from interference by the tobacco industry (Article 5.3). The Convention further recognizes that international cooperation is necessary for implementation (inter alia, Articles 5.6, 22, 25 and 26). Equally important, the treaty and subsequent decisions of the COP acknowledge the relationship between tobacco and development,<sup>7</sup> as well as the relevance of existing UN treaties — including those on human rights<sup>8</sup> — in implementing the Convention [see 5].

## 1.2. Progress in WHO FCTC implementation

With 177 Parties to date,<sup>9</sup> the WHO FCTC is one of the most rapidly embraced international treaties, and the COP has been successful in quickly developing treaty instruments such as guidelines and reporting systems, as well as negotiating the first protocol to the treaty (on illicit trade), approved in 2012 at the Fifth Session of the COP (COP5). However, actual implementation at country level has not matched this pace, mostly due to limited administrative and technical capacity, lack of public and government awareness, inadequate financial resources and interference by the tobacco industry.

Anticipating these critical barriers, COP decisions have attempted to respond to them. Article 26, which covers financial resources, stipulates that each “Party shall provide financial support...in accordance with its national plans, priorities and programmes”; however, to support the efforts of developing-country Parties and those with economies in transition, the same article also mandates that the First Session of the COP (COP1) reviews existing and potential sources and mechanisms of assistance to determine their adequacy [see 5].<sup>10</sup> Article 5.6 of the Convention also stipulates that Parties must “cooperate to raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms.” Moreover, in its Decision FCTC/COP1(13), the COP called on developing-country Parties and those

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<sup>6</sup> Such a coordinated, whole-of-government approach has been successful in tackling other health issues, most notably HIV/AIDS (i.e. the ‘Three Ones’ principle) [3].

<sup>7</sup> See COP1, noting the interrelationship between tobacco consumption and achievement of the MDGs [4].

<sup>8</sup> The preamble to the WHO FCTC acknowledges the WHO Constitution’s Right to Health; the UN Convention on the Rights of the Child; and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) [see 5].

<sup>9</sup> As at January 2014.

<sup>10</sup> While developing countries preferred that a new mechanism of assistance be established, developed countries favoured channelling assistance through existing agencies or mechanisms. It was eventually agreed that donor countries would work to ensure that money was made available through existing financial instruments, and that developing countries would simultaneously prioritize tobacco control initiatives in their health and development strategies [11].

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with economies in transition to conduct needs assessments and communicate their prioritized needs to development partners [12].

Later, recognizing that low- and middle-income country (LMIC) Parties do not have the resources to perform these assessments with the detail required by donors, the COP mandated the Convention Secretariat to assist Parties with their needs assessments on request [13]. Other COP reports and decisions have stressed the need for technical assistance in the form of South–South and triangular cooperation<sup>11</sup> so that countries can compare challenges and experiences in implementation — for example, legal challenges from the tobacco industry [14].

The result is that two concrete mechanisms have emerged to help LMICs access assistance: the database of resources presented at COP<sub>1</sub>, now maintained by the Convention Secretariat to locate funding for tobacco control initiatives, and country needs assessments, which include support from the Convention Secretariat on request and are now underway [4].<sup>12</sup> Even so, a lack of resources applied to WHO FCTC implementation remains a serious limitation. WHO recently estimated that only US\$0.001–\$0.005 is spent annually per capita on tobacco control in LMICs [15], and the latest implementation reports produced by the Parties continue to reveal that developing countries and Parties with economies in transition receive only limited direct technical or financial support from other Parties or bilateral and multilateral funding agencies.<sup>13</sup>

## 1.3. Support for accelerated implementation of the WHO FCTC

The push from the broader public health community for action on NCDs has gained momentum in recent years; this push has included the first global ministerial meeting on healthy lifestyles and NCD control, held in April 2011 in Moscow; the rounds of preparatory regional consultations for the UN High-Level Meeting on NCDs; and the eventual High-Level Meeting itself, held in September 2011 — only the second UN General Assembly session devoted to a health issue.<sup>14</sup> At each stage, NCDs were clearly identified as a major development issue linked to the achievement of the Millennium Development Goals (MDGs), with tobacco use being recognized as the one common modifiable risk factor. Accordingly, accelerated implementation of the WHO FCTC was called for in the Moscow Declaration [17], regional statements [18–20], and the eventual UN High-Level Political Declaration on NCDs [21].<sup>15</sup> The commitments from the UN High-Level Meeting on NCDs were subsequently confirmed and amplified by the Rio Declaration on Social Determinants of Health [22], and in 'The Future

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<sup>11</sup> COP<sub>1</sub> called for the promotion of South–South cooperation in the exchange of scientific, technical and legal expertise as relevant to the implementation of the Convention; the Second Session of the COP (COP<sub>2</sub>) recalled the need to assist developing-country Parties and those with economies in transition; the Third Session of the COP (COP<sub>3</sub>) included South–South cooperation in the workplan for the biennium 2010–2011 [14].

<sup>12</sup> Funding for these assessments has recently been provided by the European Commission and Australia, and, by the end of 2013, the Framework Convention Secretariat was anticipated to have helped 30 Parties to identify their needs and required resources [13].

<sup>13</sup> See, for example, the Convention Secretariat's progress note on 'Financial resources and mechanisms of assistance — implementation of decisions WHO FCTC/COP<sub>1</sub>(13) and WHO FCTC/COP<sub>2</sub>(10) of the Conference of the Parties' (COP/3/12), noting how Parties' reports on implementation "express needs for assistance that far outweigh the resources dedicated", and that a "significant gap has developed as a result, which is affecting implementation of the Convention" (para. 11)[16]. Meanwhile, at COP<sub>4</sub>, Parties noted challenges in the mobilization of resources and limited international assistance for national tobacco control programmes and, accordingly, called for a performance review to be presented at COP<sub>5</sub> [11].

<sup>14</sup> The first being on HIV/AIDS in 2001.

<sup>15</sup> The 2011 Political Declaration called for accelerated implementation of the WHO FCTC and for WHO, in coordination with other United Nations system agencies, to support national efforts on implementation of the Convention.

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We Want', the outcome document of the Rio+20 UN Conference on Sustainable Development [23].<sup>16,17</sup> In May 2013, the Global Action Plan for the Prevention and Control of NCDs, developed by WHO, was endorsed by the 66th World Health Assembly, and in July 2013 the ECOSOC adopted a resolution on the establishment of a UN Inter-Agency Task Force on the Prevention and Control of NCDs that builds on the UN Ad Hoc Inter-Agency Task Force on Tobacco Control (IATF). The expanded Task Force will further support implementation of the WHO FCTC and coordinate the activities of all UN agencies to implement the Global Action Plan [84,85].

The COP, at its Fourth Session in November 2010 (COP<sub>4</sub>), in the Punta del Este Declaration, called for increased UN support for treaty implementation into countries' central planning processes and NDPs. COP<sub>4</sub> also acknowledged the importance of implementation of the Convention under the UNDAF as a strategic approach to ensure long-term and sustainable implementation, monitoring and evaluation for developing countries (Decision FCTC/COP<sub>4</sub>(17)). To foster strengthened implementation of the Convention at country level, COP<sub>4</sub> encouraged developing countries to utilize the opportunities for assistance under the UNDAF and shared knowledge on the tobacco industry's interference tactics and strategies. It also requested the Convention Secretariat to actively work with the UN agencies responsible for coordination and implementation of the UNDAF delivery assistance [24].

During its substantive session of 2012, the ECOSOC adopted a landmark resolution on UN system-wide coherence and interagency coordination to provide multisectoral implementation assistance to Member States on tobacco control [25]. The resolution follows the report of the Secretary-General on the activities of the IATF, which was based on the outcome of the ninth and special meeting of the IATF in February 2012 [26]. The resolution recalls, among other issues, the obligation of Parties to the WHO FCTC to set up comprehensive, multisectoral national control strategies, plans and programmes, with support from the Convention Secretariat, on request; and encourages the United Nations funds, agencies and programmes to contribute to the goals of the Convention, including through multisectoral assistance and the integration of implementation efforts within UNDAFs at country level.

## 1.4. UNDP's role in supporting accelerated implementation of the WHO FCTC

It has been proposed that UNDP take on a significant role in the prevention and control of tobacco, including through supporting accelerated implementation of the WHO FCTC. The collaboration of UNDP and the Convention Secretariat, embodied by this report, is among a broader division of labour within the UN regarding assistance to WHO FCTC implementation (with, for example, World Bank focusing on Article 6, and UNEP on Article 18) [6]. Specifically, the May 2012 report of the Secretary-General to ECOSOC on the Ad Hoc Inter-Agency Task Force on Tobacco Control, in the context of the interagency division of labour, 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. A summary of Article 5 is presented in Box 1 (next page). The same report proposes the facilitation role of UNDP in integrating both the WHO FCTC and NCDs into UNDAFs [see 6].

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<sup>16</sup> Recognizing that "substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa", the Rio Political Declaration on Social Determinants of Health paragraph 14 (iv) calls for accelerated implementation of the WHO FCTC among Parties and encourages non-member countries to consider acceding. Moreover, section 11.2 (i) pledges to: "Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard" [22].

<sup>17</sup> The Rio+20 Outcome Document para 141 states: "We also commit to establish or strengthen multisectoral national policies for the prevention and control of noncommunicable diseases" [23].

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ECOSOC resolution E/RES/2012/4 [25] took note of the report of the Secretary-General on the Ad Hoc Inter-Agency Task Force on Tobacco Control and, to promote coordinated and complementary work among funds, programmes and specialized agencies, encouraged the IATF to promote effective tobacco control policies and assistance mechanisms at the national level, including through the integration of implementation efforts in respect of the WHO FCTC within the UNDAFs, where appropriate.

### Box 1. Article 5 of the WHO Framework Convention on Tobacco Control (summary)

1. Update and review comprehensive multisectoral national tobacco control strategies, plans and programmes.
2. Towards this end, each Party shall:
  - (a) *establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and*
  - (b) *develop appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.*
3. Protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.
4. Cooperate in the formulation of proposed measures, procedures and guidelines for the implementation of the Convention and the protocols to which they are Parties.
5. Cooperate, with competent international and regional intergovernmental organizations and other bodies, to achieve the objectives of the Convention and the protocols.
6. Raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms [5].

## CHAPTER 2: METHODOLOGY

The research for this report was undertaken in five stages, comprising:

1. selection of sample countries for online desk research;
2. online desk research on the selected sample of 48 countries;
3. selection of a shortlist of 13 countries to approach for in-depth interviews;
4. telephone interviews with key personnel from 10 case study countries; and
5. a review of guidance documents, reports and evaluations on the integration of health issues relevant to national development planning processes, including UNDAFs.

### 2.1. Selection of sample countries for online desk research

As an objective of this study was to map the enablers and challenges for integrating the WHO FCTC, countries were selected based on criteria that indicate activity relevant to integrating the WHO FCTC into NDPs and UNDAFs. Specifically, data were reviewed from the WHO FCTC Party implementation reports from the 2012 reporting cycle (120 Parties in total) available at the time of research. Of these Parties:

- 74 (62 percent) reported having a comprehensive multisectoral national tobacco control strategy;<sup>18</sup>
- 43 (36 percent) reported tobacco control being incorporated into national health plans; and
- 21 (18 percent) reported including tobacco control in other national plans.

### 2.2. Desk research on the 48 countries

The UNDAFs and NDPs of the sample 48 countries were reviewed, where available, for inclusion of tobacco control measures and mentions of NCDs. For the countries where data from Needs Assessment reports were available, the data gathered online were cross-checked with this information. Working on the premise that tobacco control activities might also be organized under broader NCD units, WHO NCD Status Reports were also examined for mention of tobacco control plans and coordinating units.

A systematic online search for these planning and status documents<sup>19,20</sup> was undertaken by reviewing the websites of UNDP Country Offices, Ministries of Finance, Ministries of Planning, the International Monetary Fund and the United Nations Development Group (UNDG). UNDP Regional Office focal persons were contacted to retrieve NDPs that were not found through online searches. For the documents retrieved, a keyword search was conducted using the following search items: tobacco, non, NCD,<sup>21</sup> smoke, chronic and WHO FCTC for documents written in English; tabaco, ECNT, crónico and fum for documents written in Spanish; tabac, non, chronique and fum for documents written in French; and tabaco, fum, crónico, DCNT and DNT for documents written in Portuguese.

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<sup>18</sup> Data from the previous two-year and five-year implementation reports reveal that, to date, a total of 91 countries have reported having a comprehensive multisectoral national tobacco control strategy.

<sup>19</sup> To capture as much relevant activity as possible, both existing and recently developed UNDAFs planned in 2013 were considered.

<sup>20</sup> There are a number of different types of national development planning documents, including long-term strategic vision papers, mid-term development plans and Poverty Reduction Strategy Papers. To capture as much relevant activity as possible, the definition for this research was left broad. In some of the 10 case study countries, further clarification was provided between long- and medium-term documents.

<sup>21</sup> 'NCD' and 'non' were included as search terms based on the premise that governments might organize tobacco control activities under this broader heading, possibly indicating activity relevant to implementation of the WHO FCTC.

### 2.3. Selection of case study countries

From the sample of 48 countries for which desk research was performed, and based on the Convention Secretariat's experience of WHO FCTC Needs Assessments between 2009 and 2012, nine countries were selected to be case studies. To provide greater regional balance to this sample, an additional four countries were added, either based on the specific inclusion of support for WHO FCTC implementation in their UNDAF documents or because of evidence of relevant activity that emerged from initial research. Of these resultant 13 case study countries that were approached to participate in this report, interviews were completed with contacts from 10 countries: Bolivia, Brazil, the Gambia, Ghana, Jordan, Mauritania,<sup>22</sup> Moldova, Niger, Palau and Solomon Islands. Although the initial group of 13 countries approached included a representative from each WHO region, ultimately no Party from the South-East Asia Region completed an interview in the time available.

### 2.4. In-depth interviews

For contacts from the case study countries, an interview guide was developed to gather information on lessons learned from experience, including critical enablers and challenges with regard to integrating the WHO FCTC into UNDAFs and NDPs. For each country, in-depth interviews were conducted with some or all of the following: WHO Country Representative/WHO tobacco control focal points, Ministry of Health Tobacco Control Focal Points and UNDP staff members.<sup>23</sup> Across the case study countries, 10 government tobacco control focal points, seven WHO contacts and five UNDP contacts were interviewed.<sup>24</sup> Interviewees were asked to verify the country data obtained from the desk research, and any amendments were subsequently recorded.

### 2.5. Document search and analysis of comparative experience and existing guidelines

An online search was also undertaken for UN and WHO guidelines and reports on UNDAF processes, documents on the integration of other health and health sub-topics into national planning instruments, and notes on mainstreaming of other development issues. Information on and recommendations from these sources were collated and analysed. Further, the sources identified and used to produce Chapters 1 and 4 of this report (i.e. the background and comparative experience) have been compiled into a Resource Guide, which is intended to support this report and provide WHO FCTC Parties with some of the additional material and guidance needed to increase support for accelerated implementation of the Convention.

