Implementing an International Health Treaty in Small Pacific Island Nations

by

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Abstract

Tobacco use is one of the leading causes of death today and an increasing burden on the developing world. The global tobacco epidemic created a significant need to implement the World Health Organisation’s (WHO) Framework Convention on Tobacco Control (FCTC): the first international public health treaty. This dissertation explores the implementation of the FCTC in the Pacific region and draws on a diverse range of literature relating to tobacco control, health policy, implementation and the environments of small island developing states. A theoretical framework on public policy implementation is utilised to direct the research inquiry.

A mixed-methods multiple-case study design has been adopted to investigate FCTC implementation in four Pacific Island countries: the Cook Islands, Vanuatu, Palau and Nauru. Thirty-nine semi-structured, in-depth interviews were conducted and 129 documents were analysed. The data collected gave an in-depth insight into the variables that affect FCTC implementation in these countries, how they do so, and how barriers and opportunities can be utilised to implement the FCTC effectively. Data underwent a thematic analysis using NVIVO Version 10.

Results show that since ratification, each country made progress towards implementing the FCTC, but to varying degrees. There was room for improvement in all cases. Barriers and facilitators to FCTC implementation are explored in detail. Key themes relating to the environments of small island developing states found to influence FCTC implementation included: rural and remote islands and communities; little non-government/civil society activism; a limited local tobacco manufacturing presence; limited administrative capacity and a small number of staff “wearing many hats”; small and personalised networks and relationships; and a strong influence from global and regional forces.

Recommendations on how to overcome barriers and utilise opportunities to FCTC implementation in the context of each individual country are detailed. A cross-country synthesis revealed the following recommendations relevant to small Pacific
Island nations: to advocate that the majority of FCTC provisions are effective, relevant and needed; to build capacity, utilise resources effectively and exceed minimum FCTC requirements for cost-effective provisions; to strengthen multi-sectoral networks; to foster growth in anti-tobacco coalition activity and compensate where this activity is limited; to exploit limited pro-tobacco opposition; to globalise the FCTC to ensure that it comprehensively addresses the global tobacco epidemic; and to strengthen FCTC implementation from the bottom-up by appreciating country contingencies, local priorities and empowering civil society.

This study adds to the scarce literature available for each of the countries examined. It addresses the lack of in-depth, qualitative discourse on the variables that affect FCTC implementation. It is one of the few studies to systematically apply political science theory to tobacco control and to recognise the distinct characteristics of small island developing states and how these influence health policy implementation.
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Abbreviations

AusAID  Australian Agency for International Development
CDC  Centers for Disease Control and Prevention
COP  Conference of the Parties to the FCTC
CPI  Consumer Price Index
CSO  Civil society organisation
CTFP  Coalition for a Tobacco-Free Palau
DUHREC  Deakin University Human Research Ethics Committee
FCA  Framework Convention Alliance
FCTC  WHO Framework Convention on Tobacco Control
FCS  Framework Convention (on Tobacco Control) Secretariat
GDP  Gross Domestic Product
GYTS  Global Youth Tobacco Survey
HiAP  Health in All Policies
MFEM  (Cook Islands/Vanuatu) Ministry of Finance and Economic Management
MOH  Ministry of Health
MPOWER  Key tobacco control measures endorsed by the WHO (Monitor, Protect, Offer, Warn, Enforce, Raise)
NCD  Non-communicable disease
NGO  Non-government organisation
NZAID  New Zealand Agency for International Development
RPPL 8-27  Republic of Palau Law (RPPL) 8-27 (an Act legislating tobacco control)
SIDS  Small island developing states
SPC  Secretariat of the Pacific Community
STEPS  WHO’s STEPwise approach to surveillance (of NCD risk factors)
TAPS  Tobacco advertising, promotion and sponsorship
TCWG  (Cook Islands) Tobacco Control Working Group
UN  United Nations
US  United States
WHO  World Health Organisation
WPRO  Western Pacific Regional Office of the WHO
VANGO  Vanuatu Association of NGOs
YTS  (Palau) Youth Tobacco Survey
Chapter 1  Introduction

1.1 Introduction

This chapter first outlines the thesis structure. The global tobacco epidemic and the World Health Organisation’s (WHO) Framework Convention on Tobacco Control (FCTC) are then introduced. The harms of tobacco use at an individual level are detailed and the trajectory of global tobacco use is explored. These factors provide justification for the enhanced efforts to regulate and control tobacco use. The FCTC’s proposed solution to the global tobacco epidemic is then outlined in terms of its basic structure and function, evolution and core provisions, and how it is governed at the national level. Tobacco use and the FCTC in the Pacific islands are then explored. Finally, a rationale for this study’s focus on FCTC implementation in small island developing states\(^1\) (SIDS) of the Pacific is provided and the specific research questions that direct this dissertation are detailed.

1.2 Structure of this thesis

This first chapter provides a background to the research undertaken. It contextualises this study and explores the key issues of the global tobacco epidemic, the FCTC and tobacco control in the Pacific region. This is followed by the rationale and research questions for this study, which frame what this study intends to explore and why.

A literature review on the multidisciplinary theoretical context underlying this dissertation is undertaken in Chapter 2. The literature relating to this research produced to date not only elaborates on relevant concepts within the fields of political science, public health and health promotion, but also serves as a lynchpin...

\(^{1}\) For the purposes of this dissertation, a small island developing state is an independently governed island nation not of a very high development status (as classified by the UN) comprising less than one million people, and which does not share borders with larger countries. This definition is explained in Chapter 2.4.1. The terms “country”, “state” or “nation” are interchangeable for the
for the contribution of this thesis to the empirical evidence. Some relevant theoretical frameworks for this research, including the one that is used to guide this study, are explored.

Chapter 3 gives details of the study design and research methods utilised in this mixed-methods, multiple-case study. This chapter essentially uncovers how the research was undertaken and what strategies were used to answer the research questions.

Chapter 4 articulates the results of the research inquiry on FCTC implementation in the context of each country examined. It includes country-specific recommendations for effective FCTC implementation. A synthesis of results is provided in Chapter 5, highlighting themes that were commonly experienced across all of the four countries examined. Both of these chapters draw from an analysis of the vast amount of data produced from the research design and methods.

Chapter 6 contains recommendations for effective FCTC implementation that are derived from the cross-country synthesis. These are given from both national and global perspectives.

Chapter 7 concludes this dissertation. It discusses the implications of this research for both health promotion theory and practice. Chapter 7 also provides recommendations that are based on the theoretical approach and research methods in order for theoretical progression and to guide future researchers.

1.3 The burden of tobacco use

1.3.1 Tobacco-related harms to the individual
In order to understand the burden of tobacco use on population health, the harms to the individual must be first recognised. During the latter half of the 20th century, a plethora of studies documented the negative health effects of tobacco use, which are now summarised briefly.
The association between tobacco smoking and lung cancer was well established during the 1950s in the British doctors’ study (Doll & Hill 1956) and later confirmed by the Royal College of Physicians of London (1962) and the United States (US) Surgeon General’s Report (US Department of Health, Education and Welfare 1964). Cigarette smoke contains a vast number of chemical compounds, including 45 known or suspected carcinogens (Fowles & Dybing 2003). The 2004 US Surgeon General’s Report states that cigarette smoking harms nearly every organ of the body (US Department of Health and Human Services 2004). Evidence supports the existence of a causal relationship between cigarette smoking and cancers of the lung, bladder, cervix, oesophagus, kidney, oral cavity, larynx, stomach and pancreas; smoking is also associated with leukaemia (US Department of Health and Human Services 2004). Furthermore, there is a relationship between cigarette smoking and cardiovascular and respiratory diseases, including abdominal aortic aneurysm, atherosclerosis, cerebrovascular disease, coronary heart disease, chronic obstructive pulmonary disease, pneumonia, and other respiratory effects in utero, childhood, adolescence and adulthood (US Department of Health and Human Services 2004). It has been estimated that tobacco smoking causes around 71 per cent of lung cancers, 42 per cent of chronic respiratory diseases and 10 per cent of cardiovascular diseases globally (Alwan 2011). Other effects of cigarette smoking include cataracts, low bone density, hip fractures, peptic ulcer disease and impotence (Tengs & Osgood 2001; US Department of Health and Human Services 2004).

The aforementioned diseases not only affect the smoker, but those who are involuntarily exposed to tobacco smoke may also be at risk (US Department of Health and Human Services 2006). Furthermore, cigarette smoking is known to cause stillbirths, low birth weight, reduced fertility, pregnancy complications and sudden infant death syndrome (US Department of Health and Human Services 2004).

Using 1995 to 1999 data from the US, the Centers for Disease Control and Prevention (CDC) found that adult male and female smokers lost an average of 13.2
and 14.5 years of life respectively, which was attributable to their cigarette smoking (CDC 2002). It is also estimated that around half of all cigarette smokers will die as a result of their habit (Doll et al. 1994).

It is not only tobacco smoking that is harmful to human health. Chewing or smokeless tobacco is associated with a substantially increased risk of oral and pancreatic cancers, stillbirths and low birth weight, as well as of nicotine-related effects such as elevated blood pressure and serum cholesterol (Critchley & Unal 2003; Gupta & Ray 2003; International Agency for Research on Cancer 2007; Spangler & Salisbury 1995). Any form of tobacco contains nicotine, an addictive substance: Nutt and colleagues (2007) rank tobacco as the third most addictive of 20 common varieties of licit and illicit drugs.

While the effects of tobacco use at the individual level are many and varied, it is important to recognise its substantial health risks, its harmful constituents, its addictiveness and the involuntary harm it causes by the second-hand exposure to tobacco smoke. These factors underpin the rationale for controlling tobacco use. The remainder of this dissertation will focus on health at a population level, rather than at an individual level.

1.3.2 The global tobacco epidemic

The burden of tobacco use on the world’s population is profound and increasing globally, even though scientific consensus on its harms was established almost 60 years ago. While the global tobacco use prevalence rate is stable or slightly decreasing, the total number of worldwide smokers continues to increase due to population growth (Eriksen, Mackay & Ross 2012). Lim and colleagues (2012) state that tobacco smoking was attributable to 6.3 million deaths worldwide each year, using data from the 2010 Global Burden of Disease study. It is important to recognise the delay between the peak of tobacco use prevalence and the peak of tobacco-related mortality (Lopez, Collishaw & Piha 1994), which means that tobacco-related mortality is still projected to rise despite a recent tapering off in tobacco use prevalence. Mathers and Loncar (2006) estimate that the annual death toll attributable to tobacco use will increase to 8.3 million in 2030, when it will be
responsible for ten per cent of all deaths globally. The WHO (2008b) claims that tobacco caused 100 million deaths over the course of the 20th century. If current trends continue, one billion deaths will have been caused by tobacco use by the end of the 21st century (Jha 2009). While the share of disease burden from tobacco use has fallen slightly in North America, Australasia, southern Latin America and western Europe from 1990 to 2010, tobacco use has contributed to the rise in non-communicable diseases (NCDs) in most developing regions of the world including Asia, North Africa and the Middle East over this same time period (Lim et al. 2012). The burden of tobacco use is shifting to the developing world: the WHO estimates that by 2030, 80 per cent of premature deaths caused by tobacco will be in developing countries (WHO 2011c). The adult tobacco use prevalence, using 2008 to 2010 data, is high in many populous developing countries: 28 per cent in China, 35 per cent in India, and 29 per cent in Indonesia (WHO 2011c).

In the modern globalised environment, tobacco use is facilitated through a variety of complex factors including trade liberalisation, direct foreign investment, transnational advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes (WHO 2005c). The global tobacco industry has consolidated in recent decades through many mergers and acquisitions. In 2007 it was estimated that just five companies held 88 per cent of the global market share of tobacco; these, listed in descending order of global market share, were the Chinese National Tobacco Corporation, Philip Morris (International and Altria/Philip Morris USA), British American Tobacco, Japan Tobacco and Imperial Tobacco (Scollo & Winstanley 2008). The revenue of these companies in 2010 was estimated to be 346.2 billion US dollars (Eriksen, Mackay & Ross 2012), rendering them powerful entities that can exert considerable influence in the countries they operate and sell products in. The tobacco industry has engaged in a variety of tactics to resist and counteract government regulation of its products (Saloojee & Dagli 2000; WHO 2008a; WHO Committee of Experts on Tobacco Industry Documents 2000); these are mentioned later in this chapter. Describing the tobacco epidemic in comparison to communicable diseases, the WHO stated that “tobacco use is unlike other threats to global health. Infectious
diseases do not employ multinational public relations firms. There are no front groups to promote the spread of cholera. Mosquitoes have no lobbyists” (2000; p. 244).

1.3.3 Global tobacco control prior to the FCTC

Modern efforts to control tobacco date back to the anti-tobacco movement in Nazi Germany in the 1930s and early 1940s (Proctor 1996), although it was not until the early 1960s, after reports from institutions including the Royal College of Physicians (1962) and the US Surgeon General (US Department of Health Education and Welfare 1964), that tobacco control gathered momentum internationally. Since then, the cause for tobacco control has been facilitated through a number of major events, including several World Conferences on Tobacco and Health, WHO involvement through numerous programmes and activities, the recognition of the harms of second-hand smoke, stricter US and European regulations on tobacco use, and the US Master Settlement Agreement (Cairney, Studlar & Mamudu 2012). As the evidence base, epistemic community, extent of anti-tobacco advocacy and number of tobacco control policies grew in the latter half of the 20th century, tobacco use in many developed countries declined (Mamudu, Gonzalez & Glantz 2011; Warner 2005). In the US, tobacco control is cited as one of the ten greatest public health achievements in the 20th century (CDC 1999).

The focus of global tobacco control took a much-needed turn to the developing world in the 1990s. Two important developments that provided an impetus for policy change in developing countries was a 1995 report by the UN Conference on Trade and Development and the World Bank’s Curbing the Epidemic report (Jha & Chaloupka 1999; Mamudu 2005). The latter highlighted government fears that tobacco control measures would harm their economies were largely unfounded, and tobacco control measures could bring unprecedented health benefits without economic consequences (Jha & Chaloupka 1999). The aforementioned health consequences of tobacco use were evident to developing country governments, but these reports provided an economic rationale for tobacco control in these countries and created further momentum towards action in this area.
Despite these events, tobacco use remains a leading cause of preventable death globally (WHO 2011c). By the end of the 20th century, it remained imperative for health promotion and public health efforts to continue to focus on minimising this burden. The globalisation of the tobacco epidemic and its growth in developing countries required a massive impetus for action on a global scale (Satcher 2001; Yach & Bettcher 2000). The WHO had not previously utilised its treaty-making power, enshrined in its constitution in 1948; however, the tobacco epidemic called for radical measures (WHO 2009a). The WHO made use of this power by adopting the FCTC in a substantial effort to enhance tobacco control policy internationally.

### 1.4 The Framework Convention on Tobacco Control (FCTC)

#### 1.4.1 The FCTC and how it works

The FCTC is the first public health treaty and first legal instrument designed to promote multinational cooperation and action to minimise the spread of the global tobacco epidemic (Roemer, Taylor & Lariviere 2005). The core components or provisions of the FCTC, detailed later in this chapter, are policy measures that aim to minimise the health burden of tobacco use.

A treaty is a “legally binding agreement created by, and between, two or more subjects of international law that are recognised as having treaty-making capacity” (Dixon 2007; p. 54), and includes all of the many sorts of explicit international agreements (Janis 2008). As a framework convention, the FCTC is a treaty that establishes a system of international governance for an issue (Simpson 1999), which in this case is the control of tobacco use. Framework conventions determine general guidelines and principles for governance, and tend to be followed by more specific agreements to supplement the framework in an incremental approach (Simpson 1999).

Parties to the FCTC (which are typically in the form of sovereign nation-states) must give consent to be bound by the treaty’s obligations. This can be done by ratification, acceptance, approval, formal confirmation, accession or succession; each of these have the same effect for the purposes of this research, for in each
case parties bound themselves by the FCTC under international law. Once the FCTC has been ratified, parties are obliged to adopt it within their national (or state/provincial) legislation. As is often the case in international law, there is no formal supra-national mechanism to monitor or evaluate FCTC performance, and it relies on state parties to report periodically on its implementation (Dresler et al. 2012; Glynn 2010). While some commitments under the FCTC are obligatory, others are only hortatory and there are no punitive sanctions beyond naming and shaming of parties that do not uphold their commitments (Mamudu & Studlar 2009).

The Conference of the Parties (COP) is the governing body of the FCTC and comprises of all parties to the framework convention (WHO 2012f). This body reviews the treaty and makes decisions to promote its effective implementation (WHO 2012f). Critical roles of the COP include setting normative standards, building and disseminating knowledge, monitoring implementation, facilitating international cooperation and mobilising resources to support implementation (Liberman 2012). The COP has held five sessions since 2006, the last in November 2012. The Framework Convention Secretariat (FCS) was created by the COP and as an administrative body, it supports parties in their fulfilment of the FCTC’s obligations, provides support to the COP and translates decisions made at the COP into program activities (WHO 2012g).

1.4.2 A brief account of treaties in general

There have been a vast number of treaties developed under international law over many centuries, although a significant proportion of these post-date World War II (Denemark & Hoffman 2008). They have been developed in a wide range of domains including security, dispute settlement, strategic alliances, nation state recognition, human rights, environmental protection, trade and intellectual property. A treaty’s coming into force does not necessarily mean that it will be successful in addressing the problems it is designed to fix. Scott (2010) explains that some multilateral treaties, such as the ozone depletion regime, have met with great success; but when taking into account the mass of treaties overall, their outcomes have not been as positive and few have completed the work they set out to achieve.
A recent example of this is the Kyoto Protocol, which has not proven very effective, because it has not been ratified by, or its reduction targets are dismissed as inapplicable to, many of the larger emitters of greenhouse gases (Keller 2010). Since its inception, global emissions have increased (Keller 2010). Inevitably, state participation and compliance (and therefore treaty success) depend upon a complex array of factors including international relations, the content of the treaty itself, the normative orientation (of the regime and state), treaty enforcement capacity, state capacity, and perhaps most importantly, the domestic polity (Sitaraman 2009).

1.4.3 The evolution of the FCTC

The idea that the WHO should utilise its authority to develop international conventions to advance global health was formulated by Allyn Taylor (Roemer, Taylor & Lariviere 2005). Taylor (1992) recognised that great health disparities between developed and developing countries remained despite concerted efforts by international organisations to address them. This idea of an international convention was put forward by Allyn Taylor and Ruth Roemer at the 48th World Health Assembly in 1995, and a resolution in the 49th World Health Assembly requested the Director-General of the WHO to initiate development of the FCTC (WHO 2009a). In 1998, the new WHO Director-General Dr Gro Harlem Brundtland prioritised tobacco control (Roemer, Taylor & Lariviere 2005), and the 52nd World Health Assembly paved the way for negotiations of the FCTC in 1999 (World Health Assembly 1999). The FCTC was adopted unanimously by the World Health Assembly in its 56th session in 2003 and became open for signature. It entered into force and therefore became legally binding in February 2005 after being ratified by its 40th party 90 days earlier (WHO 2009a). The Framework Convention Alliance (FCA) (2013) highlights that of November 2013, the FCTC has been ratified by 177 parties, representing 88 per cent of the world’s population. It is one of the United Nations’ (UN) most widely embraced treaties in history (WHO 2009a).

The official negotiation process of the FCTC was undertaken by government actors (as member states of the WHO) who were its formal decision-makers. Other actors
also played an important role. Civil society organisations dealing with tobacco control were gathered under an umbrella organisation, the FCA, and successfully utilised strategies such as the publication of newsletters, media advocacy and shaming symbolism to influence the positions of countries during the FCTC negotiation process (Mamudu, Hammond & Glantz 2011). The tobacco industry participated in public hearings (Mamudu 2005); although it was excluded from the formal negotiation and decision-making processes, it was still able to exert influence, persuading some governments to opt for a weakened version of the treaty’s text at the international level (Assunta & Chapman 2006; Gonzalez, Green & Glantz 2012; Gruning et al. 2012). The treaty demonstrated a pioneering international commitment to curb the global tobacco epidemic, although much work was still to be completed after the initial negotiation of the FCTC content. Since its entry into force in 2005, negotiations have moved towards establishing detailed guidelines for FCTC provisions (some of which are yet to be completed), and the Protocol to Eliminate Illicit Trade in Tobacco Products was adopted in 2012.

In the context of the FCTC process as a whole, its negotiation and ratification may be seen as the end of the beginning. In recent years, efforts have been geared towards parties developing and implementing FCTC-based tobacco control legislation within their national jurisdictions. Although some (particularly developed) countries may have enacted strong national tobacco control legislation before or while the FCTC was being negotiated, many countries have only recently introduced legislation in order to fulfil their obligations. Once FCTC-based legislation is in place in their respective countries, parties must mobilise to implement the treaty’s provisions. A significant proportion of countries have been engaging with this since 2007, a process that is likely to continue for numerous years, particularly in the case of FCTC provisions in which detailed guidelines are yet to be negotiated. Future success of the FCTC is dependent upon the continued commitment, determination and vision of governments, non-government organisations (NGOs) and civil society organisations (CSOs) that are entrusted to transform this international agreement into a global reality (Nikogosian 2010).
1.4.4 Provisions of the FCTC

The FCTC consists of a broad range of provisions (formally referred to as articles) established through consensus on ways in which to minimise the health burden associated with tobacco use. These provisions are grouped into those measures relating to the reduction of demand, those relating to the reduction of supply, scientific/technical cooperation and communication of information. The main tobacco control provisions that are to be implemented by its parties in their respective jurisdictions are named below; brief descriptions in brackets provide further detail of some provisions.

### Measures relating to the reduction of demand for tobacco

- **Article 6** Price and tax measures
- **Article 8** Protection from exposure to tobacco smoke *(mandating smoke-free public places)*
- **Article 9** Regulation of the contents of tobacco products
- **Article 10** Regulation of tobacco product disclosures *(disclosure of toxic constituents and the emissions they produce)*
- **Article 11** Packaging and labelling of tobacco products *(place health warnings on tobacco product packages and ban misleading descriptors such as “mild” cigarettes)*
- **Article 12** Education, communication, training and public awareness
- **Article 13** Bans on tobacco advertising, promotion and sponsorship (TAPS)
- **Article 14** Promote the cessation of tobacco use and treatment for tobacco dependence

### Measures relating to the reduction of supply for tobacco

- **Article 15** Illicit trade in tobacco products *(eliminating smuggling, illicit manufacturing and counterfeiting)*
- **Article 16** Sales to and by minors *(ban sales to/by those under legal age, prohibit promotions that appeal to minors, ban sales of individual cigarettes and cigarettes in small packages)*
- **Article 17** Provision of support for economically viable alternative activities *(for individuals reliant on growing, manufacturing or selling tobacco)*


**Figure 1: Tobacco control provisions of the FCTC**

In addition to the articles listed in Figure 1, Article 5 specifies some important general obligations that assist with the provisions of FCTC overall:

- developing, implementing and periodically updating and reviewing comprehensive multi-sectoral tobacco control strategies, plans and programs (Article 5.1);
- establishing a national coordinating mechanism or focal point for tobacco control (Article 5.2);
- protecting public health policies from commercial and other vested interests of the tobacco industry (Article 5.3);
- cooperating in the formulation of proposed measures, procedures and guidelines for FCTC implementation (Article 5.4);
- cooperating with competent international and regional intergovernmental organisations (Article 5.5); and
- cooperating to raise resources for effective implementation through bilateral and multilateral funding mechanisms (Article 5.6). (WHO 2005c)

Articles 20-22, which relate to the mechanisms for scientific and technical cooperation and the exchange of information, are also important elements of the FCTC.

The FCTC articles are at various stages of their development: when planning for this research project began in 2010, time-bound deadlines and comprehensive guidelines had been produced for Articles 8, 11 and 13 only, and guidelines were provided for Article 5.3. Since then, comprehensive guidelines have been produced for Articles 9, 10, 12 and 14 (WHO 2013e).

The most cost-effective tobacco control policies (in terms of their effect on disability-adjusted life years in proportion to gross domestic product per capita) include taxation, clean indoor air laws, a comprehensive ban on advertising, and information dissemination on the health risks of tobacco (Shibuya et al. 2003). The first three policies fall within FCTC Articles 6, 8 and 13 respectively, while Article 11 is one of the most effective ways of achieving the fourth, and Articles 12 and 14 are also important in this regard. The WHO has emphasised the MPOWER package, in what it sees as the “best buys” for tobacco control (WHO 2009b). MPOWER stands for

- Monitor tobacco use and prevention policies (within Article 20);
- Protect people from tobacco smoke (Article 8);
- Offer to help quit tobacco use (Article 14);
- Warn about the dangers of tobacco (Articles 11 and 12);
- Enforce bans on tobacco advertising, promotion and sponsorship (TAPS) (Article 13);
- Raise taxes on tobacco (Article 6) (WHO 2008b).

These articles largely align with the cost-effective measures advocated by Shibuya and colleagues (2003) as well as with those FCTC articles where guidelines and deadlines have been agreed upon.

This dissertation focuses on FCTC implementation broadly, although some emphasis is placed on the taxation of tobacco products, smoke-free public places, tobacco product packaging and labelling, and bans on TAPS (Articles 6, 8, 11 and 13). This is because these articles are both cost-effective and at the most advanced stage of development of all FCTC provisions.

1.4.5 National governance of the FCTC

It is important to consider the governing role that various sectors and institutions play at the national level in order to implement the FCTC. Although the national ministries of health within governments are central actors, many provisions of the FCTC require significant collaboration with and the commitment of other government departments (Reddy et al. 2012). Passing FCTC provisions into national tobacco control legislation typically requires parliamentary and whole-of-government support. Legal departments will have a significant influence on the development of regulations to enforce the tobacco control legislation. Tax policies on tobacco products, the allocation of extra-budgetary funding, and earmarking funds for tobacco control or health promotion purposes tend to be governed by ministries of finance or their equivalent. Ministries responsible for foreign affairs and trade also have significant clout on decisions relevant to the trading of tobacco. Furthermore, the enforcement of FCTC-based provisions is performed by police officers and health inspectors/environmental health officers, and prosecutions tend to be performed by a ministry of justice or department of the attorney-general. Departments responsible for customs and border control typically oversee illicit trade, import duties and the sale of duty-free tobacco products. Ministries of agriculture and finance may have responsibilities for the provision of sustainable
alternatives to tobacco for tobacco growers. Ministry of education support is often
important in running awareness programs in schools and monitoring tobacco use
and control among youth. This complex web of actors is complicated further when
some countries (such as China, Japan and Thailand) have tobacco companies that
are totally or partially owned by government entities.

Outside government, civil society and non-government organisations often play an
important role, raising awareness of tobacco and its control, providing public and
political support, acting as watchdogs and serving as important actors for technical
expertise, training and capacity building (Champagne, Sebrie & Schoj 2010; Lin
2010; Sparks 2010). Support from the private sector is important in treating tobacco
dependence and providing nicotine replacement therapy (Anderson 2002; Bettcher
& Sanda 2008). Furthermore, businesses are required to comply with bans on sales
to minors and with smoke-free policies in workplaces and hospitality venues
(McDaniel & Malone 2012). The tobacco industry is renowned for its attempts to
thwart and subvert tobacco control legislation in many different ways, through
conducting media campaigns, buying scientific expertise, creating controversy
about established facts, funding political parties, hiring lobbyists, advocating lax
legislation, distorting WHO research, using front groups and UN agencies to oppose
tobacco control measures, corrupting public officials, cigarette smuggling and
litigation (Saloojee & Dagli 2000; WHO 2008a; WHO Committee of Experts on
Tobacco Industry Documents 2000). In countries that manufacture tobacco, the
tobacco industry may stress the economic importance of manufacturing facilities in
an attempt to counter tobacco control measures (WHO Committee of Experts on
Tobacco Industry Documents 2000). To effectively control tobacco, it is clear that
FCTC implementation requires a whole-of-government and multi-sectoral approach
that is not subject to undue tobacco industry influence.

1.5 Tobacco use and the FCTC in the Pacific Islands

The tobacco epidemic has not spared the Pacific Islands, despite the remoteness
and isolation of many countries in this region (Martin & de Leeuw 2013). There is
some disparity in the prevalence of adult tobacco use in Pacific SIDS, although the majority of countries have high prevalence rates, especially in men (Rasanathan & Tukuitonga 2007). This is displayed in Table 1.

**Table 1: Statistics on tobacco smoking prevalence in the Pacific region**

<table>
<thead>
<tr>
<th>Country</th>
<th>Adult tobacco smoking prevalence (2009 data, age standardised)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>43</td>
</tr>
<tr>
<td>Fiji</td>
<td>18</td>
</tr>
<tr>
<td>Kiribati</td>
<td>71</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>36</td>
</tr>
<tr>
<td>Fed. States of Micronesia</td>
<td>30</td>
</tr>
<tr>
<td>Nauru</td>
<td>49</td>
</tr>
<tr>
<td>Niue</td>
<td>37</td>
</tr>
<tr>
<td>Palau</td>
<td>37(^1)</td>
</tr>
<tr>
<td>Samoa</td>
<td>58</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>46</td>
</tr>
<tr>
<td>Tonga</td>
<td>44</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>51</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>43</td>
</tr>
<tr>
<td>Australia</td>
<td>20</td>
</tr>
</tbody>
</table>


The high prevalence rates in most Pacific SIDS can be contrasted to rates in Australia, where the tobacco use prevalence is projected to decrease to 14 per cent by 2020 (Gartner, Barendregt & Hall 2009). Evidence suggests that tobacco control prevalence in male populations has declined in the Pacific Islands over the last 30 years (Rasanathan & Tukuitonga 2007), but this trajectory has not been nearly as sharp as it has in neighbouring Australia. The decline in Australia, like in other countries such as Canada, Sweden and the US, can be attributed to the implementation of tobacco control policies (Gartner, Barendregt & Hall 2009; Wilson et al. 2012; Woodward 1984), which have been in place for a much longer time period than in many developing countries including the Pacific SIDS of interest.

In response to the significant burden caused by tobacco use, all thirteen independent SIDS in the Pacific region ratified the FCTC by the end of 2005 (Framework Convention Alliance 2013). Furthermore, all countries covered by the
broader Western Pacific Regional Office (WPRO) of the WHO ratified the FCTC by September 2006 (Framework Convention Alliance 2013). Rasanathan and Tukuitonga (2007) suggested that FCTC provisions should be implemented rapidly, and without immediate action, the burden of tobacco use in the region was likely to continue to increase.

Despite ratifying the FCTC at a similar time, Pacific SIDS are at various stages of its implementation. The vast majority have made some sort of progress. The following table displays the date of FCTC ratification and some indicators for the implementation of key FCTC provisions in the region.

Table 2: FCTC ratification date and indicators of key FCTC policies in Pacific SIDS

<table>
<thead>
<tr>
<th>Country</th>
<th>FCTC ratification date¹</th>
<th>Smoke-free policies (number public place categories², 2010 data)³</th>
<th>Percentage of package covered by health warnings³ (2010 data)</th>
<th>Bans on advertising that cover television, radio and print media³ (2010 data)</th>
<th>Price per pack in USD (2010-2012 data)⁴</th>
<th>Tobacco tax (2010 data)³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Islands</td>
<td>May 2004</td>
<td>Up to 2 places</td>
<td>50</td>
<td>Yes</td>
<td>8.80</td>
<td>78%</td>
</tr>
<tr>
<td>Fiji</td>
<td>Oct 2003</td>
<td>Up to 2 places</td>
<td>20</td>
<td>Yes</td>
<td>2.70²</td>
<td>n/a</td>
</tr>
<tr>
<td>Kiribati</td>
<td>Sep 2005</td>
<td>Up to 2 places</td>
<td>n/a</td>
<td>No</td>
<td>7.19</td>
<td>50%</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>Dec 2004</td>
<td>All or at least 90% of places</td>
<td>Not mandated</td>
<td>No</td>
<td>3.50</td>
<td>36%</td>
</tr>
<tr>
<td>Fed. States of Micronesia</td>
<td>Mar 2005</td>
<td>Up to 2 places</td>
<td>n/a</td>
<td>No</td>
<td>2.25</td>
<td>25%</td>
</tr>
<tr>
<td>Nauru</td>
<td>Jun 2004</td>
<td>All or at least 90% of places</td>
<td>13⁶</td>
<td>Yes</td>
<td>4.46</td>
<td>42%</td>
</tr>
<tr>
<td>Niue</td>
<td>Jun 2005</td>
<td>Up to 2 places</td>
<td>n/a</td>
<td>No</td>
<td>7.21</td>
<td>63%</td>
</tr>
<tr>
<td>Palau</td>
<td>Feb 2004</td>
<td>Up to 2 places</td>
<td>Not mandated</td>
<td>No</td>
<td>4.50</td>
<td>57%</td>
</tr>
<tr>
<td>Samoa</td>
<td>Nov 2005</td>
<td>3 to 5 places</td>
<td>30</td>
<td>Yes</td>
<td>5.23</td>
<td>61%</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Aug 2004</td>
<td>3 to 5 places</td>
<td>30</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tonga</td>
<td>Apr 2005</td>
<td>Up to 2 places</td>
<td>30</td>
<td>Yes</td>
<td>4.93</td>
<td>68%</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>Sep 2005</td>
<td>3 to 5 places</td>
<td>30</td>
<td>Yes</td>
<td>5.39</td>
<td>19%</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Sep 2005</td>
<td>Up to 2 places</td>
<td>30</td>
<td>Yes</td>
<td>8.03</td>
<td>60%</td>
</tr>
</tbody>
</table>


² Public place categories include government facilities; public transport; indoor offices and workplaces not considered in any other category; educational facilities (other than universities); universities; restaurants and food venues; pubs and bars or beverage venues.

The data in Table 2 gives a useful snapshot of Pacific SIDS, but it is predominantly numerical and outcome-oriented (like many reports from the relevant agencies), and does not provide sufficient details of the complex process of implementing FCTC-based provisions, or indicate the in-depth experiences of countries making this endeavour.

Only a limited number of studies give an in-depth account of FCTC implementation in the region. The WHO, with funding from the New Zealand Agency for International Development (NZAID), released a best practice report on overseas development assistance programs for tobacco control. This features a case study report by Allen (2009) on building the tobacco control capacity of six Pacific Island states, one of the very few in-depth reports on FCTC implementation in the region. Allen (2009) does not categorise the relevant countries as SIDS or refer to this concept, but presents several opportunities and threats to tobacco control in the Pacific Islands. The opportunities include:

- small populations resulting in one level of government mandated to set legislation and policy and an ability to reach and influence decision-makers more readily;
- a culture of chiefs, elders and religious leaders where they are potential supporters for tobacco control programs; and
- a rapid increase in NCDs in the region meaning that adopting mechanisms to reduce this have become more palpable. (Allen 2009)

The threats to tobacco control in the Pacific Islands include:

- a relatively small workforce available for tobacco control efforts, with many staff members being stretched thin with competing demands for their time;
- a lack of sustainable funding for tobacco control programs due to small national budgets and more immediate funding needs;
tobacco companies’ strong endorsement of “sensible regulation” resonating with decision-makers in the Pacific;

- a continued acceptance of tobacco use in some Pacific Island countries;

- lack of a domestic evidence base;

- counterfeit tobacco products from China and other countries posing an increasing threat that is often not recognised by Pacific Island countries; and

- the threat that economic and trade liberalisation in the region may lead to the removal of tariffs on tobacco and an increasing presence of tobacco companies. (Allen 2009)

This research was conducted largely before (or while) comprehensive tobacco control legislation passed through parliaments in the various countries. Although its primary focus was overseas development assistance for tobacco control, it provides insight into some of the factors that may affect FCTC implementation in six Pacific Island countries.

Cussen and McCool (2011) explore one provision of the FCTC, the status of advertising bans in Pacific Island countries. They suggest there are needs for improvement in this provision and for resources to support the introduction of effective policies in low-income countries in the Pacific region (Cussen & McCool 2011). A study conducted by Hale and colleagues (2012) in Niue outlines five elements to ensure the progress of tobacco control in the country, which include leadership and political support, engaged communities, a step-wise (incremental) approach, the potential for novel supply-side restrictions, and utilising the FCTC as a lever for action. Capacity building and outside technical assistance to support tobacco control have also been suggested (Hale et al. 2012).

1.6 Study rationale and research questions

A background to the central topic of this study of the global tobacco epidemic and the FCTC, has been provided thus far. The rationale that directs this inquiry and shapes the research questions is now provided. The detailed concepts and literature that underlie this rationale are explored in greater detail in Chapter 2.
The threat of the global tobacco epidemic and the solution proposed in the FCTC have been detailed. Developed countries have made some progress in tobacco control and FCTC implementation, but literature indicates that there are significant challenges to implementing the FCTC in developing countries. Official FCTC reporting and global information collected in this area is largely limited to brief, outcome-oriented, quantitative data which does not give a detailed account of the variables that affect policy implementation in participating countries. Even less is known on FCTC implementation in the environments of SIDS, which are hypothesised to have a considerable impact on the variables that affect FCTC implementation. Broader literature on health promotion and public health has given extremely scant attention to these environments. There is also limited use of political theory in public health and health promotion relative to the importance of public policy in relation to population health. This study aims to contribute to in-depth knowledge of the variables\(^2\) that affect implementation in SIDS and seeks to address gaps in the FCTC discourse and the literature.

This study investigates the Pacific SIDS, which by ratifying the FCTC, have signalled an intention to implement it. Progress towards FCTC implementation in this region tends to be varied, piecemeal and has not been thoroughly accounted for in the literature. A strong evidence base serves as a contributor to sound policy. It is expected that this dissertation, through providing detailed evidence on how the FCTC is received in the Pacific region, will generate knowledge on how it can be implemented effectively and achieve its aim of minimising the harm associated with the tobacco epidemic. This will have implications for FCTC implementation globally, particularly in other nations that share similar experiences to the four Pacific Island nations examined.

Based on this rationale, the central research questions are as follows:

\(^2\) The term “variables” as used in this dissertation should not be interpreted as simply values that are quantifiably measured. They are largely qualitative and could be equally interpreted as “factors” or “determinants”.
• What variables influence the implementation of the FCTC in SIDS of the Pacific and how do they affect its success or failure?

• How can barriers be overcome and opportunities be utilised to ensure effective FCTC implementation in SIDS of the Pacific?

To answer these questions, a multiple-case study design using a mixed-methods approach has been employed. This is explored in more detail in Chapter 3.

In answering these relatively objective, in-depth research questions, some interesting insights will emerge: How much of the FCTC has been successfully implemented in the Pacific Island nations under examination thus far? Are the countries of interest fulfilling their promises made by ratifying the FCTC? Are the implementation environments of SIDS putting a significant strain on the effectiveness of the treaty? Is the tobacco industry countering the FCTC in the countries of interest? How will the scenarios in these countries reflect on FCTC implementation globally? The remainder of this dissertation will add to the knowledge which serves to answer such queries.
Chapter 2  
Literature Review

2.1 Introduction

The previous chapter provided a background to the global tobacco epidemic and the FCTC. It explored these issues in the Pacific region and provided the rationale to this study. This chapter explores the theoretical underpinnings of this study in political science, public health and health promotion. This dissertation is of a multidisciplinary nature and the empirical evidence is drawn from a wide range of literature. This chapter commences with a literature review on public policy and the policy-making process, with implementation as a part of this process. The evolution of policy implementation theory and top-down, bottom-up and synthesised implementation approaches are described. The domain of health policy, with its foundation in health promotion and public health, are explored. This chapter then defines SIDS, explores their environments, and is followed by an exploration of policy implementation theory as it relates to developing countries and SIDS. A review of FCTC implementation in developing countries and in SIDS is conducted, which is followed by an exploration of health policy implementation in SIDS. A review of some alternative theoretical frameworks that could be used to analyse FCTC implementation is conducted and the selected theoretical framework for this study is detailed. Finally, an outline of the gaps to be addressed by this dissertation is provided.

2.2 The policy process and policy implementation

2.2.1 Defining public policy and the policy-making process

Empirical knowledge on public policy and the policymaking process has been established since the pioneering work of Harold Lasswell in the mid-20th century. There are various definitions of public policy. Bridgeman and Davis define policy as “the instrument of governance, the decisions that direct public resources in one direction but not another” (2004; p. 3). Dye defines public policy as “whatever governments choose to do or not to do... public policies may regulate behaviour, organise bureaucracies, distribute benefits, or extract taxes, or all of these things at
once” (2002; p. 1). Both these definitions, although somewhat brief, are apt. The latter definition may be criticised on the grounds that it overlooks actors outside government, who may have a significant influence on what governments choose to do (Howlett & Ramesh 2003). A more comprehensive definition by Jenkins states that public policy is “a set of interrelated decisions taken by a political actor...concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve” (Jenkins 1978; p. 15). This definition considers that multiple actors (and not only governments) may be involved in policy decisions and it also recognises that the political actors may not always have the power or resources to carry out intended policies precisely. Describing public policies is a relatively easy task in comparison to determining why a government did what it did and assessing the consequences of its actions (Howlett & Ramesh 2003). The formation of political decisions is extremely complex, and any analyst must find a way to simplify the dynamics of policymaking in order to understand it (Sabatier 1999). There are various analytical frameworks available to direct the study of public policy. Parsons (1995) describes numerous approaches, including stages-heuristic, pluralist-elitist, neo-Marxist, sub-system, policy discourse and institutional approaches. No one theory or model can capture or explain the complexity involved in the “web of decisions” which comprise public policy (Easton 1953; cited in Parsons 1995); hence the approach used is likely to be dependent upon what is being analysed and for what purpose. Ultimately, the analytical or theoretical framework acts as the specific lens a policy analyst utilises to study the complexity of public policy.

The sub-system approach, which tends to analyse policy through networks or systems of actors, has some relevance for the purposes of this research as the influence of various stakeholders on FCTC implementation is clear. A common theoretical framework utilising a sub-system approach is the Advocacy Coalition Framework by Sabatier (1986). This highlights the influence that coalition groups (and other factors) have on decision-makers and the policies that are constructed within the policy sub-system. Another sub-system approach relevant to agenda-
setting is Kingdon’s streams model, which suggests that organisations do not rationally adopt solutions to problems (Parsons 1995) but that an issue may become part of the policy-makers’ agenda when three independent streams, problem, policy and politics, align to create a window of opportunity for policy change (Kingdon 1995).

A stages-heuristic approach to analysing policy, which is central to this study, delineates the various stages of the policy-making process. Lasswell (1951) was instrumental in conceptualising the policy process in stages and developing a policymaking sequence of intelligence, recommendation, prescription, invocation, application, appraisal and termination. The stages-heuristic approach is still a common way to conceptualise and analyse policy today, although the delineation of the stages of the policy process may vary between texts. Dye (2002) outlines six stages: problem identification, agenda setting, policy formulation, policy legitimization, policy implementation and policy variation. The stages-heuristic approach allows for some simplification of the complex process by which governments (or other organisations) put policy into practice. This approach is commonly cited in academic literature, but it can give the false impression of a process that acts like a conveyer belt, with agenda-setting and problem identification at one end and policy implementation and evaluation at the other (Parsons 1995). In reality, some theorists claim, the policy process is much more rich and complex than what is portrayed (Schlager 1999), and the “text book approach” may neglect blurred distinctions between phases (Nakamura 1987). Nevertheless, the stages-heuristic approach can be defended on the ground that it simplifies the very complex and messy reality so that it may be understood and articulated (Dorey 2005). It is often difficult to analyse such information from a theoretical standpoint without distinction between certain stages of the policy process. The stages-heuristic approach is endorsed to a certain degree in this project, but not only for this necessary simplification. The significant global emphasis placed on the implementation of the FCTC also justifies this approach, particularly as many (especially developing) countries have recently introduced and are implementing comprehensive tobacco control legislation. Here, implementation
is clearly distinguishable as a specific stage of the FCTC process. Nonetheless, some
appreciation is given to the weaknesses of this approach and it is acknowledged
that in reality, the stages of the policy process may be somewhat more blurred and
complex than is portrayed in theoretical models.

Over the last decade, literature on the policy process has largely utilised the already
established theories and frameworks. However, theories and frameworks continue
to be developed and efforts to integrate existing theories of the policy process have
also been made (Nowlin 2011). There remains no superior way of using a stages-
heuristic approach to analyse the policy process, or indeed using any particular
theory in public policy studies. Cairney (2013) explains that political scientists do not
agree on how to combine theoretical insights in public policy to accumulate
knowledge of policy making, although the insistence on a rigid universal scientific
standard in relation to public policy studies may harm rather than help scientific
collaboration and process.

2.2.2 The evolution of policy implementation theory
Implementation is a particular stage often conceptualised in a stages-heuristic
approach to analysing public policy. Implementation can be adequately yet simply
defined as “what happens between policy expectations and (perceived) policy
results” (Ferman 1990; p. 39). Howlett and Ramesh describe implementation as
“the process whereby programs or policies are carried out, the translation of plans
into practice” (2003; p. 185). Implementation is dependent on the broader policy-
making process in which it is embedded. Pressman and Wildavsky argue that “there
must be something out there prior to implementation; otherwise there would be
nothing to move toward in the process of implementation. A verb like ‘implement’
must have an object like ‘policy’” (1984; p. xxi).

Until the early 1970s, public policy implementation was seen as unproblematic
(Howlett & Ramesh 2003). There was a tendency to believe that administrators
would simply do what their political bosses demanded of them (Hill & Hupe 2003)
and little effort was directed towards analysing implementation. However, this
changed as a result of work by Pressman and Wildavsky in 1973, whose first edition
of their book carried the title, *Implementation: How Great Expectations in Washington are Dashed in Oakland; or, Why it’s Amazing that Federal Programs Work at all, this being the Saga of the Economic Development Administration as told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation of Ruined Hopes* (Pressman & Wildavsky 1973). Palumbo and Calista (1990) highlight that early implementation studies concluded that most government programs fail, as depicted by the tone the aforementioned book title. This is the result of a perceived gap between the promises made in legislation and the delivery of government programs based on these promises (Palumbo & Calista 1990).

Over the late 1970s and 1980s, this view evolved and political theorists demonstrated a profound interest in exploring policy implementation. Models to conceptualise it emerged, typically embodying a top-down approach to implementation. Theorists utilising this approach tended to start with a policy decision and examine the extent to which its legally-mandated objectives were achieved over time, and why (Sabatier 1997). One of the well-known top-down analytical frameworks to conceptualise implementation, developed by Mazmanian and Sabatier (1989), claimed that policy implementation was primarily affected by the tractability of the problem to be addressed, the ability of statute to structure implementation (such as the prescribed solution and institutional capacity to implement it), and non-statutory variables (including wider socioeconomic conditions and the support of the public and other constituency groups). Although this and other theories that saw policy implementation from a top-down perspective had prominence, debate ensued between those supporting this approach and proponents of the alternative bottom-up approach.

Critique of the top-down approach to implementation stresses that it overemphasises the perspective of central decision-makers and tends to neglect other actors such as local implementing officials, the private sector or those from other policy sub-systems (Sabatier 1997). In addition, top-down models may be difficult to use where there is no dominant policy or agency, but a multitude of governmental directives and actors (Sabatier 1997). Lipsky’s (1980) articulation of
“street-level bureaucrats” is pertinent to this bottom-up approach to implementation. Lipsky states that “public policy is not best understood as made in legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made out in the crowded offices and daily encounters of street-level workers” (1997; p. 390), and these workers exercise some individual discretion in regard to implementing the policy. Under such circumstances, it may be said that if “street-level bureaucrats” and local departments are not fully committed, are constrained by limited resources, or act in their own interests (or the interests of the target population to whom they are close) in neglect of the policy’s intentions, then policies as they are defined at the top level may not be carried out as intended.

In recognition of this critique, theorists such as Elmore (1985), Sabatier (1986), and Goggin and colleagues (1990) have demonstrated the need to synthesise or incorporate elements of both top-down and bottom-up perspectives, as they are seen as complementary. Using this synthesised approach, Elmore (1985) states that the use of forward-mapping (top-down implementation analysis) and backward mapping (the influence of the policy on choices by individuals and organisations at the bottom level of the implementation hierarchy) both serve useful purposes. He argues that “in order to be good strategists, policy makers have to calculate the consequences of their actions from the point of view of the decisions they are trying to influence” (Elmore 1985; p. 69). Hence it is important to consider not only those at the top levels at which policies may be constructed, but also those who are placed where the policy meets the people whose behaviour it is intended to change. This synthesised approach was adopted for the purposes of this research, and the theoretical framework used for this project, described later in this chapter, was developed accordingly.

Utilising the synthesised approach may not necessarily be the “best” approach to analysing policy implementation. Matland (1995) argues that it is more fruitful to determine when top-down and bottom-up approaches are most appropriate, rather than attempting to combine them, which can result in diagrams and charts with an
extraordinary number of variables. Similarly, Sabatier (1986) suggests that a top-down approach may be useful in cases where there is a dominant piece of legislation structuring the situation, research funds are limited, and one is interested in mean policy outputs and outcomes. He also considers that the bottom-up approach is useful in situations where there is no dominant piece of legislation, there are large numbers of actors without power dependency, and the primary interest is in the dynamics of different local situations (Sabatier 1986). This argument is valid. Nevertheless, a single synthesised theoretical framework is utilised in this research as it captures a general, holistic perspective on policy implementation across a range of policy provisions in the FCTC. This was seen as suitable for a study undertaken with limited resources to observe FCTC implementation in numerous countries.