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<sup>22</sup> Mauritania was selected as a case study country following discussions about the project at the Regional Meeting to discuss implementation of the WHO FCTC in the WHO African Region held in Senegal on 9–12 October 2012.

<sup>23</sup> Because there is no dedicated UNDP focal point on tobacco control, the interviews were held with staff members with knowledge of national development planning and UNDAF processes.

<sup>24</sup> In the cases of Mauritania and Niger Ministry of Health contacts, the questions were provided in French and written responses were returned.

## CHAPTER 3: THE WHO FCTC IN NATIONAL DEVELOPMENT PLANNING INSTRUMENTS — A SNAPSHOT

Findings from the 48 sample countries for which desk research was performed reveal a low level of integration of tobacco control and WHO FCTC implementation into NDPs and UNDAFs. Of the 35 sample countries for which 2012 WHO FCTC implementation report data were available, two thirds (23) reported having a comprehensive national multisectoral tobacco control plan (Table 1). Among the 29 retrieved NDPs, just over a quarter included references to tobacco control, with only one NDP specifically referring to the WHO FCTC (Table 2). Of the 45 UNDAFs retrieved from the sample countries, however, less than a quarter (nine) included any commitments to support WHO FCTC implementation or tobacco control (Table 3). Only four of the 48 sample countries included either tobacco control or WHO FCTC implementation in both their NDP and UNDAF.

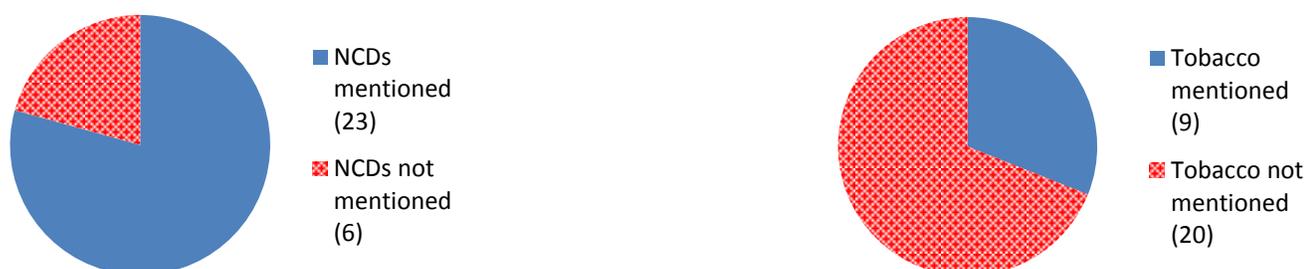
**Table 1. Tobacco control in national plans**

2012 WHO FCTC Parties' Implementation Reports <sup>25</sup>	n = 35
Comprehensive national multisectoral tobacco control plan	23
WHO FCTC or tobacco control included in national health plan	13
WHO FCTC or tobacco control included in other national plans	7

**Table 2. Tobacco control in NDPs**

NDPs	n = 29
Specific mention of support for WHO FCTC implementation	1
Specific mention of support for tobacco control measures without mention of WHO FCTC	7
Any other mention of tobacco or smoking in relation to health	1
No mentions of WHO FCTC or tobacco control	20
Any mention of NCDs	23

**Figure 1. Mentions of NCDs and tobacco in NDPs**



<sup>25</sup> For the ten case study countries this information has been updated from the verification provided through the interview process.

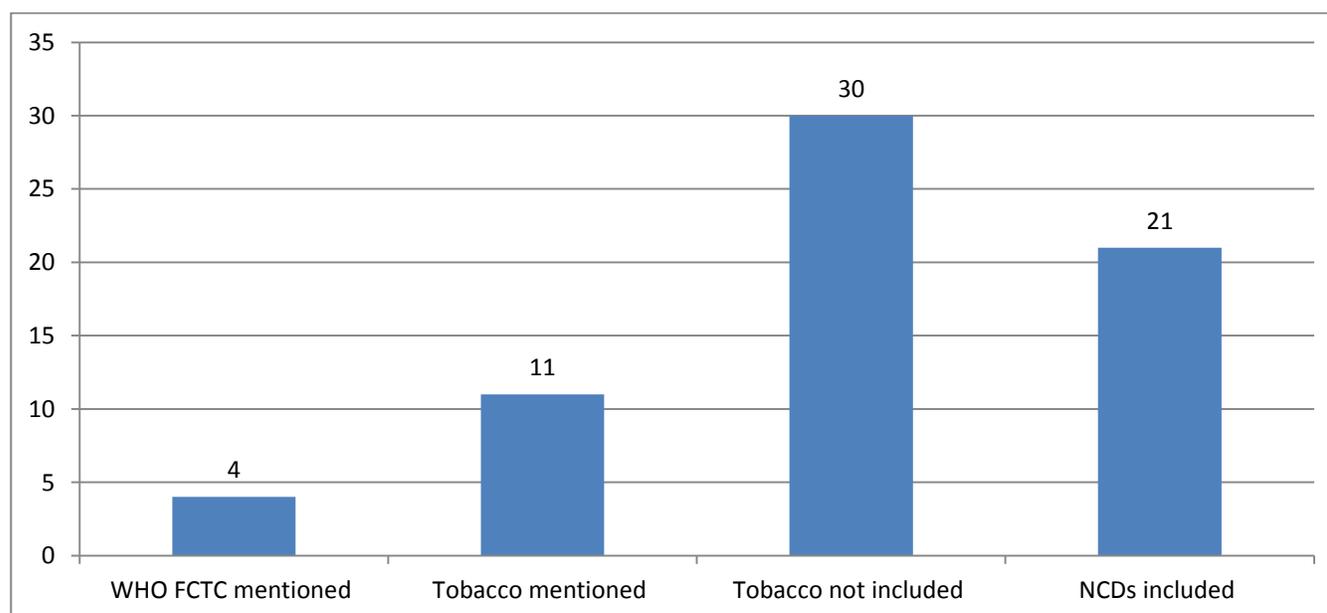
# THE WHO FCTC IN NATIONAL DEVELOPMENT PLANNING INSTRUMENTS — A SNAPSHOT

Brazil is the only country with a specific mention of the WHO FCTC in its NDP, although the inclusion is under agricultural objectives. The health-sector objectives only include mentions of tobacco control without any reference to the WHO FCTC. The countries with NDPs that include mentions of support for tobacco control measures but are without specific mention of the WHO FCTC are Bolivia, China, Cook Islands, India, Mexico, Moldova and Thailand; the Fiji NDP mentions tobacco in relation to health without committing to specific activities.<sup>26</sup>

**Table 3. Tobacco control in UNDAFs**

UNDAFs	n = 45
Specific mention of support for WHO FCTC implementation	3
Mention of WHO FCTC in context of international treaty obligations	1
Specific mention of support for tobacco control measures without mention of WHO FCTC	5
Any other mention of tobacco or smoking in relation to health <sup>27</sup>	6
No mention of tobacco or WHO FCTC	30
Any mention of NCDs	21

**Figure 2. Tobacco and NCD integration in UNDAFs (n=45)**



<sup>26</sup> The case study interviews for Jordan reported that commitments to tobacco control were included in the NDP, but the document itself was not retrieved so is not included in these figures.

<sup>27</sup> Such mentions were generally in descriptive passages — for example, listing tobacco use in the context of NCD risk factors.

## THE WHO FCTC IN NATIONAL DEVELOPMENT PLANNING INSTRUMENTS — A SNAPSHOT

Only three UNDAFs — those of Bolivia, China and the Philippines — were found to include commitments supporting WHO FCTC implementation. Thailand's UNDAF, meanwhile, mentions the WHO FCTC in an annex of international treaty obligations. The Pacific Sub-Region UNDAF 2013–2017,<sup>28</sup> which covers 14 countries (five of which were included in the research sample of 48 countries: Cook Islands, Fiji, Palau, Samoa and Solomon Islands), includes prevalence of tobacco use as an indicator under its outcome of increased access to quality health services,<sup>29</sup> but the country results frameworks were not yet finalized at the time of research. Four more UNDAFs — those of Pakistan, Turkey, Moldova and Burkina Faso — include commitments to tobacco control measures but do not specifically mention the WHO FCTC. Although India and Jordan's documents do not include support for WHO FCTC implementation in the coordinating mechanism of the UNDAF, they do include such support in annexes for agency activities. The four sample countries that include support for WHO FCTC implementation or tobacco control in both their NDPs and UNDAFs are Bolivia, China, Moldova and Thailand.<sup>30</sup>

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<sup>28</sup> Seen in its final draft form, dated 21 March 2012.

<sup>29</sup> From the case study interviews in Palau and Solomon Islands it is understood that commitments to FCTC implementation have been included in drafts of the country results frameworks that will capture the UNCT activities at country level under the subregional UNDAF, but the finalized versions of these documents were not yet made available at the time of research.

<sup>30</sup> For Thailand, support for WHO FCTC implementation is inferred by its inclusion in the Annex of Treaty Obligations.

## CHAPTER 4: EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

This chapter synthesizes information from several areas to provide emerging lessons for the integration of WHO FCTC implementation into NDPs and UNDAFs. These areas include: a broad overview of the major issues driving the development assistance agenda and their context; the potential impact of these on inclusion of the WHO FCTC in NDPs and UNDAFs; key information derived from the review of the documentation from comparative experience; and, finally, the interviews conducted with tobacco control focal points from governments and relevant WHO and UNDP contacts in the 10 case study countries. The emerging lessons move from the general perspective of how the global development agenda has evolved (4.1.) to the more specific guidance derived from the review of the documentation of comparative experience and case study interviews (4.2.). The enabling factors and challenges in operationalizing this guidance as identified by interviewees are then outlined (4.3.).

The lessons, enablers and challenges within this section will be relevant to Parties, the UN system, international development partners and civil society organizations. Some lessons, enablers and challenges will be more relevant to some actors than to others. Roles are specified where needed contributions are clear. Chapter 4.4., for example, outlines possible roles for UN Country Teams and WHO FCTC Focal points. However, it is intended that all actors consider how the following lessons, enablers and challenges impact their core work and can be harnessed to facilitate accelerated implementation of the WHO FCTC.

### 4.1. Responding to a changing development planning landscape

The constantly evolving development planning landscape creates new frameworks and concepts that should be addressed to respond effectively to the calls for the improved integration of WHO FCTC implementation into national development planning and UNDAF processes. This Chapter, therefore, identifies and describes key components of this changing landscape.

- Discussions to define a post-2015 development agenda to replace the MDGs are underway. Since 2000, the Millennium Declaration and the MDGs have driven the development agenda. Three of the eight MDG goals<sup>31</sup> focus on health issues, and the MDGs have been widely acknowledged to have succeeded in mobilizing funding and targeted effort [28]. It has also been argued, however, that the MDGs have not adequately addressed inequalities and have created a vertical, siloed approach [28]. In terms of assistance for implementing the WHO FCTC, in the dialogue leading up to the UN General Assembly High-Level Meeting on NCDs, the exclusion of any specific reference to NCDs within the MDGs was cited as having had a prohibitive effect on garnering resources to tackle NCD risk factors, such as tobacco use. In the discussions on post-2015 successors to the MDGs, there have been debates on how the existing MDGs and emerging health and development issues such as NCDs will be accommodated within the new framework, as well as consideration of the need for increased coordination, alignment and harmonization [29]. It remains to be seen whether the post-2015 agenda, iterated through the sustainable development goals still being defined, will accommodate more explicit support for action against tobacco use and the NCDs it causes.
- The aid effectiveness agenda attempts to provide alternatives to the vertical, siloed approaches associated with 'funder-led' development. Commitments have been made through the 2005 Paris Declaration, the 2008 Accra Agenda [30] and, most recently, the 2011 Busan Fourth High-Level Forum [31] that support five core principles: 1) ownership of the NDP by recipient countries; 2) alignment of aid with national priorities; 3) harmonization of efforts to support the given country across various agencies; 4) a results-based approach; and 5) mutual accountability of donors and recipients. In

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<sup>31</sup> MDG4: Reduce child mortality; MDG5: Improve maternal health; and MDG6: Combat HIV/AIDS, malaria and other diseases.

## EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

line with these principles, and moving away from a project-based approach, some bilateral funding agencies<sup>32</sup> along with the International Health Partnership [32] have adopted general budget support for NDPs. To capitalize on these nascent aid effectiveness principles, countries are expected to prioritize WHO FCTC implementation in their NDPs, thereby unlocking international development assistance for tobacco control, whether in the form of programme or budget support. The evolving WHO FCTC implementation assistance framework should align completely with these principles of aid effectiveness.

- New concepts are also being applied to health in the development agenda. A health systems strengthening approach has been identified as key to not only sustain progress made through the targeted, vertical approaches but also to realize the demand for increased coordination, alignment and harmonization, and greater provision for emerging health issues [29]. Universal health coverage is also being promoted as a comprehensive approach to addressing inequalities in health service provision. Health systems strengthening and universal health coverage are salient and potentially useful avenues for countries seeking accelerated implementation of the WHO FCTC, through both a multisectoral and preventative approach that WHO FCTC implementation demands.
- The UNDAF process is a tool used to enable the UN as a whole to respond to national priorities, while building on key UN mandates; however, it is likely to be reformed again. Specifically, the current process of the Quadrennial Comprehensive Policy Review [33] of operational activities for development of the UN system is likely to result in more revisions to the process, aimed at reducing the transaction costs involved while improving the ability to deliver (see Box 2).

### Box 2. UN reform and UNDAFs

The 'One UN' reform initiative launched in 1997 has sought to bring together a more coordinated approach to the diverse agencies and programmes activities. The UNDAF is a key tool for realizing this approach at country level, as it strives to unite resident and non-resident agencies and programmes, with the aim of producing a coherent, coordinated plan that reduces duplication and optimizes advantages. The UNDAF incorporates the principle of national ownership in producing a strategic programme framework that is based on and aligned with national development policies, strategies and plans. It also requires the incorporation of five UNDG programming principles — namely, a human-rights-based approach, gender equality, environmental sustainability, results-based management and capacity development.

The system was most recently revised in 2010 with the introduction of the UNDAF Action Plan as an optional single-country coordinating plan designed to replace the separate agency country plans. However, recent thinking on UNDAF reform seeks to address criticisms of the apparent trade-off between the ability to deliver results and high transaction costs. There is, in fact, a considerable management burden involved when seeking to organize in one framework, which includes: a multisectoral plan to support national priorities focused on achieving the eight MDGs; capturing support for meeting international obligations to more than 90 international laws, conventions and declarations (of which WHO FCTC is one); application of the five UNDG programmatic principles; and the priorities, plans and accountability mechanism of the diverse resident and non-resident UN agencies and programmes. Future reforms from the Quadrennial Comprehensive Policy Review of the General Assembly are anticipated to focus on delivering a simplified, more 'light-touch' approach that prioritizes results over process, allows for more flexibility depending on local circumstances, has greater focus on national priorities, and is responsive to the future development agenda. UNDAFs will thus likely move towards activities with specific references to technical assistance, which would help clarify where to best position references to WHO FCTC integration.

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<sup>32</sup> For example, the development agencies of the UK, the Netherlands and Denmark.