When analysing policy implementation, an important question that may be asked is what makes ideal or perfect implementation? Hogwood and Gunn (1997) argue that perfect implementation is unattainable and unlikely to be achieved as it relies upon the belief that:

- the circumstances external to the implementing agency do not impose crippling constraints;
- adequate time and sufficient resources are made available to the program and the combination of resources are available;
- the policy to be implemented is based upon a valid theory of cause and effect and there are few intervening links in this relationship, so that dependency relationships are minimal;
- there is understanding of, and agreement on, its objectives;
- tasks are fully specified in correct sequence;
- there is perfect communication and coordination; and
- those in authority can demand and obtain perfect compliance. (Hogwood & Gunn 1997)

This is not to suggest that good or successful implementation is not achievable, but rather that it is important to recognise the range of contingencies upon which
implementation depends when it is put into practice. Furthermore, what constitutes desirable implementation is likely to depend upon what the policy intends to do, whom it is created/advocated by and the background of the person asked. A managerialist or top-down advocate might suggest that successful implementation is a situation in which the results of the policy are convergent with the aims, objectives and content of the policy to be implemented. A bottom-up advocate might respond that success is when a policy makes a positive change to those it is intended to influence in a localised context. A health advocate might suggest that successful policy implementation is that which causes the least disease burden and promotes health the most significantly. Therefore the notion of successful implementation may vary in meaning according to different stakeholders. A description of implementation and successful implementation in the context of the purposes of this dissertation is provided later in this chapter.

2.3 Health promotion and the use of political theory

This literature review thus far has examined the underlying political theory in general. Health is perceived as a specific policy area or domain. From this perspective, the concepts of health promotion and healthy public policy are the foundation for policies such as the FCTC.

2.3.1 A background to health and health promotion

In 1948, the WHO defined health as a “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (1998; p. 1). This definition transcends the concept of health as restricted to the health care system and the treatment of disease, which are indicative of a medical or clinical model of health. During the late 1970s and 1980s, attention was brought to bear on the social determinants of health. This was evident through the release of The Black Report, which detailed a strong correlation between socioeconomic levels and health inequalities (Townsend & Davidson 1982). Five years later, these findings were reiterated in The Whitehead Report (Whitehead 1987). More recently the WHO Commission on the Social Determinants of Health in 2005 emphasised this
approach, stressing that the greatest causes of health inequities are the social conditions in which people live and work (WHO 2005a). It became clear that in order to improve the health of populations, it was necessary to look beyond the narrow medical model and adopt a social model of health. Wilkinson and Marmot (2003) articulate the most important social determinants of health as the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food supply and transport.

Health promotion was defined in the Ottawa Charter for Health Promotion as “the process of enabling people to increase control over, and to improve, their health” (WHO 1986; p. 1). It has since been defined as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (WHO 2005b; p. 1). The latter definition emphasises the determinants of health. These determinants are social as well as political, environmental, cultural and economic, and health promotion perforce adopts a holistic view of health. The Ottawa Charter, which emphasised “health for all” by the year 2000 and beyond (WHO 1986), resonates strongly as a means by which health promotion can be achieved. It argues that the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (WHO 1986). The Ottawa Charter also identifies three strategies for health promotion: advocacy for health; enabling people to achieve their health potential; and mediating between differing interests (and sectors) in society for the pursuit of health (WHO 1986). Based on these concepts, the Ottawa Charter states that action on health promotion is achieved through five key areas:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- reorienting health services. (WHO 1986)

The FCTC, along with the WHO as its governing institution, strongly endorse this holistic approach to improve population health and wellbeing. For the FCTC and this
dissertation, all action areas of the Ottawa Charter are important, although building healthy public policy is central.

2.3.2 Health policy, healthy public policy and the use of political theory for health promotion

"Health policy" can be defined as a “generic term for any policy, public, private or elsewhere, explicitly addressing health and/or quality of life issues” (de Leeuw 2007; p. 53). The FCTC overall may be considered a health policy as it was designed specifically in response to the globalisation of the tobacco epidemic (WHO 2005c). The concept of “healthy public policy”, one of the key components of the Ottawa Charter (WHO 1986), is frequently used in the literature. The *Adelaide Recommendations on Healthy Public Policy* state that it is “characterised by an explicit concern for health and equity in all areas of policy, and by accountability for health impact” (WHO 1988; p. 2). This upholds the notion that health is determined by policies outside the health sector, as evidenced by Milio (1981) and Hancock (1985). Here, health is put on the agenda of policy makers in all sectors and at all levels (WHO 1986) and many policies that affect health are not explicitly “health” policies as such: examples include a social welfare net, or policies mandating national parks or green spaces. More recently, this notion has been endorsed in the *Adelaide Statement on Health in All Policies* (HiAP), which outlines the need for a new social contract where there is joined-up leadership across all sectors and between all levels of government, in order to promote health and advance human development (WHO & Government of South Australia 2010).

The provisions of the FCTC are health policies guided by scientific evidence on effective ways to control tobacco and promote the health of its intended targets (Fong & Cummings 2006). The FCTC recognises that the huge burden of NCDs can be reduced and health can be promoted using a multi-pronged approach that embraces the social determinants of health. Policies such as mandating smoke-free environments, communicating health warnings through mass media and packaging and labelling requirements, and banning TAPS, directly aim to promote healthy lifestyles and prevent the health burden of tobacco use. Other policies within the
FCTC, such as the national taxation rate on cigarettes, or those aimed at combating the illicit tobacco trade, tend to be determined and implemented outside the health sector, but contribute to healthy public policy.

The importance of health policy and healthy public policy has been recognised in health promotion since its inception. However, the health promotion literature tends to neglect the vast amount of empirical knowledge on policy and its implementation from the standpoint of political science. In many cases, policy research in health promotion tends to be a-theoretical, and the knowledge developed in political science has made little inroad into health policy research (Breton & de Leeuw 2011). Health promotion and public health researchers also tend to be caught in a naïve, idealistic and narrow view of public policy (Bernier & Clavier 2011). Despite this, some studies demonstrate the effective application of political theory to health promotion (and in particular, the FCTC and tobacco control). Breton and colleagues (2008) applied Sabatier and Jenkins-Smith’s (1993) Advocacy Coalition Framework to analyse the adoption of Quebec’s Tobacco Act, and found that the framework had merit in grasping the complexity of the policy process. Sato (1999) also used the Advocacy Coalition Framework, in conjunction with a stages-heuristic model built on the foundations of many theorists, to explore the tobacco control policymaking process in Japan. Blackman (2005) utilised Kingdon’s streams theory of agenda-setting in her analysis of the tobacco control policy agenda in California. Cairney and colleagues (2012), in the first comprehensive attempt by political scientists to examine global tobacco policy broadly, utilised an analytical framework comprising five key areas: institutions, agendas, networks, socioeconomic factors and ideas. This was based upon an array of models in public policy, including Kingdon’s streams and the Advocacy Coalition Framework.

Political science provides a more extensive and elaborate range of theoretical frameworks which form a solid basis for research on health policy and healthy public policy; hence, health promotion professionals aspiring to build healthy public policy should embrace the empirical knowledge from political science. Health
promotion needs to translate its words into actions, which often implies that health disparities be addressed politically (Breton & de Leeuw 2011). Bernier and Clavier (2011) suggest that the political science approach to analysing policy can help open unexplored levers of influence for public health. The use of a relevant theoretical framework developed outside the field of health in this dissertation is an exemplification of this notion.

2.4 The environments of small island developing states (SIDS) and policy implementation

This chapter has thus far focused on the underlying principles of health promotion and policy implementation. The environments\(^3\) in which policies are implemented are now explored in detail.

The broad social, economic and political environment is likely to have an influence on policy implementation; this is documented in numerous theoretical models. Sabatier and Jenkins-Smith (1993) and Mazmanian and Sabatier (1989) highlight socioeconomic conditions as a variable affecting policy change or implementation. Van Meter and Von Horn’s (1975) model of the policy implementation process specifies economic, social and political conditions. Hofferbert (1974) places a significant amount of emphasis on historic/geographic conditions and socioeconomic composition in his model, which portrays the policy process as a funnel with these factors at the top. However, Parsons (1995) considers that Hofferbert’s model, with its emphasis on macro factors, neglects to consider the dynamics and interactions which take place within this environment. Parsons’ (1995) view is appreciated in this study, as it is important not to neglect proximal factors in pursuit of broader contextual factors. Nonetheless, some emphasis on implementation environments is justified in this study (alongside other variables

\(^3\) This may be considered as synonymous with context. However, the term “implementation environment” (or “broad context”) is used in this study to differentiate it from the “context” variable defined in the theoretical framework (which holds a narrower definition).
that affect implementation), particularly as SIDS share distinct characteristics that can significantly shape political decisions.

2.4.1 Defining SIDS

The term “small island developing states” has been used by various authors and international agencies (particularly in the contexts of environmental sustainability and economic development) to characterise particular island nations that are shaped by their smallness, remoteness, isolation and developing country status. A point of interest in this study is to determine the effects of this environment on policy implementation in the health domain. The reasons are two-fold. Firstly, the social, economic and political environments of a country in which a policy is implemented can have a significant effect on its implementation, as established above. Secondly, such countries have faced shared challenges in economic, environmental and social issues. Health may be affected as it is often dependent on these issues. By focusing on SIDS, the relevance of the findings of this study for other countries with similar environments is significantly improved. It is hypothesised that the experience of FCTC implementation in a country such as Vanuatu is likely to be more similar to other SIDS such as the Seychelles, rather than much larger developing countries it is sometimes grouped with (such as China in the WPRO, for example).

There is no universally accepted definition of small island developing states – particularly as the notions of “small” and “remote” are subjective and operate on a continuum. For the purposes of this project, a small island developing state is an independently governed island nation not of a very high development status (as classified by the UN) comprising less than one million people, and which does not share borders with larger countries.⁴ By this definition, there are approximately 26 SIDS in the world, half located in the Pacific Ocean, eight in the Caribbean, and the

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⁴ This definition was used as it was felt that countries which border larger economic powers were less remote. In the Pacific region, Papua New Guinea, with a population of over six million people and bordering Indonesia, may be considered as distinct from much smaller and more isolated nations, such as Nauru (with only around ten thousand people).
remaining five surrounding Africa, in either the Indian or Atlantic Oceans. This
definition is somewhat arbitrary and it is not advised that SIDS be categorised using
a specific threshold that determines whether they are exclusively a SIDS or not – a
continuum and some flexibility should be appreciated. The number of SIDS is likely
to be greater by other, more expansive definitions. For example, there are 51 SIDS
recognised in the UN Department of Economic and Social Affairs (UN Division for
Sustainable Development 2012). This definition was not used in this study, as it is
postulated that the environments of countries such as Cuba with over 11 million
people, and developed countries like Singapore may be rather different than the
extremely small and less populated Pacific SIDS of Nauru and the Cook Islands for
example. The literature on SIDS uses a variety of definitions; hence there is some
variation in the categorisation in the studies on SIDS cited in this dissertation.
Where other studies have not explicitly used the term “SIDS”, but rather “island
developing countries” or “small island states”, the original terms remain in this
dissertation. The concepts of smallness, remoteness, and isolation are likely to
remain crucial characteristics throughout such nations, regardless of their
definition.

2.4.2 The environments of SIDS and their vulnerabilities

The problems faced by island developing countries were cited in the UN Conference
on Trade and Development in 1972 (Briguglio 1995). By 1988, a wide array of
disadvantages peculiar to these countries was recognised (Briguglio 1995). The
vulnerabilities of SIDS gained further significance in the 1994 UN Barbados
Programme of Action, which highlighted economic and environmental
vulnerabilities of SIDS as well as the social consequences of these, and set an
agenda to mitigate these vulnerabilities (UN 1994). This was reaffirmed in 2005 by
the Mauritius Strategy for Further Implementation of the Programme of Action for
the Sustainable Development of SIDS (UN 2005). To date, much of the discourse
pertaining to SIDS has been generated from economic and environmental domains.
While there are many characteristics that are likely to affect SIDS, there can be
diversity in regard to their particular vulnerabilities or characteristics (Encontre
1999).
A large body of literature on the economic characteristics of SIDS and small states indicates that the nature of small, isolated and remote economies may lead to a number of vulnerabilities, including limited resource endowments, a small domestic market, dependence on a narrow range of products, vulnerability to external economic shocks, high exposure to international trade, limited ability to exploit economies of scale, high per-unit transport costs, uncertainties of supply, and volatility in economic growth (Briguglio 1995; Campling & Rosalie 2006). Furthermore, SIDS tend to experience problems in the public administration workforce as their skill base is typically narrow and professionals often have to be trained overseas; they also tend to have high government expenditure relative to gross domestic product compared with larger nations (Armstrong & Read 2002; Briguglio 1995). Read (2004) explains that the global location of small island states is a critical determinant of growth, as proximity to large and prosperous neighbouring states may serve as a benefit through access to markets and economic interaction. Many SIDS tend to form an economic model that is focused on either; migration, remittances, aid financing and bureaucracy (Bertram & Watters 1986), a significant tourism industry (McElroy 2006), or as offshore tax havens and finance centres (Baldacchino 2006). Some SIDS may utilise a combination of these three models (Bertram 2006). The concept of economic vulnerability has been challenged by some theorists, who suggest that on average small developing countries have performed no worse than larger ones (Baldacchino 2000); it has also been suggested that rather than smallness or island-ness, the only systematic vulnerability to economic growth evident is remoteness from global markets (Armstrong & Read 2006).

The literature on SIDS from the environmental domain is large in volume and reveals a number of vulnerabilities, including proneness to natural disasters, depletion of undeveloped land, waste management issues, a lack of safe drinking water, fragile ecosystems, the erosion of beaches, cliffs and soil, and limited resources making them less able to cope with environmental pressures (Briguglio 1995; Briguglio 2003; Campling & Rosalie 2006; Springer, Gibbons & Bikenibeu 2002; UN Environment Programme 1998). A significant amount of attention has
been paid to climate change in SIDS, as the very existence of some nations consisting of low-lying atolls is at threat, including Tuvalu, the Marshall Islands and Kiribati (Pernetta 1992).

While the consideration of economic and environmental vulnerabilities is important, an understanding of the social (and health) impact is vital to a full consideration of the potential consequences and the possible deepening of these vulnerabilities (Campling & Rosalie 2006). The high costs of public administration and a shallow pool of skilled workers may render government-oriented social and health programs significantly less efficient, for example. Such social consequences are rather complex and are not well documented. However, Springer and colleagues (2002) outline several issues such as population density and carrying capacity, extremes of dense and sparse settlements, low quality of formal education, food insecurity and the threat of NCDs. Feeny and Rogers (2008) add that the efficiency of public sector expenditure and foreign aid in achieving social sector outcomes is lower in SIDS (and in sub-Saharan African countries) than in other nations.

2.4.3 Beyond vulnerability – resilience, adaptation and opportunities

The analytical perspective of identifying deficits and challenges has, over time, been transcended by one that intends to look at assets and resilience, as well as adaptation in the case of environmental and climate change concerns. This has been a major focus in SIDS in the last two decades, and the literature suggests that it is important for countries to adopt policy measures to enable them to build resilience (Briguglio 2003), use strategic flexibility and seek to exploit opportunities (Baldacchino & Bertram 2009), and circumvent their specific handicaps by developing a strategic approach to globalisation (Encontre 1999). Technological advances in information and communications technology may also serve to mitigate certain aspects of vulnerability (UN Department of Economic and Social Affairs 2010). Some studies have recognised numerous strengths inherent in SIDS, such as tourism appeal, social cohesion, strong international linkages, rapid policy development and being more responsive to change, as well as having substantial
voting power in some multilateral institutions relative to their population (such as in the UN General Assembly) (Read 2001; Scheyvens & Momsen 2008; Springer, Gibbons & Bikenibeu 2002).

The vulnerabilities and opportunities of SIDS and the determinants of each of these are complex and seemingly endless. Nonetheless, it is important to appreciate those factors which shape the environments in which policies are implemented. Slade (2003) explains that smallness, geography, environmental fragility and a general state of vulnerability are key determinants of the international policy of small island states. These specific characteristics justify attention being paid when implementing policies in these environments, and that a top-down, one-size-fits-all approach in international agreements may be met with major challenges when applied to SIDS.

2.4.4 Policy implementation in developing countries and SIDS
Policy implementation theory offers substantially less literature relating to the context of developing countries than for developed countries, as much of the research is Western-centric (Najam 1995; Saetren 2005; Walt et al. 2008); what exists is also somewhat unclear and disparate (Ferraro 2010). Nonetheless, important insights into policy implementation in the environments of such countries have been offered. Policy implementation is likely to be more difficult in developing countries as the complex variables that influence implementation tend to be even more complex in these environments (Najam 1995). Migdal (1988) put forth the notion of strong societies and weak states, suggesting that in many developing nations, state control is fragmented and policies are unlikely penetrate populations where centralised social control does not exist. Grindle (2007) argues that developing countries may engender weaker environments for governance reforms and have limited capacity to implement policies. Horowitz (1989) notes that there are major differences in institutional capacity and policy effectiveness between industrialised and developing nations. It has also been explained that governments in developing countries tend to formulate broad, sweeping policies, which their governmental bureaucracies may lack the capacity to implement (Smith
Grindle and Thomas (1991) suggest that policy elites play a more decisive role in developing countries and there may be less civil society influence at the policy formulation stage, although this may be balanced by stronger influence at the implementation stage.

The policy implementation literature relating to SIDS is even scarcer and very much on the periphery of research on policy implementation. It shows great diversity in terms of definition, as the few existing studies conceptualise countries variably (for example as microstates, small states or small island states) or offer case studies confined to a single country or region. Many studies of the implementation of specific policies in SIDS also tend to be highly contextualised and on the periphery of the literature in various policy domains (or at various levels within these domains). This has rendered reviewing and collating literature relevant to FCTC implementation in SIDS formidably challenging and rather unfruitful. However, one study of particular relevance (and outside the health domain) explores the implementation of multiple environmental treaties in the Pacific Islands. In this study, Chasek (2010) notes several challenges including capacity building, coordination, data/information and funding. She suggests that the proliferation of international meetings is a challenge where there are small bureaucracies and few people trained in negotiation or implementation (Chasek 2010). Efforts to control international environmental problems in such countries are carried out in a piecemeal manner, rather than holistically, and effective implementation can only happen with greater cooperation among those involved in the environment and the development of innovative solutions to compliance, rather than strict enforcement measures (Chasek 2010).

### 2.5 FCTC and health policy implementation in challenging environments

The literature pertaining to the specific policy to be implemented – the Framework Convention on Tobacco Control – is now reviewed. Firstly, a description of FCTC implementation and what is successful implementation is provided. FCTC
implementation is then explored in relation to developing countries. This is followed by a review on FCTC and health policy implementation in SIDS. FCTC implementation in the Pacific region was explored earlier in Chapter 1.

2.5.1 Defining FCTC implementation

For the purposes of this dissertation, FCTC implementation is primarily concerned with the period from the development of FCTC-based national legislation to the ultimate impact of this legislation in the given country. The legislative process of incorporating FCTC articles in national legislation is important and covered briefly, but not a key focus of this dissertation. Through this lens, FCTC implementation can be viewed in terms of whether FCTC-based policies have reached the people they are intended to influence and whether they have been institutionalised in the relevant organisations. The latter includes enforcement and may depend upon the development of regulations, which are more specific legal rules governing behaviour or practice, such as a directive established and maintained by an authority (Oxford English Dictionary 2013). For example, in the case of smoke-free public places, this study is concerned with whether those who visit public places are free from exposure to tobacco smoke, and whether this has been institutionalised in all relevant businesses, workplaces and authorities designated to enforce this policy. It is less concerned with the legislative process of writing the contents of the FCTC article into national legislation.

This study’s research questions are concerned with exploring the variables that affect the implementation of the FCTC, and how barriers can be overcome and opportunities utilised to ensure effective FCTC implementation, in SIDS of the Pacific. De Leeuw explains that “a policy can only be regarded effective if the problem it has defined has been reduced significantly, and if that reduction can be attributed unequivocally to changes that the policy has brought about” (2007; p. 55). The link between tobacco consumption and loss of life is unequivocal and there
is no safe level of exposure to tobacco smoke⁵ (WHO 2009b). Minimising the tobacco-related health burden can therefore be achieved directly through a reduction in the prevalence of tobacco use. Tobacco use prevalence is reduced by tobacco control policies designed to reduce both the demand and supply of tobacco. Successful and/or effective FCTC implementation in this dissertation is therefore concerned with reducing the demand and supply of tobacco through institutionalising the evidence-based tobacco control policies that have been proven to be effective in many countries internationally.

2.5.2 FCTC implementation in developing countries

Despite the success of the FCTC process itself and its ratification by most of the world’s nations, it largely remains a tool whose “success or failure depends on how it is used by countries and how well it is explained and implemented at national and community levels” (WHO 2009a; p. 37). In the 2010 Global Progress Report on FCTC implementation, it was self-reported by countries that more than half of FCTC provisions had attracted high implementation rates (WHO 2010). As mentioned in Chapter 1, tobacco use has been in decline in many developed countries. In many of these countries, tobacco control efforts were made before the FCTC came into force, but it is acknowledged that the FCTC may accelerate progress (Jatoi, Cummings & Cazap 2009). The real benchmark for the FCTC’s success lies in developing countries.

Some studies on the implementation of FCTC-based policies in developing countries have been undertaken and some significant challenges in these environments are described. In China, industry interference is one of the most crucial obstacles to

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⁵ This point explicitly states tobacco smoke, which is the dominant form of tobacco use internationally. However, most forms of chewing tobacco can be placed in the same category due to the harmful consequences described in Chapter 1. The underlying principle of harm reduction is ascribed to in this thesis. There is some debate in health promotion circles on whether products such as snus and e-cigarettes are “safe” to use, but the evidence is still inconclusive. In theory, if there is to be a safe mode of tobacco use that does not negatively affect one’s health, then encouraging tobacco users to use these modes would also achieve this goal. However, due to the dominance of harmful uses of tobacco and the inconclusive evidence on the harms of snus and e-cigarettes, reducing tobacco use can be directly linked with reducing harm.
FCTC implementation, through the State Tobacco Monopoly Administration (Lv et al. 2011). A limited budget and professional capabilities for tobacco control, a lack of awareness of health risks, and a lack of enforcement and monitoring are also significant barriers (Lv et al. 2011; Wan et al. 2012; Yang et al. 2010). In a study of the FCTC in China, Tanzania, Nepal and Thailand, Sussman and colleagues (2007) found that a rural-urban divide exists in all four countries, and that the state is less effective in monitoring tobacco-related laws in small towns and villages than in larger cities. China, Tanzania and Nepal had experienced some progress in FCTC implementation, but there was a lack of anti-tobacco activism and enforcement (Sussman et al. 2007). FCTC implementation in Nepal was hindered by changes in government leadership, and there was a need for monitoring by active NGOs and civil society (Sussman et al. 2007). In Ghana, a tobacco control bill had been drafted but not yet passed into law; key barriers included the absence of a legal framework, a lack of adequate resources and a lack of prioritisation of tobacco control efforts (Owusu-Dabo et al. 2010). In Ecuador, although tobacco legislation had been passed, its regulations were weakened, and key challenges arose in the form of poor government readiness and intervention, a lack of legislative technical capabilities, weak civil society involvement and industry interference (Albuja & Daynard 2009). Industry interference was also seen as a vulnerability in Malawi, although this had not directly resulted in the weakening of FCTC implementation in the country (Otanez, Mamudu & Glantz 2009). A study observing Africa as a whole suggested that only modest progress in FCTC implementation had been achieved, and that the tobacco industry was a major obstacle (Tumwine 2011). Tumwine (2011) indicated the need for countries to prioritise resources for capacity building to draft strong legislation and conduct research to inform policy and boost political will. In terms of achieving the MPOWER objectives in India, Schwartz, Wipfli and Samet (2011) found that there was a need for capacity building, with a lack of infrastructure for cessation services and the heterogeneity of tobacco products creating some difficulty for FCTC implementation. This study did, however, find that commitment was present in the Indian government and NGO agencies in the country (Schwartz, Wipfli & Samet 2011). Kaur and Jain (2011) found that different levels of success had been achieved within Indian states, although non-prioritisation
at the state level still existed and effective tobacco control policy implementation was a challenge.

In terms of successful FCTC implementation developing countries, Thailand is one of the few countries in which the discourse on FCTC implementation was substantially positive, suggesting it may provide a model for other developing countries to follow. Here, significant progress in FCTC implementation was due to active anti-tobacco activism and tobacco industry interference being controlled by the public health community, government and NGOs (Charoenca et al. 2012; Sussman et al. 2007). Furthermore, tobacco taxes were used to finance health promotion in Thailand, which strongly facilitated capacity for tobacco control and FCTC implementation (Sussman et al. 2007).

Warner (2008) suggests several obstacles to FCTC implementation exist internationally, which include inadequate in-country research talent, inadequate financial institutional resources to support implementation, a lack of political will and interest in many countries, and political and economic opposition led by the powerful tobacco industry in numerous countries. These, in conjunction with weak civil society involvement and, to a certain extent, rural-urban disparity, typify the scenarios of FCTC implementation in many of developing countries. The literature highlights several needs: for capacity building efforts; a focus on building the local evidence base; expanding infrastructure in each country including knowledge, tools, data, people and organisations; developing the next generation of leaders; and encouraging networking (Cairney, Studlar & Mamudu 2012; Maziak et al. 2006; Stillman et al. 2006; Wipfli et al. 2004). The 2010 WHO Global Progress Report on FCTC implementation also suggests that globally, parties tend to consider the fundamentals of tobacco control their main priority, including the establishment of infrastructure, a national action plan and tobacco control legislation, in conjunction with the specific FCTC articles to be implemented (WHO 2010). Although the FCTC has enjoyed success in its ratification, there is a significant amount of work to be completed before international implementation can be deemed successful.
2.5.3 FCTC and health policy implementation in SIDS

There are no known studies in peer-reviewed journals that comprehensively explore the implementation of the FCTC in light of the characteristics of SIDS, or even within individual SIDS. Tumwine’s (2011) study on FCTC implementation in Africa did include several SIDS in its regional analysis, but it only provided (minimal) in-depth detail on Mauritius. It was suggested that some progress in FCTC implementation had been made in Mauritius, although industry interference and subversion of FCTC-based legislation was evident (Tumwine 2011). The grey literature on FCTC implementation in countries considered SIDS is largely quantitative and outcome-oriented, with little detail on the variables that affect implementation. Analysing all of the reports on FCTC implementation produced in each SIDS internationally goes beyond the purview of this dissertation; however, this study does draw upon all obtainable data within the countries of interest in later chapters.

Health policy in SIDS has been explored only in a limited number of studies. In relation to health impact assessment, where potential health impacts are observed in proposed policies or projects, Douglas (2003) considers that small island states and territories provide a case for the application of these assessments. The author proposes some guidelines for conducting health impact assessments, based on the health determinants of certain characteristics of small island states and territories: he explains the positive and negative health impacts of tourism as an example. The WPRO adopted the Yanuca Islands Declaration, which gave recognition to the common features shared by Pacific Islands and promoted the concept of “healthy islands” in health promotion settings (Galea, Powis & Tamplin 2000; WHO 1995). This was conducted within a regional, rather than international, framework, and it did not address policy implementation specifically. Thow and colleagues, in a study on taxing soft drinks in four countries in the Pacific, explained that “political processes are unique to individual countries, and policy makers should be aware of their status as small island developing states” (Thow et al. 2010; p. 62); this study did not explore in detail the environments of SIDS and how they affected the health-oriented policy.
In the only known comprehensive, peer-reviewed study with a direct focus on health policy and its implementation in SIDS, McNaught (2003), in developing a model of the public policy and public administration system in two Caribbean SIDS to analyse the policy implementation process, made numerous important contributions in this area:

- Discourse relating to health policy in SIDS was generally characterised by failure or incompetence, with little attempt to understand the nature of the policy processes of their small and complex societies.
- The local context was considered important, as although both territories were British Overseas Territories, each had specific individual characteristics.
- “Advocacy and coalition forming were extremely rare and few academics, journalists or policy analysts were active in the health policy arena” (p. 323).
- Western models of public administration theory should be scaled down to fit SIDS.
- More mainstream research needs to be conducted in SIDS in order for them to be better understood. (McNaught 2003)

It is clear that in FCTC and health policy implementation, some recognition needs to be given to the environments of SIDS and developing countries. In such nations, some common and significant barriers can be foreseen, but these are not always uniform and may vary across countries.

2.6 A review of potential theoretical frameworks to analyse FCTC implementation in Pacific SIDS:

Public policy is complex, and so is the process of implementing it. To simplify this complexity and guide the research procedure, the adoption of a suitable theoretical framework was an important component of this study. With respect to the use of a theoretical framework, it should be recognised that endorsing any one or a “best” theoretical approach to analyse FCTC implementation, particularly in multiple countries, is fraught with complexity for a number of reasons. There is no supreme
model to analyse policy implementation in general, and no single model is superior in analysing FCTC implementation; and developing one is neither practical nor desirable. As Parsons (1995) explains, no single model can adequately explain the political activity of the modern state, even though models simplify the process of understanding the complex reality of policy activity. In addition, the FCTC consists of a vast bundle of different policies. According to Lowi’s (1972) policy typology, many of these are regulatory, such as packaging and labelling, bans on advertising, and smoke-free environments. Other important aspects are distributive, such as funding for FCTC implementation, or redistributive, such as taxation. Although one synthesised theoretical framework was selected in this dissertation, it is not necessarily superior and it is useful to consider different frameworks for different policy types, or for articles that are substantially different in their characteristics. With respect to this, a brief description of five theoretical frameworks that were considered but rejected from use in this dissertation is now provided and a rationale for this rejection is given. However, these frameworks may be useful for those exploring FCTC implementation with different objectives or in different contexts. The selected theoretical framework used in this dissertation is then explored in detail.

2.6.1 Mazmanian and Sabatier’s (1989) variables involved in the implementation process

One potential theoretical framework considered was Mazmanian and Sabatier’s (1989) description of variables involved in the implementation process, outlined earlier in this chapter. This model has been comprehensively tested and used in a large number of studies (by its authors and other scholars) in a variety of countries analysing a range of policy types, including social/welfare, education and environmental policies (Meier & McFarlane 1996; Naka, Hammett & Stuart 2000; Parsons 1995; Sabatier 1997; Sarbaugh-Thompson & Zald 1995; Siler-Wells 1987; Zhang, Yang & Bi 2011). It has also been used to analyse health care policy (Linhorst 1997; Touati et al. 2007).
Despite the model being well tested and appreciating the variables that affect implementation, there was a significant shortfall in its perceived application which resulted in its rejection. Its rather managerialist, top-down emphasis did not bode well as international agreements are often highly subjected to decisions at the national level (as explained in Chapter 1) and even further, decisions at the national level may be subjected by decisions at the sub-national level. This model is partly concerned with the potential for hierarchy to confine and constrain implementers to achieve legal objectives defined in the policy (Parsons 1995). It did not show great appreciation for degrees of complexity, especially when considering the implementation environments of the countries in this study and the actors operating at multiple levels. For example, in exploring FCTC implementation in SIDS, limited resources and competing commitments at the bottom level are suspected to be serious impediments to any top-down model. Some allowance for discretion at the various levels in which the FCTC is implemented was desirable, which a synthesised perspective permits to a greater extent.

### 2.6.2 Sabatier and Jenkins-Smith’s (1993) Advocacy Coalition Framework

A second model considered was Sabatier and Jenkins-Smith’s (1993) Advocacy Coalition Framework. Although this framework utilises a sub-system (rather than stages-heuristic) approach, it is recognised in the policy implementation literature as an attempt to synthesise top-down and bottom-up implementation approaches (Hill & Hupe 2003; Najam 1995; Sabatier 1986). The Advocacy Coalition Framework explains that policy change is made according to a sub-system in which significant force is exerted by opposing coalition groups on decision-makers. These coalition groups can influence the decisions by policy brokers (and decisions made by policy brokers can feed back into the coalition groups). The influence of relatively stable parameters (such as attributes of the problem and social and constitutional structure), and of external system events (such as changes in socioeconomic conditions, systemic governing coalition and decisions from other sub-systems) are recognised. These parameters feed into the constraints and resources of subsystem actors. This model was applied to tobacco control policy by Sato (1999) and Breton and colleagues (2008), and has been used by many studies outside tobacco control.
(and health) (Elliott & Schlaepfer 2001; Jenkins-Smith & Sabatier 1994; Kubler 2001; Weible, Sabatier & McQueen 2009).

The Advocacy Coalition Framework suited certain aspects of this study, particularly through recognising resource limits, coalition groups and the implementation environment. However, one of its core premises is its focus of the interaction of actors from different institutions as the most useful way to think about policy change (Sabatier 1993). This may overemphasise the activities of coalitions and their influence on policy outputs, at the expense of other factors such as goal palatability and capacity. Sabatier and Jenkins-Smith’s (1993) model does include constraints and resources of sub-system actors, but this is peripheral. Its overemphasis on coalitions is likely to be shortcoming in its application in developing countries and SIDS where there is less coalition activism and capacity constraints may be more prominent. Finally, as it represents a departure from a stages-heuristic approach (Sabatier 1993), it is less suitable where a single policy or set of policies is to be implemented. This is fundamental in the scenario of the FCTC, where comprehensive legislation on tobacco control has been developed and is sought to be implemented at a given point in time. Sabatier and Jenkins-Smith’s (1993) model does not appreciate the specific intentions and methods of a policy itself as a factor that may influence its implementation.

2.6.3 **Cairney, Studlar and Mamudu (2012)**

Cairney, Studlar and Mamudu (2012) made a significant contribution to the global tobacco control policy literature after planning and data collection for this research was undertaken. Nonetheless, it is useful to retrospectively review their conceptual framework in light of the research objectives of this dissertation. Cairney, Studlar and Mamudu (2012) identified five related factors responsible for policy change: the role of institutions, the agenda-setting context for policy choices, the balance of power within subsystems (through networks), the socioeconomic context and the role and transfer of ideas. This is underpinned by a variety of political theories including the work of Kingdon’s (1995) streams, Baumgartner and Jones’ (1993)

While Cairney, Studlar and Mamudu (2012) provide a useful framework for analysing policy change, it has a strong emphasis on what led to this change, through exploring agenda-setting and ideas. It provides less emphasis on determining the success of implementation once the policy has been changed. The majority of countries examined in this study had already passed through comprehensive tobacco control legislation. While these concepts may provide a useful insight in exploring how this legislation came into place from a historical perspective, they do not explore what affects implementation after the legislation is developed in the detail sought after in this study. The other components of the role of institutions, networks and the socio-economic context were useful, but another major shortcoming for its use in this study was their relatively limited emphasis on capacity which is critical in the developing country context. Finally, Cairney, Studlar and Mamudu’s (2012) research provides little account of discrepancies between levels of government, especially in relation to the subnational level, which is less important in terms of exploring policy change and political discourse, but can be crucial in terms of implementation.

2.6.4 Green and Kreuter’s (2005) PRECEDE-PROCEED model

Green and Kreuter’s (2005) PRECEDE-PROCEED model is focused on planning and evaluating health behaviour change programs. It consists of eight phases: social assessment; epidemiological, behavioural and environmental assessment; educational and ecological assessment; administrative and policy assessment; implementation; process evaluation; impact evaluation and; outcome evaluation (Green & Kreuter 2005). The first four phrases are concerned with planning, the fifth with implementation and the remaining three with evaluation. It takes account of the factors that influence health and quality of life, which range from ecological to individual factors, with a focus on what can be changed through health promotion. The PRECEDE-PROCEED model is among the most popular in health
education (Sharma & Romas 2012) and approximately 1,000 applications of this model had been published by the early 2000s (Green & Kreuter 2005).

The PRECEDE-PROCEED model may be useful for health promotion planners and those interested in contextualising tobacco use in a community as it draws upon a much broader process of planning to implementation to evaluation. However, it is too concerned with health behaviour change rather than policy change and has limited use for an in-depth analysis of FCTC implementation. Its implementation phase exhibits some relevance to the substance of the FCTC, but the PRECEDE-PROCEED model does not give a comprehensive description of how policies are implemented and therefore how successful policy implementation can be facilitated. Furthermore, there is a vast array of existent literature on how tobacco use affects quality of life, what affects tobacco use and what interventions are successful in tobacco control in many countries internationally. Using such a model to articulate this would result in much of the data being superfluous to the current body of literature.

2.6.5 The theoretical framework selected: Najam’s 5C Protocol

The four theoretical frameworks previously mentioned have some relevance to the topic of interest and maybe worthy of studying certain aspects of the FCTC from other angles or in different contexts, but none were utilised as a central theoretical framework in this dissertation. The theoretical framework selected synthesises some of these and other models of implementation, and is more suitable for the context of this study.

Adil Najam’s (1995) 5C Protocol offers interesting and important possibilities in its use of key clusters of variables affecting policy implementation (see Figure 2 below). This model was developed after Najam (1995) reviewed an array of top-down and bottom-up policy implementation theories, and synthesised them. The 5C Protocol was developed with respect to the domestic implementation of international environmental policies in both developed and developing countries (Najam 1995). Many models prior to this suited the contexts of developed countries only. Although the 5C Protocol was designed with the intent of analysing policies in
the environmental domain, it has general applicability and can explain implementation and its success or failure in a variety of policy domains such as health, population, crime prevention and others, at international, national, and local levels (Najam 1995). The 5C Protocol explores clusters of variables under five categories that are interrelated and affect each other, under the headings content, context, commitment, capacity, and clients and coalitions:

- The **Content** of the policy itself – what it sets out to do (i.e. goals); how it problematises the issue (i.e. causal theory); how it aims to solve the perceived problem (i.e. methods).
- The nature of the institutional **Context** – the corridor (often structured as operating procedures) through which policy must travel, and by whose boundaries it is limited, in the process of implementation.
- The **Commitment** of those entrusted with carrying out the implementation at various levels to the goals, causal theory, and methods of the policy.
- The administrative **Capacity** of implementers to carry out the changes desired of them.
- The support of **Clients and Coalitions** whose interests are enhanced or threatened by the policy, and the strategies they employ in strengthening or deflecting its implementation.


**Figure 2: Najam’s 5C Protocol**

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6 Najam defines clients as “all actors whose behaviour is targeted by the implementation” (1995; p. 52)
Figure 2 provides a concise summary of the theoretical framework. Najam explores these clusters of variables in greater detail in his 24-page description of the 5C Protocol. The model implies a stages-heuristic approach at face value, as it embraces the notion of implementation as a stage of the policy process. However, Najam notes that “there is general agreement that implementation is complex, dynamic, multi-level, multi-actor process influenced both by the content and context of the policy being implemented” (1995; p. 22). Therefore, this framework lies somewhere between a stages-heuristic approach and a subsystem approach to analysing public policy.

The 5C Protocol was found to be the most suitable theoretical framework for this dissertation for a number of reasons. Firstly, its emphasis on implementation is desirable given that all countries of interest are seeking to implement the FCTC and emphasis has been placed by the WHO and key stakeholders on FCTC implementation globally. Secondly, the theoretical framework’s general applicability means that it can be used to analyse various issue areas, at various levels, in both industrialised and developing countries (Najam 1995). This is attractive, given that the FCTC consists of a wide range of policy provisions and numerous jurisdictions in developing countries are to be examined. The 5C Protocol’s endorsement of the synthesised approach also means that the effects of FCTC implementation at both the international/secretariat level (top-down) and at the local community level within Pacific SIDS (bottom-up) can be appreciated. This is important, particularly as capacity constraints are expected to influence FCTC implementation in SIDS. The 5C Protocol’s emphasis on implementation at the national level is valuable as the FCTC (like many international agreements) is largely driven nationally. Finally, as coalitions interested in FCTC implementation and tobacco control tend to be highly polarised, the 5C Protocol’s accentuation of coalition groups is useful. The 5C Protocol is applied in detail to the context of this case study in Chapter 4.1.3.

Najam’s 5C Protocol has been tested by numerous researchers such as Bayrakal (2006), Buan (2008), Dongol (2011) and Czunyi (2012). Each of these researchers
found benefit in its use. In analysing the implementation of the US Pollution Prevention Act, Bayrakal (2006) found the 5C Protocol valuable in understanding interactions between the variable clusters in policy implementation. Buan (2008), looking at the barriers to more environmentally friendly energy production in China, stated that Najam’s 5C Protocol enabled the inclusion of contextual elements not addressed in the other theoretical framework used by this author. Czunyi (2012) found that the 5C Protocol served as a valuable framework to investigate climate change adaptation. Dongol (2011) utilised the 5C Protocol to explore policy implementation gaps in the Convention on International Trade in Endangered Species of Wild Fauna and Flora in Nepal. Although the 5C Protocol has been tested predominantly in the environmental domain, its general applicability means that it is equally useful elsewhere.

There is little critique of the 5C Protocol in these studies, although Czunyi (2012) outlined two key limitations. Firstly, Czunyi (2012) felt that it lacked an in-built element of time and learning. This criticism is valid and this is an inherent limitation to any case study or model focusing on a single point in time. Implementation is dynamic, as Najam (1995) points out, and the variables that affect implementation in any contemporary policy are likely to be in flux. Secondly, Czunyi (2012) had to include a new variable, “environmental conditions”, as a sub-component of content, as the 5C Protocol did not lend itself to an explicit focus on the ecological context in her analysis of climate change adaptation; this seems to be pertinent only to the subject of Czunyi’s (2012) research. A critical review of the 5C Protocol, based on its use in this research project, is provided in Chapter 7.

Najam’s 5C Protocol is used to guide the research methods of this dissertation in several ways, including through conceptualising implementation, identifying key stakeholders and shaping some of the interview questions and data codes. These are discussed later in Chapter 3.
2.7 Conclusion

2.7.1 Summary of the literature review

This chapter explored the fundamental concepts related to the implementation of health policy. A stages-heuristic approach to the policy process was acknowledged in the delineation of the implementation stage, which is justified by the many countries that are seeking to implement the treaty. This was reiterated by the UN High-level Meeting on Non-communicable Diseases, who called upon member states to “implement international agreements and strategies to reduce risk factors, including the WHO Framework Convention on Tobacco Control” (WHO 2011a; p. 7).

Top-down, bottom-up and synthesised policy implementation approaches have been explored, the last of which is used in the theoretical framework of this dissertation. Consideration was given to the use of political theory in health promotion, a relatively scarce approach given its importance in contributing to better health outcomes through healthy public policy. Literature on the implementation of the FCTC has been explored where it matters most: in developing countries. Many obstacles to FCTC implementation success are documented. In addition to the often more proximal determinants of FCTC implementation, the broad environments in which policies are implemented are recognised. These are hypothesised to influence FCTC implementation distally. Here, SIDS and their special economic, environmental and social circumstances pertaining to their smallness, remoteness and isolation are taken into account. An analysis of the literature on health policy implementation in both developing countries and in SIDS was conducted. Some useful alternative frameworks were examined and their rejection justified. The chosen theoretical framework, Najam’s 5C Protocol, was detailed.

The empirical evidence explored sets the foundation for this research project. Although the multitude of layers drawing from a broad range of literature seems rather complex, this is merely a reflection of the complexity of the variables affecting FCTC implementation. It is believed that by conducting effective research on FCTC implementation in such countries and building upon this knowledge,
evidence will emerge that can support the achievement of the ultimate goal of minimising the harm associated with the tobacco epidemic, both in the Pacific region and globally.

### 2.7.2 Gaps in the literature to be addressed by this study

There are a number of ways in which this dissertation aims to address research gaps and limitations in the current body of empirical evidence. It seeks to provide a contribution to knowledge on several levels.

Firstly, this study seeks to ameliorate somewhat the scarcity of research at the nexus of health promotion and political science. This is especially important to the concept of building healthy public policy. A vast range of models and theories in political science can be applied to analyse health policies, but they remain largely untested in terms of both health policy broadly and the FCTC in particular. Using a specific model of policy implementation will allow this research to test its parameters and usefulness in the health domain, and to determine how this theoretical framework could be improved to enable the generation of further knowledge.

This dissertation will add to the literature on health policy implementation in SIDS. Thus far, only one known study has addressed this area. The FCTC-based discourse does not recognise the environments of SIDS that affect implementation. As a multiple-case study, this research will provide in-depth evidence of how the implementation of a health policy (and the FCTC specifically) may be shaped by the environments of SIDS. It will also serve to verify and build upon the study conducted by McNaught (2003).

Neither academic literature nor FCTC-based reporting has thus far provided in-depth detail on the variables that affect FCTC implementation in the Pacific region, with the exception of Allen’s (2009) study conducted very early in the FCTC implementation process. The subject of this dissertation is important on both theoretical and pragmatic levels by exploring FCTC-related progress in numerous countries, where the current body of knowledge is extremely scarce. This study will
provide an insight into how the FCTC can be improved upon and brought forward; the experiences of these countries will also serve as case studies enabling a reflection on the performance of the first international public health treaty at a global level.
Chapter 3  Research Procedure

3.1 Introduction

The previous chapter explored the theoretical underpinnings of this dissertation. This chapter is concerned with the practical methods that were utilised to undertake the research project. It illuminates the research techniques utilised in this study and justifies their use. The foundations of the mixed methods and multiple-case study design are explored and justified. The research methods are then outlined in detail, which include the processes of case selection, participant sampling and selection, data collection, data analysis and the sources of evidence. Finally, the procedures that ensure research integrity and research quality are outlined, limitations inherent in the research design and methods are acknowledged and the measures taken to address these are explained.

3.2 Research design

This project employs a mixed-methods multiple-case study design. Yin defines a case study as an “empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (1994; p. 13). Case studies are pertinent in addressing research questions that are either descriptive or explanatory, and in determining what is happening, and how or why something happened (Yin 2012). A case study, in comparison to other research designs, has a distinct advantage when “a ‘how’ or ‘why’ question is being asked about a contemporary set of events over which the investigator has little or no control” (Yin 2004; p. 9). The reasons for utilising the case study approach in this research are three-fold. Firstly, the research questions in this dissertation are primarily “how” questions, which require an in-depth insight into the issues of interest. Secondly, being the first international public health treaty, the FCTC itself is highly contemporary and implementation has only recently been a focus after its entry into force in 2005. Due to the newness of the subject, literature in this area is still in its infancy and a historical research
approach to answer the research questions would not be appropriate. Finally, policy implementation in the context of Pacific SIDS is a highly complex phenomenon in which the investigator has little control and such conditions cannot be replicated. Therefore any type of experimental study is not possible.

A multiple-case study allows for examining numerous cases to which theories can be applied and developed. Examining two or more cases can ultimately produce a stronger effect than a single case study (Yin 2009). This study’s examination of four cases can be seen as having a substantial advantage over a single case study. As it was not feasible to explore all SIDS of the Pacific region in sufficient depth required for a doctoral project conducted by a single person, this dissertation was perforce limited to four case studies. This permits greater rigour than a single case study, but is also manageable and allows for reasonably rich detail to be presented from each case.

A mixed methods design synthesises both qualitative and quantitative data sources. Yin (2009) explains that a mixed methods design allows the researcher to address more complicated research questions and collect a richer and stronger array of evidence than any single method. Furthermore, a mixed-methods design facilitates the validation of data through triangulation (Denscombe 2010), a process which allows findings to be cross-checked across various sources, as more than one method is used (Bryman 2004). All primary data collected in this study, and much of the secondary data, was of a qualitative nature. Some secondary, quantitative, data also guided the research. A mixed-methods design is particularly suitable for this project as the variables that affect the implementation of a treaty are quite complex and require a rich analysis using detailed sources of evidence. For example, when assessing policy content, the qualitative data measuring such things as the appropriateness of policy goals, causal theory and methods is supplemented and enhanced by quantitative data determining such matters as tobacco use and NCD prevalence rates.

The qualitative emphasis of the research means that, to a large extent, it upholds a constructivist (or interpretivist) ontology, characterised by subjectivity, induction
and theory development to interpret findings (Grbich 2010). This approach sees the world as complex and interconnected, and research must maintain this complexity if it is to be true (Maykut & Morehouse 1994). This is in contrast to a positivist ontology which is seen as objective, deductive, uses statistical analysis, and seeks to be generalisable and replicable (Grbich 2010). An integrated mixed methods approach is a pragmatic compromise, as it can change focus depending on which mix of data collection approaches is most useful to answer the research questions (Grbich 2010). It holds the middle ground between the polarities of qualitative and quantitative approaches (Grbich 2010). While this study technically adopts a mixed-methods approach, the research questions and mode of inquiry tend to be geared towards the qualitative end of the continuum. The complexity and interconnectedness of policy-based research require this, as policy implementation is influenced by a vast array of factors, many of which cannot easily be measured quantitatively.

The advantages of the mixed-methods multiple-case study are that they permit a study of complex social phenomena and allow the investigator to retain the holistic and meaningful characteristics of real-life events (Yin 2009). Furthermore, the mixed-methods design allows for stronger triangulation and more comprehensive findings than a purely qualitative or quantitative approach. Its main disadvantage is that there can be difficulty in being able to externally validate or generalise research findings (Bryman 2004). Although having multiple cases can ameliorate this, to a certain extent each case is set within a specific context. This is unavoidable; it is impossible to wholly replicate studies of complex and contemporary social phenomena. Although some generalisations can be made about FCTC implementation in the countries in this study, each country shows a degree of difference from the others. This does not mean that one should adopt the problematic notion that each case study has a unique context and none of its findings can be generalised. Such a stance would render all policy-related research meaningless, limiting its applicability to anecdotal accounts of specific cases, and would foster the belief that no two countries could learn from each other; cross-country theory regarding FCTC implementation, or any other matter, could not be
developed. Unique things are still comparable, particularly if a focus is made on specific variables or dimensions that allow us to perceive the commonalities that are there (Ember & Ember 2001). Each country may have a unique story in regards to FCTC implementation, but through analysing variables through a theoretical framework, some similarities can be drawn upon and generalisations across cases can be made, although there are some limits to these generalisations.

In order to analyse such a complex topic, this study adopts some of the principles of Pawson and Tilley’s (1997) realist evaluation. It is appreciated that policies are embedded in systems of social relationships, interventions involve multiple perturbations and there tends to be a nuanced outcome pattern of successes and failures within and across them (Pawson & Tilley 2004). This may result in findings that are provisional or “middle-range” and therefore the researcher must be somewhat modest in their ambitions for evaluation (Pawson & Tilley 2004). A dichotomous answer to questions, such as whether the FCTC works or not, or whether it has failed or succeeded in the countries examined, will not be provided. Instead, a nuanced answer will be given. For example, instead of answering whether the FCTC works or not in an absolute manner, it is appreciated that some parts of the FCTC are likely to be effective under certain circumstances.