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

## 4.2. Emerging lessons

Calls by the WHO FCTC COP [24] and ECOSOC [25] for improved integration of WHO FCTC implementation into national development planning and UNDAF processes should be viewed in the context of a broader series of efforts within the UN system to mainstream other issues, such as HIV and AIDS, NCDs and gender equity. These efforts, codified in various planning and guidance notes, were analysed to identify lessons that could be transferred from their original context to WHO FCTC implementation. The main sources of comparative experience for this evaluation are presented in Box 3 below.<sup>33</sup> Findings from this evaluation were supplemented and compared with the practical experiences and lessons learned in the case study countries.

Countries struggling with implementation might do well to begin with a focus on Article 5. 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.

### Box 3. Review of documentation from comparative experience

- In addition to guidance on the UNDAF process, the UNDG has produced guidance addressing the UNDG programmatic principles: a human-rights-based approach, gender equity, environmental sustainability; tools and guidance on more specific issues such as climate change and disaster risk reduction; and study reports and guidance on integrating issues related to indigenous people [34].
- In the case of gender equity, a specific agency, UN Women, was established in 2010 with the mandate to lead, coordinate and promote the accountability of the UN system for gender equality and women's empowerment [35].
- In recent years significant resources have been invested into mainstreaming HIV into development and sector planning processes [36, 40, 41].
- WHO has also produced its own guidance for its country teams for working with Poverty Reduction Strategy Papers (PRSPs), Sector-Wide Approaches (SWAPs) and UNDAFs.
- WHO has additionally worked with the Office of the UN High Commissioner for Human Rights (OHCHR) to produce guidance on a human-rights-based approach to health [37, 38].
- WHO has done further work with UNFPA to build capacity to support sexual and reproductive health in national health and development planning processes, and derived guidance and recommendations [29, 39].

### 4.2.1. National development planning and PRSPs

To achieve integration of WHO FCTC implementation into NDPs, the case should be made for tobacco control as a national health and development priority.

NDPs are the key planning instruments to which other planning instruments, such as health and tobacco control plans, should relate. For low-income countries, NDPs are commonly developed to provide the PRSPs that are required by

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<sup>33</sup> The Resource Guide on tobacco control produced to accompany this report provides details of the key guidance documents and reports that were used in producing this section of the report. Only the sources that are specifically referred to in this section are included in the Resource Guide's references to this chapter. See Annex 3.

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

international financing institutions (World Bank, International Monetary Fund etc.) and increasingly by bilateral agencies taking a budget financing approach. The MDGs are a major influence on these plans,<sup>34</sup> and yet, despite the three health-related MDGs, health as a whole has not been well represented in PRSPs, and there is still a need to make the case that health must be at the centre of any poverty reduction strategy [38, 39]. Health strategies that have been included in NDPs as 'pro-poor' have tended to be those tackling communicable diseases, maternal and child health, health services in rural areas, water and sanitation [38], and generally not those tackling NCDs and their risk factors.

## Key points

- Unless WHO FCTC implementation is prioritized within national health plans, as part of a specific NCD strategy or otherwise, and championed by the Ministry of Health within the planning process, it is unlikely to secure the necessary multisectoral support or be included in NDPs.<sup>35</sup>
- Strong commitment and engagement from other ministries relevant to tobacco control (e.g. Ministry of Finance and Ministry of Trade) enables tobacco control to be included in different sectors' national plans, which in turn can serve as a key entry point for inclusion in the NDP.
- The national development planning and budgeting processes 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 responsibilities for tobacco control. Tobacco control should be linked clearly to development issues of national economic growth and reducing the number of people in poverty, using disaggregated (by income groups, age and gender) prevalence, morbidity and mortality data, and evidence on the cost-effectiveness of action versus inaction.
- Policy advocacy should be able to counter the arguments of the tobacco industry and entities working to further its interests about the benefits of tobacco production (revenue and livelihoods) with evidence of the health and economic costs of tobacco, even in countries where prevalence of tobacco use is still relatively low.
- In accordance with Article 5.3, public health policies should be protected from the commercial and other vested interests of the tobacco industry and those working to further its interests. Civil service codes of conduct are a key tool for preventing interference by the tobacco industry in tobacco policy.
- Focusing on the tobacco control interventions that are most likely to improve the health of the poorest and most vulnerable populations and help reduce poverty will allow for clear connections to national development priorities [36].
- The national tobacco control strategies' targets and indicators should be developed to demonstrate their relevance to national development priorities, and structured to fit the needs of the planning instrument framework.

## 4.2.2. UNDAFs

To be included in the country UNDAF, UN agencies and programmes beyond WHO should recognize the UNDAF's relevance to achieving their objectives and plans as well as implementing the UNDG programming principles.

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<sup>34</sup> The 2005 MDG summit called on countries to focus their PRSPs on MDGs, while the World Bank and other key institutions saw the PRSPs as the key vehicle for achieving the MDGs.

<sup>35</sup> In line with the review of findings from the documentation of comparative experience, a *caveat* was made by some interviewees that, as NDPs are top-line development strategy papers, there should be limited expectation of inclusion of the implementation detail of health and tobacco control plans in the NDP itself — this detail should be worked out in health-sector plans and tobacco control strategies.

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

## Key points

- The UNDAF is intended to be a tool for aligning the UN system's country-level activities with national priorities, so the promotion of tobacco control in an UNDAF can signal its importance to the Parties and facilitate its integration into NDPs.
- The UNDAF is also a tool for coordinating and harmonizing UN agency plans and activities; therefore, to promote WHO FCTC inclusion in the UNDAF, more than one agency should specify plans for supporting WHO FCTC implementation.<sup>36</sup>
- To achieve the above, effort should be invested to sensitize UN agencies to the relevance of tobacco control to their respective mandates, and to shift their responsibilities towards WHO FCTC implementation so that they will incorporate relevant activities into their plans.<sup>37</sup> Such sensitization efforts should be supported by clear direction from the UN agency and programme headquarters. Recent commitments support categorizing specific areas of treaty implementation as an outcome; the ninth meeting of the UN Ad Hoc Inter-Agency Task Force and the Secretary-General's reports to the ECOSOC provide evidence of progress in this direction.
- As part of these sensitization efforts, clear links could also be made to the UNDG programming principles, to which all UN agencies and funds are committed to adhere in the delivery of their mandate to support national action. Indeed, the WHO FCTC's relevance in delivering these programming principles provides a strong entry point for UN Country Teams (UNCTs) to proactively promote treaty implementation in the UNDAF. The legally binding WHO FCTC acknowledges the developmental impacts of tobacco and makes connections to relevant UN conventions that protect populations, including those on human rights, particularly the right to health. Box 4 provides an outline of the key entry points for connecting the WHO FCTC to a human-rights-based approach, gender equity, environmental sustainability, a results-based management approach and capacity-building.

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<sup>36</sup> A number of interviewees noted that, given that the UNDAF is intended as a coordinating framework, it was a challenge to include WHO FCTC implementation when WHO was the only agency to have included it in its country work plans.

<sup>37</sup> UNDAFs should include support for countries' existing international commitments and treaty obligations, including the WHO FCTC.

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

## Box 4. UNDG programming principles and WHO FCTC implementation: overlapping goals

UNDG programming principles	Supportive WHO FCTC text
<p>A <b>human-rights-based approach</b><sup>38</sup> to tobacco control should highlight the government's responsibility to respect, protect and fulfil the human right to health. Under this framework governments must honour, for example, the right to be free from second-hand smoke and to enjoy a healthy workplace and environment, the right to access information needed to make healthy choices, and the responsibility to protect public health more broadly [43].</p>	<p>The preamble to the WHO FCTC places the treaty in the context of human rights treaties by citing: the WHO Constitution's assertion of the fundamental right to the highest attainable standard of health without discrimination; the provision of CEDAW that requires measures be taken to eliminate discrimination against women in the field of health care; and the right of the child to the highest attainable standard of health, as asserted in the Convention on the Rights of the Child. Human rights principles are also promoted less directly throughout the WHO FCTC, as the text clearly prioritizes the protection of the public's health. For example, Article 8 (requirement to protect people from exposure to second-hand smoke in public places) inherently embodies the right to have one's health protected from third-party endangerment, such as from co-workers. Meanwhile, Article 11 (packaging and labelling of tobacco products) and Article 12 (education, communication, training, and public awareness) inherently promote the right to have access to information [see 5].</p>
<p>A <b>gender equality</b><sup>39</sup> approach to tobacco control requires data disaggregated by age and gender, and indicators to demonstrate and track the differentiated prevalence of smoking, impact of tobacco use and effectiveness of tobacco control measures [44].</p>	<p>In addition to aligning with CEDAW, the preamble to the WHO FCTC describes the Parties to the treaty as "alarmed by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policymaking and implementation and the need for gender-specific tobacco control strategies." The Guiding Principles in Article 4 of the WHO FCTC further recognize that Parties should take into consideration "the need to take measures to address gender-specific risks when developing tobacco control strategies."</p>

<sup>38</sup> For further details, see Annex 1: Tobacco, health and development: Tobacco and human rights.

<sup>39</sup> For further details, see Annex 1: Tobacco, health and development: Tobacco use as a barrier to socio-economic development: Tobacco use and gender.

## EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

<p>An <b>environmental sustainability</b> approach to tobacco requires environmental impact assessments of tobacco production, including data on the use of pesticides, chemical run-off and deforestation from the use of wood in curing tobacco leaves. The impacts of tobacco cultivation on human health are also needed, such as the incidence of green tobacco sickness caused by workers' absorption of nicotine through the skin during harvest, as well as illnesses caused by the pesticides used [45].</p>	<p>The preamble to the WHO FCTC references the Parties' concern for the environmental consequences of tobacco consumption, and Article 18, also with respect to the environmental aspects of tobacco cultivation and manufacture, requires Parties to have a due regard for the protection of the environment and the health of persons in relation to the environment.</p>
<p>A <b>results-based management approach</b> to tobacco control should include the development of appropriate targets, indicators and systems for collection and analysis of data [29].</p>	<p>Accountability is built into WHO FCTC Article 21, as it requires the Parties to submit periodic implementation reports to the COP; this reporting mechanism has been refined through subsequent decisions of the COP.</p>
<p><b>Capacity-building</b> at all levels of government and across governments will be required for successful WHO FCTC implementation, as widespread understanding of the responsibilities required for a comprehensive tobacco control strategy must be developed. South–South and triangular sharing of experiences and technical expertise with regard to WHO FCTC implementation is needed. Tobacco control focal points (government and WHO) should also be supported to develop a sound understanding of the national planning and UNDAF processes, including the capacity to address tobacco control through macroeconomic planning.</p>	<p>Article 22 of the WHO FCTC outlines specific expectations for cooperation between Parties to strengthen capacity and fulfil the treaty obligations. These expectations take into account the needs of developing countries and countries with economies in transition for scientific, technical and legal expertise. Further, COP decisions have sought to promote South–South and triangular assistance to exchange expertise and experience (see Chapter 1.2.).</p>

### 4.2.3. A multisectoral approach

WHO FCTC implementation is a multisectoral endeavour requiring a whole-of-government approach to planning, operational activities and accountability, thereby making implementation relevant to both NDPs and UNDAFs.

Article 5.1 of the WHO FCTC requires Parties to have multisectoral national tobacco control strategies, plans and programmes. The case studies and comparative experience together provide concrete examples of the type of multisectoral action necessary to achieve effective implementation.

- A multisectoral coordinating committee for tobacco control is widely seen as vital to WHO FCTC implementation and integration into broader government planning and accountability, able to bring together ministries beyond health — for example, trade, education and communication — to build understanding and increase commitment. Different WHO FCTC provisions require actions and policies from different sectors of government. A multisectoral coordinating committee can ensure that these actions and policies are coherent and consistent.
- The comparative experiences underline the potential for using the national development processes as an opportunity to improve dialogue between ministries — for example, between Ministries of Finance and Planning and Ministries of Health, and to increase understanding among these ministries of the role of health in development [36, 39, 42].

## EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

- Conducting country-specific stakeholder analysis to identify governance and leadership structures best suited for mobilizing multisectoral engagement and resources would be crucial.
- Passing treaty-compliant tobacco control legislation and subsequent legislative instruments and regulations requires working with relevant ministries outside health; such collaboration is needed to first support the drafting of the legislation and to sensitize parliamentarians to support passage of the bill thereafter.
- A tobacco taxation strategy will help reduce prevalence of tobacco use while increasing government revenues and reducing health care costs. For such taxation to be established, however, close cooperation is required between the Ministry of Health and the Ministry of Finance and other relevant revenue authorities. This cooperation should seek to construct a shared understanding of the evidence and issues.<sup>40</sup>
- Effective implementation of tobacco control legislation and subsequent enforcement requires the sensitization of non-health ministries including finance and revenue, justice, trade, agriculture, tourism and education as well as civil society organizations; it requires full-scale supportive communication and training provided down to the district and community level. Efforts to raise public awareness and educate the public not only to the dangers of tobacco use but also to the benefits of tobacco control measures require large media campaigns as well as community-level outreach, the latter including through educational institutions.

### 4.3. Putting the guidance into practice

The emerging lessons on integrating the WHO FCTC into NDPs and UNDAFs may be operationalized on the ground with varying levels of success, depending on context. For optimal WHO FCTC implementation, and for putting the guidance outlined in Chapter 4.2. into practice, the challenges below must be addressed and the enabling factors harnessed.

#### Key challenges

- Across the board, a lack of both financial and human resources is a critical problem, with some countries reporting little or no funds allocated to tobacco control, and others pointing to a critical lack of capacity across health services.
- There is a lack of awareness among non-health government ministries as well as development partners, including UN agencies, on how tobacco use is a pressing health and development problem tied to achieving other development priorities.
- Governments, including ministries of health, tend to be influenced by their development partners' priorities for funding, which do not focus on tobacco control but, rather, issues explicitly included in the MDGs such as HIV, malaria, TB and maternal and child health.
- A lack of data and the information-gathering systems needed to help make a compelling case for WHO FCTC implementation are a major impediment to gaining broader government and UN agency support.
- Fear of negative economic impacts of tobacco control (e.g. loss of jobs, reduced income and government revenue from tobacco cultivation and production, and impacts on tourism) create resistance in some parts of government.
- Related to this, the tobacco industry has a strong restraining influence on government action on tobacco control.
- Management structure and related problems in aligning plans and budgets create challenges for resource allocation and accountability where tobacco control units, or more broadly health promotion units, are not well aligned with the departments responsible for NCDs — even though WHO FCTC implementation would contribute to NCD prevention.

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<sup>40</sup> In some of the case study countries, tax revenues are also seen as a possible source of funding for supporting tobacco control or other health-related government expenditure.

## EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

- The UNDAF process is complicated by conflicting timetables of the different agency planning cycles, an already long list of issues to be mainstreamed, and a lack of harmonization among various agencies' approaches to national-level issues.

### Key enablers

- High-level government leadership, that is institutionalized, makes a major difference in terms of integrating tobacco control into the government's overall priorities (i.e. engendering a whole-of-government approach).
- Where needs assessments have been undertaken, jointly conducted with the Convention Secretariat, they have made an important contribution to sensitization across government ministries and UNCTs, providing a foundation for improving WHO FCTC integration. Conversely, where needs assessments have not been conducted, WHO FCTC implementation was considered more challenging.
- As recognized by the government tobacco control focal points, WHO plays a critical role in supporting the Ministry of Health through the planning processes.
- Clear monitoring and implementation plans and legislative instruments are crucial in implementing WHO FCTC or tobacco control activities.
- Timing is an enabling factor for integration where key steps in the NDP or UNDAF processes coincide with needs assessments processes and/or the development of tobacco control plans, but timing is a challenge where the NDPs and/or the UNDAF are not due for renewal in the near future. In these latter cases, mid-term reviews offer an intermediate opportunity.
- Creating networks with health offices at municipal and district levels has served as a key enabler for increasing advocacy for tobacco control activities.
- The importance of civil society advocacy in promoting tobacco control policy and building public support is widely recognized.
- The media can have an enabling effect by creating a supportive environment for tobacco control activities. In addition to increasing awareness, the media could have a de-normalizing effect on the tobacco industry by exposing the tobacco industry's efforts to undermine WHO FCTC implementation, which in turn could open space for policymakers to pass strong policies safeguarding implementation from the tobacco industry's interference.
- The WHO FCTC itself, as a legally binding international treaty, helps to promote tobacco control efforts within government, and to make tobacco control an appropriate area for UNCT support. The treaty's reporting requirements are an opportunity to increase the accountability of non-health ministries for treaty implementation.
- The increasing priority of tackling NCDs on the global agenda, including within the 2011 UN High-Level Meeting on NCDs, supports national-level efforts and arguments for investment in tobacco control.

The lack of technical and financial resources has long been recognized as an impediment to full implementation of the WHO FCTC; more recently, the 2012 global progress report on implementation of the WHO FCTC revealed it as one of the most pressing barriers to implementation. At the COP5 in Seoul, a decision on creating a working group on sustainable measures to strengthen implementation of the WHO FCTC was unanimously adopted. The mandate of the working group would extend from providing best practices and guidelines for resource mobilization and strengthening both South–South and North–South collaboration to examining methods of cooperation and information exchange (see Box 5, next page) [46].

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

## Box 5. Mandate of the working group on sustainable measures to strengthen implementation of the WHO FCTC

1. Prepare a report on barriers and successful experiences in mobilizing the range of resources in implementing the WHO FCTC at the country level, including through existing bilateral and multilateral mechanisms of assistance.
2. Provide recommendations on how resources can be accessed for WHO FCTC implementation and best practices can be shared.
3. Provide recommendations to strengthen South–South and triangular cooperation as well as North–South cooperation for WHO FCTC implementation, contributing to capacity-building in Parties.
4. Review existing tools and mechanisms of assistance to the Parties to ensure they meet Parties' needs.
5. Identify new tools to support Parties to implement Article 5.2 of the WHO FCTC.
6. Identify and recommend best practices to access international resources for tobacco control through bilateral and multilateral cooperation and other opportunities in development cooperation.
7. Examine the possibilities of using modern technologies for the exchange of information and cooperation between Parties and to promote the effective implementation of the WHO FCTC.
8. Provide recommendations on how to promote the WHO FCTC in wider international forums.

## 4.4. Practical steps: Possible roles for UN Country Teams and WHO FCTC Focal Points

UNDAFs are comprehensive documents that are normally negotiated between the national government and the UNCT, led by the Resident Coordinator. Before the negotiations on the content of the UNDAF are initiated, a 'Common Country Assessment' (CCA) is usually undertaken. The CCA is a comprehensive study and analysis of the major socio-economic and development challenges facing a developing country. At this stage various factors are taken into account, including development- and health-related priorities, and international obligations under various treaties to which the country is a Party, including for instance the WHO FCTC.

Following such assessments, which are normally supported by the UNCT or a lead development partner at country level, the process for translating the findings of the CCA into identifiable objectives with outcomes and monitoring/timelines starts between the government and the UNCT.

To ensure that WHO FCTC implementation is adequately addressed in UNDAFs, the Resident Coordinator, in consultation with the UNCT members, could take the following steps:

- Inform and alert the CCA exercise team about the WHO FCTC being a Convention and the obligation of the country to meet its implementation requirements, just as the CCA team would take into account other treaties while making its assessment of the potential development/health challenges.
- Inform the nodal agency of the government that is authorized to take part in the CCA about the WHO FCTC and of its implementation being an international obligation. The nodal agency or agencies, depending on the context, could be a national planning commission or Ministry of Foreign Affairs/Planning, or any other.
- Coordinate with the WHO Country Representative, to sensitize the Ministry of Health — or the nodal ministry of the government in charge of health — to the WHO FCTC. As an international obligation, its inclusion in national health policies should be a priority.

# EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

## Scenario 1: UNDAF negotiations are underway

In such a scenario, the following steps could be undertaken:

- Include a mention of WHO FCTC as an international obligation in the Annex where the international treaty obligations are listed, such as the human rights treaties.
- Include WHO FCTC implementation under the relevant objective — for instance, under one of the health-sector-related objective areas such as NCDs, both as an objective and an outcome; and then also reflect it suitably in the programmatic matrix where the activities are listed corresponding to various objectives/outcomes.
- If the UNDAF features an objective related to NCDs, then elaborate it to specifically include reference to WHO FCTC implementation.
- Further, if there is an objective on implementation of a country's international cooperation/obligations, then elaborate it to specifically include reference to WHO FCTC implementation.
- Bring to the attention of donors/development partners the treaty aspect of tobacco control.

## Scenario 2: UNDAF is finalized and implementation in progress

In such a scenario, the following steps could be undertaken:

- During the Joint Annual Review (if there is provision for it, or otherwise during the Mid-term Review), take up integration of WHO FCTC implementation, either in the context of existing objectives such as NCDs or independently, highlighting the treaty's applicability to these objectives.
- Suggest including reference to the Convention in the Annex to the UNDAF.
- Suggest including treaty implementation activities as part of broader support to the health sector in the country, since the WHO FCTC is an international obligation for the country/government.
- Bring to the attention of donors/development partners the treaty aspect of tobacco control.

## Possible role of national WHO FCTC Focal Points

Under Article 5 of the Convention, Parties are obligated to appoint national implementation focal points. Such focal points exist in nearly all 177 Parties to the Convention. The degree of resources and technical capacity available to these focal points, however, varies significantly. Notwithstanding these factors, the role of national focal points both as individuals and institutions is crucial. The following practical steps could be undertaken by national focal points to ensure integration of the WHO FCTC into the UNDAF:

- During the consultation process on national health and development objectives or CCA within the Ministry of Health, bring up the integration of the WHO FCTC as part of national priorities on health. This could be articulated in view of the Convention's implementation being an obligation for the government.

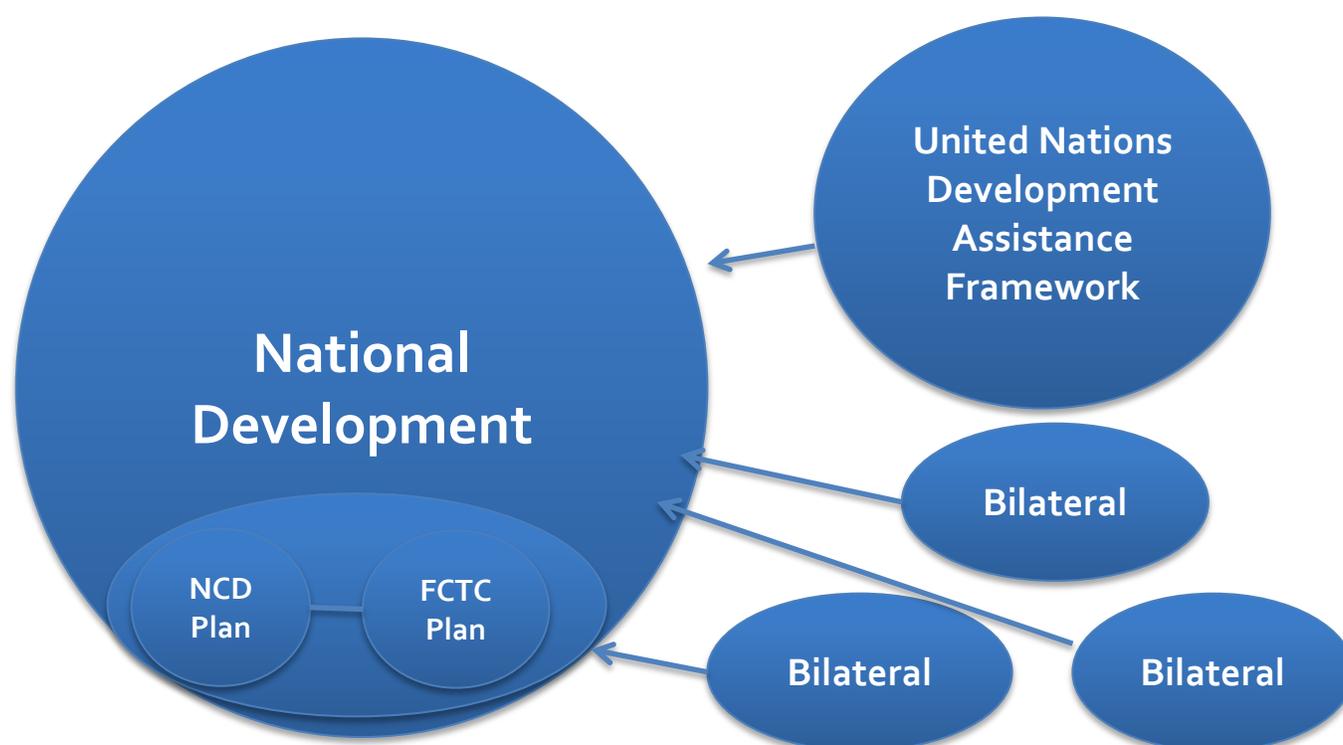
## EMERGING LESSONS, ENABLERS AND CHALLENGES FOR WHO FCTC IMPLEMENTATION

- Provide inputs to the authorities in the Ministry of Health regarding multisectoral assistance required and advocate the case for the need for WHO and other UN agencies to provide specialized assistance for implementation of different articles of the Convention.
- Actively put the subject of the integration of the WHO FCTC implementation into the UNDAF in the agenda of the meetings of the National Coordination Mechanism, where such exist. If a National Coordination Mechanism does not yet exist, explore possibilities for its establishment. Otherwise, identify an alternative health or relevant line-sector coordination mechanism.
- Proactively liaise with the WHO Country Office to engage the attention of the UNCT and the Resident Coordinator on FCTC implementation support, to facilitate discussion within the UNCT, in the CCA process and during the Joint Annual Review or the Mid-term Review of the UNDAF.
- Seek further assistance or input from the WHO Country Office or Secretariat of the WHO FCTC (write to [fctcsecretariat@who.int](mailto:fctcsecretariat@who.int)).

## CHAPTER 5: RECOMMENDATIONS

This report has laid out several critical considerations for the UN system and WHO FCTC Parties seeking to engender support for integrating WHO FCTC implementation into national development planning and UNDAFs, including an understanding of the evolving development planning landscape (4.1.); the emerging lessons learned extracted from both case study countries and documentation from comparative experience (4.2.); and key enabling factors and challenges for integrating WHO FCTC implementation into NDPs and UNDAFs, as identified and experienced by case study interviewees on the ground. A general framework for WHO FCTC integration at national level is presented in Figure 3 (below). Toward that end, this Chapter makes recommendations for further action and investment of resources to support progress at the country level, specifically through advocacy, capacity-building, data generation, and protection from interference by the tobacco industry. The recommendations within these categories are aimed primarily at UNDP and relevant UN agency staff, WHO FCTC focal points within government ministries, WHO, the COP, and civil society and national partners. However, not all 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.

Figure 3. Integration Framework



# RECOMMENDATIONS

## 5.1. Leadership and advocacy

International development partners, civil society, the UN system and Parties themselves should support continued advocacy efforts at international and national levels to make the case for WHO FCTC implementation and its integration into development priorities.

Despite the recent emergence of NCDs on the international agenda and the awareness of the need for accelerated action on tobacco control, there remains an identified need to convince government officials to prioritize their WHO FCTC obligations, which requires the combined efforts of international agencies, bilateral donors and civil society organizations.

The support from the Convention Secretariat and other international agencies is especially crucial in building cooperation for treaty implementation and delivering effective mechanisms of assistance. The needs assessment missions provide a key opportunity to fulfil this obligation and create multisectoral understanding across government ministries and UNCTs. Along these lines, the UN system should support country-specific stakeholder analysis to identify the governance and leadership structures best suited for mobilizing engagement and resources. This includes developing a better understanding between Ministries of Health and other relevant ministries to leverage their comparative strengths for a multisectoral response.

The treaty also mandates the Convention Secretariat to ensure, under the guidance of the COP, the necessary coordination with the competent international organizations and bodies. WHO's leadership in championing tobacco control on the global development agenda and its technical support at the national level is also central to WHO FCTC implementation and scale up, and thus should be supported by international development partners. Finally, both Parties and UNCTs should replace the traditional approach in which tobacco control is included in the NDPs prior to its integration in the country UNDAF with a more proactive approach that promotes the integration of tobacco control into the UNDAF regardless of the status of tobacco control in NDPs. As the UN is mandated to support countries to fulfil their international commitments, this proactive approach enables UN Regional Centres to take a leadership role in guiding UNDAF development, strengthens UN agencies' support in WHO FCTC implementation and allows UNDAFs to reach beyond actions outlined in the NDP.

Bilateral donors and the World Bank also play an important role in scaling up WHO FCTC implementation. For instance, in Nepal, where tobacco control efforts are covered under the World Bank's sector-wide approaches, resources can be mobilized to support implementation of the Convention under the UNDAF in various programmes including poverty reduction, education of children and young people, and promotion of economically viable alternatives to tobacco cultivation. There is thus a clear need for UNDP, WHO and the World Bank to raise development partners' awareness of the burden of tobacco and its role in exacerbating poverty. A possible approach to delivering these messages is to organize meetings between the UN and key donors or institutionalized side meetings at COPs for interested actors.

The role civil society organizations play in advocating national tobacco control policy and building popular support is also critical. The tobacco control community should widen its constituency and create pressure for action on non-health ministries, which can be accomplished by sensitizing a wide range of civil society organizations to the harmful effects of tobacco on labour rights, poverty reduction, maternal and child health, environmental sustainability and gender equity. Ongoing funding to support these civil society efforts is, therefore, essential.

## 5.2. Capacity-building

The UN system and the Convention Secretariat should resource and deliver a capacity-building strategy to improve and support the integration of WHO FCTC implementation into country-level development planning processes and UNDAFs.