The research objectives in this dissertation primarily aim to explore the variables that influence FCTC implementation in Pacific SIDS as a collective group. Here, the hypothesis is that there will be several common themes across countries in this group, and this group will have an experience that may be varied to other types of countries. Effective and successful FCTC implementation is seen as an end-point, rather than comparing the extent to which FCTC implementation may be different between the countries selected. The latter would preclude the hypothesis and be more indicative of a comparative approach in policy research, which is associated with descriptive accounts of national similarities or dissimilarities in public policies (Geva-May 2010). While the country experiences of FCTC implementation were often similar, some degree of disparity between them remained. A comparative
approach is useful to distinguish this disparity. However, the comparative method is of secondary interest and utilised to a limited extent in the cross-country synthesis.

### 3.3 Research methods

#### 3.3.1 Case selection

Each case in this study is a self-governing small island developing state of the Pacific. Initially all thirteen independent Pacific SIDS were considered: the Cook Islands, Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nauru, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. All these countries have ratified the FCTC and are members of the WPRO and the Secretariat of the Pacific Community (SPC).

The selection criteria were designed to ascertain the extent to which it would be possible (and feasible) to conduct meaningful research in each country, as well as to determine what extent the countries could represent the other Pacific SIDS. The former set of criteria was included for convenience and pragmatic purposes, while the latter was to ensure representativeness and generalisability. These are shown in Table 3 below:

**Table 3: Case selection criteria**

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<thead>
<tr>
<th>For pragmatism and feasibility</th>
<th>Political stability</th>
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<tbody>
<tr>
<td></td>
<td>English language proficiency</td>
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<td>Availability of potential sources of data</td>
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<td>Existence of NGOs associated with tobacco control</td>
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<td>Completion of COP reporting</td>
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<td>Participation in previous tobacco control studies</td>
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<td>Costs of travel from researchers’ location</td>
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<tr>
<th>For representativeness and generalisability</th>
<th>Considered a small island developing state that is independent for WHO purposes</th>
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<tr>
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<td>Political stability</td>
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<td></td>
<td>Diversity in population size¹</td>
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<td>Diversity in geopolitical background²</td>
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<td></td>
<td>Diversity in cultural background</td>
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¹ It was important to include some spread of population sizes. However, it was not desirable to include SIDS either much larger or smaller than all other SIDS by several orders of magnitude as this may affect representativeness.

² Geopolitics may have many and varied influences on the broad social, economic and cultural context of the countries. Geopolitics may also influence FCTC implementation, particularly through the tobacco trade and health-oriented development and technical assistance. For representativeness of Pacific SIDS, it was desirable to include a diversity of geopolitical backgrounds.
Due to the representativeness and generalisability upheld in the selection criteria, it is hypothesised that this research may be generalisable to Pacific Island nations other than those selected, including Kiribati, Marshall Islands, Federated States of Micronesia, Samoa, Tonga, Tuvalu, and to a lesser extent, Fiji, Solomon Islands, and Niue. Pacific SIDS are the primary frame in which the findings of this study are the most generalisable. Particular FCTC implementation experiences may also be shared by and applicable to other, especially developing, countries internationally. Findings relating to the environments of SIDS may be generalisable to other SIDS in the Caribbean and surrounding Africa.

When applying the selection criteria to the region of interest, Niue was excluded because of its relative size and population in comparison with other SIDS. Fiji and, to a lesser extent, the Solomon Islands were also excluded, given their political instability at the time of data collection, because of the political nature of this project. The remaining countries were ranked according to the selection criteria. Those which ranked as most favourable included: the Cook Islands, Nauru, Palau, Tonga, Tuvalu and Vanuatu. Key stakeholders in each of these countries were approached by the primary researcher. Organisations including the Ministry of Health (MOH), members of the FCA and relevant NGOs from this pool of countries were contacted formally by email and traditional mail. This contact was repeated up to two times if the previous communications did not elicit a response. The initial contact offered an early gauge of their interest in the study before effort and resources were spent applying for research permits and ethical clearance for each jurisdiction – a requirement of the Deakin University Human Research Ethics Committee (DUHREC) before data collection commenced. Tonga did not respond, and only limited interest was evinced by Tuvalu; these countries were excluded. There may have been a variety of reasons for this apparent disinterest, such as potential informants being busy during the time period of contact, unwillingness to dedicate resources to the research or a lack of interest in, or sensitivity to, the topic of this research.
The remaining countries, the Cook Islands, Nauru, Palau and Vanuatu, showed interest and were selected to participate in the study. This selection of countries varied in their populations, the largest being Vanuatu with approximately 240,000 people and the smallest being Nauru, with approximately 10,000 people (WHO 2012e). Cultural backgrounds were mixed: the Cook Islands is Polynesian, Palau is Micronesian, Vanuatu is Melanesian and Nauru is primarily Micronesian with some Polynesian influence7. They also had somewhat different geopolitical influences, as the Cook Islands was primarily associated with New Zealand, Palau with the US, Nauru with Australia and Vanuatu with both Australia and France. These four countries participated in all stages of the research process.

3.3.2 Participant sampling and selection

Purposive sampling was used to select informants within each country. This form of sampling is strategic and aims to establish correspondence with the research questions (Bryman 2004). In this type of study, those who participate tend to play the role of informant rather than that of respondent (Yin 2009); they are variously and interchangeably referred to as informants or participants throughout this dissertation. These informants were typically specialists within their field, had expert knowledge of the topic of interest, and were involved in policy networks in their respective countries. The informants acted as gatekeepers to information of interest to the researcher. However, the validity of the information provided by informants was not infallible (Pawson & Tilley 2004) and subject to triangulation where possible. Potential participants consisted of people and organisations that had some involvement and/or a substantial interest in the FCTC implementation process. They included representatives of national health ministries, provincial health authorities, enforcement/legal/customs departments, policy advisors, regional organisations associated with tobacco control (WHO, SPC, FCA), tobacco sellers, representatives from both pro- and anti-tobacco NGOs, and civil society groups. The roles of informants from ministries of health included health promotion

7 Chapter 4 contains a more detailed background of the countries in this study and the regions they are a part of.
officers and environmental health officers (whom operate at ground level), those who oversaw environmental health or public health departments, or are advisors to them (whom operate at the middle level), and those who oversaw several health departments, including secretaries of health or advisers to a minister of health (whom operate at the senior level). In several cases informants suggested additional participants who might be interested in participating and the researcher followed these leads. This has some similarity to snowball sampling. However, in such cases, the researcher still applied a purposive sampling method, and the relevance of potential informants to the research questions was paramount in determining whether or not they were deemed eligible to participate.

A total of 47 potential informants were approached. Of these, 39 agreed to participate in the study, an 83 per cent response rate. Of the other eight, six were unable and/or unwilling to participate as they did not have sufficient spare time, or were located overseas while the investigator was conducting interviews in their country and were not interested or unable to participate through telephone or internet. One potential participant was located in a country that the researcher did not have ethical clearance to conduct research in. One participant was excluded from the study as they did not have proficient English language skills, which were assessed by the primary investigator (with guidance from DUHREC) prior to formal acceptance into the study. Of those who did not participate, three were in senior positions in government and two worked in government positions at ground level; two had some association with the tobacco industry and one with a trade affiliated NGO. By country, three potential informants not included in this study were from Palau, two were from Vanuatu, two were from Nauru and one was from the Cook Islands.

The final number of key informants in each country included nine in the Cook Islands, ten in Vanuatu, nine in Palau and eight in Nauru. Three additional regional informants were included. Of the total 39 informants, 27 operated in government or government-related advisory positions, ten were based in health-related NGOs or civil society groups, one came from a business/trade affiliated civil society group,
and one was a seller of tobacco products with some involvement in tobacco control policy. This extrapolation of participants is shown in Figure 3. In respect of anonymity, particularly as participants resided in countries with small populations and communities, details relating to the positions of individuals within their respective countries are not revealed: these details are pooled from all four countries.

Figure 3: Participant backgrounds

Substantially more participants from the government sector participated than those in health-related NGOs/CSOs or in industry and trade-related NGOs/CSOs. This may indicate some imbalance in representativeness; however, the proportion of participants from within each group largely reflected the nature of FCTC implementation in the countries examined, which was predominantly government-led and influenced. NGOs and CSOs both for and against tobacco control were
typically non-existent or very small, especially in Vanuatu and Nauru. All countries relied on the importation of tobacco, and had no large-scale tobacco manufacturers\(^8\). In these small countries, government departments had relatively few people involved in tobacco control policy implementation. This is reflected in what may seem a low number of total participants when taking into account four countries are involved. Even so, government stakeholders were well represented and the vast majority of those involved in the FCTC implementation process were included. It was more difficult to arrange full-length interviews with senior government staff (such as those in the most senior positions in a MOH), so the representation of informants may be somewhat skewed towards those lower in the hierarchy; this is partially addressed through the use of multiple sources of evidence, as information relating to the participation of senior government officials in the FCTC process could often be obtained through documentation (such as legislative documents and media reports). Lower-level participants also provided some indications of the views of their superiors in the in-depth interviews.

### 3.3.3 Data collection and sources of evidence

The primary researcher went on field visits in each country for ten to fourteen days to collect data from key informants. Work was conducted primarily in the main towns where key stakeholders and government offices were located. The researcher also collected data at a regional tobacco control conference held in Australia. This was seen as an opportunity for some regional informants who were involved in the FCTC implementation process in either of the selected countries (but not physically based in them) to participate.

This study utilised a range of sources of evidence, as advocated for the case study method (Gray 2004). Primary data was collected predominantly in the form of in-depth interviews, followed by a limited use of questionnaires and observation. Secondary data in the form of documentation was also a significant source of data.

\(^8\) In Vanuatu some rural farmers were known to grow tobacco on a small scale, but there were no large-scale tobacco manufacturers, branded cigarettes or formal associations of tobacco growers that sought to influence policy.
3.3.3.1 Interviews

A total of 39 semi-structured, in-depth interviews were conducted by the researcher. Interviews were conducted with an interview guide containing a list of specific topics and questions based on the theoretical framework (see Appendix 1), developed by the primary researcher with assistance from the principal supervisor. The semi-structured interview format is encouraged in case study research by Bryman (2004), as it allows for some flexibility while still maintaining relevance to the research questions at hand. This is especially important given the various roles of stakeholders in the FCTC implementation process.

All interviews were conducted face-to-face, except for one which was conducted over the phone, with notes taken by the interviewer. Interviews were recorded using a digital audio recorder and transcribed verbatim by the primary researcher. The key proceedings of the interviews (i.e. the responses to opening, key and closing questions) lasted between 20 and 70 minutes. The interview duration was dependent upon various factors such as the relevance of the informant’s role, background and involvement in regard to FCTC implementation; their personality and conversational attributes (such as talking speed, length of answers to questions and ability to provide elaborate responses); and their ability and willingness to dedicate their time to the interview. In the vast majority of interviews, informants were happy to take all the time necessary to conduct a full-length interview.

The interview guide consisted of an introduction, opening questions, key questions and closing questions, as advocated by Hennink, Hutter and Bailey (2011). The interviewer opened with an introduction in order to set the scene. Informants were notified of the broad interest in FCTC implementation, with some emphasis on its key articles and/or the provisions the informant was primarily involved with. The opening questions were designed to ascertain the informant’s background in relation to the topic of interest. This was important given the highly contextual nature of the research and the fact that informants provided data based on highly specialised roles and responsibilities. Ascertaining the participant’s background and conducting the opening questions assisted the researcher in framing the following
questions and building rapport with the interviewee, as recommended by Hennink, Hutter and Bailey (2011). Key questions that formed the main substance of the interview were then asked by the interviewer. These were largely open questions, structured under the five topic areas aligned with the clusters in Najam’s (1995) 5C Protocol. They were adapted to suit the policy/context of interest and to ensure that meaningful data could be collected. The interviewer introduced and described the factors that affect implementation, and questions based on these were asked in simple language (rather than in language pertaining directly to the theoretical framework). The interview guide shows all topic areas covered in the interviews, although questions were adapted to the position of the interviewee and not all questions were asked of each interviewee. For example, health inspectors at ground level were not always familiar with the FCTC and its broad-based provisions but were familiar with the specific areas of the national tobacco control provisions that they were mandated to enforce; the questions asked of them centred on what they enforced at ground level. Finally, the interviewer asked two closing questions of the informants to give them an opportunity to add further comments that could have had relevance but were not addressed in the key questions of the interview. The closing questions also allowed time for the interviewee to “fade out” of the interview (Hennink, Hutter & Bailey 2011). The interview concluded with the interviewer closing the proceedings and thanking informants for their participation.

3.3.3.2 Documentation

Documentation was obtained by searching for publicly available documents pertaining to FCTC and national tobacco policy implementation in the countries examined, and by obtaining relevant documentation from key informants. Participants were made aware of the researcher’s interest in any documentation relevant to the FCTC implementation process in the country, and participants, with organisational consent, provided such documents to the researcher. If participants referred to a document in the course of the interviews, they were asked if they could provide a copy of it.
For publicly available documentation, websites of relevant organisations were searched as well as key depositories of tobacco-related information including tobacco.org, which contains a large amount of news items from all countries internationally. The Legacy Tobacco Documents Library from the University of California, and the Document Gateway from the University of Sydney’s Tobacco Control Supersite, both of which contain a database of documents obtained from the tobacco industry as a result of the Tobacco Master Settlement Agreement, were searched using the names of each nation between the years 2005 and 2012. In addition, an internet search using Google was conducted using key terms including “tobacco”, “Framework Convention on Tobacco Control”, “FCTC” and the name of each nation. Results of the searches were scanned by the primary researcher to determine their relevance. Formal searches were performed before the stage of data collection (mid 2011), and towards the latter stages of analysis (mid 2012). The latter search recognised events that occurred after the interviews had been undertaken. As shown in Table 4 below, a total of 129 documents were obtained.

Table 4: Composition of documentation analysed

<table>
<thead>
<tr>
<th>Document type</th>
<th>Cook Is.</th>
<th>Vanuatu</th>
<th>Palau</th>
<th>Nauru</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative documents</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>FCTC implementation reports</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Tobacco monitoring studies/reports</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Organisational plans/reports/statement</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Media reports and newsletters</td>
<td>9</td>
<td>10</td>
<td>27</td>
<td>1</td>
<td>10</td>
<td>57</td>
</tr>
<tr>
<td>Presentations and meeting notes</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Personal communications</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Country total</td>
<td>21</td>
<td>28</td>
<td>52</td>
<td>10</td>
<td>18</td>
<td>129</td>
</tr>
</tbody>
</table>

Documentation was only analysed in this study (and included in this table) if its content was associated with the FCTC or national tobacco legislation implementation process within the four countries of interest. Included were
legislative documents, FCTC implementation reports, tobacco monitoring studies and reports, organisational reports, media reports, newsletters, presentations, meeting notes and personal communications. These came from a range of organisations including ministries of health, ministries of finance, NGOs, CSOs, media agencies, WHO WPRO, SPC, FCA and tobacco companies, as well as from individuals. For documentation relating to the Pacific region, only publicly available documents with relevance to FCTC implementation in the countries of interest were collected. Documentation was more readily available from Palau and Vanuatu, than for the Cook Islands and Nauru. Access to documentation was affected by several factors, including the extent of record-keeping in the organisations of interest, the willingness of participants and organisations to provide documentation, the presence of parliamentary libraries and media agencies (Nauru had no regular newspaper, for instance) and the prominence of the issue in the media. The tobacco control issue gained significant media attention in Palau, as the number of media reports indicates.

3.3.3.3 Written questionnaires

A short introductory questionnaire was given to each key organisational stakeholder (i.e. the MOH and NGO(s) related to tobacco control) prior to the primary researcher’s visit to the designated country. This was to assist in preparation for the field visit but did not contribute to the final analysis. The introductory questionnaire made it possible to ascertain the general position of and discourse surrounding FCTC implementation in the country, the relevant organisations of interest, how they could be contacted, and logistical matters such as determining the appropriate time and place to conduct interviews.

3.3.3.4 Field notes

Field notes were utilised by the researcher, particularly during the course of the interviews, to record data that could not be extrapolated from an audio recording. They recorded such things as body language, tone, suspected bias and relevant content that may have been said outside the recording of the interview.
3.3.3.5 Direct observation

Direct observation was utilised to a lesser extent for the purposes of collecting data relating to a small proportion of research questions. Direct observation assisted in examining the capacity of implementing agencies, the popular brands/types and origins of tobacco sold, and the implementation of some FCTC provisions at ground level (such as packaging and labelling, tobacco taxation and to a lesser extent, smoke-free environments).

3.3.4 Data analysis

Data was transcribed and entered into the computer-assisted qualitative data analysis program, NVivo (Version 10) made by QSR international, which is based in Melbourne, Australia. A thematic analysis was used, which involves identifying recurring themes within the data, exploring typologies of these themes and looking at the relationships between and within themes (Green 2012). Data was coded into conceptual categories (referred to as codes) with guidance from the research questions, and themes were created and used for analysis as advocated by Nueman (2003). Codes relating to the variables that affect implementation were structured in up to four hierarchical branches or levels. These ranged from overarching or broad codes (for example, the commitment of implementers) to more narrow and specific ones (for example, competing priorities amongst staff in the MOH which negatively impacted on commitment). The overarching codes were generally deductive and based on the theoretical framework and interview guide, while the narrower codes were the result of an inductive (or grounded theory) approach in which they emerged from themes and issues determined by the data itself.

Factors relating to the concept of SIDS often proliferated across multiple clusters of variables that affect implementation. These themes were coded separately and not within a hierarchical framework (although in some cases they appeared within narrow codes of variables). An inductive approach was also used in relation to these codes. However, as with any inductive approach, to a certain degree extent they may have been shaped by the primary researcher’s previous understanding of the
concepts. The primary researcher was conscious of this and endeavoured to maintain a neutral perspective.

The interviews and documents were read through in detail and analysed twice. The codes were developed and structured before the second round of analysis. Data was analysed both in the context of each individual country and as a cross-case synthesis of all countries examined for an analysis of the shared (and contrasting) experiences across all countries. This was particularly important in drawing upon themes relating to the notions of SIDS, the Pacific Island cultural environment, and the common challenges and opportunities to FCTC implementation experienced across a number of countries.

No comprehensive statistical analysis using raw data was conducted by the primary researcher; however, secondary sources of data contained useful quantitative information which provided additional insight into various components of the codes.

3.4 Research integrity and quality

3.4.1 Research integrity
Ethical considerations are paramount in any research activities. Ethical approval for this research project was mandatory and obtained from DUHREC on 6 October 2010 (Project ID #2010-103).

3.4.1.1 Conducting research overseas
Research was conducted outside the primary researcher’s home country, and required national approval from the relevant authorities in each jurisdiction. Approval was obtained from the Cook Islands MOH and National Research Committees (Permit #16/11), the Palau Institutional Review Board (Protocol ID #2011-001), the Vanuatu MOH, and the Acting Secretary for Health and Medical Services in Nauru. As the relevant human research authorities were not easily discovered, this was a significant task for the primary researcher. For example, in Vanuatu, approval was sought through the MOH after seeking advice from the
Department of Foreign Affairs, as a formal human research committee or institutional body did not exist (one could speculate that such institutions may not exist in numerous SIDS). This is a challenge to any overseas research project and particularly those that involve collecting data from multiple developing countries. The primary researcher also obtained knowledge on the cultures of each of the countries examined and noted where sensitivities might arise. Here, guidance by the supervisor and other experienced professionals in the field was sought.

In conducting research overseas, language barriers can be of a significant concern. This was not a major barrier in this study as English was an official language in all of the selected countries and all except one of the potential participants (who was not included in the study) were highly proficient in English.

3.4.1.2 Confidentiality and anonymity

Privacy and confidentiality were ensured throughout the research process by undertaking various measures. Informants’ names and personal information were not disclosed to anyone else, interviews were conducted in public but secluded locations where participants could not be heard by others, and data was scanned to ensure that it did not contain identifiable information. This issue was a particular concern as the communities and organisations of interest were very small. In such settings, it may be possible to identify others from very little information. For country-specific quotations, only the informant’s country of residence is detailed, as adding further background information could lead to participants being identified by others. The majority of interviews were conducted in a private room or office in the informants’ workplaces. Some interviews were conducted in an open area such as a park outside the informants’ workplace, or a café or restaurant with no other diners in the immediate vicinity. Transcripts were only accessible by the primary researcher and the principal supervisor.

Some notable and expert informants were included in this study, but their statements are included with no distinction in order to ensure their anonymity. The use of publicly available documentation allowed the names of some notable experts or political leaders to be placed alongside quotes relating to the public information.
However, this could not be achieved for quotations drawn from the in-depth interviews. The implication of this is that anonymous quotations from notable experts may carry less weight than if the quotations were placed alongside their names and roles.

3.4.1.3 Data security
Physical documents obtained through data collection were stored in a locked cabinet, and electronic documents were password-protected to ensure data security. Participants’ transcripts were re-identifiable by a numerical code affixed to each transcript, as backgrounds were important given the nature of this research, and were to be considered in the analysis. Information that linked the codes to the participants was kept in a password-protected file in a separate location. After recording the interviews on a digital audio recorder, the files were immediately transferred to a password-protected USB drive. A backup of all data was kept in a password-protected hard drive stored in a separate location at the primary researcher’s home.

3.4.1.4 Informed consent, non-malfeasance and beneficence
Data was only collected with informed consent from participants and organisations after they had read and understood the plain language statement (see Appendix 2). Participants were informed that all stages of the research were voluntary and that they could withdraw from the study at any time. They were given the option of not having the interview (or parts of the interview) recorded if they did not feel comfortable with this. In all except four in-depth interviews, participants gave permission and the interview was recorded. Participants also had the chance to review their transcript and make potential changes. This was done to reduce recall bias, to allow inaudible words or phrases in the recording to be clarified, and to enable participants to remove any data from the transcript that they did not wish to be retained. Organisations received the opportunity to review the results of the research to ensure that materials did not contain sensitive information; they could opt for this in the consent forms. Furthermore, organisations could decide whether they could be named in public documents produced by the researcher without
further agreement. Participants and their respective organisations were given copies of the results in draft form, and this courtesy bore fruit as it gave timely feedback. In the future, copies of this thesis and any publications associated with this research will be provided to participants, organisations and relevant human research institutions in each country.

3.4.1.5 Other measures to ensure research integrity

As the primary researcher collected data away from the principal supervisor, efforts were made to establish regular communication to ensure that the principal supervisor could provide guidance during the field visits.

Participants were given a gift (worth no more than 20 Australian dollars) as a symbol of appreciation for giving time for the interviews; this was not in the form of cash, which could have created a false incentive to participate.

3.4.2 Study limitations and ensuring research quality

It was of utmost importance that high research standards were maintained throughout this project. However, several weaknesses in collecting the qualitative data, especially in terms of study design, participant selection, and sources of bias, are noted. Measures were undertaken where possible to minimise their negative effects on the quality of the project. Some of these limitations have already been alluded to. Further limitations, as well as the activities undertaken to minimise such limitations, are now specified.

3.4.2.1 Subjectivity and generalisability within the study design

As the primary mode of data collection was qualitative, which inherently entails a constructivist approach, the nature of the interview questions (as well as of the answers) to a certain extent was subjective. This is a common criticism of qualitative research in general (Bryman 2004). Measures undertaken to reduce subjectivity included maintaining a neutral stance throughout interview proceedings, providing a definition of more subjective terms in the interviews (such as “commitment” and “capacity”), and opening the interviews with an explanation of the aim of the research. The semi-structured interview process in which an
interview schedule is followed allows for some degree of standardisation, as did having all interviews transcribed and analysed in the same way by the primary researcher. Subjectivity was partially addressed through triangulation, as documentation, quantitative (secondary) data, observation and comparisons between informant interviews were used in an effort to maintain coherence in the data. For example, if a respondent claimed that tobacco prices were excessively cheap, this notion was cross-matched with prices observed by the primary researcher, responses from other informants, and evidence provided in documentation, which helped to maintain an overall balance based on multiple sources of evidence.

Flick (2009) explains that one problem with qualitative research is that statements are often made in a certain context or for a specific case. This holds true for this study, and generalising all aspects of the research to other countries or contexts should be treated with caution, as has been noted earlier. This is an inherent problem in any case study design, although a multiple-case study has an advantage in this regard (Yin 2009). It is believed that covering four relatively diverse countries in this study is of significantly more value than dealing with only one or two, and this is likely to result in a higher degree of generalisability in the conclusions about SIDS and the common aspects of FCTC implementation in these countries. However, it is recognised that while countries can share some similar characteristics, each also has its differences, and this is a sound reason for offering two layers of results and recommendations – one that is country-specific, and another in the form of a cross-country synthesis.

3.4.2.2 Response and recall bias
Poorly articulated interview questions may result in response bias, which occurs when the interviewee may tell the researcher what they want to hear rather than providing a personally-held insight (Yin 2009). Response bias may have occurred in two particular scenarios: when participants, particularly those outside health groups such as tobacco sellers and supporters of the tobacco trade, may have wished to show strong support for health; and when government representatives
may have exaggerated the positive work or commitment to tobacco control in order to make a positive impression. Despite the research being anonymous, in some cases participants may not have wanted to reveal sensitive information, thus skewing the information they offered. Yin (2009) notes that inaccuracies may also occur due to poor recall. This is acknowledged in semi-structured interviews, as participant responses could have been biased towards what was readily recalled. Furthermore, interviews were taken at a specific point in time, and informants are likely to emphasise what is relevant at that stage, with a poorer recollection of past events and no way to account for later developments (at least within the interview).

Measures were undertaken to address these possible weak points. Firstly, two pilot interviews with the principal supervisor were conducted to test interview questions and reduce response bias before data collection took place. It was important for the primary researcher not to ask any vague, overly complex or loaded questions in the interviews. Recall bias was partially addressed by giving informants the opportunity to review the transcript and fill in any gaps several months after the interviews had taken place (although not all informants analysed their transcripts in depth). The triangulation of data also assisted in reducing response and recall bias as it allowed for the cross-checking of information across a range of sources. For example, NGO-based respondents were useful in providing a critique of government commitment, and this could be cross-checked by other data such as media reports, legislative proceedings and so forth. In scenarios where bias was foreseeable by the primary researcher, field notes were made in order to ensure that this was taken into account in data analysis. To a certain extent, document analysis after the interviews as well as interviewee reviews of their transcripts could take note of any changes or developments that occurred over time, ensuring the relevance of the research over a longer period.

3.4.2.3 Participant selection and representativeness

One of the potential concerns about participant representativeness already mentioned may be the significantly larger proportion of government representatives over those in other sectors. This was largely unavoidable as
government representatives constituted the key stakeholders involved in the FCTC implementation process in each country. As the researcher was only in each country for ten to fourteen days, there were occasions when potential informants were unavailable during that time span. Efforts were made for the interviewer to travel to each country at a time most convenient for the organisations involved; this was discussed with key stakeholders in advance, but inevitably some informants still were missed. The interviewer informed potential participants of the opportunity to use phone or internet communication, but only one telephone interview was undertaken. Unreliable internet/phone connection and participants (who had not met the primary researcher) feeling unwilling or unable to participate via such means served as barriers here. Furthermore, as the interviewer was advised by DUHREC not to interview anyone located in a country other than the four involved in the research without ethical approval from both DUHREC and the other country, it was not feasible to include participants who were out of the country for an extended period of time. A regional conference provided an opportunity to recruit participants who operated at a regional level, but there was the possibility of bias in that only those who attended this conference were approached to be interviewed. Despite these concerns, it was felt that the response rate of 83 per cent was fairly high; given the circumstances of conducting research overseas in small, developing countries; and therefore the representativeness of participants is considered to be relatively strong.
Chapter 4    Country-specific Results

4.1 Introduction

This chapter provides a detailed description of the results found in each country examined in this study, based on the research design and methods used. It commences with a background to the Pacific Islands, some introductory country information and then details the structure of the results. This is followed by a comprehensive analysis of FCTC implementation in the context of each of the four countries examined. Recommendations for successful FCTC implementation relating to each country are also provided. The synthesised results and recommendations across all of the four countries are provided later in Chapters 5 and 6.

4.1.1 A brief background to the Pacific Islands

Culturally and geographically, the Pacific Islands can be divided into three groups: Polynesia, Melanesia and Micronesia. The distant history of the Pacific Islands is extremely complex as there is much diversity amongst its many isolated islands and populations which have, in some cases, been influenced by many forces over thousands of years. Both Polynesian and Micronesian people descend from Austronesians who came from East Asia between 2,000 and 1,000 BC (Campbell 2003). Melanesians are more strongly related to Papuans, a pre-Austronesian people whose migration patterns were less extensive (Campbell 2003). They moved from Papua, to the nearby islands of the Solomon Islands, Vanuatu, New Caledonia and Fiji, thousands of years before the Polynesians or Micronesians.

There is enormous linguistic diversity across Melanesia, whose inhabitants traditionally tended to live in nucleated villages in islands with significant land mass, and whose lifestyle was more closely linked with the land than the sea (Campbell 2003). In contrast, most Polynesians share similar linguistic characteristics (Campbell 2003). This is remarkable considering their diffusion across tiny islands in vast expanses of ocean stretching from Aotearoa (New Zealand), to Hawai’i and Easter Island (Campbell 2003), made possible by their seafaring skills. Micronesians were also great seafarers, typically lived close to the sea and depended on the
ocean’s resources (Campbell 2003). Micronesians are culturally and genetically more heterogeneous, with some influences from Melanesians (Campbell 2003). In the map shown in Figure 4, Melanesia comprises the countries located within the yellow line, Micronesia consists of the area above the blue line and Polynesia includes those countries east of the green line. Some Pacific Islands are outliers and do not fall neatly within these distinct categories. Nauru serves as an example, with both a Micronesian and Polynesian influence.

There were and still are differences in the political organisation across the three cultural groups. Polynesia and Micronesia have aristocratic, hierarchical structures with traditional authority vested in chiefs (Fairbairn et al. 1991). Melanesia is more egalitarian, where “Big Man” leadership is acquired through skill and achievement (Campbell 2003; Fairbairn et al. 1991). In Micronesia, decisions were typically made by council, while chiefs were more autocratic in Polynesia (Campbell 2003). In Melanesia, decision-making was rather consensual with a small village focus (Campbell 2003). In almost all Pacific Island countries, there is still recognition of traditional chiefly leadership today, particularly in local government and through councils of chiefs which can play a role at the national level (Hassall & Tipu 2008).

Over the last 200 to 300 years, the history of the Pacific Islands has been significantly shaped by foreigners: first by explorers, missionaries, traders and naval officers; then by settlers, plantation developers and colonial officials (Campbell 2003). By the beginning of the 20th century, the Pacific was no longer an area with isolated cultures “hidden” from the Western world, and after two centuries or more of contact by various outsiders, the region had been transformed into “fragments of empires annexed or ‘protected’ by powerful European nation-states” (Hempenstall 1994; p. 29). Many Pacific Islands have colonial ties with larger powers, the more recent of which include Australia, New Zealand, France, the United Kingdom and the US. Historically, colonial powers also included Spain, Germany and the Netherlands. World War II significantly affected many islands in a variety of ways, and substantial destruction occurred in countries in the direct proximity of fighting, such as Papua New Guinea and the Solomon Islands (Lal & Fortune 2000). World
War II had an extremely diverse range of consequences for local populations, but a dominant theme was a disruption of the colonial order (Lal & Fortune 2000). Since the second half of the 20th century, territories of the Pacific Islands have increasingly become independent or self-governing nations, although some remain under the sovereignty of colonial powers. Since the colonial period, contact with outsiders is often made through politicians, investors, development advisors, educators and tourists (Campbell 2003). Even countries that have become independent often maintain strong diplomatic ties with their old colonial rulers. The independent Pacific Island countries have generally adopted governmental systems based on the structure and processes of their former colonial power (Fairbairn et al. 1991). For example, the former British colonies have a variation of the British constitutional framework and have elected parliaments (Fairbairn et al. 1991).

4.1.2 A snapshot of the four countries
The four independent Pacific Island nations of interest to this study (and the vast majority of independent Pacific Island nations) can be classified as SIDS; the ramifications of this on FCTC implementation are explored in the next chapter. Given the uniformity imposed by this classification, it is important to reflect on the contrasts between the selected countries. The following map shows the location of each country in the Pacific, and provides an indication of their relative size in comparison to countries like Australia or Papua New Guinea.
The red lines represent the location of the four countries examined and an approximation of the geographical areas that they cover. It should be noted that the borders and islands contained within these outlines (and the coloured lines) do not necessarily represent the official delineations of each country/region.

**Figure 4: Map of selected countries and a delineation of their respective regions**

Table 5 shows some basic background statistics for each country examined, along with Australia and New Zealand for comparative purposes.

**Table 5: Background statistics for selected countries, Australia and New Zealand**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Is.</td>
<td>20</td>
<td>12</td>
<td>240</td>
<td>1,960,135</td>
<td>75%</td>
<td>72/80/76</td>
<td>20,452 ('10) n/a</td>
<td></td>
</tr>
<tr>
<td>Vanuatu</td>
<td>240</td>
<td>65</td>
<td>12,200</td>
<td>827,891</td>
<td>26%</td>
<td>69/72/71</td>
<td>2,856 ('10) 0.617</td>
<td></td>
</tr>
<tr>
<td>Nauru</td>
<td>10</td>
<td>1</td>
<td>21</td>
<td>308,502</td>
<td>100%</td>
<td>56/65/60</td>
<td>5,551 ('09) n/a</td>
<td></td>
</tr>
<tr>
<td>Palau</td>
<td>20</td>
<td>9</td>
<td>458</td>
<td>604,289</td>
<td>83%</td>
<td>68/77/72</td>
<td>9,983 ('09) 0.782</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>22,404</td>
<td>n/a</td>
<td>7,692,024</td>
<td>6,362,934</td>
<td>89%</td>
<td>80/84/82</td>
<td>56,117 ('10) 0.938</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>4,368</td>
<td>n/a</td>
<td>271,000</td>
<td>3,423,231</td>
<td>86%</td>
<td>79/83/81</td>
<td>32,455 ('10) 0.919</td>
<td></td>
</tr>
</tbody>
</table>


Each of the countries examined is described individually later in the chapter, but some interesting contrasts are now made. Vanuatu stands out as having a significantly higher population and land area than the other three countries. It also contains a large number of inhabited islands, many of which have distinct cultural differences. Nauru’s land area in particular is very small: the country consists of just one island. While the Cook Islands has a small land area, it is scattered across a vast area of ocean, which is reflected in its large exclusive economic zone, which is more than half the size of New Zealand’s exclusive economic zone. Three of the countries examined (and Australia and New Zealand) have a majority of people living in urban areas, but Vanuatu has a high proportion of rural dwellers. Life expectancy is
particularly short for Nauru; it is highest in the Cook Islands of the countries examined. Gross Domestic Product (GDP) per capita is also higher in the Cook Islands, and to a lesser extent Palau, than in the other countries examined. Vanuatu is the least developed in terms of GDP per capita, and its Human Development Index is also lower than that of Palau. Australia and New Zealand have much larger populations and land areas, higher life expectancies, GDP and human development index than the countries examined. Australia and New Zealand also have larger exclusive economic zones, but when observing these relative to population, the populations are more sparsely spread in the Pacific Island countries examined than in Australia or New Zealand.

Table 6: Basic health system statistics of selected countries in the Pacific region

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Is.</td>
<td>28.9</td>
<td>64.4</td>
<td>525</td>
<td>62</td>
<td>20.5</td>
<td>21.1</td>
<td>40.1</td>
<td>28.1</td>
<td>59.7</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>1.2</td>
<td>17.0</td>
<td>160</td>
<td>56</td>
<td>9.2</td>
<td>9.6</td>
<td>40.7</td>
<td>36.5</td>
<td>22.9</td>
</tr>
<tr>
<td>Palau</td>
<td>13.8</td>
<td>57.1</td>
<td>825</td>
<td>65</td>
<td>17.5</td>
<td>19.0</td>
<td>34.6</td>
<td>25.5</td>
<td>44.9</td>
</tr>
<tr>
<td>Nauru</td>
<td>7.1</td>
<td>70.7</td>
<td>700</td>
<td>56</td>
<td>12.8</td>
<td>15.2</td>
<td>40.3</td>
<td>29.9</td>
<td>67.5</td>
</tr>
<tr>
<td>WPRO avg.</td>
<td>14.8</td>
<td>18.4</td>
<td>580</td>
<td>63</td>
<td>9.2</td>
<td>8.6</td>
<td>28.7</td>
<td>23.7</td>
<td>5.1</td>
</tr>
<tr>
<td>Australia</td>
<td>29.9</td>
<td>95.9</td>
<td>4,750</td>
<td>79</td>
<td>9.6</td>
<td>6.7</td>
<td>22.8</td>
<td>13.7</td>
<td>25.2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>27.4</td>
<td>108.7</td>
<td>3,300</td>
<td>77</td>
<td>11.1</td>
<td>8.8</td>
<td>22.8</td>
<td>15.1</td>
<td>26.2</td>
</tr>
</tbody>
</table>

Variables for the WPRO region are significantly skewed towards China as it boasts a far higher population than the other countries in the region (followed by Japan, the Philippines and Vietnam).


Table 6 compares basic health (care) systems and NCD statistics for each of the countries examined, as well as the WPRO regional average, and Australia and New Zealand data for comparison. These are extracted from WHO’s (2012a) Global Health Observatory database, one of whose aims is to provide access to country statistics with a focus on comparable estimates (WHO 2012a). These are described in more detail within each individual case study; however, some comparisons can
now be made. The Cook Islands and Palau have a greater amount of doctors per 10,000 population than in Vanuatu and Nauru. Although Nauru has fewer doctors relative to its population, it has more nurses relative to population than the other countries examined. Statistics indicate a weak health care workforce in Vanuatu in terms of the presence of doctors, nurses and per capita health expenditure, which is in stark contrast with Australia and New Zealand. Despite having a high number of doctors per population, per capita health expenditure in the Cook Islands is relatively low. NCDs account for a significant proportion of years of life lost in all countries examined, and although this tends to be greater in the more developed countries, risk factors for NCDs are uniformly high in the four countries of interest, and in most cases exceed those of Australia and New Zealand. This highlights the urgent need to tackle NCDs in each of these countries. Tobacco use is high in the male populations of all the countries examined. Vanuatu and Palau have a particularly large disparity between male and female tobacco use, while this is more evenly distributed in Nauru and the Cook Islands.

4.1.3 Structure of case study results and application of Najam’s 5C Protocol

The remainder of this chapter explores the results regarding the variables that affect FCTC implementation in each country examined. An introductory section sets the scene with a brief background of the country, which is followed by sections on tobacco use, FCTC ratification and national tobacco control legislation, tobacco control policy-making and institutional structure, and the current stage of FCTC implementation and enforcement in the country.

The main results of the informant interviews and document analysis are produced in a table showing facilitators and barriers to FCTC implementation. These are produced with respect to each variable cluster in Najam’s 5C Protocol:

- **Content** is the goal, causal theory and methods of the national tobacco control legislation and the FCTC. In all cases, the goal is to minimise the burden of tobacco use; the embedded causal theory is that tobacco use causes NCDs; and the methods are the FCTC-based policy provisions adopted to achieve the goal. In most cases, the national tobacco control
legislation and the FCTC are convergent, although where this is not so (as in Palau), the content is mostly restricted to FCTC provisions only.

- **Context** reflects on three key areas including the policymaking process and decision-making structure associated with the tobacco control legislation and its implementation; the extent to which the relevant institutions have adapted to the content of the FCTC/national tobacco control legislation; and the relevant institutional networks, relationships and support mechanisms that drive the implementation process.

- **Commitment** focuses on the overall commitment and enforcement of policies by the government in general, as in certain cases general observations were provided. This is followed by commitment at ground level, which considers health inspectors, legal enforcement officers and health promotion staff who come into contact with clients. Commitment at the MOH and at the public health/health promotion department level is then explored, followed by commitment at the whole-of-government level. The latter explores the commitment of government departments other than health, as well as senior decision-makers that operate at the parliamentary or cabinet level. Finally, external sources of commitment outside the country of interest, including those from multilateral agencies (such as the WHO and SPC), bilateral agencies, external advisors and consultants, are explored.

- **Capacity** refers to the ability of those entrusted to implement the policy. Like commitment and context, this primarily focuses on government actors. First capacity is expressed in regard to factors relevant to logistics, including the number and skill levels of staff; the mandated authority of those implementing and enforcing the policy; the knowledge of tobacco control issues generally and the monitoring of tobacco use and policy compliance; and the physical facilities and technology at hand. Capacity is then discussed in terms of funding and resourcing, which is more politically grounded and a means to achieve the logistics.

- **Clients and coalitions** are then explored. Clients include any persons affected by FCTC-based policy provisions. This can be framed in reference to
particular groups (such as smokers, non-smokers, business owners and transport users), but also in terms of the general population. This is because the vast majority of people are affected by one or more FCTC-based provisions in some way. Coalitions include organised stakeholders with an interest in FCTC implementation, who seek to influence political decisions. The anti-tobacco coalition is discussed first, which includes NGOs, civil society and broad coalition groups (i.e. multi-sectoral teams). The ways in which these seek to influence clients (i.e. through community awareness and advocacy) is then explored, followed by the activity of the tobacco industry and any pro-tobacco coalition activity. Client support to the FCTC-based provisions is then detailed.

The key influences on each component of the variable clusters are documented. As the variables that affect implementation are interrelated (Najam 1995), factors that were pertinent to implementation are often cited on more than one situation because of their influence on numerous variables.

A summary of the variables that affect the implementation of the FCTC for each country is then provided. This includes quotations to detail some of the lived experiences of the respondents. It was not possible to provide quotations reflecting the nuanced details within each variable cluster, but those included generally reflect the overall mood or position in relation to the variable cluster within that country. The impact the policy has had on clients, giving an indication of how the tobacco control legislation has been felt on the ground, is included in the country summary. Finally, country-specific recommendations to overcome barriers and utilise opportunities for effective FCTC implementation, are provided.

### 4.2 Cook Islands

#### 4.2.1 Brief country background

The Cook Islands is a small Polynesian nation consisting of fifteen islands, spread across a large area of ocean between Tonga and French Polynesia. The majority of the country’s approximate 20,000 people live on one island, Rarotonga.
Until the early 1800s, each island was autonomous and in most cases was run under a hereditary chiefly hierarchy (Hassall et al. 2008). The Cook Islands, annexed by New Zealand in 1901, remained a protectorate until 1965. Since then, it has been self-governing in free association with New Zealand, which oversees defence and some aspects of international relations, although this can only be enacted upon request by the Cook Islands government (Government of the Cook Islands 2012). The Cook Islands follows a Westminster parliamentary system. Officially, the Parliament consists of a single chamber of 24 elected members, 10 of whom are from Rarotonga and the remainder are from the outer islands (Government of the Cook Islands 2012). The House of Ariki, made up of traditional chiefs, can be sometimes labelled as a “second” chamber (Levine & Roberts 2009). This body does not make law, but serves to consider laws and voice suggestions from the standpoint of traditional values (Levine & Roberts 2009).

The country’s main sources of revenue are from tourism, fishing, agriculture and financial services (Government of the Cook Islands 2012); major trading partners include New Zealand, Australia and Japan (Australian Government Department of Foreign Affairs and Trade 2012b). Official languages of the country are Cook Islands Maori and English.

The Cook Islands government spent 11.9 per cent of its total expenditure on health in 2010 (WHO 2013d). Health spending accounted for 4.6 per cent of its GDP and 90.5 per cent of this spending came from government sources (WHO 2013d). External assistance accounted for 5.8 per cent of total expenditure on health in 2010 (WHO 2013d), which is the lowest of the countries examined. The WHO’s (2012a) Cook Islands Health Profile shows that the country enjoys a life expectancy slightly above global and regional averages: 72 years for men and 80 for women. Its health workforce includes 28.9 physicians and 64.4 nurses and midwives per 10,000 people, above the regional average (WHO 2012a). In 2008, NCDs accounted for 62 per cent of years of life lost, roughly on par with the regional average (WHO 2012a). High blood glucose, high blood pressure, obesity and female tobacco use are all higher than regional averages, with only male tobacco use being lower (WHO
Like much of the region, per capita expenditure on health has increased significantly over the last decade (WHO 2012a).

### 4.2.2 Tobacco use

Smoking manufactured cigarettes is the major form of tobacco use in the Cook Islands. Informants claimed that the vast majority of tobacco in the country is imported from Australia and New Zealand. The three most popular tobacco brands were Marlboro (produced by Philip Morris International), Winfield and Port Royal (both produced by British American Tobacco), according to the 2010 and 2012 FCTC implementation reports (Tairi 2010; Tangaroa 2012). Tobacco use is reasonably high in the country: the WHO estimated the 2009 tobacco prevalence rate to be 43.0 per cent for males (aged fifteen and over) and 31.0 per cent for females (WHO 2012e). The latest comprehensive prevalence rates are somewhat dated: 46.6 per cent of males and 41.1 per cent of females aged 25 to 64 were current smokers according to data collected in 2004 (Cook Islands Ministry of Health & WHO 2011). The Global Youth Tobacco Survey (GYTS), a more recent study conducted in youth, revealed that in 2008, 35.1 per cent of school students aged thirteen to fifteen used tobacco (CDC & WHO 2008). A comparison between the 2003 and 2008 GYTS studies showed a promising sign with a 13.6 per cent decrease in smoking prevalence amongst those aged thirteen to fifteen; but trends in tobacco use in the overall population cannot be ascertained until comparable studies are conducted in the future.

### 4.2.3 FCTC ratification and subsequent tobacco control legislation

The Cook Islands ratified the FCTC in May 2004 (Framework Convention Alliance 2013). Since then, the country has made significant progress towards its implementation, having passed the Tobacco Products Control Act (also referred to as the Act) in 2007 and developed Tobacco Products Control Regulations based on the Act in 2008. In respect to the key articles of the FCTC, the Tobacco Products Control Act is compliant and reasonably comprehensive. The Act prohibits TAPS and mandates health warnings to cover at least 50 per cent of the retail package; it also states that the Australian and New Zealand health warning regulations, which are
strict and fully compliant with the FCTC, are recognised as an acceptable standard.
The legislation prohibits smoking in indoor or partly enclosed public places and workplaces, including restaurants and bars, although it permitted smoking areas inside restaurants and bars, with some restrictions, until 2009 when it was no longer permitted. Other provisions in the Act include bans on selling tobacco products in small quantities, bans on sales to minors under eighteen, regulations on the contents of tobacco products, and requirements for disclosure of product additives.

4.2.4 Tobacco control policy-making and institutional structure
The tobacco control bill passed through parliament on its second reading with no major objections or requests for amendment. The Tobacco Products Control Act was heavily based on the FCTC, with some advice from Allen and Clarke, a WHO-sponsored agency from New Zealand. The MOH is the key focal point for the Tobacco Products Control Act and the Secretary of Health has the powers to appoint staff (health inspectors) and enforce provisions of the Act. The MOH oversees most matters including smoke-free environments, bans on TAPS, packaging and labelling, sales to minors, sales of small quantities of cigarettes, and regulations on the contents of tobacco products. Although the MOH has some enforcement powers, at the time of the interviews prosecution under the Tobacco Products Control Act was dealt with by the Crown Law Office, headed by a Solicitor-General who advises the government on legal matters. Informants claimed that the MOH was in the process of requesting direct prosecution powers under the Act, although this was yet to be achieved. The Ministry of Finance and Economic Management (MFEM) is the advisor to the government on finance and economic issues, and oversees the taxation of tobacco products and the provision of funding for government activities. The customs department is responsible for ensuring that tobacco products that come in to the country meet the national requirements. A brief structure detailing the staff relevant to tobacco control in the MOH is shown below.
The MOH is split into four directorates, one of which is Community Health Services. This houses the Health Promotion Unit (and the tobacco control focal person within it) and the Health Protection Unit, which includes health inspectors who oversee tobacco control legislation on the ground. The Funding and Planning directorate oversees finance, legislative compliance, policy and planning within the MOH. The other two directorates consist of Hospital Health Services and Outer Island Health Services.

4.2.5 Current status of FCTC implementation and enforcement

The Cook Islands has focused on enforcing FCTC provisions and maintaining compliance to its legislation over the 2011 to 2012 period. The MOH employs a team of eleven health inspectors who have enforcement powers under the Act, although their duties are spread across seven issue areas (including food hygiene, water safety and border control amongst others). Tobacco control is a relatively new addition to their responsibilities, and staff had recently undergone training workshops after the time of interviews. In a basic observation of the key articles of interest by the primary researcher during a two week stay on Rarotonga, it was noted that health warnings and labels on cigarette packages typically consisted of those from New Zealand, which cover approximately 70 per cent of the package and include pictures. The primary researcher did not observe any TAPS in...
Rarotonga, aside from one small cigarette brand painted on a building which did not appear to be in use. It was apparent that smoke-free environment policies were largely enforced in most public areas, although two instances of smoking were seen in bars and restaurants that were partially open-air (but not indoors).

The 2012 FCTC implementation report suggested that there was a need to monitor compliance with smoke-free environments, and although most indoor public places are smoke-free, some individuals smoke in retail shops “now and again” (Tangaroa 2012). The report showed that in 2008, manufactured cigarettes were subject to an import levy of 279.40 New Zealand dollars per 1000 cigarettes, an increase of 172 per cent in the eight years since 2000 (Tangaroa 2012). There was no evidence of any further increase since 2008.

4.2.6 Variables that affect FCTC implementation

The comprehensive findings on the variables that affect implementation in the Cook Islands according to informant interviews and document analysis are listed in Table 7 below.

Table 7: Facilitators and barriers to FCTC implementation in the Cook Islands

<table>
<thead>
<tr>
<th>Variable that affects implementation</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Minimising harm associated with tobacco use seen universally by informants as important for the country. This is also substantiated by the WHO’s STEPwise approach to surveillance (STEPS) and GYTS studies.</td>
</tr>
<tr>
<td></td>
<td>The goals of FCTC were somewhat ambitious (claimed by one informant).</td>
</tr>
<tr>
<td></td>
<td>Alcohol may potentially be a more serious issue than tobacco use (claimed by one informant).</td>
</tr>
</tbody>
</table>

9 The points written in bold text are the facilitators or barriers deemed to be highly important as they affected numerous FCTC provisions and/or were expressed as a facilitator or barrier to a key variable cluster by a large proportion of informants. This also applies to similar tables for Vanuatu, Palau and Nauru. For some of the more subjective points, the number of informants that this was claimed by is mentioned in brackets. This should not be treated as a proportion of all informants in the country, as informant knowledge on particular aspects of FCTC implementation tended to vary.
Methods

- The vast majority of the FCTC’s methods were seen as effective and appropriate for the country.
- The tobacco control bill passed through parliament with little objection or request for amendment.
- Country adoption of FCTC methods (and involvement in the FCTC in general) allowed for exposure to international knowledge, networks and meetings on tobacco control.
- Some FCTC provisions, including illicit trade and the provision of sustainable alternatives for growing tobacco, were perceived as less relevant to the local context.
- The proposed methods in national legislation may have been drafted without sufficient consultation in the outer islands (claimed by one informant).
- FCTC methods were subject to limited capacity, particularly at ground level, in islands outside of Rarotonga.
- Nicotine replacement therapy is expensive to administer by government.

Context

Policy-making/institutional structure

- The MOH oversees most FCTC provisions.
- The MOH does not have enforcement powers to prosecute under the Act (which it was in the process of requesting).
- Decision-making was top-down and rather limited consultation was conducted at ground level (claimed by one informant).

Institutional adaptation to policy

- Agencies responsible for implementation adapted to the majority of provisions in national legislation. This was evidenced by the duties of the tobacco control focal person, legal officer and health inspectors.
- Institutional adaptation was evident in planning and reporting in the Tobacco Control Action Plan, NCD Strategy 2008-13 and activity reports (Cook Islands Ministry of Health 2011b; Cook Islands Ministry of Health 2004; Cook Islands Ministry of Health 2011c).
- Institutional adaptation of smoke-free environments (particularly in hospitality venues) was hindered by limited capacity.
- Organisational documentation pertaining to tobacco control and FCTC implementation was relatively scarce.

Institutional networks and relationships

- MOH staff had strong working relationships with colleagues in tobacco control and FCTC implementation.
- A strong relationship between the MOH and NGO actors through the Tobacco Control Working Group (TCWG) did exist, but this diminished while the TCWG was inactive over the one to two years preceding interviews.
- The MOH maintained strong links to the community through activities in schools, workplaces and radio communications.
- Established and supportive networks with the WHO and SPC were apparent.
- Institutional networks between the MOH and departments outside health were not as strong (i.e. there were challenges in encouraging the Crown Law Office, police and MFEM to rigorously support provisions. Little inter-sectoral collaboration was apparent at ground level.)
- Staff turnover had taken place at the senior level and therefore tobacco control relationships needed to be re-established with several staff.

Commitment

Commitment broadly

- There was scope for scaling up the overall enforcement of legislation (i.e. authorities were going through an incremental process with regard to enforcing legislation).
- Overall commitment to bans on TAPS
- Room for improvement in the overall enforcement of smoke-free bars and restaurants, and making more use of litigation and penalties, was apparent (which could be attributable to limited funding and mandated authority).
and smoke-free environments (outside of bars and restaurants) was demonstrated.

**Ground level commitment**
- Enforcement officers underwent further training since the time of interviews, and a media release stated that those failing to comply with the Act would be penalised (Ponini 2012), suggesting intention to scale up ground level enforcement.
- Ground level enforcement officers were loaded with additional responsibilities under the Act, while additional capacity had largely not been provided (claimed by one informant).
- The enforcement of provisions at the ground level was undergoing a "teething process" while legislative changes were under way to allow health inspectors to prosecute.

**MOH/health promotion departmental commitment**
- Decision-makers were supportive through showing leadership in and providing support for provisions (i.e. dedicating time for meetings and tobacco control events, allocating resources for training, appointing legal officer and declaring the MOH a smoke-free zone).
- Senior staff were advocating for taxes to be earmarked for tobacco control and requesting amendments to legislation to allow greater enforcement responsibility.
- MOH commitment was facilitated through its collaboration with the TCWG.
- MOH/health promotion departmental staff had many competing issues to attend to.
- The prioritisation of tobacco control shifted in the past due to government and staff turnover.

**Whole-of-government commitment**
- The passage of the Tobacco Control Act through parliament with little objection demonstrates intention to commit to its implementation.
- The magnitude of the NCD problem and advocacy by TCWG resonated amongst senior government decision-makers.
- Achieving a high level of commitment in departments outside of health was challenging. This is attributable to the following points:
  - MFEM not wanting to allocate tobacco tax revenues to towards health promotion. MFEM were also not as strictly adhering to smoke-free policy in its workplace (claimed by one informant).
  - Police (the only ones who could prosecute under the Tobacco Act at the time) would not necessarily prioritise enforcement of tobacco control provisions (claimed by one informant).
  - The Crown Law Office had many other legal priorities and could not prioritise mandating health inspectors with prosecution authority (claimed by one informant).

**External sources of commitment**
- Allen and Clarke, a WHO-sponsored technical group based in New Zealand, had a positive influence through developing legislation and providing technical assistance.
- A needs assessment was conducted by the by the FCS (WHO 2012d).
- The WHO, SPC, NZAID and AusAID facilitated commitment, but more at an overall health systems level which was not necessarily concentrated in tobacco control.
- Commitment from Australia and New Zealand in packaging and labelling may have an impact on cigarettes imported in the Cook Islands, which recognises this
- Aside from Allen and Clarke, external sources were not cited as a key driver of commitment to FCTC implementation, which tended to be framed in the national context.
labelling as an acceptable standard.

### Capacity

<table>
<thead>
<tr>
<th>Number and skill levels of staff</th>
<th>Number and skill levels of staff</th>
<th>Number and skill levels of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>A legal officer was appointed to assist with health-related legislation including Tobacco Products Control Act.</td>
<td>A lack of staff and competing priorities for existing staff was apparent (claimed by five informants). The tobacco control focal point in government consisted of only one staff member.</td>
<td>A minority of informants suggested that the required number of staff did exist, but rather a lack of resources hindered capacity.</td>
</tr>
<tr>
<td>Numerous training sessions to assist relevant staff in tobacco control had been undertaken.</td>
<td>Some training sessions were completed several years before interviews, but trained staff relocated before this training could be applied.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge of tobacco issues, surveillance and monitoring</th>
<th>Knowledge of tobacco issues, surveillance and monitoring</th>
<th>Knowledge of tobacco issues, surveillance and monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders had a strong knowledge of general tobacco control issues.</td>
<td>There was no systematic collection of data to measure the extent to which businesses complied with Tobacco Products Control Act (this may occur once enforcement is solidified).</td>
<td></td>
</tr>
<tr>
<td>Expertise in a newly appointed legislative officer was evident.</td>
<td>A need for more tobacco control data (i.e. people’s history of tobacco use) in the MOH’s database was apparent (claimed by one informant).</td>
<td></td>
</tr>
<tr>
<td>The monitoring of tobacco control prevalence was assisted by 2004 STEPS and 2008 GYTS surveys (which are supported by WHO, CDC and SPC). Another STEPS survey was being conducted at the time of interviews and the GYTS is ongoing every five years (Tangaroa 2012).</td>
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<table>
<thead>
<tr>
<th>Mandated authority</th>
<th>Mandated authority</th>
<th>Mandated authority</th>
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<tbody>
<tr>
<td>Health inspectors within the MOH were mandated under the Tobacco Products Control Act to inspect, investigate and seize.</td>
<td>There was a limited mandate for health inspectors to prosecute under the Tobacco Products Control Act. Prosecution was limited to the police force. Legislative processes beyond this Act need to occur for this to be achieved.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical facilities and technology</th>
<th>Physical facilities and technology</th>
<th>Physical facilities and technology</th>
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</thead>
<tbody>
<tr>
<td>Difficulty in communicating with people in the outer islands was apparent. Some locations were only contactable by radio and have neither internet nor television.</td>
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</table>

<table>
<thead>
<tr>
<th>Resourcing and capacity politics</th>
<th>Resourcing and capacity politics</th>
<th>Resourcing and capacity politics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional government assistance to the MOH was provided for media advertising against tobacco use.</td>
<td>A lack of funding or resources was amongst the most frequently mentioned barriers to FCTC implementation.</td>
<td></td>
</tr>
<tr>
<td>Tobacco control programs in remote areas sometimes benefitted from funding for other causes.</td>
<td>There was a small government budget with many competing demands in conjunction with limited opportunity for external grants.</td>
<td></td>
</tr>
<tr>
<td>Allen and Clarke (through funding assistance from WHO, NZAID, and AusAID) facilitated capacity through policy development and technical assistance.</td>
<td>Sustainable funding was mentioned as a barrier to health promotion in the outer islands in two documents (Cook Islands Ministry of Health 2011b; Cook Islands Ministry of Health 2011c), and financial constraints were heavily cited in the MOH’s overall business plan (Cook Islands Ministry of Health 2012) and the 2012 FCTC implementation report (Tangaroa 2012). MOH demands to earmark tobacco taxation to health promotion, a source of sustainable funding, have not been approved at the national level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Added to the lack of resources was the high cost of: conducting activities in rural and remote islands, offering nicotine replacement therapy, and referring hospital patients to New Zealand</td>
<td></td>
</tr>
</tbody>
</table>
### Clients and Coalitions

#### Anti-tobacco coalition activity
- The TCWG, formed in 2003, is a central coalition consisting of both government and non-government representatives which directly supports tobacco control legislation and activities.
  - The TCWG had a significant influence on tobacco control bill passing through parliament, through advocacy, lobbying, exploiting networks and collaborating with the MOH.
  - Facilitators of the TCWG included funding for community awareness activities, the skills and experience of its members, public support, and collaborative relationships with government representatives and external technical advisors.
- TCWG activity had waned in the one to two years preceding interviews due to a lack of funding, a reliance on volunteers who were stretched with responsibilities, and a lack of new incoming volunteers.

#### Anti-tobacco community awareness
- The TCWG historically conducted awareness activities through a song and dance competition in schools and participation in radio talkback programs.
- The MOH conducted numerous activities including research, awareness campaigns about the legislation, community presentations, participating in radio talkback programs and taking part in World No Tobacco Day events.
- The MOH engages the community through its smoke cessation services.
- Anti-tobacco community awareness was almost exclusively driven by government actors since the TCWG’s inactivity.
  - There was some desire for more community awareness on the legislation in outer islands and on smoke-free environments in restaurants and bars.
  - Informing remote communities of the legislation and its requirements was costly and difficult.

#### Tobacco industry and pro-tobacco coalition activity
- No tobacco manufacturing presence and no civil society group overtly opposing tobacco control provisions in the Cook Islands meant that overall resistance to FCTC implementation was fairly weak.
  - There was no indication of smuggling or black market tobacco products by informants or in documentation (Tairi 2010; Tangaroa 2012).
  - The MOH was able to consult with the Chamber of Commerce which became more sympathetic to MOH’s cause and were willing to support the legislation (after its initial concerns with a part of the legislation).
  - Some resistance to tax increases was shown by businesses involved in selling tobacco.
  - Restaurants, bars and the Chamber of Commerce initially showed some resistance to the creation of smoke-free environments (Cook Islands Chamber of Commerce 2008).
  - British American Tobacco representatives occasionally visited and attempted to talk with decision-makers in government, but there was no evidence to suggest that they had a significant influence on tobacco control policy or related activities.

#### Client support for policy
- Non-smokers were considered generally supportive of the legislation and some informants suggested that this was true of the population overall.
  - Public support for smoke-free environments was indicated by informants. The GYTS showed that 68.7% of youth supported banning smoking in public places (CDC & WHO 2008).
- Minor opposition to legislation by smokers was evident, but there were no formal protests or disruptions in respect of implementing the legislation.

(which hindered the MOH budget).
4.2.7 Summary of the variables that affect FCTC implementation

The content variable cluster was supported strongly in the Cook Islands, as the goals, causal theory and methods resonated amongst clients and politicians, as shown in the following quotation:

I think at that time [the goals of the Tobacco Products Control Act were] so important for the Cook Islands because it was noticeable that the incidence of NCDs was very high and then still climbing, so it was very important for politicians at the time to take heed of what that trend is and to do something about it. (Cook Islander informant).

The institutional context was fairly supportive as: the Tobacco Products Control Act passed through parliament with little objection; many agencies responsible for implementation fell within the MOH, which had institutionalised many provisions; and institutional networks within the MOH were strong. However, one major setback was the limited extent of networks and relationships in government departments outside the MOH, such as the MFEM and police officers. The following quotation highlights the challenge inherent in the decision-making processes surrounding prosecution under the Tobacco Products Control Act:

Our plan at the moment is [that] once we have the amendment to the Act, we will have enforcement powers so we would do our own prosecution... At the moment we can’t because we don’t have the law behind [us] to prosecute them. [It’s] not only in this area, but also in non-compliance in sewerage, sanitation, food, and water pollution. So [in] all of those areas it’s the police who [do] that, or we sometimes ask them when they are policing the night clubs, to make sure that there is no smoking inside – but then they are [often] looking for something else – they are looking for dope. (Cook Islander informant)

Progress in attaining commitment to FCTC implementation was evident, particularly in the leadership of senior decision-makers in the MOH and in parliament, where tobacco control legislation passed without objection. However, commitment has
been hindered by the MOH staff being stretched with numerous competing priorities, and a lack of commitment in departments outside of the MOH. This former reflected poorly on the overall enforcement of provisions:

They’ve got the policies. I don’t know whether it’s a five or a six [out of a ranking of ten for commitment to the FCTC]. I know they’ve got those things in place but I think the enforcement is the big downfall there. (Cook Islander informant)

The variable cluster of capacity was the most significant barrier to FCTC implementation. There was limited staffing on the ground, as shown in the following quotation:

I would say that we have insufficient capacity to carry out this Tobacco [Products Control] Act because we have too much on the plate and this is an added [responsibility]... but we are trying our best to accommodate it within our restricted capabilities, in terms of staffing as well as funding. We don’t have any other form of support. Whatever we have, we have to do with that. (Cook Islander informant). (Martin & de Leeuw 2013; p. 3)

Furthermore, an apparent sector- and government-wide lack of resources in light of many other competing issues, and limited opportunity for a sustainable funding mechanism specifically for tobacco control, was evident. The major facilitator for capacity was the mandated authority of health inspectors to carry out activities (except prosecution) under the Act, meaning that a significant proportion of most provisions were implementable by the MOH.

The clients and coalitions variable cluster was facilitative in the Cook Islands due to: no tobacco manufacturers operating in the country, limited public resistance to tobacco, and reasonably favourable client support for provisions in the Tobacco Products Control Act, as shown in the following quotation:

At first, the reaction [from the general public] wasn’t that receptive [to the tobacco control legislation introduced], and also the price [increase] that was
part of the review wasn’t being welcomed nicely. But I think as years go by, the general public is accepting it and receiving it very well. (Cook Islander informant)

The recent inactivity of the central anti-tobacco coalition group was the only major barrier in the clients and coalitions variable cluster:

The [Tobacco Control] Working Group has sort of [been] slipping for a year and a half now, so at the time [of the passing of the Tobacco Products Control Act]... they were active then. But I guess there was a bit of a disappointment that there’s not enough resources to put in place... In the every two year [youth community awareness] activity... we still couldn’t sustain it for this year, so I guess it probably needs a revival. (Cook Islander informant)

Some barriers to the impact of FCTC provisions on clients in the Cook Islands were present. Several informants stated that restaurants and bars were not fully complaint with the smoke-free environments policy; the health benefits were not fully achieved in such places. One informant considered that offering cessation assistance in the form of nicotine replacement therapy required a significant boost. The high prevalence rate of cigarette smoking and the lack of enforcement in remote islands were also a concern. Despite these challenges, informants stated that many of the FCTC provisions had influenced the Cook Islander population in a positive way. The most commonly mentioned were that the majority of public places had become smoke-free, bans on TAPS were being enforced, and the price of tobacco products had increased. Some informants reflected positively on the large, pictorial health warnings on tobacco product packages, and on the restriction on sales to minors. The ultimate outcome – a reduction in tobacco use – was partially supported: the GYTS showed that between 2003 and 2008, the proportion of those aged thirteen to fifteen who smoked fell to 35.1 per cent: a reduction of 13.6 per cent (CDC & WHO 2008). To what extent this is attributable to the Tobacco Products Control Act specifically is debatable, given that the Act passed in 2007. No reduction in prevalence can yet be determined among the adult population, although some informants anecdotally suggested that there was a general decline in tobacco use.
Overall, it is apparent that the FCTC implementation has gained significant traction in the Cook Islands since ratification, and substantial progress has been made, albeit with some significant challenges.

4.2.8 Recommendations

Of the four countries examined in the study, the Cook Islands was the most advanced in the implementation of the FCTC, although some barriers to its comprehensive implementation are evident and need addressing.

It was obvious that financial and staff capacity were substantial impediments. Attaining a sustainable funding mechanism would go a long way towards comprehensive FCTC implementation. If additional capacity cannot be sourced, emphasis should be placed upon implementing the most cost-effective and relevant provisions: smoke-free environments and taxation (packaging and labelling, and bans on TAPS are already of a high standard). The monitoring of compliance with smoke-free environments is important, particularly in restaurants and bars. There were some concerns expressed about the mandated authority for health inspectors to prosecute staff; this should be rectified where possible, and the MOH is already acting in this area; as they will be important in maintaining ground level capacity and commitment.

Institutional networks between the MOH and non-health departments did not appear to be strong. It may be important to establish and maintain such networks at both ground and senior levels, for instance to include the Crown Law Office, police officers, the customs department, the MFEM, and the Ministry of Education. This could foster greater whole-of-government commitment to FCTC implementation. As a significant disparity between Rarotonga and other islands is apparent, there is also a need to strengthen enforcement networks to the remote islands where this is feasible. Using networking to garner commitment to tobacco control activities from leaders in remote islands may be an efficient way to do this.

There is a need to stimulate commitment to the tobacco control legislation, particularly among health inspectors on the ground. This may be achieved through
training and the provision of additional resources; some action in this area has already been undertaken by the MOH.

It is recommended that more NGO and CSO activity in tobacco control be maintained. This could be achieved through a reinvigorated TCWG. A strengthened collaboration here would assist in raising community awareness, disseminating information and increasing enforcement. This may serve to reduce some of the capacity burden the MOH experiences in these areas. There may be a need for further recruitment into this group as existing staff have competing demands for their time. Since there is no strong pro-tobacco lobby in the country and minimising NCD-related harm resonates strongly amongst the population, active anti-tobacco advocacy may be able to make significant advances in driving FCTC implementation even further.

If FCTC implementation were to progress further in the Cook Islands, the country would not only further prevent loss of life from tobacco-related diseases amongst its own population, but would serve as a prominent example of successful FCTC implementation both for the Pacific region and for SIDS elsewhere.

4.3 Vanuatu

4.3.1 Brief country background

The Republic of Vanuatu is a Melanesian nation consisting of 83 islands located between the Solomon Islands and Fiji. With a population of around 240,000 and a land area of 12,281 square kilometres, Vanuatu is significantly larger than the other countries in this study. Approximately 50,000 people live in Vanuatu’s capital, Port Vila; 74 per cent of the country’s inhabitants live in rural areas (WHO 2012e).

From 1906, Vanuatu was co-administered by France and the United Kingdom. World War II saw military bases set up in the country, and the presence of wealthy American troops stimulated the rise of nationalism in the country, and the people (known collectively as Ni-Vanuatu) challenged the system of government of the time (Michigan State University 2012); Vanuatu became independent from France.
and the United Kingdom in 1980. Vanuatu has a unicameral parliament with 52 members who are elected by popular vote. The President in Vanuatu has primarily ceremonial powers, while the Prime Minister, who is head of government and elected by a majority vote, appoints the Council of Ministers (Parliament of the Republic of Vanuatu 2013). While there is no formal local government in Vanuatu, chiefs play an important role at the local level and the national Council of Chiefs (Malvatumauri) is elected and has an advisory role to the national government (Parliament of the Republic of Vanuatu 2013).

Vanuatu’s primary sources of income are from agriculture, tourism and offshore financial services (Australian Government Department of Foreign Affairs and Trade 2012a). Major trading partners include Thailand, Japan, Australia and Singapore (Australian Government Department of Foreign Affairs and Trade 2012a), although its diplomatic ties are aligned with Australia, France and the United Kingdom. The country has three official languages: Bislama (a creole language of mostly English origin), French and English.

The government of Vanuatu spent 17.2 per cent of its total expenditure on health in 2010 (WHO 2013d), which is the highest of the countries examined. Spending on health accounted for 5.2 per cent of GDP and 90.2 per cent of this expenditure came from government sources (WHO 2013d). External assistance accounted for 24.7 per cent of total expenditure on health in 2010 (WHO 2013d). Per capita expenditure on the health care system is significantly below the regional average: there are only 1.2 physicians and 17.0 nurses and midwives per 10,000 people (WHO 2012a). The WHO Health Profile for Vanuatu shows that life expectancy is 69 years for men and 72 years for women, which is below the regional average (WHO 2012a). In 2008, NCDs accounted for 56 per cent of years of life lost (WHO 2012a), high blood pressure and obesity rates were somewhat higher than the regional average, high glucose and high blood pressure rates were around the average, and overall tobacco use was slightly below average (although male tobacco usage is high in Vanuatu and in the region) (WHO 2012a).
4.3.2 Tobacco use

The majority of tobacco is consumed in cigarettes in Vanuatu. Informants indicated that consumers often use imported cigarettes from Philip Morris and British American Tobacco, a significant proportion of which come via Australia. Cigarette brands that the primary researcher saw for sale in the country included Winfield, Dunhill (both produced by British American Tobacco), Benson and Hedges (produced by Philip Morris International) and Peter Jackson (produced by Imperial Tobacco). In addition to manufactured imports, locally-grown cigarettes are produced on a small scale by farmers for local consumption. One informant noted that tobacco grows naturally in the wild in some parts of the country. Documents indicate a small proportion of tobacco users chew tobacco with betel nut, particularly in Vanuatu’s northern province and amongst expatriates from the Solomon Islands and Papua New Guinea (Rory 2010; Wanem 2012). Tobacco chewing is a minor form of consumption and prevalence rates are largely unknown.

Kava is popular in Vanuatu, and cigarettes are often smoked in nakamals or kava bars, which are predominantly patronised by men.

Tobacco use is high amongst men in Vanuatu, although overall prevalence is less than in Nauru or Palau. A 2011 STEPS survey in the country defined 52.5 per cent of males and 20.2 per cent of females aged 25 to 64 as current smokers, and 33.5 per cent of males and 7.8 per cent of females as daily smokers (WHO 2011d). The National Population Housing Census indicated that in 2009 the prevalence of cigarette consumption was 44.9 per cent in males aged fifteen and over, and just 4.4 per cent in females (Vanuatu National Statistics Office 2010). Vanuatu also participated in the GYTS, which indicated that in 2007, 28.2 per cent of male and 11.4 per cent of females aged between thirteen and fifteen were current cigarette smokers (Garae & Syha 2008).

4.3.3 FCTC ratification and subsequent tobacco control legislation

Vanuatu ratified the FCTC in September 2005 (Framework Convention Alliance 2013). The Vanuatu Tobacco Control Act was passed by parliament in 2008, but there have been significant delays in developing regulations based on it: at the time
of data analysis these were still pending. The provisions of the Tobacco Control Act are similar to those of the Cook Islands and compliant with all key articles of the FCTC. Bans on TAPS are included. Health warnings must cover a minimum of 30 per cent of the package (the minimum requirement under the FCTC) and be written in Bislama, English and French. Smoking is prohibited in all workplaces that are fully or partly enclosed, with a twelve-month grace period for restaurants and licensed premises, and smoking is prohibited in public transport vehicles. Other provisions in the Act include restrictions on selling tobacco products in small quantities, prohibition of sales to those under eighteen, controls on the contents of tobacco products, and requirements on the disclosure of additives to tobacco.

4.3.4 Tobacco control policy-making and institutional structure

In order to have an act passed, the designated ministry must put a proposal to the Council of Ministers; once this is approved, the proposal is forwarded to the State Law Office where a draft bill is developed. This is sent back to the Council of Ministers for approval and it then goes to parliament for discussion. The Tobacco Control Act went through this process with little difficulty. Its regulations were drafted by the State Law Office but have not been completed. The Minister of Health has the power to execute certain directives, and this was power was exercised to direct the prohibition of sales of small quantities of cigarettes. Enforcement of most provisions of the Act lies with the Health Promotion and Environmental Health Units of the MOH. This includes banning TAPS, sales to minors and sales of cigarettes in small quantities, packaging and labelling, health warnings, additive disclosures and enforcing smoke-free environments. Customs oversees the tobacco products that come into the country and enforces import taxation. The Director-General of Health (similar to a Secretary of Health) has the power to carry out the functions of the Act and appoint authorised officers to enforce it. There is no specific allocation of funding for tobacco control or FCTC implementation, and the MOH must use its standard budget for this area. A proposal for additional funding can be submitted by the MOH for extra-budgetary needs, but grants depend on the financial situation of the government. The Ministry of Finance and Economic Management (MFEM) oversees tobacco taxation. The
Council of Chiefs was cited as an important stakeholder in regard to tobacco control provisions relating to small rural shops.

4.3.5 Current stage in FCTC implementation and enforcement

Vanuatu had two environmental health officers appointed to enforce the Tobacco Control Act and three other public health-related acts at the time of the interviews. Provincial health officers, approximately one in each of the six provinces, also had some tobacco control responsibilities. Enforcement of the tobacco control legislation was still in its infancy, partially due to regulations based on the Act not yet coming into fruition. No TAPS was observed by the primary researcher over a ten-day period in Port Vila, and informants provided no indication that it occurred. Text-only health warnings covered approximately 30 per cent of the packages of manufactured cigarettes, as viewed by the primary researcher in Port Vila. One instance of cigarette smoking in a restaurant that was partially outdoors in the vicinity of a no-smoking sign was observed. However, opportunistic observation over a short period of time in the country’s capital is a weak representation of the whole country, especially considering Vanuatu has a large rural population. The 2012 FCTC implementation report confirmed that people smoke in indoor public places occasionally, and some establishments are yet to comply with the Act (Rory 2012). This report states that imported manufactured cigarettes are subject to an import tax of 10 per cent and a value-added tax of 2.5 per cent (Rory 2012). Despite the Tobacco Control Act prohibiting the sale of single cigarettes, informants explained that a number of kava bars persist in selling them. This posed significant challenges to enforcement, especially considering the substantially rural population. The MOH released a notice reiterating the prohibition on the selling of single cigarettes not long before the time of the interviews (Selmen 2011).

4.3.6 Variables that affect FCTC implementation

The comprehensive findings on the variables that affect implementation in Vanuatu according to informant interviews and document analysis are listed in Table 8 below.

Table 8: Facilitators and barriers to FCTC implementation in Vanuatu
<table>
<thead>
<tr>
<th>Variable that affects implementation</th>
<th>Facilitators</th>
<th>Barriers</th>
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<tbody>
<tr>
<td><strong>Content</strong></td>
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<tr>
<td><strong>Goals</strong></td>
<td>• The goal of minimising the harm associated with tobacco use was seen as important by vast majority of informants. This was substantiated by GYTS and sub-national STEPS surveys.</td>
<td>• Some lack of attention towards tobacco control in comparison to HIV/AIDS and malaria was evident, as tobacco control tended to be amalgamated with other NCDs and received limited funding (claimed by one informant).</td>
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<tr>
<td><strong>Causal theory</strong></td>
<td>• The causal theory that a significant amount of NCDs are caused by tobacco use is empirically unequivocal and informants generally agreed.</td>
<td>• Unhealthy diet and physical inactivity may be more significant contributors to NCDs in Vanuatu (claimed by one informant). This could be more easily justified in its female population.</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td>• FCTC-based provisions were relevant and effective in order to achieve its goals (claimed by a substantial proportion of informants). • The Tobacco Control Act passed through parliament with little difficulty.</td>
<td>• Locally-grown tobacco is not comprehensively addressed in the legislation, and provisions such as health warnings, taxation and regulating ingredients may be subverted in this form of tobacco. The difficulty in controlling locally grown tobacco was exacerbated by a lack of governmental resources. • Nicotine replacement therapy as a cessation aid was considered too costly for the government to implement (claimed by one informant).</td>
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<tr>
<td><strong>Context</strong></td>
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<tr>
<td><strong>Policy-making/institutional structure</strong></td>
<td>• The MOH oversees most FCTC provisions and has enforcement powers.</td>
<td>• The development of regulations, which have been pending since 2008, is dependent on the State Law Office.</td>
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<tr>
<td><strong>Institutional adaptation to policy</strong></td>
<td>• The activity of a multi-sectoral working group on tobacco control had waned since the Act passed. • Some momentum towards tobacco control adaptation was produced with two enforcement officers being gazetted. • Training sessions on tobacco control provisions had been conducted within the MOH. • Tobacco control provisions were integrated with the NCD strategic plan fairly comprehensively (Vanuatu Ministry of Health 2010).</td>
<td>• The MOH’s procedures were yet to change significantly, and this change was hindered by delay in passing tobacco control regulations and limited funding. • The FCTC had therefore not been adopted in full, and a piecemeal approach had been undertaken thus far (claimed by two informants).</td>
</tr>
<tr>
<td><strong>Institutional networks and relationships</strong></td>
<td>• Collaboration between relevant departments and staff within the MOH were clearly evident. • Collaboration between the MOH and the customs department was apparent. • Some collaboration between MOH and Ministry of Youth and Sport and Ministry of Education was evident (claimed by one informant) • Supportive networks with international and regional bodies through Allen and Clarke (with support from NZAID), and the WHO and SPC who had in-country</td>
<td>• Networks between the MOH and most other government departments were not strong. There was little indication of a collaborative relationship with police officers, limited response from State Law Office on regulations (claimed by one informant), and little evidence of engagement on tobacco issues between the MOH and Department of Agriculture (claimed by one informant). • Networks between the MOH and NGO actors were virtually non-existent in tobacco control. • A steering committee in tobacco control, active during the passing of the Act, had since dissolved (although some relationships in</td>
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liaison officers in Vanuatu. Tobacco control remain in a less structured form).

## Commitment

<table>
<thead>
<tr>
<th>Commitment broadly</th>
<th>The overall enforcement of FCTC was yet to be felt, particularly due to a lack of regulations as claimed by informants and in the local media by a representative of the WHO (Toa 2011).</th>
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<tr>
<td></td>
<td>Smoke-free legislation in indoor workplaces and public places was only partially enforced.</td>
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<tr>
<th>Ground level commitment</th>
<th>Despite strict enforcement not being in place, implementers at the ground level conducted activities in raising awareness, adhering to taxation and labelling and reporting on enforcement (Vanuatu Ministry of Health 2011).</th>
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<td></td>
<td>Some areas of Vanuatu are very difficult for health inspectors to access. Support and access to island communities was cited in a 2010 regional workshop as a strong challenge to enforcement (Rory 2010).</td>
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<td>Due to many people knowing each other in Vanuatu, it can be difficult for those on the ground to enforce the law upon those they may know (claimed by one informant).</td>
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<thead>
<tr>
<th>MOH/ health promotion department commitment</th>
<th>The MOH hired two additional staff to enforce a number of acts including Tobacco Control Act.</th>
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<td></td>
<td>The MOH carried out a directive prohibiting the sale of single cigarettes (Selmen 2011).</td>
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<td>A lack of prioritisation of tobacco control amongst competing issues and shortfalls in funding were significant barriers to commitment (cited by three informants and Rory (2010).</td>
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<td></td>
<td>Room for more leadership and support from senior staff was evident (claimed by one informant). Senior staff found it difficult to attend meetings due to competing responsibilities; they may only be present if urgent tobacco-related concerns were on the agenda (claimed by one informant).</td>
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<thead>
<tr>
<th>Whole-of-government commitment</th>
<th>The passage of the Tobacco Control Act served as an intention of commitment.</th>
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<tr>
<td></td>
<td>The customs department had embraced tobacco taxation as a positive for health.</td>
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<td></td>
<td>The Ministry of Education and the sports association supported the community awareness of tobacco control. The Ministry of Education was an important stakeholder in conducting the GYTS (Garae &amp; Syha 2008).</td>
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<td></td>
<td>Commitment was challenged in government departments outside of health, particularly through the following points:</td>
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<tr>
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<td>Regulations remained pending in the State Law Office.</td>
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<td></td>
<td>The Ministry of Finance was reluctant to earmark tobacco tax revenue to tobacco control (Rory 2012).</td>
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<td></td>
<td>A proposal for tobacco manufacturing garnered some support from government decision-makers outside of health (including the Vanuatu Investment Board).</td>
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<tr>
<th>External sources of commitment</th>
<th>The WHO and SPC (partially funded by AusAID and NZAID) acted as sources of support for implementation. This was evident in the form of planning, liaising, the provision of technical assistance and assisting with policy development.</th>
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<td>There was a need for more assistance, primarily in the form of capacity development and harnessing local expertise or in-country advisors trained in tobacco control (rather than being dependent on foreign experts flying in and out) (cited by two informants).</td>
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## Capacity

<table>
<thead>
<tr>
<th>Number and skill levels of staff</th>
<th>Two environmental health officers were recently appointed.</th>
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<tr>
<td></td>
<td>Workshops and WHO technical assistance in enforcement facilitated some skill development for those in</td>
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<td></td>
<td>A lack of staff and competing responsibilities, especially for those on the ground, were seen as major hindrances to FCTC implementation by informants (i.e. the tobacco control focal point consisted of one staff member who had</td>
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</table>
tobacco control. competing responsibilities).
- Some need for training in tobacco control activities and legislation was evident (claimed by two informants).

<table>
<thead>
<tr>
<th>Knowledge of tobacco issues, surveillance and monitoring</th>
<th>Vanuatu’s participation in both STEPS and GYTS surveys indicated some surveillance of tobacco use was being undertaken.</th>
<th>There was a need for more comprehensive monitoring and evaluation of tobacco use and compliance to legislation (claimed by one informant).</th>
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<tr>
<th>Mandated authority</th>
<th>Environmental health officers in the MOH were gazetted with powers to inspect premises and enforce provisions of the Tobacco Control Act.</th>
<th>The lack of regulations supporting the Tobacco Control Act was mentioned as a significant challenge by the majority of informants. This was also cited in the 2012 FCTC implementation report (Rory 2012).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physical facilities and technology</th>
<th>The MOH was intending to purchase a new vehicle to facilitate the environmental health officers’ ability to main a presence on the main island (claimed by one informant).</th>
<th>The lack of funding and resources was amongst the most significant impediments to implementing the Tobacco Control Act (claimed by the majority of informants, Rory (2010) and in the 2012 FCTC implementation report (Rory 2012)).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resourcing and capacity politics</th>
<th>The government and several external agencies allocated some resources for various tobacco control activities: NZAID and the WHO assisted in technical assistance and training workshops, AusAID and NZAID supported the SPC’s regional NCD program, and the WHO provided support through an in-country liaison officer, collecting data, and its World No Tobacco Day activities.</th>
<th>The geography of Vanuatu strains the capacity to implement and enforce legislation because of transportation costs.</th>
</tr>
</thead>
</table>

**Clients and Coalitions**

<table>
<thead>
<tr>
<th>Anti-tobacco coalition activity</th>
<th>Some peripheral support for tobacco control was provided by the Seventh Day Adventist Church.</th>
<th>No NGO, CSO or coalition group with a strong and direct interest in tobacco control or FCTC implementation existed, hence there was very little influence from NGO or civil society actors.</th>
</tr>
</thead>
</table>

- There was some desire for the MOH to engage with the Vanuatu Association of NGOs (VANGO) and other NGO/civil society actors, particularly once regulations were established.
- Occasional advice on tobacco control

- The VANGO serves as a network for a range of NGO activities, but did not conduct tobacco-related activities and had little interaction in relation to tobacco control with the MOH.
policy was provided by the FCA.

<table>
<thead>
<tr>
<th>Anti-tobacco community awareness</th>
<th>There was evidence of the MOH conducting awareness of the Tobacco Control Act toward businesses and at the national level (Selmen 2011; Toa 2011; Vanuatu Ministry of Health 2011).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government actors sought to increase general tobacco awareness through media advertising, World No Tobacco Day, promoting smoke-free sports and other activities.</td>
</tr>
<tr>
<td></td>
<td>There was a need for more community awareness and advocacy amongst the general population on tobacco-related issues (claimed by three informants).</td>
</tr>
<tr>
<td></td>
<td>Only very few small-scale peripheral community awareness activities had been undertaken by NGO actors, where this was included as a part of broader health awareness.</td>
</tr>
<tr>
<td></td>
<td>Rurality and remoteness restricted community awareness in many parts of the country, particularly as certain areas were hard to reach, did not have television reception, and some populations had low levels of literacy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco industry and pro-tobacco coalition activity</th>
<th>The local tobacco industry is small-scale and most tobacco products are imported.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There was little evidence of any NGO or civil society group actively lobbying against or seeking to influence tobacco control. There was no organised group of farmers directly seeking to influence tobacco control policy and no distinct presence from bar or restaurant owners in response to legislation on smoke-free environments.</td>
</tr>
<tr>
<td></td>
<td>A Singaporean tobacco company, Rock International, is interested in establishing operations in Vanuatu (Marango 2012), although the government rejected this company’s offer, citing health concerns (Australia Network News 2012).</td>
</tr>
<tr>
<td></td>
<td>Tobacco industry representatives, including those from British American Tobacco and Philip Morris, have attempted to visit the MOH and other government departments. This was cited as a threat in a 2010 presentation and the 2012 FCTC implementation report (Rory 2010; Rory 2012).</td>
</tr>
<tr>
<td></td>
<td>During the Tobacco Control Act’s development, some opposition was expressed through individual businesses and representatives of tobacco importers (claimed by the majority of informants).</td>
</tr>
<tr>
<td></td>
<td>Philip Morris submitted comments on the Tobacco Control Act, providing detail on some technicalities and advocating reducing or extending the time frame for some provisions; however, the comments did not vehemently oppose the principles of the Act (Philip Morris Limited 2009).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client support for policy</th>
<th>Overall, and especially in terms of non-smokers, informants indicated that the population was supportive of the measures in the Tobacco Control Act (claimed by three informants).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Some smokers were not supportive of the legislation (although there was no public protest against it) (claimed by several informants).</td>
</tr>
<tr>
<td></td>
<td>Public support may not be as strong for a minority of provisions in certain segments of the population; there was some resistance to the prohibition of single cigarette sales by shop owners and smokers, and the 2007 GYTS showed that only 36 per cent of those aged thirteen to fifteen thought smoking should be banned in public places (Garae &amp; Syha 2008).</td>
</tr>
</tbody>
</table>

4.3.7 Summary of the variables that affect FCTC implementation

The facilitators evident in the goals, causal theory and methods suggest that overall the content variable cluster is conducive to FCTC implementation. This is
notwithstanding some barriers relating to this variable cluster, the most prominent of which is the presence of locally-grown tobacco. The remaining four variable clusters were not as well supported in Vanuatu.

People know some parts of [the Tobacco Control Act], but the full implementation of it – not yet, because most of the things in the Act rely on the regulations to [be] fully [implemented]. So the regulations are the thing that is always the stumbling block for implementation of this full Act. (Ni-Vanuatu informant). (Martin & de Leeuw 2013; p. 3)

The lack of regulations had a negative influence on several variable clusters, including in the institutional context where relevant departments are yet to fully institutionalise the provisions of the Tobacco Control Act. Other significant barriers in the institutional context included: fairly poor networks between actors in the MOH and most departments outside of health (excluding the customs department), no networks between the MOH and NGO actors, and the inactivity of a tobacco control steering committee:

In the very beginning we had come up with a sort of a tobacco control [steering] committee, and then with certain circumstances that we’ve had here... these people moved to other places and [there were] some difficulties and the committee was dismissed or out of service. But just recently, this year, in regards to the framework of the NCD strategic planning, we are looking at proposing new nominations to ensure that the tobacco control steering committee is there and working to support the Ministry [of Health] for the WHO FCTC... although the steering committee is not in [at the moment], we still have some good relationships with some actors that [are] facilitating some areas to support in going forward with the FCTC. (Ni-Vanuatu informant)

The lack of regulations impacted on the perceived commitment as a whole and the ability for the MOH to carry out enforcement activities under the Tobacco Control Act. Furthermore, competing priorities were seen as a major barrier to commitment
at the MOH level. At the whole-of-government level, commitment was challenged in most departments outside of health. However, there was some intention that commitment would be expanded in the future, particularly once regulations are finalised:

I think the political will is there, but the commitment – [it’s] sort of reflected by the political will, is [shown by] the passage of the law in parliament to start off with, and the other things will come later on – the regulations. I think in principle, politicians recognise the fact that tobacco is not good for people to use, and everything about it that we know. However... at this point in time and the commitment is... mostly verbal, rather than in terms of providing resources. (Ni-Vanuatu informant)

A key barrier primarily affecting the capacity variable cluster was the limited funding and staff on the ground, as indicated in the following quotation:

All of the different aspects of the FCTC are good – I mean nobody denies that because many of them are actually evidence-based, you know what I mean? But the problem is the applicability of all these different aspects at country level, or in each country setting. You know it’s okay for big countries like Australia because you have the resources, the expertise and et cetera to actually address tobacco use comprehensively, but when it comes to small countries, the issue of resources, the issue of capacity and the issues of priority become a real concern. (Ni-Vanuatu informant)

In the clients and coalitions variable cluster, the non-existence of anti-tobacco NGOs or civil society actors was the most significant barrier. There was limited public pro-tobacco coalition activity evident. Currently, tobacco manufacturing is limited to small-scale farming operations, but this could change in future if manufacturing operations of Rock International commence. In relation to clients, informants indicated that they are supportive overall, although further community awareness would assist in garnering public support, as shown in the following quotation:
I think that the public is welcoming [of the Tobacco Control Act]. They do welcome that, but there needs to be a lot of awareness and advocacy through all sorts of means, like mass-media, community interventions and even through their constituencies. (Ni-Vanuatu informant)

The vast majority of informants indicated that the implementation of the FCTC in Vanuatu was in its early stage, or yet to be fully implemented. In several areas, such as the sale of individual cigarettes (outside of retail outlets), tobacco use cessation and the presence of locally-grown cigarettes, little impact on clients was apparent. Nevertheless, improvements have been made in relation to several provisions since the passage of the Tobacco Control Act, including those concerning packaging and labelling, taxation, bans on single cigarette sales in retail outlets, and bans on TAPS. One informant claimed that although there was no strict enforcement at the time of the interviews, people were generally complying with provision regarding smoke-free environments. In terms of the prevalence of tobacco use, as the major studies conducted in Vanuatu thus far have not been repeated and are typically dated before the Tobacco Control Act came to pass, it is difficult to confirm definitively whether the legislation has made any influence on tobacco usage rates. However, the 2011 NCD STEPS survey shows the highest prevalence rate, indicating that it is unlikely that tobacco use has fallen. It may be that the FCTC thus far has not had a substantial impact in terms of minimising the burden associated with tobacco use.

4.3.8 Recommendations

Vanuatu has made some significant efforts towards FCTC implementation, but several provisions are yet to come into fruition. There are a number of significant challenges that need to be addressed in order to move FCTC implementation forward, and it is likely that the MOH has put some of these recommendations into action already.

The lack of regulations was a significant barrier across many aspects of FCTC implementation. It is therefore crucial that the MOH and State Law Office work diligently to finalise them.
Financial and staff capacity were also substantial impediments. A sustainable funding mechanism would enhance this significantly. There is also a need to resource more staff, as the existing staff on the ground have competing demands for their time; the MOH was already working towards appointing more staff at the time of the interviews. Allocating additional resources from an already stretched budget is difficult to achieve politically, and if additional capacity cannot be sourced, emphasis should be placed on packaging and labelling, taxation, monitoring and surveillance of tobacco-related harm, enforcing smoke-free environments, and compliance to legislation; bans on TAPS were already implemented. It may be cost-effective to increase the size of health warnings to beyond 30 per cent of cigarette packages, and include pictorial warnings. Pictures would provide graphic information concerning the harm associated with tobacco, which is translatable to parts of the population who may be illiterate (or unable to comprehend one or more of the three official languages that an accompanying health warning may be written in).

Recent surveys have monitored tobacco use well across the country; however, given that the four surveys differ in representativeness, there is a strong need for the MOH, WHO and other relevant agencies to conduct repeat surveys to establish trends and ascertain whether recent efforts to implement the FCTC have been effective.

Locally-grown tobacco is a significant issue and it has shown to be difficult to regulate, especially in rural areas. The availability of local tobacco (that may in some cases be illicit and/or not contain packaging) also subverts many FCTC provisions. Along with the enforcement of bans on the sale of single cigarettes, efforts should be made to inform people of the dangers of locally-grown tobacco, in similar ways to those used for manufactured cigarettes. The government may need to provide support for alternatives to growing tobacco, as low-income farmers may be reluctant to forego a cash crop without a replacement. There is a need to cooperate with government departments outside health and perhaps external agencies to tackle this issue.
There was room for government departments outside the MOH to strengthen their commitment to FCTC provisions. Efforts to strengthen networks with other departments, such as the MFEM, Ministry of Education and Ministry of Justice are likely to facilitate FCTC implementation. This could be achieved by re-establishing a multi-sectoral task force or committee that engages in regular dialogue about tobacco control (which is proposed by the MOH); such a group would foster greater commitment and might also reduce the vulnerability of other departments to coercion from the tobacco industry, which is of some concern given a tobacco manufacturer’s interest in establishing operations in Vanuatu.

There is a need to strengthen enforcement networks (and communications between these networks) between Port Vila and the remote islands, where this is feasible. It may be important to convince local leaders in outlying islands of the importance and magnitude of the harms of tobacco use to their communities. Local evidence of the burden of tobacco use in these communities is an important way in which to achieve this.

A need to stimulate civil society activity was evident. Non-government and civil society actors, perhaps through collaboration with the VANGO and the FCA, could assist by increasing awareness of the harms of tobacco, monitoring compliance, and advocating strong legislation and enforcement. If there is no full-fledged NGO or CSO willing to dedicate activity towards the issue as an organisation, it may be useful to establish a multi-sectoral working group or committee similar to the Cook Islands’ TCWG, to harness the efforts individuals with interest or expertise in tobacco control and FCTC implementation.

4.4 Palau

4.4.1 Brief country background
The Republic of Palau is a Micronesian archipelago located east of the Philippines and north of eastern Indonesia. The country consists of approximately 20,000 people. Although there are more than 350 islands in Palau, the majority of the population is located in Koror, which is connected by a road bridge to the largest
and second most populated island, Babeldaob. Eighty-three per cent of the population live in urban areas (WHO 2012a).

In the late 19th and early 20th centuries, Spain, Germany and Japan each had control over Palau before it became UN Trust Territory under US administration during World War II (when military battles took place in the country). In 1994, Palau became independent, with a Compact of Free Association with the US. Palau is a representative democratic republic and has a presidential form of government and a bicameral legislature (Levine & Roberts 2009), in a model which is similar to the US. Traditional leaders through the Council of Chiefs have an advisory role to the President at the national level, particularly on matters concerning traditional laws and customs (Republic of Palau 2008). Tourism, agriculture and fishing are the major sources of revenue and Palau’s major trading partners include the US, Japan, Taiwan and Singapore (US Department of State 2012). Palauan and English are the country’s official languages.

In 2010, Palau’s government spent 16.0 per cent of its expenditure on health (WHO 2013d). Expenditure on health accounted for 11.5 per cent of GDP in 2010 (WHO 2013d), which is substantially above the WPRO average and the highest amongst the countries examined in this study. Government sources accounted for 80.4 per cent of total health expenditure, while external assistance accounted for 37.5 per cent, which is a large portion of total expenditure on health (WHO 2013d). The WHO Health Profile for Palau shows that life expectancy in 2010 was 68 years for males (below the WPRO average) and 77 years for females (the same as the WPRO average) (WHO 2012e). The profile estimates that Palau has 13.8 physicians and 57.1 nurses and midwives per 10,000 people, which is comparable to the WPRO average (WHO 2012e). In 2008, NCDs accounted for 65 per cent of years of life lost, with all risk factors with the exception of male tobacco use – high blood pressure, high blood glucose, obesity and female smoking – higher than the WPRO average (WHO 2012e).
4.4.2 Tobacco use

Tobacco use in Palau is characterised by both chewing tobacco with betel nut and cigarette smoking. The majority of cigarettes are imported from the US, although some come from Korea, the Philippines and Taiwan (Oseked Sr. 2012). The three most widely sold brands, according to Palau’s third FCTC implementation report, include White Crocodile, Cambridge (both produced by Philip Morris USA) and Doral (produced by R.J. Reynolds) (Oseked Sr. 2012). Other advertised brands observed by the primary researcher during the research visit include Red Man (a brand of chewing tobacco from the Swedish Match company) and Sonoma (produced by Imperial Tobacco). Informants indicated that black market Chinese cigarettes also existed in the country and some Palauans may grow a limited amount of tobacco for personal use.

The practice of chewing betel nut has been prevalent in certain areas of south-east Asia and Micronesia for hundreds, if not thousands, of years. Tobacco was introduced in the Pacific in the 16th century by Europeans (WHO 2012b). Betel nut chewing is carcinogenic, and tobacco (either from cigarettes or in other forms), is often chewed with it simultaneously (WHO 2012b).

The prevalence of tobacco use is very high, particularly in terms of chewing tobacco. The Palau Youth Tobacco Survey (YTS) has been conducted several times. Some tobacco usage prevalence rates from this survey are reproduced below in Table 9.