## RECOMMENDATIONS

The capacity-building needs identified in this study range from the simple, such as a development of planning guidelines to indicate key entry points for tobacco control, to the complex, such as a strategy for ministries of health to utilize a macroeconomics approach in addressing health priorities and thus to be involved in national development planning. Cross-the-board capacity development is also necessary to understand the tobacco epidemic, the specific multisectoral obligations of WHO FCTC implementation and the evidence base for tobacco control measures. Thus, a feasible management, coordination and accountability-inclusive approach should be developed by the UN system working together with Parties and the Convention Secretariat. For instance, as a first step, UNDP and other agencies identified via discussions within the IATF could develop an online course for government tobacco control officials on the function of development processes and how to integrate WHO FCTC implementation. In addition, a multisectoral mechanism should report directly to the head of government or another high-level authority within the national government to truly gain political weight.

The WHO FCTC requires multisectoral coordination — for example, Articles 8, 11, 12, 13, 15, 17 and 18. The role of ministries of finance in building capacity for developing, delivering and monitoring tobacco taxation policies is especially important and should be prioritized. Not only is tobacco taxation policy one of the most effective ways to reduce prevalence of tobacco use, it provides a clear link between tobacco control and the economic planning of the NDP process. Tobacco taxation policy can strengthen capacity-building, as it creates the necessary multisectoral cooperation between the health ministry and other key government ministries, such as finance and revenue. Improved taxation administration would also increase understanding of the economic evidence and arguments for tobacco control, and furthermore contribute to building good governance, providing a clear argument for why support for WHO FCTC implementation goes well beyond the sole responsibility of WHO within the UNDAF.

A capacity-building strategy should incorporate lessons from the investment in mainstreaming HIV into development instruments by the joint UNDP, World Bank and UNAIDS programme. Well-organized and concerted mainstreaming activities will enable development actors to address the causes and effects of tobacco use in an effective and sustained manner in the context of routine functions of sectors. HIV mainstreaming provides several lessons on ensuring the sustainability of these activities [36]. The first key lesson is to underpin the mainstreaming approach with a logic model that features a clear monitoring and evaluation framework, which can help build an evidence base for the effectiveness of mainstreaming. Second, an in-depth focus on a few selected countries over a period of time is recommended to build a critical mass of mainstreaming competence. Third, efforts should be made by relevant international organizations to develop the capacities of (particularly national level) civil society organizations in mainstreaming tobacco, as these organizations play a critical role in advocating tobacco control policies and building social support, as mentioned in 5.1. Lastly, international development partners and Parties themselves should make resources available to develop communities of practice for mainstreaming, comprised of mentoring and coaching, to support a critical mass of capacity in country over time.

### 5.3. Evidence and data

WHO, the World Bank and the UN system should generate and analyse national disaggregated data to support the argument for integrating tobacco control into development priorities and planning processes.

At country level, various types of evidence can be generated, varying from crude national estimates of the health and socio-economic benefits of WHO FCTC implementation to national disaggregated morbidity and mortality data. Investment in the collection and synthesis of such evidence could be linked to other efforts to strengthen health information systems.

## RECOMMENDATIONS

These data are needed to make the case for the connection between tobacco control and key development issues such as economic growth, poverty reduction, inequity reduction, gender equality and environmental sustainability. Among these analyses, political economic analysis of tobacco and economics is key, as it builds understanding of the economics of tobacco production and control. This understanding provides benchmarks in the form of targets and indicators for an effective monitoring and evaluation system.

Understanding the economics of tobacco is also needed to provide budget estimates for tobacco control implementation so that the costs of tobacco control can be weighed against the social and economic costs of inaction at the country level. The work already done by WHO [47] on the costing of some WHO FCTC interventions could be developed further to provide, for example, a tool for calculating indicative budget estimates to support government planning. UN agencies, working with the World Bank and the Convention Secretariat should utilize costing analyses of WHO FCTC interventions to develop a model budget for WHO FCTC implementation to scale up tobacco control efforts. Although governments are ultimately responsible for tobacco control, they should know that they can request support from the Secretariat or the COP.

These surveillance information and analyses would be reported to the Convention Secretariat. Reporting is a key part of the Parties' obligations as outlined in Article 21.

### 5.4. Protection against tobacco industry interference

The WHO FCTC Article 5.3 provision for protection of public health from tobacco industry interference should be made integral by Parties, with support and promotion from UNCTs and civil society organizations, as part of any multisectoral discussion of tobacco control.

Many interviewees cited as a challenge the influence of the tobacco industry. The influence of tobacco industry interests can play a powerful part in impeding pursuit of the multisectoral approach necessary for WHO FCTC implementation and its integration into national development planning processes. In cases where the tobacco industry cannot sway ministries of health, it can shape the considerations of other government ministries regarding the fulfilment of WHO FCTC-related policy objectives, such as revenue generation, combating illegal trade and promoting economic growth. Alongside WHO and the Convention Secretariat, UNCTs play an important role in promoting a broad understanding of the implications of compliance with Article 5.3, including the article's relevance to governance programming and the whole-of-government response necessary for integrating tobacco control into NDPs.

Guidelines on protection against tobacco industry interference were adopted by the Conference of Parties. Above all, specific measures should be made to limit interaction with the tobacco industry, such as a guideline to specify circumstances where interaction is possible and the code of conduct relating to transparency, disclosure of records and public notice. Further, Parties should reject any form of partnerships, agreements and contracts with the tobacco industry, and avoid conflicts of interest for government officials and employees. The latter can be achieved by mandating policies on conflict of interests, implementing guidelines for public officials to deal with the tobacco industry, developing policies on hiring applicants with a history of employment in the tobacco industry, and prohibiting the involvement of the tobacco industry with political parties, candidates or campaigns. A main tactic employed by the tobacco industry is to organize socially responsible activities to distance its image from the intrinsic harm of tobacco. It is incumbent upon the WHO FCTC focal points in governments, working with WHO and the UNCT, to make known the true purposes and scope of these activities to all branches of government and the public. For these efforts to take effect, a state-owned tobacco industry should be treated in the same way as any other tobacco industry.

## RECOMMENDATIONS

The increasing interference from the tobacco industry suggests that tools and mechanisms should be developed to monitor this interference and facilitate an all-of-government approach in committing to WHO FCTC obligations. Existing models and resources, such as the WHO database on tobacco industry monitoring, should be used by Parties, in coordination with the Convention Secretariat to record and share country experience in dealing with the tobacco industry. WHO, non-governmental organizations and other members of civil society not affiliated with the tobacco industry could also play essential roles in monitoring the activities of the tobacco industry.

## CONCLUSION

The need for multisectoral and specialized assistance to Parties in general and to developing and low-resource Parties in particular has been recognized in the reports of the Secretary-General to the ECOSOC on the activities of the IATF on Tobacco Control and the decisions of the COP. In his 2008 report to the substantive session of the ECOSOC, the Secretary-General emphasized how tobacco use, by increasing public-sector (government) expenditure on treatment and care of cancers, cardiovascular diseases and other risk factors and conditions, is responsible for a high disease burden and a drain on national overall GDP. He emphasized the need for multisectoral assistance to developing countries to address this situation.

In his 2010 report, the Secretary-General clearly mentioned the need for implementation of the WHO FCTC as part of a 'Single United Nations Strategy' under 'aid effectiveness' at country level, and called for a special meeting of the IATF to look at WHO FCTC articles and potential areas of contribution, hence the special meeting of the IATF in 2011 and the landmark decision paving the way for inter-agency cooperation based on principles of division of labour. The decisions of the ECOSOC in substantive sessions in 2010 and 2012 were duly recognized by the COP, which called for greater promotion and utilization of the potential of the IATF to optimize assistance to Parties to the Convention.

The implementation strategy of the Secretariat, based on the decisions of the COP and the principles of division of labour and aid effectiveness, already includes support for integration of the WHO FCTC into national planning processes and UNDAFs. This is evident from the joint needs assessment exercises that have been completed and the follow-up with the Parties on UNDAFs and national health and development planning processes. Some Parties have profiled implementation integration in the UNDAF under the broader health agenda. Some are more specific, and most of the Parties, where the timing of the assessment did not coincide with national planning or UNDAF cycles, are working on it through active engagement of the WHO Country Representatives and the UN Resident Coordinators.

The mandate for accelerated implementation of the WHO FCTC is clear: tobacco use, the only modifiable risk factor common to all four main NCDs, kills 6 million people per year and, if unabated, will cost the global economy trillions of dollars in medical expenses and lost productivity in the years to come; tobacco use results in widespread poverty, inequality and human rights infringements; it is impeding progress on every MDG; having recognized the health burden and threat to social and economic development posed by NCDs, the UN General Assembly called for accelerated implementation of the WHO FCTC to tackle tobacco use; and the WHO FCTC itself is legally binding, requiring Parties to not only implement the treaty within their own countries but to assist developing Parties and Parties with economies in transition to implement the treaty in their countries.

Despite the above, this report reveals few current examples of integration of WHO FCTC implementation into national development planning instruments or UNDAFs. Findings from the case study interviews and review of documentation on comparative experiences presented herein are, therefore, critical to uncover the story behind the numbers, including key enablers and challenges. These key enablers and challenges as well as the recommendations they informed should be carefully reviewed by the IATF and the WHO FCTC Parties, international development partners and civil society organizations seeking accelerated implementation of the treaty. The IATF on Tobacco Control has been expanded into the IATF on the Prevention and Control of Noncommunicable Diseases, which should ensure coherence between UN action on tobacco control and NCDs. To move forward, increased support for implementation among and within governments is crucial; the enablers in this report should be harnessed, the challenges addressed and the recommendations heeded to facilitate progress in operationalizing the WHO FCTC without delay.

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## ANNEX 1: TOBACCO, HEALTH AND DEVELOPMENT

The global political push for accelerated implementation of the WHO FCTC is supported by the increasing recognition of tobacco use as a major health and development issue with far-reaching consequences on not just disease burden but also economic growth and poverty, education and gender. Driven by social and economic policies, norms and inequities, tobacco consumption is expected to kill 1 billion people in the 21st century if unabated [48], and to cost the world economy trillions of dollars in medical expenses and lost productivity. Tobacco use is also infringing on human rights to health and impeding achievement on every MDG. It is, therefore, imperative that countries urgently integrate tobacco control, and more specifically the WHO FCTC, into their development planning processes.<sup>41</sup>

### The health burden of tobacco

High blood pressure, tobacco use and alcohol use are the three leading risk factors for global disease burden. In 2010 tobacco use accounted for 6.3 percent of global DALYs, and was a major contributor to the global health and development challenge posed by NCDs [49, 50]. Of the 1 billion people who smoke or chew tobacco, approximately 5.4 million die each year, or 15,000 every day [51, 52]. Also approximately 600,000 non-smokers die from exposure to second-hand smoke annually [53]. Consumption of tobacco accounts for one in six of the 36 million global deaths per year due to NCDs and is the only modifiable risk factor common to all four 'main' NCD categories [51, 53].<sup>42</sup> The impact of tobacco on health extends beyond NCDs, especially in LMICs, where tuberculosis continues to be a tremendous issue. A recent study also found that when ARVs are free of charge and treatment is easily accessible, HIV-positive patients receiving treatment who continue to smoke lose more life-years to smoking than to HIV and are, therefore, more likely to die from a tobacco-related disease than from AIDS [54].

The global distribution of tobacco mortality and consumption parallels the broader NCD epidemic.<sup>43</sup> The prevalence of tobacco use and related deaths are declining in high-income countries (HICs) but rising rapidly in LMICs, where 82 percent of smokers now reside [50, 55]. If current trends continue, deaths from tobacco are projected to decrease by 9 percent between 2002 and 2030 in HICs, and yet double from 3.4 million to 6.8 million per year in LMICs over the same period [53]. By 2020, 7.5 million people will die globally from tobacco use annually, accounting for 10 percent of global deaths. Two-thirds of these deaths will occur in LMICs, and half will be among those in their economically productive middle years (35–69) [45, 51].

### Tobacco use as a barrier to socio-economic development

#### Tobacco use linked with economic growth and poverty

Tobacco consumption poses a barrier to economic development at household, national and global levels.<sup>44</sup> At the household level, money spent on tobacco costs poorer families a significant percentage of income — income that may otherwise have

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<sup>41</sup> The *Lancet* has described tobacco control as the “most urgent and immediate priority” for confronting the NCD epidemic and its socio-economic impacts [52].

<sup>42</sup> WHO names cardiovascular disease, diabetes, cancer and chronic respiratory disease as the ‘four main NCDs’ [56]; other NCDs include mental and neurological disorders such as dementia and Alzheimer’s disease; autoimmune disorders such as psoriasis; bone and joint conditions such as osteoporosis and arthritis; and renal, oral, eye and ear diseases [53].

<sup>43</sup> Contrary to common perception, 80 per cent of NCDs now occur in LMICs [57].

<sup>44</sup> The World Economic Forum has labelled tobacco use as one of the greatest global threats to economic development [64].

been spent on food, health care or education, all of which are vital to economic advancement [45, 58].<sup>45</sup> Second, the poor health outcomes caused by tobacco result in medical costs, often out-of-pocket in LMICs, that can financially cripple a household.<sup>46</sup> Finally, illness, disability and premature death render people and their caregivers unable to work, depriving families of income and driving households further into poverty [50, 57].<sup>47</sup>

Tobacco consumption also has an economic impact at both national and global levels. One study found that Russia lost \$24.7 billion in productivity in 2006 (more than 3 percent of GDP in 2005) due to premature deaths caused by smoking [59], while another estimated that smoking costs the world 1–2 percent of its GDP each year [48]. The pathway to these devastating losses is clear: tobacco use and resultant NCDs strike people in their most productive years in LMICs, which inhibits a country's productivity, burdens already weak health care systems and displaces scarce national resources [57].<sup>48</sup> A 2012 analysis found that tobacco use results in approximately \$500 billion globally in annual expenditures related to health care costs, productivity losses, fire damage and other costs [60].

The economic impact of tobacco use is further borne out by more general data on the NCD epidemic, which, because of its close relationship to tobacco consumption, serves as a viable proxy for the economic impact of tobacco use. For example, a recent World Bank study found that chronic conditions have depressed Egypt's labour supply nearly one fifth below its potential. As a result, GDP is estimated to be 12 percent below its potential [61]. Moreover, a major global-level study predicts that the four main NCDs will cost the world economy more than \$30 trillion over the next 20 years — 48 percent of global GDP in 2010 — and send millions of people below the poverty line [62]. LMICs specifically are projected to lose an average of \$500 billion per year due to NCDs between 2011 and 2025, representing 4 percent of cumulative annual output [63].

In contrast to these losses is the fact that many countries derive income from growing, processing, managing and exporting tobacco; however, for most of these countries, the health and economic costs of tobacco consumption exceed the economic benefits of tobacco production [66].<sup>49</sup> Meanwhile, tobacco production also carries harmful individual and societal health impacts, including environmental destruction (e.g. from pesticides and deforestation), which lead to a loss of biodiversity, land resources and food insecurity as well as green tobacco sickness among those harvesting the tobacco plant (often women and children) [67]. Finally, because the tobacco industry manipulates the costs of production as well as sale prices, small-scale tobacco farmers are often not economically rewarded so much as forced into debt-bonded labour [44].