Table 9: Prevalence of tobacco use amongst Palauan high school students (grades 9-12)

<table>
<thead>
<tr>
<th>Year</th>
<th>Current use of chewing betel nut with tobacco (%)</th>
<th>Current use of cigarette smoking (%)</th>
<th>Current use of chewing smokeless tobacco (%)</th>
<th>Overall tobacco use prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>67.9</td>
<td>23.2</td>
<td>8.3</td>
<td>71.0</td>
</tr>
<tr>
<td>2005</td>
<td>61.1</td>
<td>27.6</td>
<td>16.5</td>
<td>69.3</td>
</tr>
<tr>
<td>2009</td>
<td>54.1</td>
<td>41.4</td>
<td>28.5</td>
<td>52.9</td>
</tr>
</tbody>
</table>

1 Adapted from the Palau Youth Tobacco Survey 2001
2 Adapted from the Palau Youth Tobacco Survey 2005
3 Adapted from the Palau Youth Tobacco Survey 2009
The most recent YTS revealed that in 2009, 52.9 per cent of high school students use tobacco in some form. This data suggests that the use of chewing tobacco with betel nut and overall prevalence has gone down in this population between 2001 and 2009; however, this has been compromised by an increase in the prevalence of cigarette smoking and chewing smokeless tobacco without betel nut. The most recent and comprehensive study of tobacco use amongst adults is the 2003 Palau Community Assessment Report. This shows the prevalence of tobacco use at a very high 83 per cent amongst those aged fifteen and over (Oseked Sr. 2012). The WHO Health Profile estimates 2009 overall tobacco prevalence at 39 per cent in males and 9 per cent in females aged fifteen and over, but it is possible that this represents cigarette smoking only (WHO lists it as “tobacco use”) or is factually incorrect, as there is a large discrepancy between this and the aforementioned studies.

4.4.3 FCTC ratification and subsequent tobacco control legislation

Palau ratified the FCTC in February 2004 (Framework Convention Alliance 2013). Despite this, the country passed its FCTC-based legislation, Republic of Palau Law 8-27 (referred to as RPPL 8-27 or its Act) through congress only recently. RPPL 8-27 was signed by the President in August 2011, very soon after the country visit by the primary researcher. The Act is only somewhat compliant with the key articles of the FCTC, as some of its provisions were omitted from the initial bill sent to congress. It does not mandate any specific health warnings on tobacco packages. RPPL 8-27 prohibits smoking in enclosed public places, but this excludes outdoor areas of restaurants and bars and permits designated smoking areas within such places provided they are physically separated from non-smoking areas. Prohibitions on TAPS are compliant with the FCTC. However, it has been claimed that RPPL 8-27 may allow for tobacco companies to engage in “corporate social responsibility” by conducting activities described as socially responsible to distance its image from the harmful nature of the product produces (Coalition for a Tobacco-Free Palau 2011). Other provisions in the Act cover licensing and regulations for selling tobacco, prohibitions on sales from vending machines and selling tobacco in packages containing fewer than 20 cigarettes.
4.4.4 Tobacco control policy-making and institutional structure

The executive branch of the Palauan government consists of the President, the Vice-President and the Council of Chiefs, assisted by cabinet ministers and supporting staff (Republic of Palau 2008). The legislative branch consists of two houses, the House of Delegates and the Senate, in the Olbiil Era Kelulau (the Palau National Congress) (Republic of Palau 2008). The MOH is the key department in regard to FCTC-based policies and the central coordinator for tobacco control, although its enforcement powers were more limited than those of the other countries in this study. RPPL 8-27 specifies that its enforcement is primarily the responsibility of the Bureau of Public Safety and the Ministry of Justice. The Ministry of State oversees international treaties and is to a certain extent involved in FCTC proceedings at the international level. The Ministry of Finance oversees the taxation on cigarettes in Palau, and police authorities have the power to enforce bans on sales to minors. Palau’s MOH consists of its Administration, the Bureau of Clinical and Hospital Services, and the Bureau of Public Health. Tobacco control activities are the primary focus of the Tobacco Use Prevention and Control Program which operates under the Bureau of Public Health. It should be noted that the Council of Chiefs, as well as having some influence in congress, hold significant political influence in local communities in Palau.

4.4.5 Current stage in FCTC implementation and enforcement

As FCTC-based legislation had not passed through congress at the time of the interviews, enforcement was limited to the few tobacco control policies already in place. These included bans on sales to minors, taxation, a smoke-free policy in all government buildings and a chew-free policy in all MOH buildings. Approximately half of the country’s restaurants and bars voluntarily banned smoking indoors, according to informants. At the time of the interviews, advertising in the form of posters of tobacco products displayed outside retail outlets was prominent, although informants have since indicated that this is no longer the case since the passage of recent legislation. In a ten-day stay in the largest and main town of Koror, the primary researcher did not observe, and informants did not provide indication of any other forms of advertising. There were no restrictions on
packaging or labelling observed by the primary researcher. Some tobacco products were imported with only a US Surgeon-General’s warning in very fine print on the side of the packet, while others had health warnings covering 30 per cent of the packet. It was observed that menthol flavoured and “mild” cigarettes were sold. The 2012 FCTC implementation report indicated that there was an import tax of two US dollars per packet of cigarettes, and a 150 per cent ad valorem tax on loose tobacco, which had not changed since the last report in 2010 (Oseked Sr. 2012).

4.4.6 Variables that affect FCTC implementation

The comprehensive findings on the variables that affect implementation in Palau according to informant interviews and document analysis are listed in Table 10 below.

Table 10: Facilitators and barriers to FCTC implementation in Palau

<table>
<thead>
<tr>
<th>Variable that affects implementation</th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>• The goal of minimising the harm associated with tobacco use was unanimously supported by informants. This has been substantiated by the high tobacco usage prevalence and Palau declaring NCDs a state of health emergency in 2011 (Palau Ministry of Health 2011; Toribiong 2011b).</td>
<td></td>
</tr>
<tr>
<td>Causal theory</td>
<td>• The causal theory that a significant amount of NCDs are caused by tobacco use is empirically unequivocal and this was supported by informants and documentation. • Oral cancer is also a major concern in Palau as a substantial proportion of its population chew tobacco.</td>
<td></td>
</tr>
<tr>
<td>Methods</td>
<td>• Overall, informants considered most FCTC provisions as relevant and effective for the country. • There was a particular need for bans on TAPS in the country (claimed by one informant).</td>
<td>• Despite Palau being a party to the FCTC, the governing administration at the time of interviews tended to portray the FCTC as guidelines rather than strict obligations, and stressed that Palau’s circumstances must be given precedence and that the FCTC should not be adopted “wholesale” (Toribiong 2011a). • Implementing the FCTC as a whole may be challenging for the country, and an incremental approach to implementation could be more suitable (claimed by one informant).</td>
</tr>
</tbody>
</table>
### Context

<table>
<thead>
<tr>
<th>Policy-making/institutional structure</th>
<th>The MOH is a central coordinator for general tobacco control.</th>
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<tbody>
<tr>
<td></td>
<td>The enforcement of provisions in RPPL 8-27 largely come under the responsibility of government departments outside the MOH. However, one informant claimed that there may be several grammatical errors in the designated authorities specified in RPPL 8-27 (and the MOH may have more of a responsibility here than specified).</td>
</tr>
<tr>
<td></td>
<td>Palau’s political situation was a key barrier to developing comprehensive FCTC-compliant legislation (claimed by the majority of informants). A previous administration (in office upon the ratification of the FCTC) was supportive of comprehensive tobacco control legislation, but the administration at the time of the interviews held a more tepid view.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Institutional adaptation to policy</th>
<th>Some adaptation was evident in minor developments, which came in the form of improvements in staff knowledge, training, reporting requirements, and participation in WHO and COP meetings.</th>
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<tr>
<td></td>
<td>The FCTC created some momentum for the MOH’s smoke- and chew-free policy (claimed by one informant).</td>
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<td></td>
<td>FCTC provisions had not materialised in the form of governing institutions adapting to its provisions at the time of interviews, largely due to the lack of legislation. However, the recent and future implementation of RPPL 8-27 is likely to create momentum towards addressing this barrier.</td>
</tr>
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</table>

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<thead>
<tr>
<th>Institutional networks and relationships</th>
<th>MOH representatives often engaged with the Coalition for a Tobacco-Free Palau (CTFP) for meetings, workshops and community events (Asian Pacific Partners for Empowerment Advocacy and Leadership 2009; Tobacco Use Prevention and Control Program 2010).</th>
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<tr>
<td></td>
<td>The Ministry of Education collaborated with the MOH in the GYTS (Tobacco Use Prevention and Control Program 2009).</td>
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<tr>
<td></td>
<td>Meetings took place between representatives in congress and the tobacco control focal point, particularly in relation to the proceedings of recent legislation.</td>
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<tr>
<td></td>
<td>Networks between the MOH and regional/international government-oriented agencies were evident, primarily in relation to the WHO, CDC, and to a lesser extent, the SPC.</td>
</tr>
<tr>
<td></td>
<td>No regular meetings or any kind of unitary working group or task force between spanning government departments outside of health was apparent. Information relating to the FCTC is often not channelled between the MOH and Ministry of State (claimed by one informant). Despite the need for an interdepartmental committee or task force, there were few resources available to facilitate it (claimed by one informant).</td>
</tr>
<tr>
<td></td>
<td>The relationship between the CTFP and the government had been strained in recent times (Coalition for a Tobacco-Free Palau 2011; Otto 2011).</td>
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### Commitment

| Overall/ground level commitment | The enforcement of bans on sales to minors\(^\text{10}\) was said to be effective by some informants. This is supported by a low violation rate by tobacco retailers (Substance Abuse and Mental Health |

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\(^{10}\) Aside from this FCTC-based provision, there were few other provisions enforceable at the time of interviews.
The MOH displayed some commitment through its representatives attending FCTC-based meetings, it declaring all MOH offices as smoke- and chew-free, and it participating in a FCTC needs assessment (claimed by several informants).

There was a perceived lack of prioritisation, leadership, willingness to comprehensively support the FCTC and understanding of some FCTC provisions amongst government actors\(^\text{11}\) (claimed by several informants).

The original and more comprehensive tobacco control bill, drafted before the FCTC came into force in 2005, showed initiative and commitment at the legislative level even though it did not pass through congress (claimed by one informant).

The eventual passage of legislation in Palau is a signifier of some commitment.

Whole-of-government commitment was significantly hindered due to the following challenges listed in the points below:

- A minority of informants simply noted “politics” (i.e. power struggles and conflict between different politicians and administrations) as a key barrier to the bill’s passage and the final outcome of the legislation.
- The governing administration was reluctant to earmark funds from tobacco taxes or manufacturing licenses for specific health-related purposes, as it was possibly unconstitutional and probably difficult to administer (Coalition for a Tobacco-Free Palau 2011; Toribiong 2011a).
- The bill that passed both houses of congress in 2011 was not signed by the President until amendments were made that weakened some provisions, which reflected poorly on the country’s leadership in tobacco control, particularly from the Office of the President (claimed by a minority of informants).
- Dissonance between the promises and the ultimate actions of politicians in regard to the tobacco control bill was evident (claimed by several informants).
- The tourist trade was provided as a rationale for not legislating restaurants and bars to be smoke-free (Toribiong 2011a).
- There was some speculation (by two informants) that RPPL 8-27 was subject to industry influence in the private realm. There was no direct evidence to support this, although it was cited in a 2010 regional presentation (“WHO Tobacco Indicators Workshop” 2010).

A needs assessment for the FCTC in Palau was conducted by the FCS.

Tourism from Asian countries (where smoking is perceived less negatively than in western countries) was a rationale for the recommendation not to sign the tobacco control bill of early 2011.

The government’s reliance on US funding support (despite it being beneficial for certain aspects of

\(^{11}\) Relations between government and NGO/civil society members were at a weak point at the time of interviews, which may have influenced the tone of such responses.
tobacco control in Palau), meant that funding was not based on FCTC provisions and there may not be a strong incentive to fully endorse them (claimed by one informant).

- The WHO’s promotion of the MPOWER objectives minimised the importance of the broad provisions of the FCTC (claimed by one informant).

### Capacity

<table>
<thead>
<tr>
<th>Number and skill levels of staff</th>
<th>Four staff were designated to tobacco control in the Tobacco Use Prevention and Control Program in the MOH.</th>
<th>A shortage of staff and competing demands was evident (claimed by a minority of informants).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12 Statements regarding capacity were somewhat more theoretical in Palau than those in the other countries examined, as there was no comprehensive FCTC-based legislation in place at the time of the interviews. Nonetheless, some important insights were made concerning the capacity to implement the tobacco control activities already in place and the perceived capacity to implement FCTC provisions in future.</td>
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<tr>
<td>Knowledge of tobacco issues, surveillance and monitoring</td>
<td>Comprehensive data on NCDs in Palau’s young population was collected, as Palau Youth Tobacco Surveys have been conducted in 2001, 2005 and 2009 (which also provided some data on people’s exposure to anti-tobacco awareness campaigns).</td>
<td>Several informants were critical of the government’s understanding of FCTC-related issues (this notion may have been influenced by recent disagreements and political differences).</td>
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<tr>
<td></td>
<td>Data collection is under way for a STEPS survey, which will cover the adult population.</td>
<td>There was some difficulty in obtaining statistics relevant to tobacco use from health care authorities (claimed by one informant).</td>
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<td>Data was collected on the compliance of vendors with the ban on tobacco sales to minors (Substance Abuse and Mental Health Services Administration 2011; Tobacco Use Prevention and Control Program 2009).</td>
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<td>Two small-scale surveys of public opinion regarding smoke-free restaurants had been conducted.</td>
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<tr>
<td>Mandated authority</td>
<td>The Council of Chiefs declared tobacco illegal to sell shortly after the time of interviews (Palau Council of Chiefs Office 2012). Despite this, a declaration by traditional chiefs, however forceful and influential, is not law; only the elected leaders can make laws in the country (Tia Belau 2012).</td>
<td>Customs and police officers, rather than officers from within the MOH, were largely responsible for enforcing the provisions already in place. Much of RPPL 8-27 is enforceable by the Bureau of Public Safety and the Ministry of Justice.</td>
</tr>
<tr>
<td>Physical facilities and technology</td>
<td>Easy access to media communications and the internet was recognised as an opportunity to promote tobacco control and FCTC implementation (Asian Pacific Partners for Empowerment Advocacy)</td>
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</tbody>
</table>
and Leadership 2009).

| Resourcing and capacity politics | • US federal funding provided most of the government resources used in tobacco control at the time of interviews. | • There was a lack of funding for the tobacco control program and its associated activities (claimed by some informants). Scarce government resources were cited by the Office of the President as a reason for reducing some of the bureaucratic requirements to regulate tobacco in RPPL 8-27 (Toribiong 2011a). |
| • Tobacco control was not as highly funded as other health issues such as tuberculosis, malaria or HIV/AIDS (“WHO Tobacco Indicators Workshop” 2010). | • Funding towards workshops and training programs for relevant workers was still inadequate (claimed by one informant). |
| • Scarce government resources were cited by the Office of the President as a reason for reducing some of the bureaucratic requirements to regulate tobacco in RPPL 8-27 (Toribiong 2011a). | • The administrative requirements of the FCTC were anticipated to be somewhat overwhelming for the small country (claimed by one informant). |
| • Funding towards workshops and training programs for relevant workers was still inadequate (claimed by one informant). | • It was suggested that there was some agency competition at the international level between the US funding agency and the WHO, and there may be less incentive for politicians to prioritise implementing FCTC provisions as the US funding was not dependent on it (claimed by one informant). |

| Clients and Coalitions | • There was a reasonably strong anti-tobacco coalition presence in Palau (unlike the other countries examined), led by the CTFP. Informants indicated CTFP members were influential in developing tobacco control policy and lobbying for its approval. | • There was limited funding support available, a reliance on volunteers and some inactivity amongst NGOs in the country. |
| • The CTFP played a role in community awareness and education (of both legislators and the general population), and in networking with decision-makers in government. | • The CTFP endured a fairly difficult relationship with the MOH at the time of the interviews. |
| • The Council of Chiefs’ declaration against tobacco sales indicated coalition support. | • Despite significant advocacy efforts from the CTFP, a significant portion of its demands failed to gain traction. |
| • A strong coalition relationship between the CTFP and the FCA, Omelemele ma Ulekerreuil a Bedenged (a cancer coalition), the Pacific Partnership for Tobacco Free Islands, Ulekerreuil a Klengar (an NGO focused on promoting healthy lifestyles) and the Council of Chiefs was evident. | • A challenge for the CTFP was the extent to which they represented the interests of the community, as it consisted of few instrumental members but lacked the characteristics of a widespread social movement (claimed by a minority of informants and cited by Toribiong (2011a)). |
| • A lack of public participation was a barrier to civil society anti-tobacco activity (claimed by several informants). |

| Anti-tobacco coalition activity | • The CTFP was crucial in creating awareness of the tobacco control bill in both houses of congress and among the general population (claimed by several informants). This was achieved through use of television, radio, newspaper articles, public meetings and consultations. | • The CTFP was crucial in creating awareness of the tobacco control bill in both houses of congress and among the general population (claimed by several informants). This was achieved through use of television, radio, newspaper articles, public meetings and consultations. |
| • Community awareness had also been | • Community awareness had also been |
Tobacco industry and pro-tobacco coalition activity

- There was a limited public presence from local tobacco industry and no evidence of any pro-tobacco NGO or civil society group, possibly due to tobacco being largely imported in Palau.
- There was no hard evidence of direct industry interference being successful, but some informants speculated that the government had links to those representing the tobacco industry.
- Philip Morris had once offered to “assist” the Palauan government with its tobacco legislation and in drafting health warnings (one informant suggested that the language of their proposed translations was weak). To its credit, the administration of the time strongly rejected this offer (Dairo 2008). However, health warnings were not included in RPPL 8-27 (it is uncertain if this is a result of industry interference).
- A powerful media owner had opposed those who supported tobacco control legislation, but no affiliation with the tobacco industry was known (claimed by one informant).

Client support for policy

- The majority of informants indicated that the public was generally accepting of tobacco control measures (although this is in contrast to the first barrier listed).
- The Palau GYTS revealed that in 2009, 56 per cent of students thought that smoking should be banned in public places (CDC 2009). A small internal survey found that people were supportive of restaurants that voluntarily prohibited smoking (claimed by one informant). Compliance with the MOH’s no chewing policy, and bans on sales to minors, were cited as further indicators of public support.
- There was no mention of any protest against a tobacco control measure implemented by the government.
- Palau’s third FCTC implementation report stated that public support for FCTC-based provisions was a barrier to its implementation (Oseked Sr. 2012).
- In the small island environment, people may be reluctant to stand up for something in public that their friends or relatives might not support (claimed by one informant).
- The high rate of tobacco use, and the traditional use of chewing tobacco with betel nut, indicated that persuading the population against tobacco use could be challenging.

4.4.7 Summary of the variables that affect FCTC implementation

The goals, causal theory and methods in the FCTC as a whole tended to resonate with informants who believed they were relevant for Palau. However, this view was not necessarily shared by the governing administration which tended to have concerns with some key FCTC provisions. Recent progress was made with the passing of RPPL 8-27, but further amendments will be needed for the content of

13 Client support for FCTC-related policies was difficult to ascertain, particularly as the tobacco control legislation had passed through congress so recently that clients could not be aware of its full effect at the time of the interviews.
this legislation to comprehensively comply with the FCTC, as indicated in the following quotation:

I don’t know if we will ever be able to implement [the FCTC] in its entirety, but I’m sure what we’re trying to accomplish now is another big step. (Palauan informant)

There were several barriers within the institutional context. Firstly, because legislation had only recently passed through congress, many FCTC provisions were not institutionalised in the relevant government agencies. Even taking into account the recent legislation, the majority of FCTC provisions are enforceable by agencies outside the MOH\textsuperscript{14}. In respect of the MOH, networks had been formed with the CTFP and through senior levels of government, but they did not span across government departments, as alluded to in the following quotation:

I know in the FCTC it says that Parties shall “establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control” and I suspect we probably answer “yes we do”... but I don’t know that that’s what the FCTC had in mind... I think they had in mind probably something a little more inclusive of other Ministries. [It’s] not just the tobacco program who’s supposed to be in charge of implementing the FCTC. I think the intent was a whole-of-government task force kind of thing, which we don’t have, and has no resources, and the national budget certainly has no line item for it. (Palauan informant)

Commitment was the most significantly hindered variable cluster in Palau. The attainment of whole-of-government commitment through support in departments outside of health, and in the senior levels of government, was a major barrier. It

\textsuperscript{14} As mentioned earlier, one informant claimed that there that there may be several grammatical errors in the designated authorities specified in RPPL 8-27 (and the MOH may have more of a responsibility here than specified). However, it is difficult to ascertain the extent of this until the supposed errors in RPPL 8-27 are formally addressed.
was apparent that this changed rather dramatically over the last ten years and was
dependent on the administration in power, as shown in the quotation below:

I think we have not met any one of [the FCTC’s time-based requirements]... it
says [in] 2008 we were supposed to implement let’s say Article 11 [packaging
and labelling]... and we didn’t meet those, due to as I already mentioned –
people have different priorities. The previous administration thought of things
differently than this administration and I don’t know... it’s just the politics
that’s [making] it [hard] for people at the [lower levels] who are really
struggling to meet and to do things. (Palauan informant)

There were some barriers in terms of capacity, including the limited mandated
authority within the MOH to enforce FCTC provisions and a desire for more
resources for tobacco control. However, barriers here was not as pervasive as the
other countries examined; the Tobacco Use Prevention and Control Program in the
MOH was supported by US funding and there were four staff dedicated to tobacco
control in this agency. It was evident that increasing capacity was dependent on
commitment in the senior levels of government:

We have that capacity over [in the MOH], but unless the FCTC or tobacco
[control] takes priority, they cannot put those skills and expertise into helping
push the issue of tobacco. (Palauan informant)

Numerous facilitators were present in the clients and coalitions variable cluster,
many of which related to the advocacy, lobbying and community awareness
activities of the CTFP, despite it having limited funding and being reliant on
volunteers, as shown in the following quotation:

I like to think that [the CTFP] did have an influence to get the House and the
Senate to agree on the decent version of the bill and then they both passed
and sent it to the President – that was really good, and the [CTFP] had done
that video campaign... that raised awareness and you know... if the [CTFP]
wasn’t around jumping up and down talking about FCTC, I don’t think
anybody would be doing anything about it. So, I think they have had some influence but obviously not on the [President of Palau]. (Palauan informant)

Furthermore, the Council of Chiefs were supportive of increased tobacco control. There was little evidence of pro-tobacco coalition activity in public, although several informants suspected that this may exist in the private domain, which may be some cause for concern.

The acknowledged impact of FCTC-based policies on clients at the time of the interviews was very little. Existing policies, such as bans on sales to minors and taxation, were present before the FCTC came into force. Over recent years some restaurants voluntarily prohibited smoking. The government rejected offers of tobacco industry support from Philip Morris, banned tobacco smoking in its premises, and provided cessation services and nicotine replacement therapy (Oseked Sr. 2012). It is difficult to ascertain whether these actions were influenced by the international FCTC process or simply by general shifts in attitudes and increased tobacco control regulation globally. Comparisons between the 2005 and 2009 YTS in Palau show that overall tobacco use prevalence in middle and high school populations declined (as a result of a decreasing prevalence of chewing tobacco with betel nut) but there was a concerning increase in cigarette smoking (Tobacco Use Prevention and Control Program 2012). During this period there was a fall in the proportion of students who saw anti-smoking media messages (Tobacco Use Prevention and Control Program 2009). One positive development since the passage of recent legislation in 2011 (and since the interviews took place) was the removal of signs displaying tobacco brands outside retail stores and at points of sale. At the time of the interviews, however, several informants speculated that there might not be many significant changes as a result of the legislation that would have significant impact on clients. Although Palau’s third FCTC implementation report indicates some intent to incorporate more FCTC provisions into the national tobacco control legislation in future (Oseked Sr. 2012), it may be several years until such developments are felt in terms of a further reduction in tobacco-related harm in the population.
4.4.8 Recommendations

Palau was on the cusp of passing its tobacco control legislation at the time of interviews, which has since been in place for some time. While the content of the tobacco control legislation may not address all FCTC provisions comprehensively, it is one positive step forward. It is likely to serve as an important platform to protect Palauans from the substantial burden of tobacco use that has affected the country.

It is encouraged that stakeholders work towards enhancing legislation; particularly in relation to the provisions that most effectively reduce tobacco use and that are politically palatable. These may include packaging and labelling, smoke-free environments, bans on TAPS, and taxation. Health warnings covering a large proportion of the package with pictures would boost FCTC implementation significantly, and is one of the most cost-effective ways to reduce tobacco use as these messages are conveyed to everyone who smokes or chews manufactured tobacco products, regardless of the remoteness of their location, at little or no cost.

As well as protecting people from second-hand smoke, smoke-free environments may be important in de-normalising cigarette smoking, which has significantly increased among the country’s young population since 2001. Cigarettes are relatively cheap in Palau in comparison to the other countries examined, and increasing taxes would significantly discourage many (and especially young) people from smoking without impeding on government capacity.

Enforcement in the above provisions should be prioritised. Palau is the best placed of the four countries in terms of staffing and financial capacity; therefore, if political commitment is high, there is a potential for the country to make significant achievements in FCTC implementation even beyond the cost-effective provisions listed above.

The monitoring and surveillance of tobacco use, its harm, and community awareness are important in justifying changes to behaviours, particularly where political leadership gives substantial weight to being seen to act in the interests of its people. It may therefore be necessary for stakeholders to maintain efforts to monitor the health burden and associated costs of tobacco use, and to educate the
public on these factors. Stakeholders may need to emphasise the provisions of the FCTC as means to an end, which is to minimise the burden of tobacco to Palauan people, rather than as the end itself.

For FCTC implementation to be strengthened, networks between the MOH and other relevant departments such as Ministry of State, Ministry of Finance, Ministry of Education, police and customs, may need to be enhanced. This would encourage knowledge transfer and stimulate whole-of-government engagement, and could be done through interdepartmental meetings, a select committee or a task force. A whole-of-government approach will become more important as enforcement of the recent legislation is scaled up, and it may be helpful in fending off industry influence on sectors outside the MOH. If enforcement of the recent legislation (and other health-related legislation) is poorly managed by the country’s authorities, the MOH might consider obtaining a mandate for its own designated staff to have enforcement powers.

Palau may seem challenged in terms of acquiring strong political commitment and having comprehensive FCTC-based legislation, but the other variables that affect FCTC implementation in the country are rather strong. It is possible that if the challenges noted above can be overcome, Palau could become a leader in minimising tobacco-related harm in the region.

4.5 Nauru

4.5.1 Brief country background
The Republic of Nauru consists of one small, isolated island east of Indonesia and north of Vanuatu. It has a population of approximately 10,000. Although technically located within Micronesia, Nauru is close to the junction of Micronesia, Melanesia and Polynesia. As there is a sealed road circulating its only island which is just 21 square kilometres, none of the Nauruan population is not considered rural or remote, which is in contrast to populations in the other countries examined.
Nauru was annexed by Germany in 1888, and a British company began mining its phosphate deposits in 1907. In World War I, Nauru was captured by Australian troops and came under British control. In 1920 it was officially administered by Australia, New Zealand and the United Kingdom (UN 2012). The Japanese occupied Nauru during World War II and a significant number of Nauruans were captured and deported to work in Chuuk, Micronesia (Skinner 1976); the Japanese surrendered Nauru in 1945 (Pollock 1991). Nauru has been self-governing since 1966, although Australia is responsible for its defence. Nauru is a republic with a unicameral parliament. The parliament’s eighteen members elect its President, who is both head of government and head of state. There are no formal political parties in Nauru and members of parliament are independents.

Because of its rich phosphate deposits, Nauru was extremely prosperous in the mid-to late-20th century, but mining underwent a sharp decline in the 1980s. With no other industries to compensate for this loss, Nauru’s wealth and employment have deteriorated since this time: hence its small GDP per capita. Nauru’s fragile economy is reliant on phosphate exports as well as foreign development grants and fishing revenues (Asian Development Bank 2012). Comprehensive economic data is scarce, but some years ago it was indicated that Nauru’s major trading partners included Australia, South Korea and the US (Nauru Bureau of Statistics 2007). The country’s official languages are Nauruan and English.

The Nauruan government spent 10.3 per cent of its total expenditure on health in 2010 (WHO 2013d), which is the lowest of the countries examined. Health spending accounted for 9.6 per cent of its GDP and 86.4 per cent of this spending came from government sources (WHO 2013d). External assistance accounted for 40.6 per cent of total expenditure on health (WHO 2013d), which is the highest of the countries examined. Nauru’s WHO Health Profile for 2010 reveals a low life expectancy, at only 56 years for males and 65 years for females – lower than both WPRO and global averages (WHO 2012e). NCDs are estimated to account for 56 per cent of years of life lost (WHO 2012a). The obesity prevalence rate, which is a major problem, greatly exceeds the WPRO average (WHO 2012a) and is among the
highest in the world (WHO 2011b). High blood pressure and high blood glucose are also greater than the WPRO average (WHO 2012a). While there are only 7.1 physicians per 10,000 people in Nauru, there are a large number of nurses and midwives in comparison to the other countries examined, at 70.7 per 10,000 people (WHO 2012a).

4.5.2 Tobacco use

There is no local tobacco growing or manufacturing in Nauru and tobacco use consists of smoking imported cigarettes. Observation by the primary researcher, and the country’s Consumer Price Index (CPI) report, indicated Alpine cigarettes (produced by Philip Morris Australia) were popular (Nauru Bureau of Statistics 2011), but there is little rigorous evidence pertaining to the most popular brands sold in the country. In addition to packets of cigarettes, shops also used to sell single cigarette sticks called pwids by the locals. One informant claimed that pwids were not packaged according to the Tobacco Control Act’s requirements and were sometimes imported from China. These have since been prohibited, although informants claimed that some vendors continued to sell them underground.

Cigarette smoking in Nauru is highest of all the countries examined in this study, although its tobacco use prevalence (i.e. including all forms of tobacco) is less than that of Palau. Data from Nauru’s 2004 STEPS report shows that the overall, tobacco use prevalence for males aged 15 to 64 was 49.7 per cent, and 56.0 per cent for females in the same age group (Nauru Ministry of Health & WHO 2007). Nauru is one of the few countries in the world with higher female than male tobacco use prevalence. The WHO Health Profile for Nauru estimates that in 2009, the tobacco use prevalence rate for those aged fifteen and over was 49.0 for males and 50.0 for females (WHO 2012e). There has been no GYTS or study of tobacco use among youth in Nauru.

4.5.3 FCTC ratification and subsequent tobacco control legislation

Nauru ratified the FCTC in June 2004 (Framework Convention Alliance 2013). In 2009, Nauru passed its Tobacco Control Act and accompanying regulations. The Act is compliant with key articles of the FCTC in all areas, except that it does not
explicitly ban misleading descriptors (e.g. “mild” cigarettes). It does include bans on TAPS, although products can still be advertised at point of sale with an accompanying health warning. Health warnings must cover 30 per cent of the cigarette package, the minimum requirement of the FCTC. The legislation also prohibits smoking in all enclosed public places. Other provisions of the Act include restrictions on tar and nicotine content, minimum package sizes of 20 cigarettes, a prohibition on supplying tobacco to persons younger than eighteen years of age, and banning the supply of tobacco in vending machines and restaurants.

4.5.4 Tobacco control policy-making and institutional structure

To become an act, a bill must pass three readings in parliament. The Minister of Health has the power to mandate authorised environmental health officers to enforce the Tobacco Control Act. Prosecutions for an offence under the Act can be made by the Director of Public Prosecutions, the Minister of Health, police or authorised officers. The authorised officers also conduct duties associated with other legislation such as the Food Safety Act. They report to the Director of Public Health, who oversees several other units within the MOH. The Director of Public Health reports to the Secretary of Health, who acts under the Minister.

Community awareness and education activities are often channelled through District Primary Health Care Workers, who work directly with their local communities. Importers are licensed by the Ministry of Finance, which provides some oversight of their activities. The oversight of taxation also goes beyond the MOH, and although there is an excise tax on cigarettes, there is typically very little taxation and government revenue from this source in Nauru. However, the government introduced a sugar levy on flavoured drinks for health promotion purposes in 2007 (Thow et al. 2010), which may serve as a model for a similar approach to be undertaken for tobacco products.

4.5.5 Current stage in FCTC implementation and enforcement

At the time of the interviews two designated environmental health officers in the MOH had powers to enforce the Act; as did police officers and the Minister of Health. The smoke-free environments legislation in hospitality venues was not
binding at the time of the interviews, but the primary researcher did not observe any instances of smoking inside enclosed restaurants or hotels during his ten-day research visit. There were no signs of any TAPS. Observation showed that cigarettes were largely sold with basic black and white health warnings covering approximately 30 per cent of the package. This is despite many tobacco products being imported from Australia, which has larger, pictorial health warnings. This suggests that tobacco companies print package warnings especially for Nauru and/or other importing countries where the 30 per cent warning is still legally sufficient. A CPI report in 2011 showed that the price of one brand of packaged cigarettes was around AU$5.55, little different from the price in 2008 (Nauru Bureau of Statistics 2011).

4.5.6 Variables that affect FCTC implementation

The comprehensive findings on the variables that affect implementation in Nauru according to informant interviews and document analysis are listed in Table 11 below.

Table 11: Facilitators and barriers to FCTC implementation in Nauru

<table>
<thead>
<tr>
<th>Variable that affects implementation</th>
<th>Facilitators</th>
<th>Barriers</th>
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<td><strong>Goals</strong></td>
<td><em>The goal of minimising the harm associated with tobacco use was seen as highly important by vast majority of informants. This was attributed to the prevalence of smoking and the high general rates of NCDs, and their burden on the health care system.</em></td>
<td><em>Physical activity and nutrition in Nauru were larger concerns (claimed by one informant).</em></td>
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<tr>
<td><strong>Causal theory</strong></td>
<td><em>The causal theory that a significant amount of NCDs are caused by tobacco use is empirically unequivocal. This was generally implied by informants and evident in documentation.</em></td>
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<td><strong>Methods</strong></td>
<td><em>The vast majority of informants generally supported the provisions in the FCTC and the Tobacco Control Act, and saw them as effective.</em> <em>The Tobacco Control Act passed through parliament with little objection.</em></td>
<td><em>Bans on the sale of individual cigarettes and sale to minors were difficult to enforce robustly (claimed by a minority of informants).</em> <em>The provisions of the Act were necessary but not sufficient to address all problems, and did not emphasise the supply side of tobacco enough (claimed by one informant).</em> <em>The FCTC and Tobacco Control Act were quite</em></td>
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<td>Context</td>
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<tr>
<td><strong>Policy-making/institutional structure</strong></td>
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<td>- The MOH oversees most provisions and has enforcement powers.</td>
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<td>- A state of emergency was declared in 2010 when a member of parliament crossed the floor, resulting in equal numbers in government and in opposition. This meant that there was little progress in reviewing bills, resulting in delays. Tobacco control legislation during this period was subject to delay (claimed by one informant).</td>
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<td><strong>Institutional adaptation to policy</strong></td>
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<td>- Environmental health officers included tobacco control activities as a part of their shop and restaurant inspections.</td>
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<td>- Tobacco control legislation features strongly in the MOH Strategic Plan for 2010 to 2015 (Republic of Nauru 2010).</td>
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<td>- There was no increase in staffing since the Tobacco Control Act.</td>
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<td>- The adaptive capability of the MOH was hindered by the tobacco control focal point undertaking training overseas for a long period of time.</td>
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<td><strong>Institutional networks and relationships</strong></td>
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<td>- Networks within the MOH were supportive.</td>
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<td>- Nauru’s small society was an advantage as key decision makers were never far away (claimed by one informant).</td>
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<td>- The government was able to hold public consultations effectively with tobacco vendors, who were said to be relatively sympathetic to the demands of the Tobacco Control Act.</td>
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<td>- Important collaborations with AusAID, the WHO and the SPC were evident through funding, training, technical assistance and support for the NCD program (Nauru Ministry of Health &amp; WHO 2007; Republic of Nauru 2010).</td>
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<tr>
<td>- There was some need for greater interdepartmental collaboration beyond the MOH: this was well achieved at the senior level, but lacking at the ground level between environmental health officers, police officers and the Office of the Director of Public Prosecutions (claimed by one informant).</td>
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<td>- Multi-sectoral collaboration outside government was challenged, particularly as there was extremely little NGO activity in tobacco control. This was also cited in Nauru’s 2007 FCTC implementation report (Bacigalupo 2007).</td>
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<th>Commitment</th>
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<td><strong>Commitment broadly</strong></td>
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<td>- The MOH’s strategic plan alluded to the enforcement of tobacco control regulation as a new activity being strengthened (Republic of Nauru 2010).</td>
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<td>- Enforcement of the MOH’s smoke-free policy was strong (claimed by several informants).</td>
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<td>- There was a lack of enforcement on bans of single cigarette sales and noncompliance by shops and buyers (claimed by three informants).</td>
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<td>- A lack of prosecutions and limited enforcement of smoke-free environments in restaurants was evident (although enforcement in this area had begun only recently: some informants claimed that there was an intention for this to be strengthened in future).</td>
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<tr>
<td><strong>Ground level commitment</strong></td>
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<td>- Two officers at the ground level in the MOH actively enforced the Tobacco Control Act and its provisions.</td>
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<td>- Enforcement had recently been scaled up from a more passive approach, but room for further improvement was evident (claimed by two informants).</td>
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<td>- Enforcement officers had other competing responsibilities, limiting their ability to be consistently active in tobacco control (claimed by several informants).</td>
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<tr>
<td>- A police officer discovered one vendor failing to comply with the Tobacco Control Act, but they referred the matter to the environmental health officers rather than pursuing it, despite having the power to do so, indicating a possible lack of ground level commitment in departments outside of health.</td>
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<tr>
<th>MOH/</th>
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<tr>
<td>- The smoke-free policy at the MOH</td>
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<tr>
<td>- The MOH’s commitment was hindered by the ambitious (claimed by one informant).</td>
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</table>
Whole-of-government commitment

- The passage of comprehensive tobacco control legislation and regulations with little objection signified parliamentary commitment.
- Due to the NCD crisis in Nauru, the leaders in the country had little option than to be supportive of the FCTC (claimed by one informant). The President expressed concern for the crisis at an international forum (UN 2011).
- The demeanour of departments outside health, namely the prosecutions department, the police and, to a lesser extent, customs, was noted as a challenge as it was perceived that tobacco control or health was not high on their agenda (claimed by several informants).

External sources of commitment

- The WHO, SPC, AusAID, and Allen and Clarke facilitated commitment through the STEPS report, technical assistance, funding, and assisting the development of tobacco control legislation (claimed by a minority of informants).
- More should be done at the global level to facilitate implementation via a mechanism similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria (claimed by one informant).
- There was some need for an international review process of the FCTC (claimed by one informant).
- A need for supply-side intervention and for the global tobacco industry to be more vigorously regulated was evident (claimed by two informants).

Capacity

Number and skill levels of staff

- The MOH responded to the need for more enforcement on the ground by submitting a proposal to AusAID, which was under review at the time of interviews (claimed by one informant).
- A shortage of staff was noted, particularly in the area of enforcement, where the two environmental health officers had to also monitor the Food Safety Act among other tasks. Furthermore, the health promotion worker who primarily oversaw tobacco control was overseas and another staff member had to add tobacco control to their own responsibilities.
- Additional skills and training in tobacco control were needed (claimed by four informants). There was a need for local expertise, rather than relying on foreign expatriates or consultants.

Knowledge of tobacco issues, surveillance and monitoring

- Senior staff members were well equipped with general knowledge about tobacco control and the FCTC.
- Informants specified needs for knowledge and training in a number of areas, including on the FCTC (one informant), the costs associated with tobacco use (one informant), and training in general tobacco control issues (one informant).
- The 2007 STEPS survey was useful in providing statistics on NCDs and tobacco usage, but its data is somewhat old. As it is the only survey of its kind so far, no statistical trend can be established. Unlike the other countries in this
study, GYTS surveys were not conducted in Nauru.
- There was little reference to the monitoring of public opinion and compliance other than in a small one-off survey that contributed to the FCA’s Tobacco Watch report (Bostic 2010). There was a need for surveillance to determine the extent of compliance to the Tobacco Control Act’s provisions amongst vendors (claimed by one informant).

<table>
<thead>
<tr>
<th>Mandated authority</th>
<th>Environmental health officers and police officers had sufficient authority to enforce tobacco control provisions in Nauru (claimed by several informants).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There was an inability to enforce Tobacco Control Act provisions in homes, which can act as unregistered or underground businesses (claimed by one informant).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical facilities and technology</th>
<th>The MOH offices had been refurbished, providing an improved environment in which staff could carry out their responsibilities (claimed by one informant).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Power outages sometimes caused problems when using electronic materials in community awareness programs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resourcing and capacity politics</th>
<th>External agencies provided a significant amount of financial support, particularly through AusAID and the WHO. These two agencies provided assistance for the STEPS report, and AusAID provided funding assistance across Nauru’s health sector. The WHO, with the support of Allen and Clarke, assisted with policy development and training workshops. The SPC assists Nauru with its regional NCD program.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insufficient funding and the need for more resources were mentioned by several informants as major challenges to implementing, and particularly enforcing, the Tobacco Control Act. The strategic plan identifies significant gaps in financing and human resources across the whole health sector (Republic of Nauru 2010).</td>
</tr>
<tr>
<td></td>
<td>Earmarking funds for the implementation of the Tobacco Control Act was seen as a challenge; such a move would be considered most unfavourably by departments outside the health sector (claimed by one informant).</td>
</tr>
</tbody>
</table>

### Clients and Coalitions

<table>
<thead>
<tr>
<th>Anti-tobacco coalition activity</th>
<th>There were no existing NGOs or CSOs active in tobacco control and scant evidence was given of any actors outside government (i.e. religious leaders, traditional leaders or journalists) speaking out on tobacco-related issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A minority of informants cited potential barriers to an NGO starting up, including the lack of a funding mechanism to support an NGO, the small population of the island, some expectation that the government should look after people’s health (rather than individuals or NGOs), and the feeling that the tobacco health burden was not “dramatic” enough to bring gravitas to the issue (unlike road accidents or suicide, for example).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other awareness activities included Attempts to influence clients through community awareness were overwhelmingly directed by government actors.</td>
</tr>
<tr>
<td></td>
<td>Awareness in tobacco control needed to be reinvigorated as it had tapered off since the Act’s passage (claimed by a minority of informants).</td>
</tr>
<tr>
<td></td>
<td>There was a desire for more prominent role models against tobacco use in the community.</td>
</tr>
</tbody>
</table>
Nauru’s participation in World No Tobacco Day ("World No Tobacco Day Activity Report" 2010), and the Diabetes Unit and District Primary Health Care Workers disseminating health information to their communities. (claimed by one informant).

<table>
<thead>
<tr>
<th>Tobacco industry and pro-tobacco coalition activity</th>
<th>Client support for policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Very little industry interference or uniform pro-tobacco coalition activity was noted as Nauru relies on imported tobacco and has no tobacco manufacturing industry.</td>
<td>• The general population was supportive overall of the measures contained in the Tobacco Control Act (claimed by the majority of informants). Non-smokers were considered more supportive than smokers by some informants.</td>
</tr>
<tr>
<td>• Shop vendors still sell single cigarette sticks, which have been prohibited, underground (claimed by two informants).</td>
<td>• There was no public movement against the Act, nor were any individuals seeking to disrupt its implementation.</td>
</tr>
<tr>
<td>• Philip Morris disagreed with the length of time legislated for health warnings to be displayed on cigarette package. However, this may be seen as a technicality rather than a symbol of overt industry influence on the country’s tobacco control policy.</td>
<td>• Smokers had sometimes complained about the legislation, particularly during the time the Act passed through parliament.</td>
</tr>
<tr>
<td></td>
<td>• There was some sensitivity to price increases and resistance to banning single cigarette sales (claimed by two informants), suggesting that these provisions were somewhat less appreciated amongst certain groups.</td>
</tr>
<tr>
<td></td>
<td>• One informant claimed that the legislation would have minimal impact as individuals could circumvent it (i.e. through using older relatives to buy cigarettes and single cigarettes being sold underground).</td>
</tr>
</tbody>
</table>

4.5.7 Summary of the variables that affect FCTC implementation

Like the other countries examined, the goals, causal theory and methods of the FCTC are particularly relevant for Nauru, as shown in the following quotation:

There’s very little [our government] can do other than being supportive [of the FCTC], because Nauru is being bombarded left, right and centre with the report of high prevalence of NCDs, of diabetes, hypertension or renal failure et cetera, and really the government must not only be doing something positive to try and prevent that, [but] also be seen to be doing something positive. (Nauruan informant)

The institutional context was mildly conducive to FCTC implementation. Networks within the MOH were supportive, although there was some need for stronger networks between the MOH, other government departments and the non-government/civil society sector. The provisions of the Tobacco Control Act had
begun to be institutionalised, notwithstanding some capacity-related barriers as indicated in the following quotation:

Since [the Tobacco Control Act’s] passage, it’s become apparent that the staffing capabilities are somewhat wanting, and... in our new budget we’re going to be putting up a proposal for enforcement, not only just for the Tobacco [Control] Act, but for broader legislation that the health department is implementing. I would like to think that any enforcement officers for the Public Health Act can also be enforcement officers for the Tobacco Control Act, so it’s not-- we’re not developing silos here. We’re trying to address enforcement across the whole sector, and one of their roles is to look at tobacco. (Nauruan informant)

Capacity also featured as a barrier to commitment, as shown in the following quotation:

I think the FCTC has been a pioneering attempt to try and address a public health issue, which the majority of the WHO’s member states signed up to. Translating it to gains on the ground is where the challenge lies. We’ve ticked off the legislation. We’ve ticked off this. We’ve ticked off that. But there needs to be some more progress in terms of enforcement and implementation. (Nauruan informant)

There was also room for greater whole-of-government commitment as informants suggested that enforcement and legal agencies did not prioritise tobacco control. Despite this, senior government members have demonstrated some leadership and intent to implement FCTC-based provisions to reduce the NCD burden. Furthermore, the existing staff recognised the need for enforcing the Tobacco Control Act and the importance of tobacco control.

Capacity was the variable cluster in which the strongest barrier to FCTC implementation was evident, particularly through there the scarcity of resources and limited staff on the ground:
For the time being, what I see [as a barrier to FCTC implementation] is the human resource – the staff... the MOH has limited staff in number and as well as in skill. So in implementing [FCTC-based] strategies, we have these limited options to manage the human resources. So there’s – for example, like the health promotion officer, they have to coordinate many things and we only have one officer. So those kinds of human resource constraints – this is the main barrier I see. (Nauruan informant). (Martin & de Leeuw 2013; p. 4)

Another key barrier in Nauru was the lack of anti-tobacco coalition activity, as there were no NGO actors advocating for tobacco control or FCTC implementation. With very few NGOs in the country, this was not necessarily unusual different to other health issues.

Really in terms of NGOs, they are non-existent in [tobacco control]. In terms of lobbying – that is non-existent here. In terms of civil society representation – everything – mostly in terms of the implementation of FCTC – is being done single-handedly by government. (Nauruan informant)

It was found that clients tended to be supportive of tobacco control measures overall:

I think the majority [of people are] in agreement and it’s just those minor [groups] that do not like the Act. (Nauruan informant)

Results were mixed in terms of the impact of FCTC-based provisions on clients. Setbacks included the need for stricter enforcement. Some informants said that single cigarettes were still being sold, minors were still able to obtain cigarettes, and people were still smoking in restaurants. Conversely, several informants claimed that since the provisions had been brought to the public, they could notice a difference in behaviour. The smoke-free policy in the MOH was mentioned by several informants as a significant change that had been well enforced – although this may be subject to response bias, given the backgrounds of the informants. Tax increases were noted by a minority of informants, although some thought that
cigarettes were still too cheap. Health warnings on cigarette packages covering 30 per cent of the package were also reaching clients. Documentation provided little information on the impact of the legislation on clients, as no research in this area had been produced between the passing of the legislation and the time of the interviews – many of the Act’s provisions had entered into force only approximately a year before the interviews were undertaken. There was an intention to scale up enforcement of the legislation in future. It is evident that the FCTC has impacted the people of Nauru to some degree, but the full extent of its impact is yet to be felt.

4.5.8 Recommendations

Nauru has significantly improved its stance on tobacco control and FCTC implementation in recent years, but there is still some work that needs to be completed for the legislation to be effectively implemented and to comprehensively reach the population.

Financial and staff capacity are a major impediment to FCTC implementation. A sustainable funding mechanism (or further external assistance) will go a long way to address this problem. There is a strong need to resource more staff, particularly to enforce health-related legislation on the ground; the MOH was already taking steps to achieve this at the time of the interviews. As allocating additional capacity is extremely challenging politically, cost-effective provisions should be implemented and enhanced wherever possible. Increasing health warnings to cover a greater proportion of the package with graphic images, or adopting Australian warnings as an acceptable standard, as done in the Cook Islands, would be a significant improvement on the existing health warnings offered. A ban on misleading descriptors would also eliminate tobacco products potentially being marketed as less harmful than what they really are. Increasing taxation (if politically feasible) and enhancing smoke-free environments may also result in substantial improvements in tobacco control with minimal pressure on capacity.

The MOH should seek stronger collaboration with other enforcement departments, including those that oversee tobacco legislation, to facilitate whole-of-government commitment. The comprehensive enforcement of smoke-free environments is
It is desirable to move FCTC implementation forward. Nauru’s geography may be favourable in this regard, as it does not have a significant rural population or remote islands to cover, as the other countries in this study have.

There is a need to stimulate civil society activity. Increasing the awareness of the harms of tobacco may be suitable here, and could be achieved by working through the district health care workers and media, and collaborating with the FCA. It is unlikely that a full-fledged NGO or CSO will appear, and therefore it may be necessary to establish a working group similar to the Cook Islands’ TCWG, comprising both government and non-government or civil society members. This would facilitate some tobacco control activity outside the government, which could improve both its commitment and capacity.

There is some need for a repeat STEPS or similar survey to establish data on trends in tobacco use and to help determine if current provisions have been effective. Networks with relevant international agencies will be important here, although it may also be useful to stimulate local capacity to conduct some research. Any NGO or civil society actors could supplement activity in this area.

If it can overcome some of these barriers, Nauru may have a comparative advantage in tobacco control over the other countries in this study, as it has a small non-rural population, making it easier to implement country-wide policies. Nauru has made some significant progress in tobacco control, and may be on the cusp of achieving the end result of minimising the burden of tobacco use in the country; but it is important to maintain the momentum that has developed over recent years.
Chapter 5    Cross-country synthesis

5.1 Introduction

The first research question of this thesis, as mentioned in Chapter 1, is: What variables influence the implementation of the FCTC in SIDS of the Pacific and how do they affect its success or failure? Whilst the variables that affect implementation have been explored within each country in Chapter 4, this chapter synthesises the findings across the four countries examined. Firstly, a comparison of tobacco control legislation in each country is provided. This is followed by an exploration of the findings within the 5C Protocol that were common across the four countries, as well as major points of difference. This chapter then explores how the implementation environments of both SIDS and the Pacific Islands may influence FCTC implementation. These synthesised findings are examined with respect to the existing literature and serve as important lessons for other countries seeking to implement the FCTC.

5.2 National tobacco control legislation

The WHO’s (2012h) global progress report on FCTC Implementation states that since ratification, 127 parties (or 80 per cent) out of the 159 that have reported have either strengthened or adopted national tobacco control legislation. Of the 61 parties that did not have legislation at the time of ratification, 46 parties (or 75 per cent) adopted legislation, and legislation is still missing in 15 parties (or 25 per cent) (WHO 2012h). According to parties that have reported on the FCTC, the implementation rates of key provisions (in terms of them being written into national law) include:

- 46 per cent for Article 6 (Price and tax measures);
- 83 per cent for Article 8 (Protection from exposure to tobacco smoke);
- 67 per cent for Article 11 (Packaging and labelling of tobacco products) and;
- 44 per cent for Article 13 (Bans on TAPS). (WHO 2012h)
Each of the four countries examined ratified the FCTC at a similar time. Palau was the first to do so in February 2004, followed by the Cook Islands later that year in May, and Nauru in June 2004 (Framework Convention Alliance 2013). Vanuatu, ratified the FCTC in September 2005 (Framework Convention Alliance 2013) and was the last country of the four examined to do so. In comparison to other countries internationally, the four examined ratified the FCTC relatively early; Vanuatu was just the 85th party out of a total of 177 to do so, while Palau was the ninth (Framework Convention Alliance 2013).

In the Cook Islands, Vanuatu and Nauru, tobacco control bills predominantly compliant with the FCTC became acts without the request of any significant amendments or opposition in parliament. In contrast, Palau’s initial bill, developed in 2007, was subject to numerous delays and amendments until its adoption in 2011. Palau’s tobacco control bill became an act at least two years after the other three countries examined and eight years after FCTC ratification. The Cook Islands passed its legislation just three years after ratification.

The scope of each country’s coverage of minimum FCTC requirements in key articles is shown in Table 12 below.

Table 12: Country compliance with key FCTC articles

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Article 6: Price and tax measures¹</td>
<td>Import levy of NZ$279.50 per 1,000 cigarettes (approx. US$4.70 per pack²) (Tangaroa 2012).</td>
<td>Excise of US$10 per 1,000 cigarettes (approx. US$0.20 per package), plus import levy of 10% of value, plus VAT of 2.5% (Rory 2012).</td>
<td>Import tax of US$2 per pack (Oseked Sr. 2012).</td>
<td>Data not available.</td>
</tr>
<tr>
<td>Article 8: Protection from smoking in public places,</td>
<td></td>
<td>Comprehensive ban on smoking in government facilities, public places,</td>
<td>Comprehensive ban on smoking in educational, sports and healthcare</td>
<td>Comprehensive ban on smoking in all government</td>
</tr>
</tbody>
</table>

¹ Information on the legislation has been simplified for the purposes of this table. Please refer to relevant pieces of legislation for a more detailed description of what is legislated under the respective acts.
exposure to tobacco smoke

workplaces, restaurants and licensed premises (including partially enclosed).

workplaces, restaurants and licensed premises (including partially enclosed).

facilities. Bans on enclosed workplaces only. No bans in designated enclosed smoking areas in restaurants, or permitted smoking rooms in guest accommodation.

facilities, public places, workplaces, restaurants and licensed premises (including partially enclosed).

<table>
<thead>
<tr>
<th>Article 11: Packaging and labelling</th>
<th>Ban on misleading descriptors.</th>
<th>Ban on misleading descriptors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health warnings:</td>
<td>Health warnings:</td>
<td>No existing legislation on health warnings or misleading descriptors.</td>
</tr>
<tr>
<td>• Cover at least 50% of tobacco package;</td>
<td>• Cover at least 30% of tobacco package;</td>
<td></td>
</tr>
<tr>
<td>• Are written in English and Cook Islands Maori and;</td>
<td>• Are written in Bislama, English and French and;</td>
<td></td>
</tr>
<tr>
<td>• Are rotated.</td>
<td>• Are rotated.</td>
<td>No ban on misleading descriptors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health warnings:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cover at least 30% of tobacco package;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Are written in English and;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Are rotated.</td>
</tr>
</tbody>
</table>

Article 13: Bans on TAPS

Comprehensive ban on TAPS. Displays of tobacco products at point of sale permitted if accompanied with a health warning.

Comprehensive ban on TAPS. Displays of tobacco products at point of sale permitted if accompanied with a health warning.

Comprehensive ban on TAPS. Ban on display of tobacco products at point of sale.

Comprehensive ban on TAPS. Displays of tobacco products at point of sale permitted if accompanied with a health warning.

*Italicised text:* Provision does not meet the minimum requirements under the FCTC.

1 There are no explicit minimum taxation requirements under the FCTC and many countries taxed tobacco products before the FCTC came into force. Tobacco taxation is legislated outside of the specific acts mentioned for each country.

2 Calculated assuming a package size of 20 cigarettes per package and an exchange rate of NZ$1 = US$0.84 as at 17 October 2013.


As a whole, the countries examined performed strongly in comparison to the international implementation rates for key FCTC articles. Legislation from the Cook Islands and Vanuatu is compliant with the minimum requirements of key FCTC articles. Nauru’s legislation is largely compliant. Palau’s legislation is the least compliant to the minimum requirements in the FCTC’s key articles. This could be attributed to appeasing the decision-makers in Palau’s congress in order for the legislation to be passed.

Health warnings covering 30 per cent of the tobacco package is the minimum requirement under the FCTC, although it recommends that it covers at least 50 per cent of the package; the Cook Islands is the only country that meets this recommendation. Nauru’s legislation does not explicitly ban misleading descriptors on tobacco packages, in which it does not meet the minimum requirements under
the FCTC. Palau’s legislation does not cover packaging and labelling, which is a major shortfall in comparison to the other countries examined.

The FCTC states that Parties should provide protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places (WHO 2005c). The four countries examined meet most of these requirements. The only limitation is the permission of enclosed smoking areas in restaurants and designated smoking guest house or hotel rooms in Palau. Nauru endured a substantial grace period before the grounds of restaurants, bars and hotels become enclosed public places for the purposes of its Act.

Legislation across all four countries includes a comprehensive ban on TAPS. The FCTC document itself does not stipulate that displays at the point of sale constitute as advertising, although this is stated in the WHO FCTC guidelines on Article 13 (WHO 2013e). Here, Palau’s ban on the display of tobacco products at the point of sale exceeds the requirements of the legislation in the other countries examined, where display at the point of sale is allowed.

### 5.3 Content

Findings relating to the content variable cluster across each of the four countries have been synthesised in the table below.

<table>
<thead>
<tr>
<th>Table 13: Commonalities and differences in content(^\text{16})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common facilitators</strong></td>
</tr>
<tr>
<td>• The goals and causal theory of the FCTC and FCTC-based tobacco control legislation were relevant and unequivocal in each of the countries examined (Martin &amp; de Leeuw 2013).</td>
</tr>
<tr>
<td>• The FCTC provisions overall are seen as achievable, appropriate and effective in all countries (Martin &amp; de Leeuw 2013).</td>
</tr>
<tr>
<td>• Tobacco control acts passed through parliament with little request for amendment or objection in the Cook Islands, Vanuatu and Nauru.</td>
</tr>
<tr>
<td><strong>Common</strong></td>
</tr>
<tr>
<td>• Physical activity and nutrition (in Vanuatu and Nauru), and alcohol use (in the Cook Islands)</td>
</tr>
</tbody>
</table>

\(^\text{16}\)The points written in bold text are the facilitators or barriers deemed to be highly important as they affected numerous FCTC provisions and/or were expressed as a facilitator or barrier to a key variable cluster by a large proportion of informants. This also applies to similar tables in the remainder of this chapter.
barriers

- A minority of FCTC provisions, including illicit trade and providing sustainable alternatives for growing tobacco, were seen as less relevant for the local context in the Cook Islands and Palau.
- Some FCTC provisions were perceived as rather ambitious and difficult to achieve in light of limited capacity (Martin & de Leeuw 2013). This included providing subsidised nicotine replacement therapy, enforcing bans on sales of single cigarettes, and regulating locally-grown tobacco in general. The enforcement of labour-intensive FCTC provisions in rural and remote areas was also cited as a challenge.

Major differences

- Palau’s governing administration suggested that the country’s circumstances must be given precedence and the FCTC should not be adopted “wholesale” (Toribiong 2011a). Hence a more nationalistic and incremental approach to adopting FCTC provisions was undertaken.

The 2010 Global Burden of Disease study confirmed that NCDs associated with tobacco use have been perceived as a growing concern internationally (Lim et al. 2012), which reflects on the appropriateness of the goals, casual theory and methods of FCTC-based legislation. In the Pacific region, Allen (2009) drew upon the rapid increase of NCDs as a key influence of tobacco control in the Pacific, which has primed countries to seize opportunities to confront it. Allen’s (2009) finding is consistent with this study, as a high proportion of informants indicated that high NCD rates justified the importance of the goals, causal theory and methods of the FCTC for their respective countries.

While the influence of tobacco use on the increase of NCDs is extensive, it is not the only cause of its increase. Attention must be paid to other determinants including physical activity and nutrition in particular. If obesity itself is a pervasive issue in contrast to tobacco use, this may place some emphasis away from FCTC implementation in terms of priority setting. However, the opposite affect is also foreseeable – a high prominence of obesity could stimulate activity in tobacco control, given that the methods by which to address various lifestyle risk factors may be related to each other. For example, the UN High-level Meeting on Non-communicable Diseases placed emphasis on smoking alongside other lifestyle risk factors such as salt, sugar and fat intake (WHO 2011a). It could be argued that not as much emphasis would be placed on this meeting, which emphasised FCTC implementation, if other contributors to NCDs were not as prevalent.
The necessity of the goals, causal theory and methods of the FCTC can be validated further by its high ratification rate, given that 177 parties out of a possible 196 have ratified (Framework Convention Alliance 2013). If the FCTC is ratified by a country, then presumably its goals, causal theory and methods are of significant value to its government. In the countries examined, there were no objections to the effectiveness of the methods in the majority of FCTC provisions, including taxation, packaging and labelling, smoke-free environments and bans on TAPS. The ability for the Cook Islands, Vanuatu and Nauru to pass FCTC-based tobacco control legislation through their parliaments with little or no objection was a testament to the methods in the FCTC.

Despite the overall necessity of FCTC methods, there were certain provisions, such as illicit trade and the provision of sustainable alternatives to growing tobacco, which were perceived by informants as less relevant. Illicit trade in tobacco is rather prominent in other WPRO countries such as Malaysia, the Philippines and Vietnam (Eriksen, Mackay & Ross 2012). However, key informants in the Cook Islands suggested that this does not occur in their country. The limited emphasis on both of these provisions in this study may be linked with the remoteness of SIDS such as the Cook Islands to global trade markets (Briguglio 1995), which may limit the potential profitability of (licit and illicit) tobacco manufacturing companies (Martin & de Leeuw 2013). This is explained in more detail in Chapter 5.8. Policies that regulate this activity may be seen as less relevant in SIDS than in countries with substantially larger markets and those that have the ability to exploit economies of scale.

The necessity of FCTC methods was influenced by the level of perceived capacity to implement them. The FCTC provisions that require active enforcement, such as bans on the sales of individual cigarettes, regulating locally grown tobacco and illicit trade, may consume scarce government resources and be restricted by limited local capacity. This may result in decision-makers perceiving these provisions as more difficult to implement. Internationally, there is less evidence to support the cost-effectiveness of supply-side tobacco control interventions (Jha & Chaloupka 1999) and it has been appreciated that the enforcement of such policies requires
infrastructure and resources that do not exist in many low- and middle-income countries (Jha et al. 2006). This difficulty is exacerbated when taking into account rurality and remoteness which often feature strongly in SIDS, which is discussed in more detail in Chapter 5.8.

Although Palau’s RPPL 8-27 constitutes as a large change in comparison to countries that have not introduced tobacco control legislation, the extent of this change is slightly more incremental and less comprehensive than in the other countries examined. The justification given by the governing administration for this aligns with the fiscal capacity of governments and the concentration of interests (i.e. in the tourism trade) being a source of incrementalism in health policy, as described by Oliver (2006). Time will determine whether or not introducing somewhat more piecemeal legislation and amending it in future, in contrast to introducing comprehensive legislation, is prohibitive to FCTC implementation. It has been claimed that there is a potential for rapid policy development in small nations (Baldacchino & Bertram 2009), which may attribute to the relative ease by which the Cook Islands, Nauru and Vanuatu passed their tobacco control legislation. Palau’s experience was to the contrary and is an example of how significant political opposition can delay and weaken tobacco control legislation. It was also highlighted in Nauru that political insecurity can result in delayed tobacco control legislation, although this delay was relatively short.

### 5.4 Context

Table 14: Commonalities and differences in the institutional context

<table>
<thead>
<tr>
<th>Common facilitators</th>
<th>The MOH oversees the majority of FCTC provisions in the Cook Islands, Vanuatu and Nauru.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Networks within MOH departments were supportive in all cases (Martin &amp; de Leeuw 2013).</td>
</tr>
<tr>
<td></td>
<td>Networks with external agencies (such as the WHO, SPC, Allen and Clarke, AusAID, NZAID) were supportive, though they were not necessarily highly involved at the ground level. These networks were geopolitically oriented.</td>
</tr>
</tbody>
</table>

| Common barriers | Political insecurity contributed to a slight delay of tobacco legislation in Nauru, and may have contributed to delays in passing regulations in Vanuatu. |
|-----------------| Networks between key actors in ministries of health and government departments in other areas tended to be fairly weak (Martin & de Leeuw 2013). |
|                 | Networks between ministries of health and NGOs in tobacco control were not evident in |
countries where these NGOs did not exist (Vanuatu, Nauru, and to a lesser extent, the Cook Islands) (Martin & de Leeuw 2013).

<table>
<thead>
<tr>
<th>Major differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A significant proportion of FCTC provisions fall outside the Palau MOH.</td>
</tr>
<tr>
<td>• Institutional adaptation to FCTC-based policies varied across countries; it was most progressed in Cook Islands and least progressed in Palau.</td>
</tr>
<tr>
<td>• Vanuatu had closer links to the WHO and SPC through in-country staff, which did not exist in other countries.</td>
</tr>
</tbody>
</table>

Institutional networks within ministries of health with regard to FCTC implementation, such as between the health promotion department, environmental health officers, and their management were typically strong and supportive. As the MOH is a central and key actor to FCTC implementation, this support is crucial. These groups tended to act in unison and there was no evidence of any major conflict. Similarly, there is no detailed evidence of poor networks or internal conflict within ministries of health being a barrier to FCTC implementation in developing countries in the literature.

Supportive networks were evident between each MOH and the WHO, SPC, bilateral aid agencies and the FCA. However, Vanuatu was the only country to contain in-country staff from the WHO and SPC. In all other countries, these two agencies did not have a representation in the form of permanent in-country staff. The WHO, SPC and bilateral aid agencies tended to play more of a role at a broader health systems or NCD level, rather than specifically in FCTC implementation or tobacco control. The WHO’s focus on health systems is important in order to operate strategically when demands grow and resources are stretched (WHO 2007). In Nauru it was mentioned that the broader system-wide support exhibited by such agencies provides the country with greater autonomy and capacity for long-term planning, rather than it being reliant on narrow streams of funding that may divert resources from other important health issues. This finding highlights the importance of (horizontal) health systems and their influence on (vertical) FCTC implementation. Atun, Bennett and Duran (2008) suggest that neither perspective should necessarily be considered superior, as both vertical and horizontal programs can be beneficial in difference contexts and there is no reason why they should not coexist.
Strong networks between ministries of health and NGOs/CSOs in tobacco control were only apparent where these organisations existed. These networks were reasonably strong in Palau, and in the Cook Islands while their coalition group was active. In Vanuatu and Nauru, such organisations did not exist, meaning that these countries could not benefit from NGO and CSO participation in tobacco control and FCTC implementation. The absence of these organisations is discussed further in Chapter 5.7.

The establishment of strong networks across government departments outside the health domain was significantly more challenged. There were few examples of successful and ongoing interdepartmental collaboration across the middle or ground levels of government departments. This can operate as a major barrier given the need for whole-of-government support for FCTC implementation. Other studies on FCTC implementation in developing countries have not assessed networks and relationships between government departments, but many recognise the importance of whole-of-government commitment, which is explored later in this chapter. The establishment of networks across various government departments should be seen as an important precursor to ascertaining whole-of-government commitment. Internationally, it appears that this is a common barrier. The WHO (2012h) cited a lack of or weakness of inter-sectoral coordination within countries as one of the most frequently mentioned constraints to FCTC implementation in 2012.

The MOH is typically more familiar with the harms of tobacco use and the benefit of implementing measures to reduce it. Therefore it could be asserted that through ministries of health having greater authority to implement and enforce FCTC provisions, a greater commitment to implementation will result, in contrast to other departments of government (assuming the level of capacity across departments is similar). Having ministries of health oversee the majority of FCTC provisions in the Cook Islands, Vanuatu and Nauru may be considered favourable to Palau’s scenario, where its legislation suggests that a significant proportion of decisions regarding FCTC implementation are determined outside its MOH. This is dependent on the
political structure of the country and the authorities designated in tobacco control legislation, which may be rigid. Nonetheless, such authority could have significant implications for FCTC implementation. MOH networks with other government departments, and the commitment of other government departments to FCTC provisions, were both weaker in this study. If a large proportion of FCTC provisions are enforceable by authorities outside the MOH, then an even greater emphasis should be placed towards it establishing networks with and facilitating commitment in these authorities.

All countries institutionalised at least some aspects of FCTC-based policies, particularly those within key provisions. The extent to which they had become institutionalised varied. In Vanuatu and to a certain extent, Nauru and the Cook Islands, this was limited by a lack of resources or competing priorities, which is a common constraint when implementing health regulations in developing countries (Gostin et al. 2010). It is important that not only legislation is passed through parliament, but that the adaptive capability of relevant institutions is sufficient to meet the requirements for implementation and enforcement. Consideration of this should be made upon developing legislation. The variability of the extent to which institutions have adapted in this study serves to caution any assumption that institutions will naturally adapt to FCTC provisions once the treaty has been ratified and national tobacco control legislation has passed.

5.5 Commitment

Table 15: Commonalities and differences in commitment

<table>
<thead>
<tr>
<th>Common facilitators</th>
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<tbody>
<tr>
<td>- Smoke-free policies in MOH offices were often seen as a symbol of commitment.</td>
</tr>
<tr>
<td>- MOH commitment tended to be favourable, although competing health issues was a</td>
</tr>
<tr>
<td>limiting factor MOH commitment in the Cook Islands, Vanuatu and Nauru (Martin &amp; de</td>
</tr>
<tr>
<td>Leeuw 2013).</td>
</tr>
<tr>
<td>- The passage of legislation in each country indicates some intent for whole-of-government</td>
</tr>
<tr>
<td>commitment.</td>
</tr>
<tr>
<td>- External agencies were seen as supportive to, although not key drivers of, commitment.</td>
</tr>
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<table>
<thead>
<tr>
<th>Common barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- There was a tendency for enforcement to be incremental.</td>
</tr>
<tr>
<td>- Commitment at the ground level was hindered by limited staffing and competing</td>
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<tr>
<td>issues (Cook Islands/Nauru) and rurality/remote ness (Vanuatu and to some extent</td>
</tr>
<tr>
<td>the Cook Islands) (Martin &amp; de Leeuw 2013).</td>
</tr>
<tr>
<td>- Whole-of-government commitment is challenged in departments outside health.</td>
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</tbody>
</table>
Commitment from the ministry of finance or equivalent, police authorities, legal departments to FCTC provisions from all countries tended to be relatively weak. (Martin & de Leeuw 2013)

- Very limited use of litigation and prosecution under national tobacco control legislation was evident in all countries.

### Major differences

- In Vanuatu, the lack of regulations was a significant limiting factor to commitment and particularly enforcement.
- Commitment to FCTC provisions from high level decision-makers was a major barrier in Palau.

Countries tended to undertake a phased approach to the enforcement of FCTC provisions, and in particular smoke-free public places. In Nauru, for example, the coming into force of various provisions came from between 6 months to 39 months after certification of the tobacco control legislation, depending on the provision. The latest implementation dates were set for the stricter definition of enclosed public places to come into force (i.e. from the definition of public places meaning indoor spaces in government buildings to it meaning any part of the grounds of government buildings). Such an approach to implementing smoke-free public places may not be uncommon internationally. The WHO (2013e) guidelines suggest that many jurisdictions recommend an initial period of soft enforcement (where violators are cautioned but not penalised) provided that businesses understand this will be followed by more rigorous enforcement.

At the MOH level in each country, commitment to FCTC implementation was generally favourable as its provisions tended to resonate strongly amongst staff and organisationally. This is unsurprising due to the nature of the FCTC and the extent of the health burden it seeks to address. However, a compromising factor in three of the four countries examined was key MOH staff having various other priorities competing for their time. Enforcement officers for tobacco control typically oversaw other health issues such as sanitation and food hygiene, for example. This may be a common occurrence internationally as a survey of environmental health organisations in 36 countries (consisting of both developing and developed) revealed that tobacco control was given a low priority amongst environmental
enforcement agencies (Mulcahy et al. 2009). This factor is strongly linked with capacity, which is discussed in Chapter 5.6.

Having smoke-free (and in the case of Palau, chew-free) MOH and/or government offices was perceived by a number of informants as both an important and symbolic commitment to FCTC implementation and tobacco control. Such places, along with schools and hospitals, tend to be among the first where smoke-free provisions are implemented and may be important in establishing a trend towards mandating smoke-free environments in other types of workplaces.

The passage of FCTC-compliant national tobacco control legislation itself is an indicator of whole-of-government commitment (or intent to commit at the least). All countries examined exhibited some commitment at the whole-of-government level in doing this. According to FCTC reporting, not all countries have experienced success in strengthening national legislation since FCTC ratification (WHO 2012h). The key barrier to whole-of-government commitment in this study was sustaining commitment to FCTC implementation in government departments outside the MOH. Despite the MOH in each country being interested, neither country was able to earmark tobacco taxes for health promotion or tobacco control purposes. This disparity in commitment between the MOH and other government departments was also seen through a more limited understanding of and level of enforcement of FCTC provisions by government departments outside of health, and limited whole-of-government participation in multi-sectoral task forces or committees in tobacco control/FCTC implementation. The lack of whole-of-government commitment is not uncommon internationally; the 2012 global progress report on FCTC implementation states that the “lack or weakness of inter-sectoral collaboration within countries, including the lack of understanding, interest or commitment of sectors other than health regarding the need for inter-sectoral action for tobacco control” (WHO 2012h; p. 64) is among the most frequent constraints mentioned. Other studies document that the lack of commitment or prioritisation of tobacco control in government departments outside of health was a significant concern in
developing countries such as China (Yang et al. 2010), Ghana (Owusu-Dabo et al. 2010) and Ecuador (Otanez, Mamudu & Glantz 2009).

A further concern to commitment is the lack of litigation and prosecution based on the tobacco control legislation in the countries examined thus far. This may be attributable to the relative newness of national legislation, as well as the tendency to incrementally increase enforcement. A lack of capacity or commitment in legal departments could be a contributing factor. The 2012 FCTC global progress report states that “although one quarter of the Parties reported having in place frameworks for criminal and civil liability in relation to tobacco control, relatively few reported details on operationalizing such frameworks” (2012h; p. 51), suggesting a need for development in this area of the FCTC internationally.

External agencies such as the WHO, FCS, SPC, AusAID, NZAID, FCA and Allen and Clarke were supportive of commitment through various activities such as advocacy, technical support, collaboration and funding. However, such agencies were somewhat peripheral to the national level of each government, which tended to be the principle determinant of commitment to the FCTC according to participants in this study. The national level government is responsible for FCTC ratification, passing national tobacco control legislation, the primary funder of implementation and the enforcer of most aspects of it. This is in line with the discussion on FCTC governance in Chapter 1.

One of the distinct differences in commitment across the four countries examined was the absence of Vanuatu’s regulations. This substantially prohibited commitment, particularly through the country’s enforcement officers being unable to actively enforce FCTC-based provisions. This case demonstrates the importance of having specific regulations to accompany tobacco control legislation, where required, in order to implement the FCTC.

Another distinct difference was evident in challenges attaining commitment from senior decision makers in Palau’s congress, which acted as the country’s foremost barrier to FCTC implementation at the time of interviews. The evidence from this
study tentatively suggests this lack of commitment was to protect the political interests of the governing administration rather than through overt tobacco industry opposition and influence. This may be in contrast to other developing countries whose national legislation was eroded or subverted by tobacco industry opposition, such as Lebanon (Nakkash & Lee 2009), Uzbekistan (Gilmore, Collin & McKee 2006), Ecuador (Albuja & Daynard 2009) and Argentina (Sebrie et al. 2005). However, clandestine activities from the tobacco industry in Palau’s case cannot be ruled out. It was found in the course of this inquiry that Philip Morris and British American Tobacco representatives sought to meet with government staff in the countries examined. Furthermore, the tobacco industry has been known to collude with and corrupt public officials (Saloojee & Dagli 2000). British American Tobacco’s influence on Kenya’s tobacco control policy through high level political connections (Patel, Collin & Gilmore 2007) is an example of this kind of influence.

### 5.6 Capacity

**Table 16: Commonalities and differences in capacity**

<table>
<thead>
<tr>
<th>Common facilitators</th>
<th>The FCTC and subsequent national tobacco control legislation partially facilitated the appointment of new staff in tobacco control implementation/enforcement.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>STEPS and GYTS surveys strongly contributed to the knowledge and monitoring of tobacco use.</td>
</tr>
<tr>
<td></td>
<td>The authority mandated in MOH staff to enforce FCTC provisions facilitated implementation in the Cook Islands, Vanuatu and Nauru.</td>
</tr>
<tr>
<td></td>
<td>Funding was commonly supported externally by the WHO, SPC, AusAID, NZAID and US CDC (Martin &amp; de Leeuw 2013).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common barriers</th>
<th>The lack of repeat STEPS and GYTS surveys in the Cook Islands, Vanuatu and Nauru limited the ability to analyse recent trends in tobacco use.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A lack of staff and competing priorities amongst existing staff, particularly those at the ground level, was a major barrier in the Cook Islands, Vanuatu and Nauru, and to a lesser extent, Palau. The tobacco control focal point in the Cook Islands, Vanuatu and Nauru consisted of one person (or less than the full time work load of one person if their other responsibilities are considered). (Martin &amp; de Leeuw 2013)</td>
</tr>
<tr>
<td></td>
<td>There was a desire for further training and skill development amongst staff.</td>
</tr>
<tr>
<td></td>
<td>Monitoring of compliance was rather piecemeal in the countries that had passed legislation at the time of interviews.</td>
</tr>
<tr>
<td></td>
<td>A lack of funding or resources was amongst the most severe barriers to FCTC implementation in the Cook Islands, Vanuatu and Nauru. Sustainable funding mechanisms in the form of earmarking taxes to health promotion/tobacco control have not been achieved in either country. (Martin &amp; de Leeuw 2013)</td>
</tr>
<tr>
<td></td>
<td>Conducting activities in rural and remote areas in countries with a high proportion of rural residents strained capacity (Vanuatu, and to a lesser extent, the Cook Islands).</td>
</tr>
</tbody>
</table>

| Major differences   | Palau was more strongly placed in terms of capacity than the other countries examined, with four staff dedicated to tobacco control activities, which was as a result of US funding. |
Across all countries examined, capacity was the most significant challenge to FCTC implementation. Although tobacco control legislation (combined with other health-related legislation) typically resulted in an increased number of staff to oversee enforcement, limited staffing (and a lack of funding) was pervasive in the Cook Islands, Vanuatu and Nauru. This was perceived as a lesser challenge in Palau, but the country was yet to enforce several FCTC provisions at the time of the interviews. The tobacco control focal point in the former three countries consisted of one person who often had other responsibilities, which is explained in more detail in Chapter 5.8. Allen (2009) also noted the small workforce and competing demands within these small workforces in the Pacific Islands. This study found that existing staff in the countries examined had some desire for skill development and training on implementing tobacco control legislation, which may be attributable to the newness of the legislation, recent advancements in tobacco control, in addition to the limited pool of skilled workers just mentioned. Staff training is a common need and source of technical assistance for FCTC implementation internationally (WHO 2012h).

The mandated authority designated to enforcement in environmental health officers and other officials significantly expanded capacity for FCTC implementation in most of the countries examined. In Vanuatu, however, the lack of regulations hampered the ability for enforcement officers, which was a key point of difference between this country and the others that passed legislation at the time of interviews (the Cook Islands and Nauru).

Capacity in the form of knowledge, surveillance and monitoring of tobacco use and tobacco control measures was significantly aided by GYTS and STEPS surveys across all countries. These tended to be the primary mechanisms by data on tobacco use prevalence, public support, people’s exposure to environmental tobacco smoke and tobacco advertising were obtained. The GYTS and STEPS surveys were strongly
supported by the WHO, SPC and bilateral aid agencies. A significant concern was that aside from Palau, there was limited repetition of such surveys thus far. This limits the ability to analyse data trends and therefore the impact of recent efforts to implement the FCTC on tobacco use. On his evaluation of tobacco control programs in the Pacific in 2008, Douglas (2008) found that despite some studies being supported by external agencies, the consequences of tobacco use had not been quantified locally and so offered little leverage for public awareness. In another report on the same program, Allen (2009) cited the lack of a domestic evidence base in the Pacific Islands. Given the presence of large-scale studies conducted more recently, this situation has improved since these reports were published. However, information on monitoring the compliance with FCTC-based provisions tended to be in its infancy across all countries. The lack of monitoring of compliance as a result of limited capacity has been cited as a barrier to bans on sales to minors internationally (WHO 2012h).

Capacity logistics in the form of number and skill levels of staff, mandated authority and knowledge are driven by the political allocation of resources. In the Cook Islands, Vanuatu and Nauru, it was clear that both individual staff and government departments were stretched thin amidst competing health (and other non-health) issues (Martin & de Leeuw 2013). The 2012 FCTC global progress report stated over half of the parties that submitted FCTC reports identified gaps between the resources available and the needs assessed (WHO 2012h), suggesting this is pertinent across developing countries internationally. Cussen and McCool (2011) also cite a need for resources to support tobacco promotion bans in the Pacific Islands. Some evidence suggests that the limited presence of resources may be further compounded in SIDS, as explained in Chapter 5.8. Douglas (2008) found that tobacco control programs in the Pacific are undertaken on very limited budgets, not confined to tobacco control and with the exception of the Solomon Islands (the largest of the countries observed), the countries are small and key staff in health promotion carry a number of responsibilities. Allen (2009) similarly reflects on domestic resource constraints and the small workforce in tobacco control. Even when technical support is provided, progress will be challenged in the absence of
sustainable funding levels (Douglas 2008). Outside the main towns, rurality and remoteness featured as significant barriers to enforcement in the Cook Islands and Vanuatu, which is explained in more detail in Chapter 5.8. This has been cited as a barrier to the enforcement of the FCTC in Fiji (WHO 2012h). Similarly, Douglas (2008) found that the implementation of tobacco control programs in rural populations was particularly limited by the lack of resources in the Pacific.

The lack of a sustainable funding mechanism compounds concerns related to capacity. Tonga is the only Pacific Island nation to fully accomplish this innovative mechanism to fund health promotion and tobacco control activities, through its health promotion foundation (Government of Tonga 2010). In the countries examined, substantial and targeted funding for FCTC implementation could not be obtained from international and bilateral agencies either. These agencies tended provide health system-wide support, rather than in tobacco control specifically. Tonga’s scenario is an exception to the norm. Allen (2009) states that there is a lack of sustainable funding for tobacco control in almost all Pacific Island countries. Insufficient resources for tobacco control was cited as a common barrier to implementation in FCTC reporting internationally (WHO 2012h).

A key difference between the countries examined was the state of capacity in Palau in comparison to the Cook Islands, Vanuatu and Nauru. Although its recent FCTC-based legislation had not passed through parliament at the time of interviews (hence the ability to determine the desired capacity is more tentative), capacity was cited much less frequently as a barrier to FCTC implementation in Palau. The country was endowed with four full-time staff dedicated to tobacco control health promotion activities, significantly more than in the other countries examined. This is attributable to the substantial level of US funding support, even though it was not tied to FCTC implementation specifically.

### 5.7 Clients and coalitions

#### Table 17: Commonalities and differences in clients and coalitions

| Common | NGOs were influential in advocating for FCTC-based legislation, where they existed (Palau) |

156
facilitators

- Church organisations and traditional chiefs are potential sources of support for tobacco control and FCTC implementation.
- World No Tobacco Day was a common avenue for community awareness in each of the countries examined.
- Limited public pro-tobacco coalition activity existed in all countries examined (Martin & de Leeuw 2013). Such activity was piecemeal and limited to those with a direct interest rather than a distinct public advocacy group being present.
- The general population has been supportive of tobacco control measures overall, as indicated in each of the countries examined. There has been no public protest or attempts to disrupt FCTC implementation by clients. (Martin & de Leeuw 2013)
- Many key FCTC provisions reached the intended clients in most countries.

Common barriers

- Anti-tobacco NGOs were non-existent in Vanuatu and Nauru, and a coalition group was inactive for some time in the Cook Islands. Where they did exist, there was limited funding and a strong reliance on volunteers. (Martin & de Leeuw 2013)
- Community awareness activities, in the absence of NGOs, were limited to those run by government actors (Vanuatu, Nauru, and to a lesser extent, the Cook Islands).
- Community awareness was limited in rural and remote areas in the Cook Islands and Vanuatu.
- Representatives from Philip Morris and British American Tobacco would occasionally visit the Cook Islands, Vanuatu and Palau and attempt to conduct meetings with government representatives.
- Minor opposition to certain tobacco control measures in some segments of the population, particularly from smokers, was apparent.

Major differences

- Palau was the only country with a consistently active anti-tobacco NGO.

Anti-tobacco NGO activity was limited and rather piecemeal across the four countries examined. NGOs with a focus on tobacco control did not exist in Vanuatu or Nauru, and the main coalition group in the Cook Islands had been inactive. The lack of anti-tobacco coalition activity is not dissimilar to several other developing countries as studies in Tanzania, Nepal, China and Ecuador (Albuja & Daynard 2009; Sussman et al. 2007) have revealed. However, there is still some anti-tobacco NGO representation in these countries, unlike in Vanuatu and Nauru. This lack of representation may be influenced by the small populations and limited institutional capacity of SIDS (Briguglio 1995), resulting in limited coalition activity towards health policy implementation (Martin & de Leeuw 2013; McNaught 2003), which is explained in more detail in Chapter 5.8. Douglas (2008) suggested that the establishment of community advocacy groups had not been achieved in Vanuatu or the Solomon Islands, and inter-sectoral dialogue had not been effective, limiting community advocacy.
With a relatively strong and active anti-tobacco NGO in the CTFP, Palau was the exception of the countries examined, demonstrating that a strong anti-tobacco NGO presence is achievable in a small island country. For developing countries internationally, Thailand is well renowned for its anti-tobacco activism, which has been instrumental in encouraging FCTC implementation (Charoenca et al. 2012; Sussman et al. 2007). In Palau’s scenario, like the TCWG in the Cook Islands, the CTFP was dependent on a small group of volunteers with very limited access to funding, which is contrast to the well-established NGOs typically present in larger countries. Both the TCWG and CTFP were influential in advocating for FCTC-based legislation. They advocated within small, close-knit networks and sometimes used personal contacts for advocacy, which is explained further in Chapter 5.8. Allen (2009) noted that in the Pacific Islands there may be an ability to reach decision-makers more readily as there tends to be smaller populations, one level of government setting legislation, and a lack of decentralisation of services.

There was some tendency for anti-tobacco non-government/civil society actors to be integrated with government agencies, which was most evident in the Cook Islands’ TCWG. Some inclination towards this was evident in Vanuatu and Nauru. This may be due to the aforementioned lack of anti-tobacco coalition activity and NGO representation; in scenarios where NGOs do not exist in the form of large, formal institutions, the related roles may fall upon few interested individuals who also have close networks with government staff, or government staff themselves.

Outside anti-tobacco NGOs, traditional chiefs and church organisations serve as potential allies that can facilitate FCTC implementation. In this study, they were either neutral to, or supportive of FCTC implementation. Church organisations tended to be fairly peripheral actors and their advocacy was typically restricted to their own members. Traditional chiefs in Palau were more directly involved in advocating for FCTC-based legislation. Given the respected role of traditional leaders in their countries, particularly in rural areas, they may hold significant political weight when advocating for tobacco control. Internationally, and particularly in parts of the Middle East and Asia, religious organisations were found
to be influential in tobacco cessation (Yong et al. 2009) and tobacco control policymaking (Cairney, Studlar & Mamudu 2012; El Awa 2004). This is explained in more detail in Chapter 5.9.

World No Tobacco Day, facilitated by the WHO, was a significant and common avenue for anti-tobacco community awareness in the countries examined. It has gained traction internationally, with a high proportion of countries participating (Ayers et al. 2012; MacKay & Eriksen 2002). Beyond this event and outside of Palau, community awareness activities in this study were often limited to government initiatives as anti-tobacco NGOs were not present. This was especially the case in Vanuatu and Nauru. There was limited community awareness reach in rural and remote areas in the countries examined. Internationally, the vast majority of studies in developing countries focus on tobacco use prevalence, NCDs or existing levels of education in rural areas, rather than examining the level of community awareness. However, Yudkin, Duling and Mueller (2012) highlight the lack of awareness efforts towards NCDs in rural India and that strained financial resources are a barrier to achieving this.

With the exception of Ni-Vanuatu farmers who grew tobacco on a small, non-industrialised scale, no country in this study had a local tobacco manufacturing presence and all were heavily reliant on the importation of tobacco. This may be common amongst SIDS internationally and is explained in more detail in Chapter 5.8. Of all Pacific Island nations, only Papua New Guinea, Fiji, the Solomon Islands and Samoa have tobacco factories, according to Eriksen and colleagues (2012).

There was little public\textsuperscript{17} pro-tobacco coalition activity in the countries examined. Such activity tended to be limited to individual business owners or importers providing complaints to government, rather than through large-scale industry

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\textsuperscript{17} The word “public” is used here as there was some suspicion amongst informants of private tobacco industry lobbying in Palau. Furthermore, it is difficult to monitor clandestine tobacco industry activity while conducting ethical research. Historically, the tobacco industry has used clandestine operations to attempt to thwart tobacco control activities internationally.
advertising campaigns, protests, advocacy front-groups, political donations and so forth. This may be partially attributable to the lack of tobacco manufacturing presence and the comparatively small markets of SIDS and Pacific Island nations in comparison to other countries (Martin & de Leeuw 2013), as explained in Chapter 5.8. This finding is in contrast to other, and perhaps larger, countries internationally where tobacco industry activity can be prolific in its marketing, funding, lobbying and facilitating undue influence against tobacco control (Cairney, Studlar & Mamudu 2012; Eriksen, Mackay & Ross 2012; Lee, Ling & Glantz 2012).

Despite the absence of local tobacco manufacturing and fairly limited pro-tobacco coalition activity, there was still some degree of suspected tobacco industry interference with health policies. It was common in the countries examined for representatives of major importers British American Tobacco and Philip Morris to visit these countries and attempt to conduct meetings with government representatives. In Palau, industry representatives attempted to make their own translated health warnings for its imported tobacco packages and the literal translations were claimed to be of poor quality. Both lobbying to influence public policy and pre-empting strong legislation by pressing for weaker changes are well known tobacco industry tactics (Lee, Ling & Glantz 2012; Saloojee & Dagli 2000).

Clients were generally supportive of most tobacco control measures within each country. This perception varied in some cases. For example, businesses tended not to be in favour of tax increases and it was claimed that smokers were somewhat less supportive than non-smokers of regulations such as tax increases and smoke-free public places. Overall, the public reaction to tobacco control regulations tended to be favourable and there was little evidence of strong opposition against FCTC-based provisions. No public protests or attempts from the general public to disrupt FCTC implementation were evident. While a plethora of studies have examined public support for tobacco control internationally over a long period of time in many different populations, the examining of which goes beyond the realms of this research, recent studies suggest public support is growing internationally and favourable in countries such as China (Yang et al. 2007), Kenya (Maina, Kitonyo &
Elements of the FCTC reached the public in all countries examined, as each made progress towards its implementation. However, there was some variation. The Cook Islands saw the most significant changes, some provisions had reached populations in Vanuatu and Nauru, while Palau had just implemented, or was on the cusp of implementing, several provisions in 2012. Such changes are likely to contribute toward some decline in tobacco use prevalence in all four countries; prevalence studies in the future will verify if this is so. Significant progress has been achieved in bans on TAPS, packaging and labelling, smoke-free public places, and to a lesser extent, tax increases. Internationally, momentum toward FCTC-based policies reaching their intended populations has been established. Amongst the key FCTC provisions and similar to the countries examined, the most progress has been made in bans on TAPS and smoke-free public places (WHO 2012h). When considering all substantive FCTC articles, however, international progress has been more subdued, which is also indicative of this study. The WHO (2012h) suggested that implementation across all articles increased by just 4 per cent for the relatively short time period between 2010 and 2012.

5.8 FCTC implementation in the environments of SIDS

The earlier sections of this chapter explored each of the variable clusters that proximally affected FCTC implementation, while the remainder of this chapter explores the environments of SIDS (and of the Pacific Islands, in Chapter 5.9) that were found to affect FCTC implementation distally across the countries examined. Given the paucity of research on health policy in SIDS, it is important that key themes on the SIDS environment are discussed in further detail and conceptualised in their own right. These themes may be applicable to SIDS internationally and in particular to those with similar geographical, political, economic and social environments to the countries examined. As they are inherent within the implementation environment, they may also apply to policy domains outside
health. This is not a prescriptive theory in which all themes can apply to all SIDS unequivocally: each country faces distinct circumstances. At the same time, if we cannot extrapolate theories from one country to another, then country case studies serve no purpose for countries outside of the initial case. The key themes below lie within this continuum. Not all of the themes presented here will be evident in all SIDS, but it is likely that they will be present within a given SIDS. These are summarised in the table below and now explored.

Table 18: The environments of SIDS and their effects on FCTC implementation

<table>
<thead>
<tr>
<th>Theme of SIDS environment</th>
<th>Proximal effect on FCTC implementation</th>
</tr>
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</table>
| Rural and remote islands and communities                      | • Establishing institutional networks and strong commitment in rural and remote areas can be challenged due to communication and distance barriers.  
• Enforcement, community awareness, training, monitoring and surveillance activities in rural and remote areas can be inefficient and may diminish the already limited resources available. |
| Limited anti-tobacco NGO/civil society activism               | • Tobacco control NGO/CSO presence may be limited and therefore may not facilitate commitment and capacity towards FCTC implementation. This could serve to benefit the pro-tobacco coalition. |
| Limited pro-tobacco activism and industry presence            | • Pro-tobacco coalitions may not be present to influence FCTC implementation. This could increase commitment to tobacco control and serve to benefit the anti-tobacco coalition.  
• Local tobacco manufacturing may not exist, which could lead to methods to controlling tobacco becoming more appealing for decision-makers. |
| A lack of administrative capacity and a small number of staff “wearing many hats” | • There may be less capacity to implement FCTC provisions and in particular those that are labour-intensive. FCTC provisions that demand capacity may become less appealing.  
• Government departments may lack technical skills and be reliant on foreign expertise.  
• Staff may have competing commitments for their time and efforts.  
• Implementers and coalitions may utilise a more streamlined, flexible approach to FCTC implementation. |
| Small and personalised networks and relationships              | • The institutional context consists of fewer organisations and staff members.  
• Close-knit and cohesive tobacco control networks may stimulate commitment, but they can act as a barrier if antagonism within these networks is present.  
• Activism can be constrained as people may not want to protest against the actions of those whom they know.  
• Enforcement officers may be reluctant to enforce provisions on friends and family, which could affect commitment. |
| A strong influence from regional forces                       | • Powerful overseas institutions (relative to SIDS) may be influential in terms of content, capacity and coalition activity.  
• The FCTC provisions implemented in larger countries nearby may have an impact on SIDS (i.e. those regarding packaging and labelling, illicit trade and community awareness).  
• The concerns of larger countries and organisations, which may be less relevant for SIDS, may dominate the regional/international discourse on FCTC implementation. |
5.8.1 Rural and remote islands and communities

Briguglio (1995) explains several economic vulnerabilities associated with remoteness in SIDS, including: high per-unit transport and uncertainties of supply, which are as a result of the inability to use land transport, small cargoes and diseconomies of scale, and SIDS economies being excluded from major sea and air transport routes. While this concept has some emphasis on goods, it can similarly apply to services and government administration – remote islands may be hard and expensive to communicate with and access, and may be distant from the administrative hubs of larger towns. The small size of SIDS in addition to this remoteness also leads to functions of government being more expensive per capita (Briguglio 1995) and public sector efficiency being lower than in larger countries (Feeny & Rogers 2008). Rurality and remoteness are of course not unique to SIDS. Problems associated with this can be faced in large countries with dispersed populations such as Australia and Canada. However, the vast majority of SIDS, as well as three out of four in this study, are made up of very small populations that are spread across several islands or archipelagos, meaning that this theme may be common in such countries. The effect of rurality and remoteness on FCTC implementation emerged strongly in the Cook Islands and Vanuatu. It did not appear in Nauru, which consists of only one small island. The presence of rural and remote communities created two significant challenges to FCTC implementation.

Firstly, barriers in both language and geography impeded communication and community awareness. It can be difficult for implementers to meet clients in person, or to raise awareness through a particular medium of communication:

Well one barrier... is the language barrier between the people in the rural areas, where you need to create the – how you are going to communicate the message to the community. So there are times when we do have interpreters to interpret the message.

*Interviewer:* Is that in the remote [and] outer islands?
Yeah, the outer islands, although even here in Rarotonga, there are remote areas where most of the people that attend are sort of non-English speakers. (Cook Islander informant)

[In relation to] the understanding of the law by the business people and the population at large, because with many... small countries like Vanuatu, there is not – I mean firstly the literacy level is low, especially in communities and then coupled with that is the fact that you don’t have a good medium to pass this information. I mean like you don’t have TV in the islands. You do have radio, but there’s only a certain amount of information [that] can be absorbed or obtained [through] radio, and so you need lots of different media and fora in order into to increase the level of awareness of the people, and then perhaps... the implementation would become a bit easier. (Ni-Vanuatu informant)

Rurality and remoteness also impeded enforcement activities due to distance and difficulties in communication. Informants cited particular concerns for the enforcement of policies that are labour intensive such as bans on sales of single cigarettes, bans on sales to minors and controls on local tobacco growing:

I would like to take this service out to the outer islands and even to enforce the law in the outer islands but we can’t.

*Interviewer:* Yes, and what’s the position at the moment for the outer islands?

They are expected to comply with the law, yeah, but because there is no one there to enforce that – so we depend on the leaders of the island. But in some cases [the leaders] are the heaviest smokers on the island, so it’s hard to ask them to monitor that when they are smoking. (Cook Islander informant)

In Vanuatu there are six provinces, and then – [I’m] talking about people trying to implement the WHO FCTC, there’s only one person – a Health Inspector in each province that is trying to do a [few] things for the
enforcement, and really I must admit to you that in regards [to] our geographical situation, it’s not really easy for this guy to visit all the villages and all the islands, and considering again the resources we are lacking with, it makes things more difficult. (Ni-Vanuatu informant)

Communication barriers may alter the parameters of institutional networks, and implementation activities may have to be channelled through village chiefs or delegated authorities in the rural location as was the case in the aforementioned quotation from the Cook Islands.

The second major effect of rurality and remoteness, which is an extension of the previous one, is the need to allocate greater resources to such communities and its subsequent drain on capacity. Accounting for higher costs can be burdensome both in terms of finance and the allocation of staff workload.

We have got the people. We just don’t have the funding. I mean we would love to take [the Act] even to the most remote island of the Cook Islands, but it’s cheaper to go from here to Australia than to go from here to Palmerston or Manihiki *laugh*... you know the airfare from here to Manihiki is 1,600 [New Zealand] dollars one way. (Cook Islander informant)

So we need to train more, and of course [with] every training [session] that takes place here we always try if we can afford to, to bring outer island staff and again there’s the costs of bringing them in that limits the number of people that can be trained. (Cook Islander informant)

Due to the interrelatedness of the variables that affect FCTC implementation, it is foreseeable that these barriers will have a negative influence on policy content; policies that are seen as costly or labour-intensive will be less appealing to decision-makers.

5.8.2 Limited NGO/civil society activism

McNaught (2003) found that advocacy and coalition forming was extremely rare and few academics, journalists or policy analysts were active in the health policy
arena in two SIDS. This could be due to the small pool of manpower from which to draw as well as the limited scope for specialisation (Briguglio 1995). The result may be that few people are specialised in tobacco control and few large institutions exist to harness such expertise. Despite the significant NCD burden and the populations in each country being receptive of most tobacco control measures, relatively little NGO/civil society activism in support of tobacco control was evident in this study. This was especially the case in Vanuatu and Nauru, and to a lesser extent in the Cook Islands. Palau had a relatively active, albeit small and voluntary, tobacco control coalition group.