### Tobacco use and education

The relationship between tobacco use and education is bidirectional. Those with lower educational achievement are more likely to smoke; while tobacco consumption in LMICs poses a barrier to schooling. Poverty is one explanation for this second

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<sup>45</sup> In Bulgaria, Egypt, Indonesia, Myanmar and Nepal, low-income households spend 5–15 percent of their disposable income on tobacco, which in many cases is more than the income spent on health care or education [45].

<sup>46</sup> The 'World Health Report 2010' states that each year 100 million people are pushed into poverty because they have to pay directly for health services; in some countries, this may represent 5 percent of the population forced into poverty each year [65].

<sup>47</sup> For instance, expenditure by Indian households in which someone has a chronic disease increases the risk of falling into poverty by 40 percent [57].

<sup>48</sup> Unlike HICs, LMICs must still grapple with communicable diseases such as HIV, malaria and TB in addition to NCDs (i.e. they face a 'double burden') [61].

<sup>49</sup> One World Bank study concluded, "Most nations would derive net economic gains, not losses, if their demand for tobacco products fell, because economic losses would be offset by economic gains at household and national levels" [66].

direction, as it independently correlates with lack of education [68].<sup>50</sup> That is, tobacco use can lead to poverty, which then leads to a lack of education. There are at least three mechanisms through which the relationship from tobacco to lack of education unfolds. First, low-income households spend a significantly greater portion of their budgets on tobacco use than do high-income households, sacrificing food, basic health care and children's education — more likely girls' education — in the process [53]. Second, caring for sick family members can prevent children from attaining education, especially in poor households; women and girls, often the primary caregivers, bear the majority of this burden [69]. Finally, in countries that grow and process tobacco, child labour in the tobacco industry and poverty also deprive children of schooling [70].

### Tobacco use and gender

In general, men are far more likely to smoke than women, especially in LMICs, where 80 percent of adult male smokers reside [48, 71].<sup>51</sup> Worldwide, there are approximately 800 million male, as opposed to 200 million female, adult cigarette smokers. Differences in smoking by sex vary considerably by region,<sup>52</sup> with the largest disparity in South-East Asia, where men smoke nearly 19 times more than women [56]. Men are also at greater risk of dying from NCDs, largely due to greater exposure to risk factors such as tobacco use but also due to their lower use of preventive health care and relatively weaker 'social ties' [50]. Recent evidence, however, suggests that the sex gap may be closing, with women taking up smoking at alarming rates,<sup>53</sup> and men's rates expected to remain steady or decline [45, 50].

Tobacco companies have even marketed directly to women to create an association between smoking and gender equality [48]. Meanwhile, second-hand smoke continues to disproportionately burden women, many of whom are unable to negotiate smoke-free spaces for themselves or their children, even in their own homes [69]. Women's vulnerabilities to tobacco are especially critical because as women's health declines, so does the welfare of their respective households — when women become sick, families fall deeper into poverty, mortality among small children rises, and children withdraw from school to compensate for their mother's lost wages [69]. Despite these realities, there are few health education and quitting programmes aimed at women, particularly among the poor, and women are often invisible from tobacco-related health statistics [73]. Although some data on tobacco consumption are disaggregated by sex and age, the majority are not, obscuring trends and health effects on males and females of all ages [44].

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<sup>50</sup> Education is in fact a common measure of socio-economic status, because, throughout the world, the probability of finding employment rises with higher levels of education, as does the probability of earning more [68].

<sup>51</sup> Tobacco marketing has appealed to men by portraying smoking as masculine, with an ability to bring happiness, wealth, virility and power [48].

<sup>52</sup> In some countries, such as the UK, tobacco use among women is similar to that among men (23 percent and 25 percent, respectively) [72].

<sup>53</sup> The proportion of female smokers is expected to rise from 12 percent in 2010 to 20 percent by 2025 [69]. Female adult smokers are globally distributed differently than men: in 2010, half of the world's female smokers were in HICs, and the remaining half in LMICs [48].

## The social determinants of tobacco use

Tobacco use and tobacco-related mortality is declining in HICs<sup>54</sup> but rising rapidly in LMICs, a phenomenon partly fuelled by social conditions.<sup>55</sup> It is well recognized that “health outcomes are profoundly shaped not just by biological factors but also by the social, economic and cultural environment” [74; see also 71, 75, 76]. Structural, macro-level social determinants of tobacco use include globalization (e.g. of trade and product marketing) and governance. Along with targeted marketing, population increases, increased social acceptability of smoking and continued economic development have also contributed to the rise in tobacco consumption in LMICs [48]. Meanwhile, governments in these regions often lack the commitment to implement tobacco control strategies and interventions [56]. Individual-level factors, such as income and ethnicity [see 71], also disproportionately burden LMICs and lower socio-economic groups.<sup>56</sup> Together, inequities and social determinants perpetuate and reinforce the destructive cycle between tobacco and socio-economic development. In LMICs, this cycle unfolds through constraints on health care systems, limited resources, less access to social protection, and increased exposure to risk factors, making it more likely for poor people to smoke and become sick [50, 57, 71].<sup>57</sup> Smoking and illness then drive families further into poverty and impede investment in children’s education, which can lead back to smoking [58].<sup>58</sup> The result is the obstruction of socio-economic development on multiple levels through multiple pathways.

## Tobacco and human rights

A human-rights-based approach is a potentially powerful means to address the social determinants of tobacco use and its socio-economic consequences [see 77]. The Constitution of the World Health Organization affirms, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition” [78].<sup>59</sup> The WHO FCTC does not challenge the right of the individual to choose to use tobacco, but it does circumscribe this right by promoting other, often mutually exclusive rights. These include the right to have access to information that would assist in making informed choices, as well as the health rights of those violated in some form by the environmental consequences of tobacco use (e.g. the right to a healthy environment, the right to sexual and reproductive health, and the rights of the child) [67,77].<sup>60</sup> The text of the treaty itself

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<sup>54</sup> Tobacco consumption is declining in HICs primarily because of governments opposing industry efforts and implementing tobacco control measures and legislation. Tobacco-related mortality is declining in HICs due to lower consumption patterns but also due to the success of population-wide primary prevention and individual health care interventions in reducing NCD mortality in general [56].

<sup>55</sup> Addiction is a biological process, but it too can be socially determined: “Disadvantaged individuals are likely to take up smoking earlier and smoke more cigarettes per day than their more advantaged peers; they therefore tend to be more addicted, making it harder for them to quit” [56].

<sup>56</sup> Those more likely to smoke include “single mothers, the long-term unemployed, new immigrants, the homeless, the mentally ill and members of ethnic minorities — all of whom are also more likely to be in lower socio-economic groups” [71].

<sup>57</sup> In Bangladesh, for example, households with an income of less than \$24 per month smoke twice as much as those with higher incomes [45].

<sup>58</sup> In countries such as Bangladesh, India, Philippines, and Thailand, tobacco use is highest among the least educated segments of the population [14]. In China, individuals with no schooling were 6.9 times more likely to smoke than individuals with a college degree [58].

<sup>59</sup> This right was reaffirmed in Article 25 of the 1948 ‘Universal Declaration of Human Rights’ as “the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” [81].

<sup>60</sup> Compared to HIC residents, LMIC residents are less aware of the tobacco industry’s targeting of women and children, and less cognizant of the fact that tobacco is the only legal product that kills when used as intended [44].

# TOBACCO, HEALTH AND DEVELOPMENT

makes explicit links to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child.

Human rights frameworks have graduated from the traditional distinction between positive and negative rights to now require governments to respect, protect and fulfil the right to health [79]. This human rights formulation is an important conceptual weapon in the context of tobacco control. First, governments must not act in a way that infringes on the right to health (i.e. respect), while also ensuring, through regulation, that non-state actors, such as corporations and private interests, comport with human rights principles (i.e. protect) [43].<sup>61</sup> But even further, and especially important with regard to accelerated implementation of the WHO FCTC, the obligation requires governments to actively adopt all appropriate legislative, administrative, budgetary and other measures needed for citizens' health to be protected (i.e. comprehensive tobacco control policies). This requirement inherently demands that governments create an infrastructure for the effective implementation of such legislation, including enforcement and monitoring mechanisms [43]. It has been argued that these acknowledgements render WHO FCTC implementation a minimum standard with which to "measure whether states are fulfilling their obligations derived from the right to health, as they exist under international human rights law" [43].

## Tobacco and the achievement of the MDGs

Tobacco consumption is impeding progress on every MDG, demonstrating its widespread negative health and development impact. Much of these associations have already been addressed in detail, but a brief synopsis is offered below.

**Goal 1: Eradicate Extreme Poverty and Hunger.** Tobacco use leads to poor health, which causes the sick and their caregivers to leave the workforce, leading to financially debilitating out-of-pocket medical expenses and constraining already weak health care systems, both of which contribute to poverty and impede economic development on multiple levels. Also, spending on tobacco instead of food is linked to malnourishment; for example, it is estimated that if impoverished people in Bangladesh did not smoke, the country would have 10.5 million fewer malnourished people [80].

**Goal 2: Achieve Universal Primary Education.** Costs from families' spending on tobacco, having to care for a sick family member, and labouring in the tobacco sector all prevent children — more often girls — from attaining an education.

**Goal 3: Promote Gender Equality and Empower Women.** Despite bearing the brunt of second-hand smoke and taking up smoking at alarming rates, women are underrepresented in tobacco-related health statistics and education programmes.

**Goals 4 and 5: Reduce Child Mortality and Improve Maternal Health.** Money spent on tobacco deprives mothers and babies of food. Smoking and poor maternal nutrition cause low birth weights and infant mortality [45]. Of the 600,000 tobacco-related deaths each year among non-smokers, nearly half are among women and a quarter among children under five [82].

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<sup>61</sup> An example of the latter would be to ban misleading tobacco marketing [77].

## TOBACCO, HEALTH AND DEVELOPMENT

**Goal 6: Combat HIV/AIDS, Malaria and Other Diseases.** One out of five TB cases is attributable to smoking [83]. Smoking causes further illness in people living with HIV, including being a co-factor for bacterial pneumonia and AIDS-related dementia [36].

**Goal 7: Ensure Environmental Sustainability.** Pesticide use and deforestation caused by tobacco farming and curing are detrimental to the environment [36].

**Goal 8: A Global Partnership for Development.** The global political agenda recognizes the scope and magnitude of the challenge posed by NCDs and their risk factors, including tobacco use. It has further recognized the need for a multisectoral response (see Chapter 1.3.). The WHO FCTC, an international and legally binding treaty, offers a unique opportunity to facilitate the global partnership needed to combat tobacco industry interference and address other barriers to sustainable development.

The growing body of evidence on the interrelationship between tobacco and social and economic development, including the fact that tobacco consumption is obstructing achievement of the MDGs, has been the catalyst for the recent high-level global commitments to accelerated implementation of the WHO FCTC presented in Chapter 1.3. Acknowledging this context and the barriers facing LMICs, the decisions of the COP and ECOSOC have encouraged the Convention Secretariat and UN system agencies to cooperate, contribute to the goals of the treaty and coordinate on delivering assistance to Parties in meeting their treaty obligations. The UNDP and Convention Secretariat are now beginning this work by developing guidance to countries regarding integrating the WHO FCTC into national development plans and processes, including UNDAFs. 'Development Planning and Tobacco Control: Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments' provides a baseline assessment of experiences, emerging lessons learned and recommendations for future integration efforts.

## ANNEX 2: COUNTRIES WHOSE UNDAF ADDRESSES EITHER TOBACCO CONTROL OR WHO FCTC



## ANNEX 3: RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

This annex briefly describes existing resources related to tobacco control. It is meant to supplement 'Development Planning and Tobacco Control: Integrating the WHO Framework Convention on Tobacco Control into UN and National Development Planning Instruments'. The resources are organized under the following headings: 1) Tobacco and development; 2) Guidance and reports on planning processes; and 3) Key decisions and declarations on tobacco, health and development. The purpose of the Resource Guide is to help provide WHO FCTC Parties and institutions providing technical support with access to some of the knowledge and technical assistance required to increase national-level support for accelerated implementation of the WHO FCTC.

### Section 1: Tobacco and development

#### 1.1. The economic argument

**The Tobacco Atlas.** Eriksen, M, Mackay, J, and Ross, H. *The American Cancer Society and World Lung Foundation*, 2012.

- Comprehensive review of tobacco and its impacts on health and economies; projects that tobacco will kill 1 billion people in the 21<sup>st</sup> century if unabated.
- Details: the harms of tobacco on different populations; tobacco products and their use; the costs of tobacco, including environmental and economic costs of tobacco production; the tobacco industry, including marketing practices; and potential solutions for reducing the negative impacts of tobacco.
- Highlights the need for accelerated implementation of the WHO FCTC.

Location: [http://www.tobaccoatlas.org/uploads/Images/PDFs/Tobacco\\_Atlas\\_2ndPrint.pdf](http://www.tobaccoatlas.org/uploads/Images/PDFs/Tobacco_Atlas_2ndPrint.pdf)

**Systematic Review of the Link Between Tobacco and Poverty.** *World Health Organization*, 2011.

- Through a meta-analysis of existing research, examines the link between tobacco use and poverty, as well as the broader relationship between income, tobacco use, and tobacco-related health consequences.
- Finds an inverse relationship between income level and tobacco use, and therefore calls for greater efforts to reduce tobacco use among the poor, including strategies to reduce inequality.

Location: [http://whqlibdoc.who.int/publications/2011/9789241500548\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241500548_eng.pdf)

**The Millennium Development Goals and Tobacco Control: An Opportunity for Global Partnership.** *World Health Organization*, 2004.

- Documents the relevance of tobacco control to achieving the Millennium Development Goals (MDGs), with an emphasis on the negative health and economic effects associated with tobacco cultivation and use.
- Introduces cost-effective strategies that developing countries can take to reduce tobacco use and promote sustainable development, noting that such measures will also lead to poverty reduction and development more broadly.
- States that implementation of the WHO FCTC is key to development and "an important step forward in the work of the international community towards achieving better health for all."

Location: [http://www.who.int/tobacco/publications/mdg\\_final\\_for\\_web.pdf](http://www.who.int/tobacco/publications/mdg_final_for_web.pdf)

# RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

**The Economics of Tobacco Use and Tobacco Control in the Developing World: A Background Paper for the High Level Roundtable on Tobacco Control and Development Policy.** *European Commission, World Health Organization and World Bank, 2003.*

- Examines the contribution of tobacco production and cultivation to the economies of several countries, in addition to impacts on farmers; it refutes the notion that economic reasons exist to delay tobacco control.
- Concludes that, given the burden tobacco use imposes on health and health systems, nutrition, education and development, “most nations would derive net economic gains, not losses, if their demand for tobacco products fell, because economic losses would be offset by economic gains at household and national levels.”

Location: [http://ec.europa.eu/health/archive/ph\\_determinants/life\\_style/tobacco/documents/world\\_bank\\_en.pdf](http://ec.europa.eu/health/archive/ph_determinants/life_style/tobacco/documents/world_bank_en.pdf)

**Curbing the Epidemic: Governments and the Economics of Tobacco Control.** *World Bank, 1999.*

- Reviews global trends in tobacco consumption and resulting health and economic costs.
- Provides measures to reduce the supply and demand of tobacco.
- Details how tobacco control would benefit rather than harm the economy, by steering income towards food, investment and other items often forgone due to tobacco consumption.
- States that jobs lost due to tobacco control have been vastly overstated, predominantly by tobacco-industry-sponsored studies.

Location: <http://ro.unctad.org/infocomm/francais/tabac/docs/tobacco.pdf>

**The Global Economic Burden of Non-communicable Diseases.** *World Economic Forum and Harvard School of Public Health, 2011.*

- Describes the NCD epidemic and its risk factors.
- Describes NCDs as a “leading threat to global economic growth” and projects that cardiovascular disease, diabetes, cancer and chronic respiratory disease will cost the global economy more than US\$30 trillion over the next twenty years, driving millions of people below the poverty line.
- Encourages governments, civil society and the private sector to coordinate a multisectoral response to NCDs.

Location: [http://www3.weforum.org/docs/WEF\\_Harvard\\_HE\\_GlobalEconomicBurdenNonCommunicableDiseases\\_2011.pdf](http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf)

**Global status report on non-communicable diseases 2010.** *World Health Organization, 2011.*

- Using global, regional, and country-level data, provides evidence and experiences related to the NCD epidemic, with a particular focus on conditions in LMICs, which now bear 80 percent of the NCD burden.
- Examines the devastating developmental impact NCDs have on households and national economies, and the role of social determinants in shaping health inequities.
- Provides cost-effective population-wide and targeted interventions, stressing the importance of tobacco control and noting that the WHO FCTC “provides a blueprint for international cooperation.”

Location: [http://whqlibdoc.who.int/publications/2011/9789240686458\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789240686458_eng.pdf)

# RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

**The Growing Danger of Non-communicable Diseases: Acting Now to Reverse Course.** *World Bank*, 2011.

- Overviews the NCD epidemic and the economic costs that NCDs exact on individuals, health systems and national economies.
- Notes that, in addition to NCDs, LMICs must still contend with the ongoing burden of communicable diseases and thus face a “double burden.”
- Policymakers in LMICs are encouraged to take action across sectors.

Location:

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/WBDeepeningCrisis.pdf>

**Priority actions for the non-communicable disease crisis.** Beaglehole et al., 2011. *Lancet*, 377:1438-47.

- Lists priority actions for the prevention of NCDs — actions chosen for their health effects, cost-effectiveness, low costs of implementation, and political and financial feasibility.
- Tobacco control is singled out as the “most urgent and immediate” priority.
- Proposes by 2040 a world essentially free of tobacco (prevalence of less than five percent) and calls for strengthened political resolve for the accelerated implementation of the WHO FCTC.

Location: <http://www.smith.edu/psgh/docs/Oct18/Priority%20actions.pdf>

**Scaling up action against non-communicable diseases: How much will it cost?** *World Health Organization*, 2011.

- Reviews the health and economic costs of NCDs.
- Recommends dual intervention strategies: population-wide interventions alongside targeted approaches (i.e. treating those with high risk factors).
- Provides a tool – based on a methodology used to derive global price tags for scaling up interventions related to MDGs – to help countries assess which interventions will bring the most benefit for the lowest costs (i.e. ‘best buys’).
- Calls tobacco control “highly feasible” and the WHO FCTC a “strong framework.”

Location: [http://whqlibdoc.who.int/publications/2011/9789241502313\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502313_eng.pdf)

## 1.2. Equity & social determinants of health

**Equity, social determinants, and public health programmes.** *World Health Organization*, 2010.

- Details the social determinants and inequities that lead to health outcomes, while identifying entry points for intervention and possible sources of resistance to change.
- Includes a large chapter on tobacco consumption, including how macro-level and downstream factors have contributed to the higher prevalence of tobacco use among lower socio-economic groups.
- Calls for implementation of the WHO FCTC from a perspective that encompasses social determinants of health, specifically encouraging governments and international agencies to consider the ‘inverse equity’ principle, in which the poor have more difficulty accessing health interventions than do the wealthy.

# RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

Location: [http://whqlibdoc.who.int/publications/2010/9789241563970\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf)

**Closing the gap in a generation: Health equity through action on the social determinants of health.** *World Health Organization*, 2008.

- Landmark study on the social determinants that drive health inequities, with emphasis on the 'vicious cycle' between poverty and ill health.
- Features a chapter each on several health outcomes, including HIV, which offers many lessons for NCDs.
- Calls the development of the WHO FCTC "an excellent (if rare) example of a coherent, global action to restrain market availability of a lethal commodity."

Location: [http://whqlibdoc.who.int/publications/2008/9789241563703\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

**Women and Tobacco: a call for including gender in tobacco control research, policy and practice.** Amos, A, Greaves, L, Nichter, M, and Bloch, M. 2012. *Tobacco Control*, 21: 236-243.

- Notes that female tobacco consumption is predicted to double between 2005 and 2025, while male use is expected to remain steady or decline.
- Reviews the toll that second-hand smoke exacts on women and discusses tobacco companies' purposeful marketing of tobacco to women; cites the need for more gender-sensitive tobacco control policies.

Location: This document is not publicly available free of charge but can be accessed using the above citation.

**Gender, Women, and the Tobacco Epidemic.** *World Health Organization*, 2010.

- Chronicles the unique relationship between gender, women and tobacco use.
- Details the prevalence of female smokers by region and the disproportionate burden women face from second-hand smoke.
- Discusses the tremendous health and economic costs smoking exacts on women and their families.
- Discusses tobacco companies' targeting of women in marketing and advertisements, concluding that more gender-sensitive tobacco control research and policies are needed.

Location: [http://whqlibdoc.who.int/publications/2010/9789241599511\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241599511_eng.pdf)

## 1.3. Human rights-based approach

**Human Rights and the Framework Convention on Tobacco Control: mutually reinforcing systems.** Cabrera, OA, and Gostin, LO. 2011. *International Journal of Law in Context*, 7(3):285–303. Cambridge University Press.

- Reviews the connection between human rights and tobacco control, looking specifically at the human rights concepts embodied and not embodied in the WHO FCTC.
- Controverses the rights-based arguments against tobacco regulation that are put forth by the tobacco industry, demonstrating that tobacco control and human rights are actually "mutually reinforcing," rather than in conflict.

## RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

- Notes that governments have the obligation to “respect, protect, and fulfill” the human right to health, and they must therefore – at a minimum – implement the WHO FCTC.

Location: [http://www.fairtradetobacco.org/wp-content/uploads/2011/10/Cabrera\\_2011.pdf](http://www.fairtradetobacco.org/wp-content/uploads/2011/10/Cabrera_2011.pdf)

**The Emerging Human Right to Tobacco Control.** Dresler, C and Marks, S. 2006. *Human Rights Quarterly*, 28:599–651.

- Examines the relationship between the human right to tobacco control and various efforts to reduce tobacco industry-driven death and disability — for example, the WHO FCTC.
- Provides suggestions for implementing human rights mechanisms that address the health and economic consequences of tobacco use and cultivation.
- Details specific human rights pertinent to tobacco control (e.g. the right to health, the rights of children, the right to a healthy environment, women’s rights) and states that “the evidence has become so compelling and the policy priorities have evolved so far that a strong case can be made for the emergence of an implied derivative human right to tobacco control.”
- Includes a substantial section on the WHO FCTC and its specific and implied human rights considerations.

Location: [http://www.hsph.harvard.edu/stephen-marks/files/2012/10/spm\\_emerging\\_human\\_right\\_tobacco\\_ctrl.pdf](http://www.hsph.harvard.edu/stephen-marks/files/2012/10/spm_emerging_human_right_tobacco_ctrl.pdf)

**Human rights, health and poverty reduction strategies.** World Health Organization and Office of the High Commissioner for Human Rights, December 2008. Health and Human Rights Publication Series, Issue No. 5. Geneva.

- Targets health policymakers in countries that are in the process of developing, reviewing or updating poverty reduction strategies (PRSs).
- Discusses how human rights principles relate to development, noting that many PRSs do not pay adequate attention to human rights and the specific health threats facing the poor.
- States that many countries face challenges in trying to operationalize commitments to human rights principles.
- Provides ‘good practices’ intended to demonstrate how human rights principles have been operationalized in the various stages of developing a PRS, from initial analysis to design of content to implementation and monitoring and evaluation.
- Includes a detailed reference section that includes pertinent human rights articles and instruments.

Location: <http://www.who.int/hhr/news/HRHPRS.pdf>

**The Right to Health: Factsheet No. 31.** World Health Organization and Office of the High Commissioner for Human Rights, 2008. Geneva.

- Describes the right to health in international human rights law.
- Illustrates human rights implications for specific individuals and groups (e.g. women, children).
- Elaborates upon States' obligations with respect to the right to health.
- Overviews national, regional and international accountability and monitoring mechanisms.

Location: <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

# RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

**Frequently asked questions about a human-rights-based approach and development cooperation.** *Office of the High Commissioner for Human Rights, 2006. HR/PUB/06/08. New York and Geneva: United Nations.*

- Primarily meant for United Nations development practitioners.
- Explains human rights from several angles, including how human rights relate to poverty, economic growth, development, gender and the MDGs; examines in detail a human-rights-based approach to these issues, with a particular emphasis on mainstreaming human rights into national development plans.
- Provides an annex of the 'seven core' United Nations human rights treaties.

Location: <http://www.ohchr.org/Documents/Publications/FAQen.pdf>

**A human-rights-based approach to health. Factsheet.** *World Health Organization and Office of the High Commissioner for Human Rights, Geneva.*

- Explains why a human-rights based approach is warranted and how the UN system understands the HRBA.
- Overviews States' obligation to "respect, protect and fulfill" the human right to health, focusing specifically on the capacity of duty bearers to meet their obligations and of rights-holders to claim their rights.
- Explains that a human-rights-based approach is one of the key programming principles guiding UN common country programmes, and, as such, has been integrated into the Guidelines for UN Country Teams (UNCTs) on Preparing a Common Country Assessment (CCA) and the United Nations Development Assistance Framework (UNDAF).
- Provides technical assistance and guiding principles on how to integrate human rights into all sectors, policies and programmes.

Location: [http://www.who.int/hhr/news/hrba\\_to\\_health2.pdf](http://www.who.int/hhr/news/hrba_to_health2.pdf)

## 1.4. Environmental sustainability

**Environmental health impacts of tobacco farming: a review of the literature.** Lecours et al., 2012. *Tobacco Control*, 21:191-196.

- Discusses the many negative environmental impacts of tobacco production at the local level — impacts often linked to social and health problems; specifically, examines how common agricultural practices related to tobacco farming, especially in LMICs, lead to deforestation and soil degradation.
- Notes that the tobacco industry and tobacco farming create 'a cycle of indebtedness' for farmers while making these farmers ill with green tobacco sickness.
- Calls for more research on: the detrimental impacts of tobacco farming; the tobacco industry's corporate social responsibility campaigns; and the tobacco industry's broader practices.

Location: <http://tobaccocontrol.bmj.com/content/21/2/191.full.pdf+html>

# RESOURCE GUIDE FOR TOBACCO CONTROL AND WHO FCTC IMPLEMENTATION

## Section 2: Guidance and reports on planning processes

### 2.1. WHO FCTC guidelines and reports on implementation

**WHO Framework Convention on Tobacco Control: Guidelines for Implementation.** *World Health Organization, 2013.*

- To facilitate implementation of certain provisions of the Convention, the Conference of the Parties has adopted seven guidelines at its second (2007), third (2008), fourth (2010) and fifth (2012) sessions, covering provisions of eight Articles of the Convention.
- These seven guidelines cover a wide range of provisions of the WHO FCTC: the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry (Article 5.3); protection from exposure to tobacco smoke (Article 8); regulation of the contents of tobacco products and of tobacco product disclosures (Articles 9 and 10); packaging and labelling of tobacco products (Article 11); education, communication, training and public awareness (Article 12); tobacco advertising, promotion and sponsorship (Article 13); and demand reduction measures concerning tobacco dependence and cessation (Article 14).

Location: [http://apps.who.int/iris/bitstream/10665/80510/1/9789241505185\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/80510/1/9789241505185_eng.pdf)

**2012 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control.** *World Health Organization, 2012.*

- The key resource in terms of an overview of the progress in implementation of the WHO FCTC, globally.
- This resource is published every two years based on the information contained in the Party implementation reports that are submitted to the regular sessions of the Conference of the Parties.

Location: [http://apps.who.int/iris/bitstream/10665/79170/1/9789241504652\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/79170/1/9789241504652_eng.pdf)

### 2.2. The UNDAF process

**The UNDG toolkit for improved functioning of the United Nations development system at the country level.**

- The UNDG Toolkit was created to assist UNCTs in pursuing the improved functioning of the UN development system at the country level. It is a repository of the guidance, lessons learned and tools derived from the experiences of UNCTs that have pursued efforts to become more coherent, effective, and efficient in delivering development assistance at the country level, including experiences from the eight 'Delivering as One' pilot countries. The Toolkit also contains relevant approved UNDG guidance on all areas of UN coordination such as programmes (e.g. UNDAF Guidelines) and operations (i.e. those related to Common Services). It serves as a comprehensive resource to support countries in their efforts towards an integrated programme and operations approach.

Location: <http://toolkit.undg.org/>

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**How to Prepare an UNDAF: Part I: Guidelines for UN Country Teams.** *United Nations Development Group, 2010.*

- Defines an UNDAF and the role of UN Country Teams.
- Offers UN Country Teams five core programming principles upon which to develop UNDAFs, stressing that there can be no defined blueprint, so these core principles should be applied depending on national context.
- Identifies specific roles for those who must prepare UNDAFs and states that four explicit steps be taken in preparing the UNDAF, namely: 1) road map; 2) country analysis; 3) strategic planning; and 4) monitoring and evaluation.

Location: [http://www.un.org/files/4%20How%20to%20Prepare%20an%20UNDAF%20\(Part%20I\).pdf](http://www.un.org/files/4%20How%20to%20Prepare%20an%20UNDAF%20(Part%20I).pdf)

**How to Prepare an UNDAF: Part II: Technical Guidance for UN Country Teams.** *United Nations Development Group, 2010.*

- Supplements 'How to Prepare an UNDAF: Part (I) Guidelines for UN Country Teams' (above) by providing detailed technical assistance to UN Country Teams in applying the UNDAF guidelines.

Location: [http://www.un.org/files/5%20How%20to%20Prepare%20an%20UNDAF%20\(Part%20II\).pdf](http://www.un.org/files/5%20How%20to%20Prepare%20an%20UNDAF%20(Part%20II).pdf)

**UNDAF Action Plan Guidance Note.** *United Nations Development Group, 2010.*

- Outlines the purpose, expected benefits and process for preparing an UNDAF Action Plan, which is an attempt to replace UN system agency-specific country programme action plans and other similar operational documents with a single document for the coordinated implementation of the UNDAF (i.e. to advance the harmonization and simplification of UN operations).
- UNDAF Action Plans, which are voluntary, are meant to complement but not replace existing UNDG guidance on common country programming and the UNDAF guidelines 'How to Prepare an UNDAF: Part (I) Guidelines for UN Country Teams' and 'How to Prepare an UNDAF: Part (II) Technical Guidance for UN Country Teams'.