I think in Nauru there are only about three NGOs [across all issues] and only one is semi-active. Semi-active in the sense that they are active only in certain things and at [a] certain time, and [for] the other NGOs, it’s mainly a one person – one woman NGO... So... really in terms of NGOs they are non-existent in that respect. (Nauruan informant)

The [Tobacco Control Working Group] has [been] slipping for a year and a half now, so at the time... they were active then. But I guess there was a bit of a disappointment that there was not enough resources to put in place. They were only able to gather – even like the every two year [smoke-free song/dance challenge] activity with the young people, because that one... puts the tobacco control issue within the family. But they still couldn’t sustain it for this year, so I guess it probably needs a revival. (Cook Islander informant)

Informants typically cited more proximal determinants to a lack of civil society/NGO activity, such as inadequate funding, insufficient volunteers or a lack of public interest in the issue. It is therefore difficult to pinpoint the extent to which distal factors relating to the specific environments of SIDS can be considered the causes of a lack of anti-tobacco activism. Nonetheless, it is clear that there are some significant challenges for active civil society groups and certainly such activity was rare amongst the countries examined. Numerous distal factors could account for this, such as small populations, limited institutional capacity (in both NGOs and
government) and other issues competing with tobacco control. The lack of civil society activity correlates with McNaught’s (2003) finding that advocacy and coalition forming is extremely rare in SIDS.

Limited anti-tobacco NGO/civil society activity could result in commitment, capacity and the institutional context being affected; if health interests are not promoted by anti-tobacco activists, government departments alone must be relied upon to protect population health. This also means that there may be less overall country capacity to carry out activities such community awareness, monitoring or assisting with policy development, and such functions are entirely driven by government and are reliant on its commitment.

5.8.3 Limited pro-tobacco activism and local tobacco manufacturing presence

As with anti-tobacco civil society activism, there was little pro-tobacco NGO/civil society activity (Martin & de Leeuw 2013). Aside from some mild resistance from the Chamber of Commerce in the Cook Islands around the time the legislation passed through parliament, no public activism, protest, or tobacco industry-funded front groups appeared in any of the four countries. This is not to suggest that vested interests were not still at play. Shop owners, importers and the foreign personnel of multinational tobacco companies had at times agitated against tobacco control regulations:

Interviewer: Is there anyone advocating against the Tobacco Control Act – that you’re aware of?

No.

Interviewer: There [are] no groups of traders or shop owners?

No groups – I haven’t had groups or... only the case of labelling – that case. They were just arguing on the labelling format. Only one shop owner – they were arguing that any type of labelling should be... accepted here. Only that time. So we’ve explained probably that there’s a certain labelling format you
have to follow according to the Act, but [there’s] no major adversary group. (Nauruan informant)

*Interviewer:* Are there any groups that push against the FCTC... in the public realm?

No, no I don’t think there are groups. They’re just like various businessmen. (Palauan informant)

It is difficult to distinguish which factors relate to the small amount of pro-tobacco NGO and civil society activism. It may be that similar distal determinants apply – that there is a small population base or a lack of institutional capacity relating to importers, chambers of commerce or shop owners; however, these were not noted by informants. Some informants did point to the lack of local tobacco manufacturing and a small market based on imports as reasons why there is little pro-tobacco activism within their respective countries:

*Interviewer:* Is there sort of a strong presence felt of the people that are against the interests of the Tobacco Control Act?

Yeah I think with the tobacco industry... the good thing is that we don’t manufacture any of the tobacco products here which is a good thing to start off with. We have... only a handful I think – there’s probably two, three or four importers. (Ni-Vanuatu informant)

Although there was limited public pro-tobacco advocacy in Palau, some informants speculated that vested interests may have had a role in persuading government decision-makers; these claims could not be substantiated with direct evidence. One informant claimed that there was a disincentive to protest in a small community if one’s views opposed those of family and friends. This is explored in more detail in Chapter 5.8.5 below.

SIDS are known to have small domestic markets in comparison to larger countries and there is a limited ability for companies to exploit economies of scale within
them (Briguglio 1995). This could have a significant impact on the profitability of (licit and illicit) tobacco manufacturing companies and their interest in maintaining a manufacturing presence in such countries as a result (Martin & de Leeuw 2013). Hence many SIDS may not produce or manufacture tobacco but rely on importation, as they often do for many other goods (Briguglio 1995). The data presented by Eriksen and colleagues (2012) indicates that only a small proportion of SIDS have tobacco manufacturing facilities and a large proportion of those that do tend to be the more populous SIDS - such as Fiji, Solomon Islands and Mauritius for example. In the Pacific Islands, Samoa is the only other country to have a tobacco factory (British American Tobacco Australia 2012; Eriksen, Mackay & Ross 2012). With the lack of local manufacturers to lobby government, mobilise civil society to protect their interests and to counteract public health interests in tobacco control, this was seen as a positive driver for FCTC implementation in the countries examined (Martin & de Leeuw 2013):

The region keeps telling me that “oh the only reason why [the tobacco control legislation] went through is because we don’t have a tobacco manufacturing sector like the Solomon Islands”, and I said “yeah”. So therefore [the passing of the Tobacco Control Act was] not an issue. (Cook Islander informant)

One should be cautious in applying this to all SIDS, as the aforementioned countries manufacture tobacco. The small amount of tobacco grown in Vanuatu was produced by individual farmers, but informants indicated that the farmers had neither attempted to influence government decisions nor formed any type of advocacy group. Nonetheless, the majority of SIDS do not manufacture tobacco on an industrial scale, especially those with fewer than 100,000 people.

Where there is no or limited local tobacco industry, the economic concerns relating to the loss of revenue or employment when developing and implementing tobacco control policies may be less significant. Hence doing this would become more appealing for governments. For multinational tobacco companies, SIDS have very small consumer markets and may be remote from global trade routes, meaning that
there could be less financial incentive to pursue tactics to thwart tobacco control legislation (Martin & de Leeuw 2013).

5.8.4 A lack of administrative capacity and a small number of staff “wearing many hats”

The small size of SIDS results in difficulties in public administration and a limited pool of skilled and experienced administrators (Briguglio 1995; Feeny & Rogers 2008). Relating to a lack of administrative capacity, it was found that government staff typically have to “wear many hats” in this study. The majority of informants expressed in some form that there was a shortage of staff with many competing issues to which to allocate their time. This was strongly referenced both in the government sector and in NGOs/CSOs. It may be applicable to the local tobacco industry in those SIDS that have one. This theme had a particularly strong influence on capacity, followed by coalition activity and commitment.

Individual workers were spread thin across many competing commitments in their small health promotion and tobacco control departments. The key focal point for tobacco control may be just one person or not even that – the focal person may have other roles in addition to their responsibilities in tobacco control, found in the Cook Islands, Vanuatu and Nauru.

I don’t think we have the capacity, because if you see the coordinator for tobacco has other roles as well – [and is] not just focused on tobacco. I think if they just focused on tobacco, it would be different, that they’ll work – yeah they have to focus on that and like any job, you’re doing so [much] other work. (Cook Islander informant)

That’s the limited capacity that they actually have within the Ministry [of Health]– probably that’s the main obstacle to the program because as you could see there are only seven people around and hardly at the ground at the provincial levels – they don’t really have focal people, although they anticipate that nurses are there who can be able to sort of assist with the program, but they can only – just assist one of the programs. It doesn’t
become routine, so therefore it’s weighted as very low priority for them at the provincial level because they’ve got a lot of other commitments, so the hard stuff they can’t be able to get it [done]. So, that’s why I’m still thinking that the limited resources... I mean technical people there – it’s really the obstacle to the delivery of the program. (Ni-Vanuatu informant)

Similar issues were experienced by staff working in NGOs or coalition groups involved in tobacco control. There may be a very small number of volunteers, and in some cases their efforts may also spread across other health or social objectives in conjunction with tobacco control:

Most of [the civil society advocates for tobacco control] actually are also members of NGOs... they wear so many hats, and if you work in... the CSO area... and... also in the NGOs then [where] there’s funding – that’s where you focus [rather than focusing on a needed area that has no funding]. (Cook Islander informant)

Such small departments and working groups, along with small and personalised networks (discussed in Chapter 5.8.5) may facilitate a stronger integration of government and NGO/civil society representatives.

Some countries are so small that it just makes sense to have a government rep on [an advocacy group], because that person is the expert on tobacco, so why wouldn’t you have them on the advocacy group? So I guess it must raise issues when it comes to lobbying, but it seems to work. (Regional Pacific informant)

Significant challenges to the administrative capacity of local organisations can occur as a result of a small population base, limited skilled workforce, limited funding and limited economies of scale in sparsely populated islands over a large geographical area (Briguglio 1995). Having stretched resources and multiple responsibilities at an administrative or organisational level is one of the strongest themes pertaining to the SIDS environment to emerge from the data:
I just think that there’s a lot of challenges all round. I mean I talked about the lack of sort of legal confidence and expertise, but just in terms of actually delivering a program there’s a few challenges [in Pacific Island countries]. They don’t usually have the money or resources to deliver things that we would consider to be part and parcel of a comprehensive program... for example, money to do say mass media campaigns which we might consider an essential component, and the skills to do that and the research required to develop one... There aren’t the resources and there’s just not the ability to do that from scratch in the way that we would consider best practice. So on the cessation side as well, they just don’t have – you can sit in a conference and hear what’s best practice in terms of cessation, or what’s best practice in terms of brief interventions, but it’s very difficult to do in the Pacific...they just don’t have everything that’s required. They don’t have help lines. They don’t have some of the mass media that goes with cessation, so those sorts of challenges – they’re really real. I think they’re barriers, so people make do you know. (Regional Pacific informant)

In addition to the factors mentioned in this quotation, other challenges arise when administering activities related to tobacco control. Aside from the YTS in Palau (which measures a narrow population age), local government agencies did not regularly collect data on tobacco use prevalence or its burden on health and most of the surveys were reliant on external resourcing and technical assistance. There was also a lack of local academic institutions and NGOs/CSOs to assist in this area. In Nauru it was apparent that the MOH relied significantly on expatriates to bring necessary skills to the service of the government, which is partly attributable to a lack of training institutions. Some informants indicated that applying for external funding grants and reporting to overarching agencies was burdensome:

There’s a lot of work now in the Pacific with FCA, TFI and the FCTC Convention Secretariat all expecting reporting by countries, and it’s a huge burden. It’s a ridiculous duplication of effort – it’s just so blatantly duplicated reporting. (Regional Pacific informant)
The limited administrative capacity and stretched responsibilities of staff may result in a decrease in commitment, as staff may be unable to devote a significant amount of time and effort to tobacco control or FCTC implementation. Furthermore, responsible departments may perceive institutionalising requirements within the policy as overly challenging and therefore be less appreciative of policy methods that require this. The governing administration of Palau recognised this in their justification for weakening some provisions of their tobacco control bill. However, it is difficult to ascertain whether this remark relates specifically to a capacity-challenged bureaucracy or a conservative political ideology (or both):

This Bill imposes significant additional responsibilities on the Minister of Finance, which may require additional personnel to perform. This, of course, would increase the size of government and its cost, something we do not need. I suggest the [Palau National Congress] take a strong look at Sections 9 [Tobacco retail licence application procedures] and 10 [Regulations] of the Bill and consider a more streamlined method of enforcing this Bill. (Letter to the Speaker of the House of Delegates in response to House Bill No. 8-8-1, from the President of the Republic of Palau, cited in Toribiong (2011a))

Baldacchino and Bertram state that “in situations where contextual features are strong and where local actors have no chance of changing these features, then these actors adapt in response to change” (2009; p. 144). In a similar way, a positive driver for FCTC implementation in this study was the ability of organisations to devise flexible ways using a more horizontal or streamlined approach, which is an inevitable result of competing demands for scarce resources across government departments:

For small countries like Nauru, we get overwhelmed very easily and very quickly... we have to multi-task. I’ve had to multi-task frequently... because there is no-one else... We have to develop and support the locals, but it will take a fair while... but even if they have the capacity, we must remember that, for instance a lot of NGOs and organisations – regardless of – I mean this is why we have the Pacific Plan that’s being administered by the SPC... to
streamline issues and work with the countries, rather than – this organisation pushes this agenda, climate people push that agenda, WHO push that FCTC – it’s only a handful of people who are handling all these things at ground level. (Nauruan informant)

Regardless of whether we have funding – the beauty of our organisation is that because in our Health Promotion Unit we have... other programs, so we either piggy-back on other programs to actually get the message out with regards to smoking... using other programs like reproductive health and adolescent health we put through their programs, we can –

Interviewer: Yes, so I guess it helps fund the organisation, the skills and so forth.

Yeah... say for example if there is a reproductive health/adolescent health workshop, we ask them if we could come in and talk about tobacco, the effects of tobacco and stuff like that. Even travel opportunities to the outer islands, we have piggy-backed on other programs. That’s how we’ve done it, and [it has] gotten us to this stage where we are now. (Cook Islander informant)

This demonstration of organisational and staff flexibility was not universal. It was more evident in Cook Islands, less in Vanuatu and Nauru. It was hard to determine this in Palau, which was yet to implement comprehensive legislation at the time of the interviews. In such scenarios, it is evident that organisations and administrative departments simply make do with what they have. It becomes necessary to streamline programs and use available resources more efficiently. Although it is not a matter of choice, there may be some advantage to this, as organisations become flexible and allocate available resources efficiently, and their personnel acquire a wide range of skills.
5.8.5 Small and personalised networks and relationships

Due to smallness, insularity and remoteness of small island states, they may experience social compression, which can result in stronger personal contacts and role enlargement (Baldacchino 2000), and a scenario where people know each other well and are often related (Briguglio 1995). There is a tendency for institutional networks in SIDs to be small and more personalised. This theme is interlinked with the notion of a small number of staff “wearing many hats”. In relation to FCTC implementation, it is likely that the same people are on multiple committees and working relationships may have already been fostered outside tobacco control. Institutional networks were often intimate and personal in the countries examined in this study. This may be advantageous if such relationships are mutually positive and strong bonds are formed (i.e. between a MOH and a tobacco control-oriented NGO). Another advantage is the easy access to decision-makers within the country, which was found by Allen (2009) and highlighted by several informants in this study:

But I mean the beauty and advantage of the small islands is that people are pretty well connected – you can pretty easily get to the President or... you know they’re either related or they live next door, unlike some of the bigger countries – the access is pretty good. (Regional Pacific informant)

As a result of this, and of a smaller bureaucracy, it may be possible that legislation can be adopted quite rapidly in SIDS (Baldacchino 2000). However, other factors such as limited institutional capacity and political instability (which was seen in Vanuatu) could compromise this facility.

In cases where key stakeholders do not collaborate well or have disagreements, small and personalised networks could accentuate these issues, especially if there is a limited number of people within a given organisation to collaborate with. This, along with political differences, was evident in the relationship between the tobacco control department in the MOH and the CTFP in Palau:
Especially when [the CTFP] comes to working with the Ministry [of Health] or staff of the Ministry, you know there are lots and lots of sensitive issues people have between each other at a personal level, and that sort of interferes and it slows down the process mostly, yeah. (Palauan informant)

It was found that close-knit networks and relationships may have a positive influence on commitment:

*Interviewer: I’ve heard [the Tobacco Act] quite quickly went through.*

*Laugh* Oh it actually went through fast, but I guess that happens because they lobby from the outside. They use personal networks and they lobby at [the] time they were planning to pass it. (Cook Islander informant)

The [Tobacco Control] Working Group… It’s a coalition, so it makes it easy for them to go and, say for the representatives to carry those voices within the Ministry of Health, and then the others – it’s a small community, so they can actually – sometimes the members would use their own networks to talk to others. (Cook Islander informant)

However, there may be adverse commitment if decision-makers within government have ties to tobacco-related interests, as was possibly the case to a limited extent in Palau and Vanuatu. Rather than it being solely positive or negative in the case of commitment, it appears that small and personalised networks within and between organisations may magnify the importance of any given relationship.

Small and personalised networks may influence enforcement of FCTC provisions. A small number of informants explained that those responsible for enforcing a policy might be less likely to do so upon those whom they know:

There [are] certain people who were trained and they were supposed to be the ones doing [the work of enforcing smoke-free environments in bars and restaurants]. Not anybody can do it... You’ve got to be a certain person to be able to get there, and it would be hard to [do], you know, you’re related to
everybody – it’s terrible, but you’ve got to be a person who would be able to
do that job. (Cook Islander informant)

This finding is related to Briguglio’s (1995) notion that public administration may be
challenged due to the difficulty of maintaining impartiality in civil service. However,
a positive aspect of enforcement and community awareness could also be seen in
small and personalised networks:

Because of the number of population that we’re dealing with – [the Act’s
implementation] can be handled pretty efficiently. You prosecute one person
under this Act – everybody in the island knows, and they comply. (Cook
Islander informant)

Because this is a very small island and this is a very unique society, so we can
learn very easily from each other, especially for... the discordant behaviours
for the health, you know like drinking, smoking – it’s very easy to learn from
each other because it’s a very unique society. (Nauruan informant)

Personal relationships may give difficulty when advocating, lobbying or protesting in
support of tobacco control in public:

When it comes to advocating a stronger policy in [congress], or in public –
nobody comes out. It’s the Coalition that comes out, so I think in the small
island environment it also affects the advocacy work of the people who
believe in the cause, that they don’t want to put themselves where their
relatives are also in the [congress]. It’s kind of like you don’t want to go
against somebody from your clan, from your family – it’s like that, so – they
can do it behind [closed doors], but it cannot be out in public, and that’s one
of the most frustrating parts of [this type of activity]. You have these strong
people who – when they just say so very strong words, but when you need
them to come out and repeat them in front of their representatives, they
might not show up. (Palauan informant)
It is clear that effects of small and personalised networks on FCTC implementation are varied. Beyond the aforementioned effects on the institutional context, commitment and clients and coalitions, it is foreseeable that policy content and capacity allocated may also be affected if senior decision-makers are influenced through the small and personal networks that they are a part of.

5.8.6 A strong influence from global and regional forces

SIDS may be particularly susceptible to global and regional forces through the influences of multilateral organisations and larger countries in their respective regions. SIDS may be dependent on external forces in a financial sense through remittances and development assistance (Bertram 2006; Briguglio 1995), being a tourism-based economy (Bertram 2006; Scheyvens & Momsen 2008), relationships with former colonial powers (Baldacchino 2000) and relying on imported goods, skills and technology (Briguglio 1995). This theme is inextricably linked to the geopolitical forces within the Pacific region and can be categorised as falling somewhere between the notions of the environment of SIDS, and the environment specific to the Pacific Islands.

The FCTC process had considerable influence on the content of national tobacco control legislation in each of the countries examined. Legislation from the Cook Islands, Vanuatu and Nauru is largely compliant with the FCTC. Technical assistance from Allen and Clarke, with support from AusAID, NZAID and the WHO, had a significant influence on the content of tobacco control legislation in the Cook Islands, Vanuatu and Nauru. Even though legislation was subject to a national parliamentary process in each country, the original bills were typically drafted with assistance from non-local agencies. The content of tobacco control legislation in Palau was formed from local expertise (but was based on FCTC provisions in its original bill) and was subject to several changes before it passed through all stages of congress; however, external influence in the form of trade in tourism was the rationale provided by Palau’s Office of the President for amending its smoke-free environments legislation in bars and restaurants (Toribiong 2011a). One informant
indicated that Palau’s bilateral relations with the US, which has not ratified the
FCTC, had a particular influence on FCTC implementation:

_Interviewer:_ How do you think the Ministry so far has been affected by, or
not affected by, the FCTC? For example have the procedures or the way they
do things changed? Have they been allocated funding or resources?

No, no. They simply ignore it. They simply ignore it... They have funding from
the United States for tobacco control so that’s good enough for them, and
they do whatever [that] funding requires and other than that it’s not
something that they – is on their radar screen. (Palauan informant)

All four countries received a significant amount of assistance from larger country
governments or institutions. This served to increase capacity in the form of funding,
strategic planning, technical support, staff training, or monitoring and surveillance.
The role of former colonial powers was evident here, with assistance in tobacco
control being predominantly provided by Australia and New Zealand to the Cook
Islands, Vanuatu and Nauru, and the US to Palau. The SPC and the WHO were
somewhat influential in all four countries.

Our principal development partner is AusAID. It has demonstrated flexibility in
its allocations to all the health sector, so that translates to [the Ministry of
Health] being able to allocate funding as it need be on a priority basis, so
that’s an opportunity. AusAID in the past used to just allocate budgets on an
annual basis based on projects, so that becomes very short term, whereas in
the new paradigm that they’re moving towards is to give a five year envelope,
agreed at the high level, and then that’s translated into annual operational
plans that are determined, so there’s opportunities there. (Nauruan
informant)

FCTC implementation efforts have been facilitated by substantial bilateral and
multilateral assistance, which enhanced capacity in these SIDS without the
country’s governments diverting resources away from other important activities.
A final influence of global and regional forces is the way in which it can shape coalition activity. Tobacco products imported from Australia, New Zealand and the US make up a large proportion of tobacco consumed in the countries examined. Both importers and representatives of foreign companies may seek to influence tobacco control activities. Informants in Vanuatu, Nauru and Palau mentioned that there was a small amount of (and in some cases, illicit) tobacco products originating from China. In relation to anti-tobacco coalition efforts, the WHO’s World No Tobacco Day was influential in stimulating community awareness in all four countries. The Coalition for a Tobacco-Free Palau (and to a lesser extent the Cook Islands’ TCWG) drew upon collaborations with and assistance from people and organisations outside their respective countries. The FCA also contributed to community awareness, although more at the Pacific regional level and in Palau than in the other three countries.

Despite their significant exposure to bilateral and multilateral forces, SIDS may find that they represent a very small proportion of their region. There are occasions when SIDS can make little impact on regional or international dialogue relative to larger countries, which may dominate FCTC-related discourse:

You know sometimes, because we are a small country, we don’t have much say at the international level... We get dominated by the Asian countries. Now [in] Asian countries the use of tobacco is very high, and for them the black market is also a problem. So we find that the whole conference or workshop is dominated by them and the discussion is mainly centred around [the] black market and those kind of things, but when it comes to discussing the act – how can we meet these goals and what not – very skimpy discussion is done on that. (Cook Islander informant)

The influence of global and regional forces is most evident in terms of its impact on content, capacity and coalitions, but the other variable clusters are not immune. External entities such as the WHO and SPC can exert influence through institutional networks. Regional forces and associated coalition groups may also act to stimulate commitment to the FCTC. Through legislating plain cigarette packaging, Australia in
particular has earned a notable reputation in tobacco control in recent years (WHO 2013b), which has resonated globally. Despite strong global and regional forces being present in SIDS, which could be higher than that of other countries, FCTC implementation (after developing national legislation) remains highly dependent on activities at the national level. This is best characterised by the high degree of national, rather than global or regional, discourse within each country when considering the variables that affect implementation.

5.9 FCTC implementation in the Pacific Island environment

The environment of SIDS was a primary interest in this study, but distal determinants other than those related to SIDS emerged in the research. Several themes determined by the cultural and historical context of the four countries cast light on the implementation environment of the Pacific Islands, and their influence is now considered. They include the prominence of NCDs, culturally divergent or ingrained tobacco use in some communities, the role of traditional leaders, and the role of the church. This closely parallels Allen’s (2009) research on the influences on tobacco control in the Pacific, which notes the rapid increase in NCDs, a hierarchical culture of chiefs and village elders, the influence of churches and some continued acceptance of tobacco use as a cultural tradition. While the prominence of NCDs and cigarette consumption may be relatively new phenomena, the practices of chewing betel nut, drinking kava, the societal role traditional leaders and the church have existed in various areas of the Pacific for centuries.

5.9.1 A strong presence of NCDs

The prominence of NCDs was noted a strong influence on FCTC implementation by a large number of informants across all the countries examined. This was highlighted earlier in Chapter 5.3, but is worth exploring in more detail here as the high rates of tobacco use and obesity are major concerns in most Pacific Island nations. These have largely resulted from shifts from traditional subsistence lifestyles to ones that rely on a poor diet and lack of physical activity (Gill 2006). Most informants referred to their own country of origin and the high rates of NCDs.
However, some informants noted that it was not only their respective country
where NCDs had proliferated, but also across the whole Pacific region, as shown in
the following quotations:

I think tobacco is probably one of the most important things that they could
be doing like globally/internationally and in the Pacific, so [the] FCTC has got it
right, and the components of it are very comprehensive and thorough.
(Regional Pacific informant)

The Pacific is in crisis. In crisis because of the high NCD [prevalence] that’s
plaguing our countries, certainly in Nauru, as you know we have one of the
highest rates of diabetes and hypertension. (Nauruan informant)

The high prevalence of NCDs is of course a significant driver of the clusters of
variables that affect FCTC implementation. Firstly, it is likely to positively contribute
towards the palatability of the goals and methods in the FCTC. The prominence of
NCDs is also likely to foster stronger client and coalition support, if they see tobacco
control as an important issue. Likewise, this appeals to the commitment of key
decision-makers, which could therefore influence capacity provision and
institutional adaptation.

5.9.2 Culturally divergent and ingrained tobacco use in certain communities
Cultural and historical beliefs surrounding some aspects of tobacco use, even when
this was not strictly traditional, had a substantial influence in particular locations.
This was evident in the popularity of chewing betel nut with tobacco, both in Palau
and in the northern province of Vanuatu. Betel nut chewing has been a practice in
certain areas in the Pacific Islands for many hundreds of years. In Palau, tobacco use
was added to betel nut chewing later, when it was introduced through European
contact (WHO 2012b):

Tobacco use on this island is so ingrained... it’s part of the cultural practice of
chewing betel nut, but you know... the addition of tobacco is not traditional.
(Palauan informant)
Tobacco chewing has become a common habit in the country, and is often performed alongside the older traditional practice. The Palau Council of Chiefs rejected the idea that tobacco use was a traditional practice and should be preserved as a part of the country’s culture (Palau Council of Chiefs Office 2012).

In Vanuatu, the practice of drinking kava is a notable cultural trait. The kava crop is said to have been domesticated around 3000 years ago (Lindstrom 2004). Informants claimed that tobacco use often occurs alongside the use of kava (which, like tobacco, is typically consumed by Ni-Vanuatu men) in nakamals (kava bars). Smoking cigarettes while consuming kava is not a part of the cultural tradition, but does occur; cigarettes can be purchased in nakamals.

With Vanuatu’s predominantly rural countryside, tobacco is grown by local farmers, but one informant indicated that it can grow naturally in the wild:

While we are trying to control the manufactured tobacco products, at the same time on the other side, tobacco – local grown leaves is growing naturally or growing wild here, and this is outside of our hands – I mean people from the island are cultivating it, and then they know the way to process it, keep it and continue to smoke it, and then it is something that is part of the culture and it’s not easy to... to change that. It’s a part of the way of habits. (Ni-Vanuatu informant)

Tobacco users in the Cook Islands and Nauru typically smoked manufactured cigarettes; there was no indication that smoking was related to or conducted alongside traditional practices or behaviours. Not all the communities inhabiting the Pacific countries have integrated tobacco use in a way that is culturally different from what is internationally common, but some have. This diversity should be recognised. In particular, ingrained tobacco use could mitigate the acceptance of measures designed to reduce the demand and supply of tobacco. It could mean that in some communities, legislation against tobacco use may be less palatable, and commitment from stakeholders and client support harder to obtain. Furthermore, decision-makers may be less willing to legislate against behaviour that they
personally partake in and institutions may be less accommodative to such legislation.

5.9.3 The potential role of traditional leaders

Before European colonisation, most Pacific Island communities were politically autonomous (Oliver 1989). Aside from a few societies in Melanesia and Polynesia where larger tribes were formed, communities tended to be independent and their chiefs were not subordinate to anyone else (Oliver 1989). Although today the executive, judicial and legislative powers in government are not typically headed by chiefs and elders, these leaders still hold some power within government and have significant influence in their local communities. With their involvement in tobacco control, traditional leaders played a significant role in Palau. Traditional leaders’ influence on tobacco control was more peripheral in the Cook Islands and Vanuatu, and no reference was made to traditional leaders in Nauru. The Palau Council of Chiefs after the time of the interviews declared that “illegal” to sell tobacco in Palau (refer to quotation below). It is hard to ascertain the degree of influence this will have on tobacco control, but it may have an influence on Palauan communities.

Palau Office of the Council of Chiefs Declaration No. 12-001:

To declare tobacco and tobacco products as illegal drugs; to call upon all parents and general public to join all forces, efforts, campaigns, activities and programs against tobacco; to appeal to the business community to look for alternative merchandise to replace tobacco as a source of revenue; and to appeal to the President and government of Palau to impose a moratorium on the issuance of business licenses to sell tobacco and tobacco products. (Palau Council of Chiefs Office 2012)

Overall, informants suggested that traditional leaders tended to value the health of their people and were either supportive of or neutral towards FCTC implementation and tobacco control. They were seen as potential, but not necessarily central, allies to pro-health coalition groups. There was little evidence of traditional leaders obstructing tobacco control policy and no evidence of them being allied to pro-
tobacco activity. Although they were not official or central decision-makers at the national level, it is evident that traditional leaders could influence FCTC implementation through fostering commitment, client support, encouraging the activities of coalition groups, and as a part of the institutional context, especially in rural and remote islands and communities. It is likely that their influence is strong in the communities they are part of, and they can affect the implementation of more localised FCTC provisions such as smoke-free environments, selling or growing tobacco in local communities and fostering education and community awareness.

5.9.4 The potential role of the church

Christianity was introduced in many Pacific Island nations in the 19th century, by missionaries of various nationalities and backgrounds (Lal & Fortune 2000). The role of the church remains important in many Pacific Island nations today; and this was evident in this study. Their support for FCTC implementation was noted particularly in terms of coalition activity and community awareness by several informants in the Cook Islands, Vanuatu and Palau, and to a lesser extent in Nauru. The Seventh Day Adventist church was the most commonly cited religious group, mentioned by informants in Vanuatu and Palau:

*Interviewer:* who are the significant institutional players or organisations that influence the Tobacco Act? Apart from the Ministry [of Health] or the [Tobacco Control] Working Group, are there any other actors?

Sometimes the churches are pretty strong, certain churches if they believe in the particular [issue] – they’re quite [strong] – especially the top people. (Cook Islander informant)

The only advocacy group who favour stronger tobacco control measures is basically [the Coalition for a Tobacco-Free Palau] plus the faith-based organisations. (Palauan informant)

One informant in Vanuatu mentioned that the government sometimes overlooked the important role the church plays in tobacco control.
It was evident that the church made some contribution to tobacco control and FCTC advocacy, but in most cases informants indicated that the contribution was peripheral. Nonetheless, churches may foster increased commitment, community awareness and client/coalition support. Religious leaders also serve as important mentors within their local communities.
Chapter 6  Recommendations for FCTC implementation in Pacific SIDS

6.1 Introduction

The second research question central to this thesis, as mentioned in Chapter 1, is: How can barriers be overcome and opportunities be utilised to ensure effective FCTC implementation in SIDS of the Pacific? Answers to this question are provided on three levels. A set of recommendations was provided in the context of each individual country in Chapter 4. This chapter provides recommendations specific to Pacific SIDS, from both national and global perspectives, based on the cross-country synthesis in Chapter 5.

In exploring a variety of policy provisions across four different countries, many nuances were present. These were explored in the previous two chapters. Integrating these nuances is an extremely complex task which is common to policy research and realist evaluation (Pawson & Tilley 2004). As a result of this, recommendations provided in this chapter are based on the major commonalities found across all four countries (explored in Chapter 5), rather than the commonalities that only affected one or a small proportion of FCTC provisions or played a limited role in the variables that affect implementation. These recommendations focus on the most pertinent issues relating to FCTC implementation that are derived from the countries examined in conjunction with the existing literature. The first set of recommendations, provided in Chapter 6.2, is directed at the national perspective. The second set of recommendations, provided in Chapter 6.3, is directed at the overarching global perspective. While the variables that affect implementation are interrelated and can affect numerous variable clusters indirectly, the most direct and critical factors leading to each recommendation are listed under each of the sub-headings. Figure 6 conceptualises the major findings and the recommendations provided in this study.
Figure 6: Framework for conceptualising recommendations for FCTC implementation in Pacific SIDS

### Distal factors affecting the implementation environment

**Factors relating to SIDS:** *(Ch. 5.8)*
- Rural and remote islands and communities.
- Limited NGO/civil society activism.
- Limited local tobacco manufacturing presence.
- A lack of administrative capacity and small numbers of staff “wearing many hats”.
- Small and personalised networks and relationships.
- A strong influence from global/regional forces.

**Factors relating to the Pacific Islands:** *(Ch. 5.9)*
- A strong presence of NCDs.
- Culturally-divergent and ingrained tobacco use in certain communities.
- The potential role of traditional leaders.
- The potential role of the church.

### Common proximal factors affecting FCTC implementation

**Major facilitators:** *(Ch. 5.2 – 5.7)*
- Relevant and unequivocal goals and causal theory.
- Methods overall are achievable, appropriate and effective.
- MOH commitment is favourable.
- Funding support from external agencies.
- Limited pro-tobacco coalition activity.
- Client support for tobacco control regulations.

**Major barriers:** *(Ch. 5.2 – 5.7)*
- Some FCTC provisions perceived as ambitious and challenging.
- Networks between MOH and other government departments are weak.
- Ground level commitment is hindered by limited staffing and competing issues.
- Whole-of-government commitment challenged in departments outside of health.
- A lack of funding and resourcing for FCTC implementation.
- Limited presence of anti-tobacco NGOs/CSOs.

### Recommendations to strengthen FCTC implementation in Pacific SIDS *(Ch. 6)*

**National level recommendations:** *(Ch. 6.2)*
- Advocate that the majority of FCTC provisions are effective, relevant and needed.
- Strengthen multi-sectoral networks and appreciate their smallness in SIDS.
- Foster growth in anti-tobacco coalition activity and compensate where this activity is limited.
- Exploit limited pro-tobacco opposition.
- Build capacity, utilise resources effectively and exceed minimum FCTC requirements for cost-effective provisions.
- Strengthen FCTC implementation from the bottom-up by appreciating local factors and empowering civil society.

**Global level recommendations:** *(Ch. 6.3)*
- Enhance global capacity for FCTC implementation in developing countries and SIDS.
- If funding capacity is inadequate, strategically prioritise cost-effective provisions and consider the suitability of MPOWER components in SIDS.
- Globalise the FCTC to ensure that it comprehensively addresses the global tobacco problem.
- Appreciate country contingencies and local priorities in the governance of the FCTC.

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1 Adapted from: Martin, E. & de Leeuw, E. (2013). ‘Exploring the implementation of the Framework Convention on Tobacco Control in four small island developing states of the Pacific: a qualitative study.’ *BMJ Open*, 3(e003982).
6.2 Recommendations to strengthen FCTC implementation at the national level

These recommendations are not prescriptive to all Pacific SIDS seeking to implement the FCTC, but they are likely to apply to many of them. These emerge from the common barriers, opportunities and themes in the Pacific SIDS examined. The recommendations may be relevant to other countries internationally, especially SIDS and developing countries.

6.2.1 Advocate that the majority of FCTC provisions are effective, relevant and needed

Findings leading to this recommendation:

- A strong presence of NCDs in the Pacific Islands.
- Relevant and unequivocal FCTC goals and causal theory.
- Methods overall are achievable, appropriate and effective.
- Client support for tobacco control regulations.

FCTC implementation is strongly justified given the high prevalence of NCDs in the region. To necessitate political action, it is crucial that both the public and politicians are informed on the NCD burden, and the FCTC as an evidence-based method to address it. The vast majority of its provisions are likely to be relevant and needed, even in small and remote Pacific Island nations with seemingly different contexts to larger nations. Governments should not reject the FCTC as a whole if a minority of provisions are seen as costly or difficult to implement. It is important to utilise a stepwise approach in which core provisions are implemented first and given priority as every country, regardless of resources, has the potential to make substantial improvements to NCD control (Epping-Jordan et al. 2005). The cost-effective and proven methods by which to address this vector are likely to succeed in resource-poor settings: taxation, packaging and labelling, smoke-free environments and bans on TAPS. This has been achievable in all types of countries; in this study, the Cook Islands is an exemplary case. Governments need to comprehensively implement these provisions wherever possible. The WHO, SPC,
FCA, FCS, bilateral agencies and NGOs may be important sources of technical support for government actors that are interested in but yet to follow this course of action.

As all Pacific SIDS have ratified the FCTC, the initial step towards implementation is complete. Most of the countries examined have enacted comprehensive national legislation that incorporates most of these provisions, but there are cases where core FCTC provisions have not been included in national tobacco control legislation; the lack of legislation on packaging and labelling in Palau being an example. The rationale for such omissions is rather weak, given the proven effectiveness of these provisions and their suitability for the resource-constrained environments of Pacific SIDS. In Palau there is scope for amendments to the existing tobacco control legislation in future. It is important for stakeholders to recognise that once a major piece of tobacco control legislation has been introduced, it should be continually assessed in terms of its efficacy and core provisions (as well as other relevant provisions that were not included) and advocated for. This is likely to be in the interests of local populations as clients tend to be supportive of tobacco control measures in Pacific SIDS.

6.2.2  **Strengthen multi-sectoral networks and appreciate their smallness in SIDS**

Findings leading to this recommendation:

- MOH commitment is favourable.
- Networks between MOH and other government departments are weak.
- Whole-of-government commitment is challenged in departments outside of health.
- Small and personalised networks and relationships.
- A strong influence from global/regional forces.
- The potential role of traditional leaders.
- The potential role of the church.

Commitment to FCTC implementation was shown in each MOH, but a major weakness of Pacific SIDS was the limited commitment in other government
departments and the weak networks between these and ministries of health. Whole-of-government commitment is crucial for FCTC implementation. Networks and partnerships between the MOH and other government departments must be established. To achieve this, a common understanding between different sectors is of utmost importance (Bettcher & da Costa e Silva 2013). From the health domain, convening power, consensus building, and strengthening capacity for generating evidence and for effective working relations with other sectors are important to achieve Health in All Policies (HiAP) (Leppo & Tangcharoensathien 2013). Networks and partnerships must not only span various departments at the national level, but local levels of government, multilateral and bilateral agencies, NGOs, civil society and the private sector, each of which are influential in FCTC implementation. These stakeholders align with those that are important for achieving HiAP (Kickbusch, McCann & Sherbon 2008) and are likely to be important for other aspects of public health and health promotion. In the Pacific Islands, traditional leaders and religious institutions may serve an important role and are potential allies. Partnerships for FCTC implementation can be facilitated by establishing synergy through trust and leadership, sharing power, and recruiting and retaining necessary partners (Jones & Barry 2011).

The importance of the often close-knit networks in the small communities of Pacific SIDS should be recognised. Tobacco control leaders and mentors are particularly valuable as their ideas may resonate strongly amongst their peers and beyond in such communities. Close-knit networks between stakeholders and government decision-makers may be utilised to lobby for comprehensive tobacco control policies, as was done in the Cook Islands. Some people in small communities may be unwilling to take a strong stance on tobacco control if it puts them in opposition to family, friends and their local community; there may be an incentive for such people to adopt techniques that are less confronting at a personal level. In situations where officers may be required to enforce the law upon people they know, the importance of FCTC measures should be stressed to help them recognise the necessity of their obligations. Measures could be taken to lessen the likelihood
of a particular officer having to enforce policies in areas where they have a high number of personal ties with members of the public.

In addition to strengthening in-country networks and partnerships, it is important to establish strong, positive networks with other members of the geopolitical region and internationally. Technical assistance and funding from external sources may enhance capacity if other countries or institutions in the region have an interest in assisting FCTC implementation. Australia’s recent funding to support the FCTC (WHO 2013a) is an example. It could be advantageous to encourage FCTC-related activity in those countries that have influence on the local country. For example, efforts should be made to encourage stronger packaging and labelling requirements, regulate tobacco product constituents, and minimise illicit trade in those countries from which tobacco products are imported. Technical consultants from multilateral institutions and larger countries should be apprised of the different criteria applying to SIDS: that is, of the conditions and limitations found in small nations that can make a one-size-fits-all approach to FCTC implementation unsuitable. McNaught (2003) found that an important lesson from his research is that the contribution of external consultancy is limited by its applicability to the local context and institutional capacity in SIDS.

6.2.3 Foster growth in anti-tobacco coalition activity (Martin & de Leeuw 2013) and compensate where this activity is limited

Findings leading to this recommendation:

- Limited presence of anti-tobacco NGOs/CSOs and anti-tobacco NGO/civil society activism.
- The potential role of traditional leaders.
- The potential role of the church.

NGO and civil society activity in Pacific SIDS may be subdued or almost non-existent. Growth in anti-tobacco NGO/civil society activity is needed to strengthen FCTC implementation. The CTFP stood out in terms of its anti-tobacco activity in Palau and may serve as a model for tobacco control advocacy in other Pacific SIDS. Its
presence was facilitated by a small group of skilled volunteers who utilised their connections in government, civil society and media. In scenarios where such groups are not established, government health agencies may need to stimulate and foster such activity, whether by an organisation or just one individual. A working group consisting of government representatives and a few civil society individuals, as was achieved in the Cook Islands, may be necessary in order to fill a void in the absence of a fully functioning anti-tobacco NGO or CSO. This working group achieved some success and may be an important model for SIDS elsewhere. In the Pacific Islands, the potential role of traditional leaders and the church facilitating anti-tobacco coalition activity should not be overlooked. Although not in the small island context, Wolff (2001b) suggests that civic engagement may be an important factor for coalition development. To foster coalition growth, governments must deal holistically with the needs of communities and yield power and responsibility to them (Wolff 2001a). For effective community health promotion coalitions, Kegler and colleagues (1998) recognise the need for skilled staff, good communication and high levels of participation.

The absence of NGOs and CSOs with an interest in tobacco control could enhance the need for government agencies to facilitate community awareness and anti-tobacco advocacy, in order to ensure that the public do not miss the health gains associated with these activities. The MOH and senior government representatives must ensure that health interests of the populations they represent are maintained and not undermined by tobacco industry interests. Engaging in such activities may go some way towards facilitating commitment and capacity for implementation in the absence of anti-tobacco activism, and mitigate pro-tobacco coalition presence.

6.2.4 Exploit limited pro-tobacco opposition (Martin & de Leeuw 2013)

Findings leading to this recommendation:

- Limited pro-tobacco coalition activity.
- Limited local tobacco manufacturing presence and pro-tobacco activism.
In the Pacific SIDS examined, pro-tobacco activity was limited to a few importers, occasional visits from foreign tobacco company representatives, shop owners, and perhaps small-scale farmers, rather than organised coalition groups supported by powerful local tobacco companies. The absence of such groups, who typically oppose tobacco control measures, should be exploited where possible (Martin & de Leeuw 2013). Little anti-tobacco coalition activity can make it easier for governments to pass legislation to protect the health of their populations as there is less political opposition, which was the case in the Cook Islands and Nauru. Wilson and colleagues (2007) suggested that in Niue, where there is a very small population with little industry resistance, the adoption of innovative tobacco control solutions that are not possible elsewhere could be facilitated. It is anticipated that other Pacific SIDS, including those examined in this study, may be similarly placed for such opportunities. However, in Palau it was evident that even with a limited local tobacco manufacturing presence and public pro-tobacco activism, significant challenges (such as attaining commitment from senior decision-makers) may prevent the adoption of strict tobacco control measures. While it may help greatly, the absence of local tobacco manufacturing and organised industry-funded front groups does not automatically play to the benefit of anti-tobacco coalition interests.

6.2.5 Build capacity, utilise resources effectively (Martin & de Leeuw 2013) and exceed minimum FCTC requirements for cost-effective provisions

Findings leading to this recommendation:

- A lack of funding and resourcing for FCTC implementation.
- A lack of administrative capacity and small numbers of staff “wearing many hats” (in SIDS).
- Ground level commitment is hindered by limited staffing and competing issues.
- Some FCTC methods perceived as ambitious and challenging.
- Rural and remote islands and communities.
Limited funding, few staff and diseconomies of scale (particularly in reaching isolated and remote populations) constrained the already limited capacity Pacific SIDS to implement FCTC-based policies. There is no silver bullet to solving this significant challenge, but some considerations should be made. It is important for ministries of health and anti-tobacco coalitions to advocate for greater government funding for tobacco control and FCTC implementation, although other important health concerns must be appreciated. Such decisions are highly political and require a strong commitment to health and tobacco control from senior decision-makers in government. It is important to utilise networks, coalitions, public support and knowledge of the NCD burden to advocate to these decision-makers, and ensure that there is no tobacco industry interference. It likely that there are limited windows of opportunity for decisions relating to increased capacity, as articulated by Kingdon (1995), hence it is important for key stakeholders to seize opportunities when the political circumstances arise.

When there are scarce resources both in tobacco control and across the health sector, sustainable funding may be secured by measures such as earmarking tobacco taxes for health promotion and tobacco control activities, or by requesting external development assistance. This first option, despite being advocated in all four countries examined, has not been achieved. A health promotion foundation that is funded by tobacco taxation in Tonga (Government of Tonga 2010) is a notable example in the Pacific. A study by Schang, Czabanowska and Lin (2011) on five health promotion foundations internationally, but not in Tonga, suggests that recognising the broad spectrum of potential sources to finance health promotion, co-financing by multiple funding sources and legislative anchoring of revenues as a base for financial sustainability are important lessons learned in securing funds for health promotion. In Thailand, achieving success in this area required legislation to endorse a fund and an independent agency with greater flexibility to oversee the management of funding health promotion projects (Tangcharoensathien et al. 2008). It may be useful for ministries of health in Pacific SIDS to explore these options in order to secure funding for health promotion. For seeking external assistance, it is important to utilise networks to potential sources of this, including
the WHO, FCS, SPC, bilateral/multilateral funding agencies and philanthropic organisations. Their expertise and resources may be required to fill gaps in local capacity, which would facilitate the implementation of FCTC-based provisions. Needs assessments, which are conducted by the FCS, are a prerequisite for the mobilisation of funding support (Liberman 2012). Countries seeking external assistance should undertake these assessments. However, funding support at an international level for needs assessments has been low compared to the need for them (Liberman 2012). Rising national debt to GDP ratios in many developed countries may challenge the allocation of development assistance for health (Murray et al. 2011), and tobacco control only attracts a small proportion of this funding (Callard 2010), suggesting that obtaining assistance through such funding agencies is possible but challenging.

If many FCTC-related needs remain present and sustainable funding is unobtainable, the inevitable result will be a necessity to allocate scarce resources to the most cost-effective FCTC provisions. It is fundamental that countries at least meet the minimum FCTC requirements of these provisions and exceed them where possible. A logical next step for the countries examined (and perhaps capacity-short countries elsewhere) who have already met the minimum FCTC requirements in packaging and labelling, bans on TAPS and smoke-free environments, is to legislate further increases in taxation, bans on point of sale displays, increases to the size of health warnings on cigarette packages to 60 per cent or more of the package (and consider plain packaging), and ban tobacco use in outdoor public places where people congregate. These provisions are the next frontier for tobacco control policy in many Pacific SIDS and would be cost-effective to implement because they are not labour intensive. In regards to plain packaging, there may be some risk of legal challenges from tobacco companies which could be costly if pursued, but Australia’s pioneering achievement in this area sets a strong precedent for the Pacific region.

Cost-effectiveness can be enhanced by building local expertise in tobacco control. This reduces dependence on expensive external technical officers and consultants. This finding aligns with those of David and colleagues (2013) in the US-affiliated
Pacific Islands: investing in local tobacco control champions, both in policy-making and the community, can yield significant benefits for tobacco control. Another important consideration in Pacific SIDS is that monitoring, surveillance and enforcement activities in rural and remote areas may be expensive to conduct. If all options to seek additional funding are exhausted, it might be important to streamline these activities to their most cost-effective components, utilising cheap and wide-reaching modes of travel and communication, and partnering and sharing information/resources with other government departments or NGOs.

6.2.6 Strengthen FCTC implementation from the bottom-up by appreciating local factors and empowering civil society

Findings leading to this recommendation:
- Some FCTC provisions perceived as ambitious and challenging.
- Client support for tobacco control regulations.
- Rural and remote islands and communities.
- Culturally-divergent and ingrained tobacco use in certain communities.

In building healthy public policy, factors at the local level may differ from those at the national or international level (Rütten 2001). Furthermore, de Leeuw and Clavier (2011) claim that local politics have allowed for the engagement of the public in healthy public policy better than the national level. In a similar way, FCTC provisions should be presented with respect to their importance to local communities so that policy methods appeal to local people. Douglas’s (2008) evaluation of tobacco control in the Pacific Islands stressed the importance for programs to be driven by local interest and to meet country-specific needs. This local approach is crucial in scenarios where remote islands or communities in SIDS differ significantly from the major towns or cities. Many FCTC provisions such as taxation, packaging and labelling, or bans on various aspects of TAPS, are primarily determined at the national level, but legislation and/or the enforcement of smoke-free environments, cessation services, education and community awareness, and bans on single cigarette sales and sales to minors are more often localised; efforts should be made to ensure that these provisions reach rural and remote
communities, particularly if they are relevant to local needs. In these communities, far-reaching modes of communication, in a medium and language that is suitable, must be utilised. Similarly, a free flow of information and follow-up support was cited by Laverack (2003) as an important determinant of success for health promotion implementation in rural areas of Fiji. In order to empower decision-makers, the presence of local knowledge is crucial. Local data was found to be essential to inspire local action against tobacco in a study of several US-affiliated Pacific Island nations (David et al. 2013). It is also important to maintain strong networks with and appreciate local authorities, community leaders and mentors who may serve as gatekeepers for their communities. Culturally divergent tobacco use exists in certain Pacific Island communities and can have a nuanced influence on various factors relating to FCTC implementation. For example, data pertaining to manufactured cigarettes in Palau may significantly underestimate the extent of tobacco use, and kava bars serve as an important location to enforce tobacco control policy in Vanuatu. These country- and community-specific situations reinforce the need for local factors to be appreciated.