Location: <http://www.un.org/files/1%20UNDAF%20Action%20Plan%20Guidance%20Note.pdf>

**The United Nations Development Assistance Framework: Process and Instruments - Guidance for WHO Country Teams.** *World Health Organization, 2010.*

- Provides WHO Country Teams with an update on important and recent developments on programming, monitoring and reporting at country level in the context of the UNDAF.
- Provides guidance in response to the need for providing a coherent and unified approach for WHO's contribution and engagement in the UNDAF.
- Summarizes the purpose, guiding principles and main components of the UNDAF; also examines important developments in relation to the UNDAF, including UNDAF Action Plans.

Location: [http://www.who.int/countryfocus/resources/undaf\\_guidance\\_for\\_who\\_country\\_teams\\_2010.pdf](http://www.who.int/countryfocus/resources/undaf_guidance_for_who_country_teams_2010.pdf)

## 2.3. WHO guidance on national planning processes

**A Guide to WHO's role in sector-wide approaches to health development.** *World Health Organization, 2006.*

- Explains the role of WHO Country Offices in sector-wide approaches (SWAs) in health development. SWAs are a tool used to harmonize and align development assistance around national policies and strategies.

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- Offers guidance on how WHO Country Teams should engage with SWAPs, and encourages that WHO Country Teams work across partners and sectors; one vital partner identified is UN Country Teams.

Location: [http://www.who.int/countryfocus/resources/guide\\_to\\_who\\_role\\_in\\_swap\\_en.pdf](http://www.who.int/countryfocus/resources/guide_to_who_role_in_swap_en.pdf)

**Poverty Reduction Strategy Papers (PRSPs) - their significance for health: second synthesis report.** *World Health Organization, 2004.*

- Uses a desk review of 21 'full' or 'final' PRSPs (national planning frameworks for low-income countries) and builds upon previous work by WHO to analyze PRSPs from a health perspective.
- Offers a systematic review of the link between PRSPs, health and achievement of the MDGs.

Location: <http://www.who.int/hdp/en/prsp.pdf>

## 2.4. Mainstreaming of issues

**Integrating tobacco control into health and development agendas.** Reddy, KS, Yadav, A, Arora, M, Nazar, GP. *Tobacco Control* 2012; 21:281-286.

- Recognizes the health and development impact of tobacco consumption and stresses the need for urgent, multisectoral action; specifically, explores the relationship between tobacco and the following: tuberculosis; maternal and child health; adolescent health; the environment; development; and human rights.
- Calls for tobacco control to be integrated into other health and national planning programmes, and stresses the necessity of a whole-of-government approach to tobacco control in general; details how this integration could be achieved through political commitment and cooperation across sectors, focusing on the WHO FCTC.
- Notes that healthcare costs, productivity losses, fire damage and other costs from tobacco use amounts to approximately US\$500 billion annually.

Location: <http://tobaccocontrol.bmj.com/content/21/2/281.full.pdf+html>

**Integrating Climate Change Considerations in the Country Analysis and the UNDAF: A Guidance Note for United Nations Country Teams.** *United Nations Development Group, 2010.*

- Provides guidance on how best to incorporate actions that address the risks and opportunities related to climate change in the Country Analysis (i.e. CCA) and the UNDAF.
- The 'Quick Guide' is organized around the main steps for UN common country programming, and outlines entry points, related actions and tools.
- WHO FCTC Parties can transfer important lessons and commonalities from climate change mainstreaming to FCTC implementation.

Location:

[http://ynccf.net/pdf/Climate\\_change\\_and\\_development/UNDG\\_Integrating\\_Climate\\_Change\\_Considerations\\_into\\_UNDAF\\_CCA\\_\(2010\).pdf](http://ynccf.net/pdf/Climate_change_and_development/UNDG_Integrating_Climate_Change_Considerations_into_UNDAF_CCA_(2010).pdf)

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**Mainstreaming HIV and AIDS in Sectors & Programmes: An Implementation Guide for National Responses.** *United Nations Development Programme, World Bank and UNAIDS, 2009.*

- Chronicles the relationship between HIV and development, citing the need for a multisectoral response.
- Provides technical assistance required for accelerated implementation of multisectoral AIDS responses at country level; specifically, enables the immediate and practical action to implement National Action Frameworks for HIV and AIDS.
- Part I offers the essential concepts and lessons of mainstreaming, whereas Part II offers a simple step-by-step approach to mainstreaming AIDS-related strategies and activities into sectors and programmes.
- Can be used by WHO FCTC Parties to guide implementation of the FCTC, particularly of those articles requiring multisectoral action.

Location:

<http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1136997394502/MainstreamingHIVandAIDSinsectors&programmesEnglish.pdf>

**Guidance Note on Mainstreaming Environment into National Development Planning.** *United Nations Environment Programme and United Nations Development Programme, 2007.*

- This guidance note is designed for Poverty Environment Initiative (PEI) country-level environmental mainstreaming programmes and aims to effectively integrate environment into the MDG Support Initiative. Subsidiary aims are to: share experiences with governments and development partners as well as the wider stakeholder community on what is involved in launching and sustaining a country level environmental mainstreaming programme; highlight some general success factors and challenges based on current experience; and explain the common steps in the process and outline the tasks typically involved as well as what tools might be applied.

Location: [http://www.unpeilac.org/documentos/Guidance\\_Note\\_Mainstreaming-eng.pdf](http://www.unpeilac.org/documentos/Guidance_Note_Mainstreaming-eng.pdf)

**Gender Mainstreaming: An Overview.** *United Nations, 2002.*

- Reviews the importance of mainstreaming gender to achieving gender equality, addresses barriers to doing so, and presents strategies to overcome those barriers.
- Acknowledges that there is no universal blueprint for effective mainstreaming, but offers core principles and guidelines. These guidelines can be transferred from gender and applied by WHO FCTC Parties for FCTC implementation, particularly of those articles requiring multisectoral action.

Location: <http://www.un.org/womenwatch/osagi/pdf/e65237.pdf>

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## Section 3: Key decisions and declarations on tobacco, health and development

**E/2013/L.23. United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases.** *United Nations*, 2013.

- Recognizes that the current work of the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control, constituted upon the request of the Economic and Social Council in 1999, is aimed at supporting accelerated implementation of the WHO FCTC by Parties.
- Requests the Secretary-General to establish the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, by expanding the mandate of the existing United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control; this new Task Force will be convened and led by the World Health Organization.
- Requests that the Task Force on the Prevention and Control of Non-communicable Diseases coordinate the activities of all UN agencies to implement the Global Action Plan (below), and include and support the work of the UN Ad Hoc Inter-Agency Task Force on Tobacco Control with regard to implementation of the FCTC.
- The resolution was adopted by the Economic and Social Council in July 2013.

Location: [http://www.who.int/nmh/events/2013/E.2013.L.23\\_tobacco.pdf](http://www.who.int/nmh/events/2013/E.2013.L.23_tobacco.pdf)

**Revised Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020.** World Health Organization, 2013.

- Adopted by the World Health Assembly in May 2013.
- Includes a comprehensive set of actions to accelerate the reduction in the burden of NCDs so that sufficient progress is made by 2020 on the global targets set for 2025 (see below).
- Provides a minimum set of NCD actions, many on social determinants, which countries with resource constraints may prioritize.
- Lists policy options for Member States in pursuance of tobacco control, among other NCD risk factors. Specifically, calls for accelerated full implementation of the WHO FCTC.

Location: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_R10-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf)

**NCD Global Monitoring Framework: Ensuring progress on noncommunicable diseases in countries.** World Health Organization, 2013.

- Adopted by the World Health Assembly in May 2013.
- Contains nine voluntary global targets with 25 indicators — all aligned with the global target of a 25 percent reduction in NCD-associated premature mortality by 2025, which was adopted by the World Health Assembly a year prior in 2012.
- One voluntary target is a 30 percent reduction in tobacco use by 2025.

Location: [http://www.who.int/nmh/global\\_monitoring\\_framework/en/index.html](http://www.who.int/nmh/global_monitoring_framework/en/index.html)

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**A/RES/66/288. Resolution adopted by the General Assembly: The future we want (RIO+20 Outcome Document).** *United Nations, 2012.*

- Outlines the common vision of the RIO+20 United Nations Conference on Sustainable Development, which includes eradicating poverty, mainstreaming sustainable development issues at all levels and promoting human rights principles.
- Its commitment to “establish or strengthen multisectoral national policies for the prevention and control of non-communicable diseases” is particularly relevant for tobacco control and WHO FCTC implementation.

Location: [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/RES/66/288&Lang=E](http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/66/288&Lang=E)

**FCTC/COP5(5) Seoul Declaration, adopted by the Conference of the Parties at its Fifth Session, 2012.**

- Declares the Parties’ determination to support comprehensive, multisectoral and coordinated approaches to tobacco control, recognizing that effective NCD prevention and control requires whole-of-government approaches;
- Declares the Parties’ resolve to strengthen action to protect tobacco control policies from commercial and other vested interests of the tobacco industry, as required by Article 5.3 of the Convention;
- Declares the Parties’ determination not to allow tobacco industry interference to slow or prevent the development and implementation of tobacco control measures in the interests of public health.

Location: [http://apps.who.int/gb/fctc/PDF/cop5/FCTC\\_COP5\(5\)-en.pdf](http://apps.who.int/gb/fctc/PDF/cop5/FCTC_COP5(5)-en.pdf)

**E/RES/2012/4. Resolution adopted by Economic and Social Council: United Nations system-wide coherence on tobacco control.** *United Nations, 2012.*

- Resolution in response to the report of the Secretary-General on the Ad Hoc Inter-Agency Task Force on Tobacco Control (below).
- Emphasizes the need to further strengthen multisectoral and interagency efforts for the full implementation of the WHO FCTC.
- Acknowledges that the work of the Task Force should be consistent with system-wide coherence approaches to ensure that the United Nations system is able to deliver in a strategic and coordinated manner at the country level in support of the implementation of the Framework Convention, where appropriate, in alignment with national priorities.
- Encourages the Ad Hoc Inter-Agency Task Force to promote effective tobacco control policies and assistance mechanisms at the national level, including through the integration of WHO FCTC implementation efforts within the United Nations Development Assistance Frameworks, where appropriate, in order to promote coordinated and complementary work among funds, programmes and specialized agencies.

Location: [http://www.un.org/ga/search/view\\_doc.asp?symbol=E/RES/2012/4](http://www.un.org/ga/search/view_doc.asp?symbol=E/RES/2012/4)

**Ad-Hoc Inter-Agency Task Force on Tobacco Control: Report of the Secretary-General.** *United Nations, 2012.*

- Presented in pursuance of Economic and Social Council Resolution E/2010/8, in which the Council requested the Secretary-General to report on the work of the Ad Hoc Inter-Agency Task Force on Tobacco Control regarding

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the possibility of further strengthening the multisectoral and interagency response to the needs related to global WHO FCTC implementation.

- Reviews the work of the Task Force to date, overviews main WHO FCTC provisions and highlights areas of collaboration among the different agencies.
- States that a UN system-wide, multisectoral and whole-of-government approach will be most effective for the successful implementation of the Convention; progress will depend on full implementation at the country level through integration with coordinating mechanisms such as UNDAFs. Deems commitment of agencies at the highest level critical in facilitating this process, and highlights three required levels of interventions for tobacco control – political, technical and operational – and the need to make the link to control of NCDs more broadly.

Location: [http://www.un.org/en/ecosoc/docs/adv2012/tobacco\\_or\\_health\\_sg\\_report\\_to\\_ecosoc\\_29\\_may\\_12.pdf](http://www.un.org/en/ecosoc/docs/adv2012/tobacco_or_health_sg_report_to_ecosoc_29_may_12.pdf)

**A/RES/66/2. Resolution adopted by the General Assembly: Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.** *United Nations, 2011.*

- Recognizes the immense threat NCDs pose to socio-economic development as well as the responsibility of governments to respond to this threat with a multisectoral, whole-of-government approach.
- Calls for accelerated implementation of the WHO FCTC in countries that have adopted the treaty, and also strongly encourages countries that have not yet acceded to do so.
- Calls upon WHO in consultation with other UN agencies to aid in this accelerated implementation.

Location: [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/RES/66/2](http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/66/2)

**A/66/83. Prevention and control of non-communicable diseases: Report of the Secretary-General.** *United Nations, 2011.*

- Reviews the current status of noncommunicable diseases, outlines the burden they impose on global health and socio-economic development and provides recommendations to counteract such diseases by monitoring their trends, scaling up measures to reduce risk factors, strengthening health systems and services and improving access to health care.
- Calls for the accelerated implementation of the WHO FCTC.

Location: [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)

**Rio Political Declaration on Social Determinants of Health.** World Conference on Social Determinants of Health: Rio de Janeiro, Brazil. *World Health Organization, 2011.*

- Codifies the declarations made by the heads of governments who came together to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
- Recognizes that “substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa.”
- Paragraph 14.2 (iv) calls for accelerated implementation of the WHO FCTC among Parties and encourages non-member countries to consider acceding; paragraph 11.2 (i) pledges to: “Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard.”

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Location: [http://www.who.int/sdhconference/declaration/Rio\\_political\\_declaration.pdf](http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf)

**First Global Ministerial Conference on Healthy Lifestyles and NCD Control & Moscow Declaration on NCDs. April, 2011.**

- Recognizes the health and development challenges posed by NCDs and the inequitable distribution of these challenges among and within countries.
- Calls for NCD control to be mainstreamed into policies that address the related behavioural, environmental, economic and social factors (e.g. MDG achievement and gender disparities).
- Stresses the need for a multisectoral approach – integrated in a coordinated manner – that pays particular attention to main NCD risk factors, such as tobacco; thus, calls for accelerated implementation of the WHO FCTC by Parties and encourages non-Parties to urgently ratify the Convention.

Location: [http://www.un.org/en/ga/president/65/issues/moscow\\_declaration\\_en.pdf](http://www.un.org/en/ga/president/65/issues/moscow_declaration_en.pdf)

**FCTC/COP<sub>4</sub>(5) Punta del Este Declaration on the Implementation of the WHO Framework Convention on Tobacco Control, adopted by the Conference of the Parties at its Fourth Session, 2010.**

- Declares the 'firm commitment' of the WHO FCTC Parties 'to prioritise the implementation of health measures designed to control tobacco consumption in their respective jurisdictions';
- Declares WHO FCTC Parties' 'concern regarding actions taken by the tobacco industry that seek to subvert and undermine government policies on tobacco control'; and
- Declares WHO FCTC Parties' 'right to define and implement national public health policies pursuant to compliance with conventions and commitments under WHO, particularly with the WHO FCTC'.

Location: [http://apps.who.int/gb/fctc/PDF/cop4/FCTC\\_COP4\(5\)-en.pdf](http://apps.who.int/gb/fctc/PDF/cop4/FCTC_COP4(5)-en.pdf)