The FCTC’s provisions should be implemented not merely to follow the administrative procedures in a treaty which a government has ratified, but because the provisions will reduce tobacco-related harm in local settings within the country of interest. National governments are central to the FCTC process; however, they are more directly accountable to their citizens than to the FCTC and its governing bodies. De Leeuw and Clavier (2011) suggest that failure of the development of healthy public policies at the national level in general is mainly due to the absence of the public from the effort. Similarly, FCTC-based legislation should resonate with civil society or clients in each country: those who are ultimately affected by its provisions (Townsend et al. 2012). While anti-tobacco NGOs may be instrumental in advocating for the right to health and the FCTC at all levels, it is important to remember that it may not channel the broad voice of civil society. In such situations, governments may ignore their demands for strict tobacco control and FCTC implementation with the claim that these groups do not represent all of the country’s citizens; this was the case in Palau. Furthermore, tobacco control
NGOs/CSOs were inactive or simply did not exist in the other three countries examined in this study, meaning that it was left to governments or the people they represented to protect citizens’ right for health. Given that tobacco use undoubtedly causes a significant health burden on its users and those around them, and this study found that tobacco control laws are favoured by the general population in each country, effective tobacco control legislation is likely to be in the interests of most people. There may be some benefit to empowering civil society in relation to political decisions and harnessing a more direct democratic approach which involves the citizenry more in policy decisions, assuming they are well-informed on tobacco control issues (Townsend et al. 2012). Public involvement is cited as an important way to trigger governance actions contributing to a whole-of-government approach to health or HiAP (Gauvin 2012). Empowering civil society could also limit the potential for industry interference and atone for any lack of commitment from government, whether at international, national or sub-national levels. Laverack (2007) explains that for successful health promotion programs to build community empowerment, they should: address community concerns; build partnerships between the community, outside agencies and the practitioners they employ; build community capacity to improve the knowledge, skills and competencies that enable communities to better address their concerns and; evaluate their effectiveness and share ideas and visions with all stakeholders. Similar principles of empowerment could be applied to tobacco control and FCTC implementation.

6.3 Recommendations to strengthen FCTC implementation at the global level

In terms of the global implementation process, the FCTC has only reached the end of the beginning. The aim of minimising the harm associated with the tobacco epidemic is far from being achieved as global tobacco use prevalence rates remain high. Only when this trend is reversed for some time can the FCTC be considered a major success. Despite the discouraging rise in tobacco use, the tide may be on the turn: a torrent of tobacco control legislation has been introduced internationally
since the FCTC’s inception. The four countries examined in this study are worthy cases in this regard, as they give indications of whether this forward momentum can be sustained, and of what is needed in order to counteract the harm that is caused by tobacco use and the efforts of the tobacco industry. The FCTC is not without some complex challenges and shortcomings. To counter these, recommendations directed to the global level can be made in four key areas.

6.3.1 Enhance global funding capacity for FCTC implementation in developing countries and SIDS

The FCTC was introduced in order to eliminate the spread of the tobacco epidemic to developing nations. Not addressing capacity-related concerns in these countries may lead to significant failure. Frenk (2010) states that strengthening national health systems is vital for progress in global health. In the words of the WHO Director-General Dr Margaret Chan at the sixth COP meeting in Seoul, Korea, “success depends on capacity to implement, everywhere” (WHO 2012c; para. 4). Tobacco control advocates may find it ideal that all FCTC provisions are implemented comprehensively and efforts should be made in every way possible to advance the FCTC as a global health good. However, as suggested earlier in Chapter 2, the reality for many developing countries is that there is a shortage of capacity to implement and enforce all FCTC provisions comprehensively. Resource constraints in developing countries are often sector-wide and not restricted to tobacco control, as found in several countries in this study. More funding to build capacity for global FCTC implementation is needed, but it is important that this funding is not shifted from other public health priorities (Ross & Stoklosa 2012). Many developing countries face a “double burden of disease”, where communicable diseases and child and material outcomes that traditionally affect the poor are combined with the NCD burden (Mathers, Strevens & Mascarenhas 2009). Concerns such as primary health care and the Millennium Development Goals are (and perhaps more) highly prioritised (Lin 2010; Ross & Stoklosa 2012); this was certainly the case in the countries considered in this study. It was stated in Chapter 6.2.5 that each of the available avenues to source additional capacity at the national level is challenging to achieve for countries with few internal resources and competing demands for them,
and which must compete with other countries when requesting international assistance for tobacco control. Like Calain (2007) claims in light of the International Health Regulations, it is crucial that scarce health resources are not extracted from fragile health systems at the national level for global initiatives which may not be cost-effective in such countries. To ensure that capacity is not misallocated at the national level in fragile health systems, it is necessary to increase global capacity. The FCTC has a mechanism for international cooperation and assistance, but its implementation rate is low despite many countries reporting gaps between the resources available and needs assessed (WHO 2012h). Furthermore, the rate of growth in multilateral assistance overall has slowed since 2008, and it even declined in 2011 (OECD Development Assistance Committee 2013).

In SIDS, there is an additional concern in respect to global funding for tobacco control. Tobacco control and in particular the MPOWER provisions have been funded by the Bloomberg and the Bill and Melinda Gates Foundation for implementation in many developing countries (Tanne 2008), but this funding has not reached SIDS as preference is given to countries with the highest (absolute) tobacco use prevalence (Bloomberg Initiative Grants Program 2009; Frieden & Bloomberg 2007), which inevitably means countries with larger populations. Therefore SIDS may miss out on such funding opportunities.

These developments foster the need for innovative global solutions to facilitate tobacco control and FCTC implementation capacity. Governments and international agencies have adopted innovative financing mechanisms for other global health challenges, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, they have so far failed to do this for tobacco control (Callard 2010). Potential solutions to the need for more global funding include creating a mechanism similar to the others that exist through global health partnerships (Ross & Stoklosa 2012), developing a mechanism to capture a share of the earnings of transnational tobacco sales (Callard 2010), and integrating tobacco control into the broader development agenda through a global coalition with inter-sectorial coordination (Reddy et al. 2012). Pursuing such options would significantly enhance
the global capacity to facilitate FCTC implementation and counter the tobacco epidemic in developing countries.

6.3.2 If funding capacity is inadequate, strategically prioritise cost-effective provisions and consider the suitability of MPOWER components in SIDS

Prioritising cost-effective FCTC provisions is the necessary alternative if there is no source of funding for FCTC implementation nationally or globally. This was part of the rationale behind the WHO’s focus on the MPOWER package, which claims to represent the “best buys” in tobacco control (Mackay et al. 2012). Even within this selection of tobacco control priorities, some research casts doubt on the cost-effectiveness of cessation services (the “O”), including nicotine replacement therapy, in developing countries (Alpert, Connolly & Biener 2013; Chapman 2011; Chapman & Mackenzie 2012). This doubt was shared by several informants in this study. In an international study, Borland and colleagues (2012) remark that low- and middle-income countries have fewer resources to invest in smoking cessation, and strategies that rely on service delivery within the health care system are likely to have limited impact, rendering strategies such as mass media campaigns, pictorial health warnings and higher taxation more likely to encourage the cessation of tobacco use; this puts even greater emphasis on the already cost-effective “W” (Warn about the dangers of tobacco) and “R” (Raise taxes on tobacco).

Furthermore, the “M” (Monitoring tobacco use and prevention policies) may be costly in SIDS and require capacity beyond what these countries can provide, given their sparse populations and lack of institutional capacity; developing countries with larger populations and skilled workforces may find this more cost-effective. The WHO, SPC, CDC, AusAID and NZAID have provided much-needed support for this, both in the countries examined and elsewhere. If such assistance was to cease, it may be appropriate to streamline monitoring in SIDS. For example, given limited resources, it might be more beneficial to conduct several small-scale surveys that are more likely to be manageable by local resources to monitor tobacco use and policies, rather than to opt for less regular but more comprehensive studies that match international standards typical of larger or developed countries, and that are reliant on foreign expertise.
Stakeholders must strategically decipher where scarce resources for FCTC implementation are best allocated. Similar to what is mentioned in Chapter 6.2.5, a possible way forward would be for the COP to raise the minimum FCTC requirements (or at least encourage further activity) of the cost-effective provisions that countries must adhere to. This could include mandating larger health warnings on cigarette packages than the existing 30 per cent minimum, plain packaging, bans on point of sale displays, bans on smoking in outdoor public places where people congregate, and further encouragement for countries to increase taxation on tobacco products. Placing and encouraging stricter requirements for these proven and cost-effective provisions at the global level is likely to result in a sharper decline in tobacco use without compromising the resources of national health systems in developing countries that are already stretched.

6.3.3 **Globalise the FCTC to ensure that it comprehensively addresses the global tobacco problem**

“Issues and problems may well be increasingly constructed in international and global terms, but decision-making and implementation still remain domains which must be analysed within the context of nation states” (Parsons 1995; p. 243). This quotation is framed in the context of policy generally, but it is highly relevant to the FCTC. Despite the tobacco epidemic being global in nature – that is, often facilitated by supra-national flows in commerce and trade through multinational companies – the formal decisions relating to the FCTC are inevitably tied to politics of each nation state (Lee 2010). This is a particular concern in light of the limited developing country capacity aforementioned and the power of multinational tobacco companies which can have a significant influence on national policies. The latter did not emerge strongly across all of the countries in this study, but it concerns many countries internationally. Despite an FCTC provision stating that public health policies should be protected from commercial and other vested interests of the tobacco industry, there is evidence of this occurring in many developing countries (Lee, Ling & Glantz 2012). Furthermore, the resources of pro-health actors in many developing countries are quite modest, especially in comparison to the resources and influence of multinational tobacco companies.
This is not to suggest that the FCTC has not been vitally important in the exchange of information, in the sharing of ideas and technical expertise, in placing tobacco control higher on the political agenda and in facilitating countries, particularly developing nations, to pass national legislation. The FCTC is a significant achievement for global health governance. However, like many international treaties it is still partially ineffectual in its ability to counteract the global forces that have driven the tobacco epidemic. The FCTC in its existing form largely serves to fight against the tobacco epidemic across 177 national battlefields with a limited degree of flow across them. This does not suggest that the authority of nation-states to determine their own priorities should be limited or restricted, as such an ideal exceeds the bounds of this project; but a stronger mandate for the FCTC to counter supra-national flows of the tobacco trade and its associated industry should be sought in order to further globalise the FCTC. Firstly, as advocated in Chapter 6.3.1, constructing a global mechanism to finance FCTC provisions that goes beyond relying on the good nature of a few governments and private philanthropists would shift the balance of power from the tobacco industry towards tobacco control. However, there are numerous other ways that the FCTC can be globalised to countervail the global forces of the tobacco industry. These include: addressing the silence of the FCTC on its relationship between trade agreements (Collin 2010); integrating health norms within the FCTC in international trade law (McGrady 2011); combating illicit trade through a strong protocol to the FCTC (Joossens & Raw 2012); regulating FCTC provisions over the internet and social platforms (Freeman 2012); eliminating the conflict of interest inherent within parties to the FCTC who also operate/invest in state-owned tobacco companies (Barraclough & Marrow 2010) or act in the interests of the global tobacco industry (Assunta & Chapman 2006; Gruning et al. 2012). While the national level is critical in terms of FCTC governance and implementation, methods such as these would go some way towards ensuring that the global flows of the tobacco trade are increasingly countered on one global battlefield, rather than on 177 individual ones.
6.3.4 Appreciate country contingencies and local priorities in the governance of the FCTC

There may be benefits to emphasising the bottom-up implementation of FCTC-based provisions which was discussed within the national context in Chapter 6.2.6. A similar approach should be undertaken at the global level through a greater appreciation of country contingencies and the local priorities of each country. Environments are likely to be different in SIDS than in either developed or larger developing countries. The Ottawa Charter for Health Promotion states that “health promotion strategies and programs should be adapted to the local needs and possibilities of individual countries and regions to take account differing social, cultural and economic systems” (WHO 1986; p. 2). In a similar way, the environment in each country may justify variation in FCTC implementation approaches. The FCTC itself allows for some flexibility and discretion, as indicated by the language used in various provisions, such as “where appropriate”, “without prejudice to the sovereign right”, “in accordance with its constitution/national law” and “taking into account national priorities” (WHO 2005c); and national governments adopt FCTC-based provisions in their domestic legislation with consideration for their suitability. The difficulty is that the stronger the treaty’s terms, the more comprehensive it is and the higher degree of institutional change it requires; and therefore (in light of limited funding) the more likely it is that there will be gaps between its requirements and what is implementable in many developing countries. Rather than forcing FCTC provisions that are more resource intensive from the top-down, it is important for global FCTC stakeholders to appreciate FCTC implementation from the bottom-up through recognising country contingencies and local priorities. Such an approach is justified due to: the divergent forms of tobacco use, the limited capacity of SIDS, and the relevance of the WHO governance structure for SIDS.

The WHO and the FCTC recognise other uses and forms of tobacco, although there tends to be general emphasis on manufactured cigarettes in FCTC-related activities. This can be justified by the magnitude of the burden associated with smoking manufactured cigarettes. However, other culturally-divergent uses of tobacco
should not be ignored or overshadowed at the global level by the dominant forms of tobacco use. The prominence of chewing tobacco in Palau justifies an approach that should be tailored to its own situation, which the government recognised in its chew-free policy in public buildings. This is an example where FCTC-based provisions have been successfully tailored to the local context. In Pakistan, however, it was found that the government’s proposed interventions were almost exclusively directed at cigarette smoking and smokeless tobacco was ignored (Bile et al. 2010). This case provides an important lesson for other countries as FCTC legislation and implementation should be based on nature of tobacco use that is dominant in the local context.

Parts of the FCTC are already difficult for SIDS to achieve. In these countries, the lack of local administrative capacity in departments with a small number of staff is a significant challenge to any top-down approach to implementation, particularly in relation to provisions that are labour-intensive. External FCTC-related agencies seeking to mobilise nations towards adopting and complying to FCTC provisions are likely to encounter significant impediments in the form of local administrative capacity, especially where little funding is available for local administrations to fulfil these activities. Participants in this study generally supported most FCTC policies, although many felt that a small proportion of its provisions were not applicable, achievable or relevant in their own countries. Many of the globally focused, outcome-oriented FCTC reports, such as those from the WHO and FCA, tend not to appreciate such nuances. It is important for SIDS (and each country alone) to have some degree of autonomy on how the FCTC is governed, due to their particular characteristics and distinct circumstances. This does not mean countries may be left to their own devices, but rather it means to empower and support each country’s approach to FCTC implementation. McNaught (2003) recommends that in health policy, Western models of public administration may have to be scaled down for SIDS. In a similar way, it is recommended here that FCTC-based policies should be adapted to suit SIDS under sound health-oriented advice, and such countries should not be held strictly to account for failing to implement complex policies that may direct scarce resources away from other important areas of the health sector, or
even from more cost-effective articles of the FCTC. Assuming they are well informed in tobacco control issues and are not subject to industry influence, it may be better for bilateral and multilateral agencies to empower local decision makers and particularly the MOH to direct resources where they will be most suitably deployed. Laverack and Mohammadi (2011) explain that to meet the varied demand of community needs, funding agencies must be flexible in the type and timing of resources they provide. This remains to be achieved broadly, but it would strengthen community action for health promotion (Laverack & Mohammadi 2011).

For example, in AusAID’s funding strategy in Nauru offered more long-term flexibility, less emphasis on short-term annual grants and significantly improved the MOH’s ability to prioritise local health needs. Funding agencies should also be conscious of the administrative burden that comprehensive reporting and grant application procedures may place upon SIDS with their limited staff and competing responsibilities.

The current governance structure within the WHO and WPRO tends to be based on geo-political affiliations rather than on other traits that may be shared between countries. Some government-oriented informants stated that their issues and needs relating to the FCTC may be vastly different to those of other members of the WPRO, and the concerns of the larger countries in the region sometimes dominated the FCTC-related discourse. To strengthen the global health system, Frenk states that “there is an urgent need to build up a body of knowledge on what works and what does not, so that each country is better equipped to adopt and adapt the lessons learned from every other nation” (2010; p. 2-3). Pacific SIDS may have more in common with, and a greater potential to share useful information amongst, other SIDS (such as those in the Caribbean or near Africa), rather than within the existing WPRO structure; and placing such countries under the same umbrella as vastly different nations such as China with 1.3 billion people and a national tobacco monopoly, and Australia, a highly developed nation with a population of 20 million, may lead to disinterest in and isolation from the regional discourse. This is a politically sensitive matter, and although the existing governance structure is rigid and difficult to change, efforts should be made to explore the establishment of
networks that transcend WHO regions. Networks should be based on other sets of characteristics that render these countries similar, and where relationships are likely to be mutually beneficial. Such characteristics may not only include categorising countries as SIDS, but may use other delineations such as level of development, the stage they have reached in FCTC implementation, the presence of local manufacturing industries, and so forth. Establishing such connections may make these networks more fruitful, facilitating the sharing of information and ideas among countries that share similarities on a variety of levels. This may help countries facilitate engagement with each other, and not be drowned out or left unheard by louder voices.

6.4 Conclusion

The global tobacco epidemic has resulted in devastating consequences for human health across the world. Although the FCTC has made a promising start to addressing this, it is clear that significant improvements need to be made before health professionals rejoice in its success. This is evident in Pacific SIDS, as in many other developing nations. All relevant stakeholders must ensure that movements towards tobacco control are sustained and improved through effective FCTC implementation. As its implementation is contingent upon many complex and interrelated variables, the means by which to achieve effective FCTC implementation across multiple countries are intricate. Attention must be paid to these nuances. Nonetheless, some clear recommendations on how to move the FCTC forward from both national and global perspectives emerged from common and distinct themes found in this study. Fulfilling these recommendations is likely to be extremely challenging and subject to highly political decisions. Through using research to inform policy, this study provides knowledge that aims to facilitate the FCTC implementation process. By making this contribution, it is endeavoured that some more momentum towards minimising the harm associated with the global tobacco epidemic will be established. Although the task ahead is arduous, so to was the notion of a framework convention to address tobacco control before it was eventually realised. The rewards for developing the FCTC in the form of population
health gains are beginning to be felt. The rewards for implementing it successfully will be exponential in comparison, in the Pacific Islands and globally.
Chapter 7  Conclusions

7.1 Introduction

The previous chapter is pragmatically important for overcoming barriers and exploiting opportunities for FCTC implementation at both national and global levels. This chapter contextualises the findings of this dissertation in the field of health promotion and draws upon the theoretical framework and research process undertaken. Here, contributions to the existing knowledge in health promotion and implementation theory are made and important recommendations for future researchers are discussed. This chapter commences with a discussion on the implications for health promotion theory and practice, which is followed by recommendations on: the theoretical approach undertaken, using implementation theory, Najam’s 5C Protocol, and research methods and practicalities. This dissertation concludes with a discussion on its contribution to the existing literature.

7.2 Implications for health promotion

7.2.1 Implications for scholarly development in health promotion

Public policy is fundamental in promoting health. Scholars have stressed the need to focus on political science in order to develop healthy public policy and HiAP, as highlighted in Chapter 2. Expanding theory and deepening political science presence is also an expressed need in international development (Leftwich 2009). This study made a contribution to this area of scholarly need by exploring one instrument of healthy public policy/HiAP in four countries. This study exposes the juncture between what the FCTC proposes and what has happened in the populations it is designed to influence, which may have important ramifications in other areas of health promotion. Global health promotion priorities, such as the Millennium Development Goals, NCD control, or the social determinants of health, are rhetorically supported, but the lack of integration of these priorities into existing health promotion programs is a common reality (Sparks 2013). This study endeavours to encourage other scholars to explore the implementation gap in
policies or programs relating to other broad issues in health promotion. In addition to implementation theory, many other theories that explain public policy need to be applied and tested in health promotion in order to develop this area of scholarly need (Breton & de Leeuw 2011).

As the first public health treaty, the FCTC has achieved a significant milestone. By critically appraising the FCTC, scholars can gain an important insight into health governance at the global level. New scholarly development in global health governance has emerged, particularly through exploring of the role of different actors and networks (Collin, Lee & Bissell 2002; Gonzalez, Green & Glantz 2012; Lencucha, Labonte & Rouse 2010; Sparks 2010), the role of competing agendas (Kay & Williams 2009; Mamudu, Hammond & Glantz 2011) and theory development (Fidler 2007; Ruger 2012). Through the prism of exploring FCTC implementation in multiple countries, recommendations that relate to health governance at the global level have been made in Chapter 6. These findings have important implications and some of these insights have already been documented in the literature. Firstly, it has been argued that a more deliberative democratic process may be facilitative when it comes to global health governance (Townsend et al. 2012). Secondly, global health governance is multilevel, multidisciplinary and dynamic, and studying such a field warrants a variety of theoretical points of view (de Leeuw et al. 2013). As the FCTC evolves, it is likely that new theories and concepts relating to global health governance will emerge and scholars will take into account FCTC-based studies such as this one. While the story of the first public health treaty takes its course, so too will the interest of it as a case study of global health governance.

This study has shown that gradual progress in tobacco control in four developing nations has been made, ten years after the FCTC was adopted. Although these health promotion achievements are acknowledged and have been significant for the communities that benefit, health promotion efforts to curtail tobacco use remain far ahead of efforts to curtail other important concerns such as obesity and alcohol use. Some authors point to the FCTC, or at least some of its components, as setting a precedent for NCD control (Chopra & Darnton-Hill 2004; Lien & DeLand
2011; Pickett 2006; Yach et al. 2003). At the same time, some important differences exist between the two domains, and the FCTC may not necessarily be an ideal tool to address obesity and alcohol use (Barraclough 2009; Lien & DeLand 2011; Yach et al. 2003). Addressing obesity is even more complex and nuanced than tobacco control (Magnusson 2007). Tobacco control progress has been rather gradual in terms of tobacco-related morbidity and mortality, even with the support of an international treaty and a decreased level of complexity in comparison to obesity. There may be formidable challenges for any similar method to solve the obesity epidemic, where in contrast to tobacco control, there are no exemplar populations in which the obesity epidemic has been reversed by public health measures (Swinburn et al. 2011). While tobacco control is emphasised in this dissertation, the health burden from other causes of NCDs, the solutions to which are even further behind in developing countries, must also be acknowledged and respected. In Australia, specific interventions such as advertising restrictions that have worked for tobacco control have not been implemented in other important areas such as obesity and alcohol use (Daube 2012). With several Pacific Islands being amongst the most obese nations in the world (WHO 2013c), other risk factors contributing to the NCD burden are stark and deserve attention from scholars in health promotion. Even further, the NCD burden itself must not override other competing health concerns that are often prevalent in developing countries. When researching a particular health issue, an important caveat is that health promotion should be treated as “the broad framework under which these often competing silos can be more objectively examined” (Sparks 2013; p. 155). Tobacco control, like all other health issues, should be seen a mean to an end to promote health, rather than as an end in itself.

Another key area of scholarly development is in the HiAP approach, a central theme in the 2013 Global Conference on Health Promotion in Helsinki, Finland. It has been established that HiAP is inevitably political, does not occur without political will (Baum, Ollila & Pena 2013), and a common understanding between different sectors is of utmost importance (Bettcher & da Costa e Silva 2013). As explained in Chapter 2, successful FCTC implementation must encompass a HiAP (or healthy
public policy) approach. As the HiAP approach is crucial for numerous FCTC provisions, studies exploring FCTC implementation serve as important lessons for HiAP in terms of its success and how it may (or may not) be influenced. Some important distinctions relating to HiAP are made throughout Chapters 4, 5 and 6 in this dissertation. Despite desires for HiAP from scholars in health promotion, de Leeuw and Clavier (2011) explain that greater levels of connectedness and commitment across civil society, governance integration between various sectors and levels, and more action is required for the further success of health integrated policies. This study, like others in FCTC implementation, has similarly highlighted the significant amount of work that remains in order to achieve successful HiAP in the countries examined. If the tobacco control scenario is indicative of HiAP in other areas, then there may be a need to facilitate stronger networks, political commitment, capacity and public support across all health issues. Leppo and colleagues (2013) reiterate most of these factors as lessons for policy makers in determinants for successful HiAP implementation.

7.2.2 Implications for health promotion practice

The importance of public policy and implementation theory to understanding the success or failure of healthy public policy has been advocated and demonstrated throughout this dissertation. It is vital that health promotion practitioners understand this field if they are to effectively advocate for policy change or enforcement in tobacco control, whether it is at a local, national or global level. This involves appreciating the content of tobacco control legislation, how it is developed, and how tobacco control policies and plans are transferred into action. Breton and de Leeuw (2011) have explained that too many health promoters are naïve about the political processes that drive health promotion planning and implementation. This study explored in detail how various actors, many of which are outside of the health sector, are involved in tobacco control policy. It is crucial that this is recognised by health promotion practitioners in order for them to be able to engage with the political process and bring about changes that promote population health. Here, multi-sectoral collaboration and a whole-of-government approach are crucial (Leppo et al. 2013). Partnerships and communication are
important forces that drive health promotion (Gillies 1998; Jones & Barry 2011; Robinson et al. 2006). Health promotion practitioners must extend their communications and collaborations to relevant actors in other sectors and levels of government, the private sector, NGOs, civil society and academia. If they limit their work to the confines of their own departments or organisations, health promotion practitioners may only scratch the surface of what needs to be done to enable people to increase control over and improve the determinants that affect their health.

This study’s findings emphasised severe limitations to health promotion that come in the form of capacity, especially in the environments of SIDS where limited resources tend to be stretched. Here, health promotion practitioners must make the best use of the limited resources that they have. It is important to be strategic and ensure that efforts are directed towards what is most cost-effective and where possible, collaborate with and “piggy-back” on other health programs. As learnt in the Cook Islands, flexibility and innovation may stretch limited capacity further. This approach necessarily involves recognising local contingencies and what is most effective in the local context. The conceptualisation of SIDS has shed light on the commonalities experienced in these types of nations, but even within this grouping, local contexts may vary. Health promotion practitioners must appreciate the strengths, weaknesses, opportunities and threats in the environments they are a part of and base their efforts on local needs. Hale and colleagues (2012) found that engaging local communities and local ownership of tobacco control activities constitutes an important step in driving tobacco control forward in the tiny Pacific Island nation of Niue. Development assistance partners and multilateral agencies must also appreciate the local context of such nations and recognise that standard health promotion practices in larger countries might have to be streamlined in order to suit such environments, as found in this study and by McNaught (2003).
7.3 Recommendations on the underlying theoretical approach

7.3.1 A mixed methods approach and triangulation are valuable for research on FCTC implementation

A comprehensive analysis of FCTC implementation is extremely complex and involves researching many FCTC provisions, ideas, organisations and participants. Allowing for both qualitative and quantitative data collection enabled the primary investigator to triangulate and validate the complex array of data, some of which cannot be fully accounted for by solely conducting semi-structured interviews. Despite being primarily qualitative, certain aspects of FCTC implementation warranted the use of quantitative data. Including this data and adopting triangulation techniques resulted in richer and more comprehensive findings. This is crucial for those who are interested in analysing FCTC implementation as a whole, given the complexity of the subject matter.

7.3.2 FCTC implementation in Pacific SIDS can and should be examined in finer detail

In this study it was decided that that the variables that affect most FCTC provisions at the national level were similar, hence a rather broad, holistic approach to FCTC implementation was undertaken and all articles were of interest (although some emphasis was placed on the key provisions). It was important not to lose sight of the general direction of the FCTC as a result of investigating the intricate details of peripheral FCTC provisions. In using this approach, the findings of this dissertation are rather exploratory, which is indicative of realist evaluation (Pawson & Tilley 2004). There is significant scope to explore implementation in more detail in regards to specific FCTC provisions and the number of points within them. It is possible for futures studies with greater resources, or studies that focus on specific and fairly narrow aspects of the FCTC (such as observing all of its sub-components or exploring its implementation at the sub-national/local level) to explore FCTC provisions and their intricacies in more detail than this study could do. Such
investigations would supplement the findings of this study and facilitate scholarly development in this field.

7.3.3 An appropriate balance between the richness and context-specificity of a single case study to the more complex multiple-case study should be appreciated

This study’s methodology provided the detailed, explorative insight sought in the research questions. However, giving justice to the complexity and nuances that exist at both the individual country level and Pacific SIDS level was a significant challenge. When considering the number of countries to include, the wider the net is cast, the more challenging it may be to provide a deep insight into the anomalies that exist in each country. At the same time, a richer and strong array of evidence is available and external validity is enhanced if there are more cases (Yin 2009). Researchers must consider the trade-off between an increased number of cases for increased generalisability, and an increased depth and breadth of description made possible by focusing in a small number of cases (Schofield 2002). Summarising the evidence from case studies is not always useful and it can sometimes be counterproductive (Flyvbjerg 2006) and burdensome in larger multiple-case studies. When taking the scope of the study into account, researchers must consider implications on the beneficence of the research. Participants, organisations and the communities they are a part of may favour detailed and context-specific findings and recommendations. In this research project, the provision of country-specific recommendations and individual reports on research findings within each country fulfilled this desire. Future scholars conducting multiple-case studies should consider similar supplements to their dissertation to benefit the people, organisations and countries interested.

7.3.4 The notion of SIDS is useful to conceptualise types of nations that may share similar implementation environments, but SIDS should not be treated as unique or mutually exclusive to other types of nations

The major purpose for the conceptualisation of SIDS in this study was to categorise types of nations that may share similar experiences in regards to FCTC.
implementation, like they have in economic and environmental domains. The common themes found in these environments justified this approach, and recommendations became more relevant to the context of these countries as a result. However, the key themes found in this study should not be considered unique to SIDS as they may exist in other and especially developing countries. Despite this, it is important to recognise that these themes are likely to be more common and exacerbated in SIDS. This is not dissimilar to other studies categorising types of countries in terms of whether they are developed, developing, low-income, high-income, and so forth. These categories should not be considered mutually exclusive when it comes to FCTC implementation (or other public policy) issues, as important concepts and lessons can be shared across different types of countries. Nonetheless, it is likely that there is more overlap between countries that have commonalities in their social, economic and geographical context.

7.4 Recommendations on using implementation theory

The use of implementation theory was an important aspect of this dissertation. It is likely to remain a common way in which to assess the FCTC, as well as other health policies or programs where researchers are interested in exploring the nexus between what is promised and what is delivered. Therefore it is important to appraise the use of implementation theory and provide recommendations for other researchers that are inclined to utilise it.

7.4.1 Implementation is time dependent: collecting data at one point in time makes it more difficult to account for policy innovation or learning

As explained by Najam (1995), implementation is a dynamic and living process. By conducting a multiple-case study in several countries and collecting data for interviews over a relatively short time period, the data collected is akin to a snapshot at one period of time. While participants could reflect historically on how the implementation was affected, and document analysis somewhat accounted for the narrow time period in which the interviews were conducted, there may be a need to follow up with participants by repeating interviews over time. This is
beyond the scope of this dissertation, but the time-dependence of implementation must be appreciated by researchers who are interested in exploring it. If one were to follow up implementation prospectively, they would provide a stronger account of the policy innovation or learning that occurs over a period of time. For example, this could provide an insight into how policymakers overcame certain barriers, whether changes in a particular variable cluster had an influence on implementation and which variable clusters were most pertinent at various stages of implementation. The importance of time is stressed in other theories of public policy such as network governance (Provan & Kenis 2007) and Kingdon’s streams (Hoeijmakers et al. 2007).

7.4.2 Implementation theory is a useful, but not necessarily a superior, approach to analyse FCTC-based policy change

Implementation, in the case of comprehensive national tobacco control legislation based on an international treaty, is an extremely complex process. While the use of a theoretical framework on implementation can assist in helping to understand this process, the product of its use in this scenario is exploratory rather than confirmatory. A reasonable account of what affects FCTC implementation in Pacific SIDS has been provided, but this account is not infallible and the findings presented cannot be proven beyond any doubt. This notion applies to realistic evaluation (Pawson & Tilley 1997) and is in alignment with Parsons’ (1995) view that a framework of the policy process can only ever be a representation of a reality which cannot be proved or disproved in an objective sense. Implementation theory (and Najam’s 5C protocol) was useful to analyse what determines success or failure in FCTC-based policy change in the context of interest, but it is not necessarily considered superior to other approaches. As explained in Chapter 2, the appropriate means by which to analyse policy change is dependent upon many factors, including type of policy, for whose purposes it is being conducted, at what level, and so forth. The synthesised approach to implementation utilised in this dissertation is recommended when implementation is to be explored broadly and an interest in stakeholders at all levels is present, but other approaches may be just as useful under different circumstances or contexts. Implementation could be
sufficiently delineated in this study and analysing it was effective. However, implementation theory is less useful if the implementation stage is not distinct from other stages of the policy process. The countries examined in this study each introduced comprehensive legislation at one time, but in Australia, for example, this approach would not have been as suitable because a substantial proportion of FCTC provisions were already place before the FCTC came into force. Furthermore, some FCTC provisions are yet to be complemented with detailed guidelines and some countries have only very recently ratified the FCTC, rendering implementation theory less appropriate in these situations. A final concern is that implementation can be affected by factors that are determined before it takes place. As Sabatier (1999) suggests, the stages of the policy process may interact with each other. The initial stage of developing policy content, a key variable cluster that affects implementation, has been defined before implementation is to occur and researchers seek to analyse it. Researchers must be aware that policy content is dependent on implementation parameters, and implementation is dependent on policy content. Therefore if one is to gain a more holistic perspective of policy change and address this conundrum, other theories of agenda setting and policy change may need to be considered.

7.4.3 A pragmatic and pluralistic approach to selecting the most appropriate theoretical or conceptual framework should be employed

The use of implementation theory for this dissertation was justified in Chapter 2, but by taking the factors in Chapter 7.4.2 into account, other models to analyse FCTC-based policy change may be more useful under certain circumstances. There is no one supreme theory that should be used to analysed FCTC-based policy change. This recommendation is similar to that advocated by Estabrooks (2006) in the health care setting, who explains that finding a fit between context and theory is important for knowledge translation because one theory will not fit all contexts. At the same time, this is not to argue that there is no useful model, or that some models are not inherently better than others. Researchers must adopt a pragmatic approach to selecting the most appropriate theoretical framework that aligns with the type of policy in question, the context in which it exists, the stage of the policy
process, and the purpose for which it is being used, amongst other things. For example, a model of agenda-setting may be helpful in countries that have ratified the FCTC but not translated it into national action; or Sabatier and Jenkins-Smith’s (1993) Advocacy Coalition Framework could prove useful to explore the FCTC’s influence on governments in countries that have a sizeable pro-tobacco coalition presence. It is also important to consider that this field is still under development; new (or existing) theories will be developed in future and hybrid theories are likely to emerge that may be useful under particular circumstances. A recent example of the latter is the work of Greenhalgh and Stones (2010) who combine elements of both structuration and actor-network theories.

7.5 Recommendations on Najam’s 5C Protocol

According to Popper (2002), falsifying or corroborating a theory through testing is vital for scientific progression. In the interests of the need for more critical application of existing theories of the public policy process to guide and inform health policy enquiry (Walt et al. 2008), the applicability of Najam’s 5C Protocol is now discussed. The 5C Protocol was a useful theoretical framework for this study, but a few setbacks were apparent in its application.

7.5.1 The 5C Protocol has not been operationalised by its author

A drawback of the 5C Protocol is that it has not been fully operationalised in the literature by Najam himself. It is evident in the 5C Protocol paper that Najam (1995) intended to do this, but it was not possible to access any subsequent work on this framework by the author. It has only been operationalised by other authors in the public realm. Therefore, significant effort in the planning stage of this research went into determining the most appropriate way to analyse the variable clusters mentioned and to structure the research inquiry. The 5C Protocol was operationalised for the purposes of analysing tobacco control (and health) policy for the first time in this study; hence suggestions on its applicability may be valuable for those intending to use it in this field.
7.5.2 Further complexity within clusters of variables should be recognised

First, the logic proposed by Najam (1995) does not give much attention to the complexity within each cluster of variables that affect implementation. One can assume some complexity with the array of lines passing between the clusters, but in reality, the clusters of variables are simply clusters; there is a range of variables within each that could affect implementation independently. Furthermore, interrelationships within each cluster may exist, and some of these variables within each cluster (or within the clusters overall) may be significantly more important than others under particular circumstances. Najam’s (1995) diagram of the 5C Protocol cannot depict this. For example, commitment at the senior level of government is a significantly more important determinant of capacity than commitment at ground level, and departmental size and the amount of staff are significantly more important and insightful determinant of capacity than physical facilities, infrastructure and technology. The diagram serves to simplify this complex reality, as many others do, but it can be somewhat deceptive. It is for this reason that the diagram is used only in the introduction of the model and not reproduced thereafter. The effect of representing each of many factors within each cluster of variables would result in an extremely complex diagram with little utility that is almost impossible to follow.

7.5.3 “Context” does not account for the implementation environment

The context variable cluster was difficult to operationalise because of the range of provisions and actors at various levels within the FCTC. Furthermore, it was important to give some distinction to the broad social, geographical and economic environments of SIDS, which was challenging to account for in the 5C Protocol. Najam (1995) explains that his definition of context was narrowed to the institutional context through which a policy travels, and that the broad social, geographical, economic and political context would affect each of the variables; but he did not give a detailed account of how this would occur. To do so would be a monumental challenge to any political scientist. This created some difficulty in applying the concept of SIDS within the model. A useful addition to the visual model (if used in a similar way to this study), would be to embed it within a circular
boundary that represents the social, economic, political, cultural and geographical implementation environment: this is delineated in Figure 7. This can be conceptualised in a similar way to the socio-ecological model of public health; like the broad (upstream) social, economic, political and cultural environment affects more proximal (downstream) determinants that shape an individual’s health, the broad environment affects the more proximal variables that shape the implementation of a given policy. However, the causal pathways in the case of policy implementation differ to those in the area of health.


Figure 7: Model of variable clusters that affect implementation with appreciation of the implementation environment
The changes in the above diagram should be appreciated as only minor adjustments to the visual appearance of the 5C Protocol, to allow for appreciation of the implementation environment and delineate the difference between distal and proximal factors that affect implementation.

7.5.4 **Networks and the relationships between actors are not well conceptualised within the 5C Protocol**

The networks and relationships between various actors and how they may shape policy implementation are intertwined across context, commitment, capacity and coalition variable clusters. This makes it difficult to portray the networks and power relationships that are at play or how one actor may have influence over another in the way that policy network mapping would. Rather, the 5C Protocol is more focused the links between each of these many actors on implementation, rather than the links between each of the various actors. Researchers should recognise that it may be necessary to use an alternate or additional framework to conceptualise how actors may have an influence over each other. This is especially the case where a horizontal analysis is of interest, which is now detailed.

7.5.5 **The 5C Protocol provides little in terms of horizontal analysis**

The 5C Protocol gives little account of what is happening outside of the policy and issue of interest. Ministries of health, governments and the WHO are complex institutions that deal with many health issues and have relationships defined outside tobacco control. The 5C Protocol as used in this study gives some account for these institutional systems through the prism of tobacco control. However, it is difficult to obtain a complete picture of capacity, commitment, institutional relationships, coalitions and the policy content of issues that tobacco control may be competing with. Similarly, recommendations based on this study are made in the context of tobacco control, while other potential health issues are not entirely taken into account. While a greater extent of bottom-up decision-making is advocated in light of FCTC implementation in Pacific SIDS, for example, the ability to achieve this is dependent on institutions that have much broader areas of responsibility. This exhumes a sense of rigidness; once barriers to implementation
in such areas are found, it is difficult to determine to extent to which addressing these barriers may alter other aspects of the particular institutions and the other health issues that they may be responsible for. A horizontal analysis is necessary to determine such implications. At the same time, it would be difficult to explore specific health issues such as tobacco control in a horizontal analysis. Therefore it may be necessary to combine both approaches when analysing policy change, as advocated by Atun, Bennet and Duran (2008). Hill and Hupe (2003) make this same distinction in relation to implementation theory and policy analysis in their three proposed levels of governance action: implementation theory is seen as operational governance, while a horizontal analysis is aligned more with constitutional and directive types of governance. To gain a more comprehensive insight, it may be necessary to incorporate how actors, systems and institutions are shaped outside the issue of interest. In order to gain this broader perspective, it may be necessary for future researchers to supplement the 5C Protocol with a theoretical framework that accounts for a more horizontal analysis.

7.5.6 The 5C Protocol, despite its shortcomings, is remains useful due to the need to simplify a complex reality and the lack of superior alternatives in the literature

Despite the aforementioned shortcomings of the 5C Protocol, this framework remains very useful and it would not have been used in this study otherwise. Its general applicability allowed for its application to multiple countries and it gave attention to variables that affect implementation at multiple levels, embracing a synthesised approach to implementation. It also allowed for an analysis of a range of FCTC provisions and it can be applied to policy domains outside of health. Furthermore, the 5C Protocol facilitated the collection of in-depth data on FCTC implementation and provided a deep insight into how implementation is affected. The use of the 5C Protocol is justified and recommended under such circumstances. However, under different circumstances, its applicability must be weighed up against the many other theoretical models available in the field of public policy.
7.6 Research methods and practical recommendations

7.6.1 At least three countries should be included in multiple-case studies exploring similar issues within groups of countries (i.e. developing, developed, SIDS) to allow some degree of generalisability

Having two or more cases is more likely to address scepticism or fears of uniqueness and analytic conclusions become more powerful than those from a single case alone (Yin 2009). Four cases proved to be adequate for the purposes of this study, with each country providing useful input into the research; a degree of saturation was felt in cross-country and SIDS-related information. For similar studies that are concerned with using several countries as a case study for a category of countries, it is recommended that at least three countries, selected with an eye to diversity, should be examined. This is because generalising information that is gathered from only one or two countries alone may be difficult in the context of FCTC implementation. Including greater than four countries may result in increased generalisability, but the value gained could be offset by: diminishing returns in the usefulness of data collected for each additional country, significant resource constraints, and the amount of time it takes to complete data collection and analysis.

7.6.2 Multiple-country case studies may require a significant amount of resources and time to complete

One of the disadvantages of multiple-case studies is that they can require a significant amount of resources and time which may be beyond the means of a single investigator (Yin 2009). The small size of the relevant populations and organisations in the countries examined allowed the primary investigator to examine FCTC implementation effectively in this scenario. There were approximately eight to twelve potential participants in each country. This approach may not be suitable for a single primary investigator exploring countries with substantially larger numbers of potential participants. Another potential barrier may be obtaining ethical approval in each of the jurisdictions to be included, which are likely to have different requirements. In this study, applying for ethical approval
in four countries and the primary investigator’s own country was a substantial task. A final concern is the beneficence for the participants, communities and organisations involved. The significant amount of time taken to organise travel to, collect data from, and analyse data in multiple countries can result in a longer delay between the time of data collection and the production of findings and recommendations relevant to each country. In this research, participants were kept informed with multiple newsletters and brief reports on the anticipated findings in order to ensure that feedback for their benefit was provided in a timely manner. Future researchers conducting multiple-country case studies should consider similar arrangements.

7.6.3 Record-keeping in SIDS and possibly other developing nations may vary

Access to documentation may vary between countries and organisations. Record-keeping in SIDS or developing countries may not be undertaken to the extent of developed countries. Furthermore, it was fortunate that each country stored documentation in English and spoke the language proficiently in this study; collecting data where English is not an official language may prove a significant additional barrier to research. The extent to which each of the organisations in the countries examined kept documents varied across countries, which is noted in Chapter 3. Another concern may be the willingness of organisations to share their documents. Researchers should be aware of the implications this may have on the depth of data and the ability to triangulate findings. With recent technological advancements, the availability of electronic documents has facilitated this, but the varying extent of record-keeping may remain challenging for those researching in multiple countries and organisations.

7.6.4 FCTC implementation may be most fruitful if researched at least seven years after ratification, or at least two years after national legislation has passed

In all countries examined, the FCTC was ratified by 2005. The time taken to pass FCTC-based legislation was the greatest Palau, where this occurred seven years after ratification. The duration of this process was approximately four to five years
in each of the other countries examined. After the passage of national legislation, it may then take at least a year for the relevant actors to implement it. Assuming that other countries have to endure a similar length of time to pass and implement FCTC-based legislation, similar research on implementation may be most fruitful if undertaken at least seven years after the FCTC is ratified, unless the countries of interest ratify and pass FCTC-based legislation swiftly. After this period, research on implementation would be useful whenever there is a need to explore the gaps between the policy content and what is implemented. Data collection for this study was undertaken at the early end of this range. In the case of Palau, there was some difficulty in collecting data on the capacity present to implement the FCTC, although this was somewhat mitigated by the ability to collect documentation after their tobacco control bill had become a part of the national legislation.

**7.6.5 It may be difficult to include an array of organisational backgrounds to reduce bias in countries with small populations**

A shortcoming of this study was the representativeness of participants. A large proportion of participants in most countries were from the government sector, as detailed in Chapter 3. For triangulation purposes and to account for bias, it may be preferable for studies exploring similar issues to include a substantial proportion of various types of stakeholders to enhance the credibility of findings (Farmer et al. 2006). In this study, the nature of the participants was a fair reflection of the backgrounds of stakeholders in the FCTC implementation process in each country, but it may not always be possible to achieve a proportionate representation. Future policy studies in SIDS may inevitably encounter difficulty achieving a balance between those in government and those in other sectors. For tobacco-related research, an additional challenge is the ability to include tobacco industry representatives, who may be less willing to participate in health-oriented studies. Such studies in small populations still need to be undertaken, particularly in developing countries where it is needed, but it is important to be wary of potential bias in the resultant data.
7.7 The contribution of this thesis to the literature and proposed directions for future research

This exploration of the variables that influence the FCTC in SIDS of the Pacific, and how FCTC implementation can be improved, contributes to the literature on a number of fronts. First, a multidisciplinary approach was undertaken and a political science model applied to analyse the implementation of the first international public health treaty, thereby addressing some of the neglect of political science that is evident in healthy public policy in the health promotion/public health discipline. It also drew on and synthesised a wide range of literature, from political science, to health promotion, to legal texts, to development literature on SIDS, to very specific studies on tobacco control in the Pacific and in developing countries. Many documents relating to FCTC implementation in each of the countries were examined. This study tested and operationalised the theoretical framework, which was used in few other studies that were outside the health domain. Knowledge has been generated with regard to this theoretical approach and recommendations have been provided for future researchers.

Second, this is the second study of its kind to explore health policy in the environments of SIDS, and the first to explore tobacco control policy or an international public health treaty in SIDS. Here, the environments of SIDS and their relationship with the implementation of an international public health treaty were examined and conceptualised under six key themes that emerged in the course of the research: rural and remote islands and communities, little NGO/civil society activism, limited pro-tobacco activism and local tobacco manufacturing presence, a lack of administrative capacity and a small number of staff “wearing many hats”, small and personalised networks and relationships, and a strong influence from global and regional forces. Recommendations were produced as to how these might be approached in light of FCTC implementation. It may be possible for these themes and recommendations to be extrapolated to SIDS internationally, and they may apply to other international treaties or policies beyond the health domain. Themes pertaining to the Pacific Island implementation environment were also outlined,
adding to the content provided by one other comprehensive study of tobacco control in the region.

Third, the clusters of variables that affect implementation of the FCTC were explored in detail in the Cook Islands, Vanuatu, Palau and Nauru. This is one of the very few in-depth, qualitative, multi-country studies exploring FCTC implementation. Most of the literature in this field is restricted to either global reports that are largely quantitative, outcome oriented, and do not provide sufficient detail on the actual FCTC implementation process, or in-depth accounts within an individual country context only. This research has conceptualised the implementation scenario in each of the countries and enabled their perspectives to be presented, as only scant information about each country was present in the literature. Furthermore, recommendations for how the FCTC could move forward from a national perspective and within the contexts of each country provide a valuable insight into the issue at a practical level.

A fourth contribution lies in this study’s discussion of how to move FCTC implementation forward globally, with particular focus on developing countries and SIDS. Recommendations for FCTC implementation were provided in four key areas: the need to enhance global funding capacity, the need to strategically prioritise cost-effective provisions, the need to globalise the FCTC, and the need to appreciate country contingencies and local priorities. This adds to the global discourse on FCTC implementation. As an in-depth exploration of the first international public health treaty, this study contributes to the emerging scholarly discourse on global health governance and is a useful insight to those examining the global governance of other health issues or health in general. Most importantly, this study makes a contribution towards building knowledge on healthy public policy in tobacco control. It is hoped that this will ultimately lead to a reduction in the harm done by the global tobacco epidemic and result in longer, healthier lives for people of the Pacific Islands and of our global village.
Despite the aforementioned contributions, there are still many gaps to be explored and ways in which this study can be built upon and improved through future research.

First, there is a need for further research to validate suitable theoretical frameworks to analyse FCTC implementation. Greater recognition of political theory to analyse the FCTC, and health promotion and public health generally, is needed. This is particularly important where the barriers to health gains are substantially political. The FCTC is among the most comprehensive and distinct efforts towards building healthy public policy and HiAP globally. It is critical that research in this area continues to build upon the contribution of political science to the concerns of public health and health promotion. Theoretical frameworks such as the one used in this study, and many others, should be applied and tested, and the evidence derived from them can be built upon. Without theory, research merely serves as anecdotal accounts that cannot be extrapolated and applied elsewhere. The more such theories are validated, the better their ability to predict outcomes in public health and health promotion. This applies not only to implementation theory, but to the many other theories of public policy.

Implementation can be conceptualised as a dynamic process rather than an outcome (Najam 1995). Furthermore, Pawson and Tilley (2004) explain how interventions are open systems and cannot be fully isolated or kept constant, which is indicative of the FCTC. At the country level, there will be a need to track the variables that affect implementation in future as it is dependent on time. Research undertaken in the countries examined (and all others) in future will offer insights into how FCTC implementation is affected over time and the policy learning that has occurred amongst key stakeholders. Further developments of the FCTC at global or regional levels could also feed into changes to its implementation in various countries as the treaty and its parameters change over time. For example, the Protocol to Eliminate Illicit Trade in Tobacco Products has been substantiated since this study commenced and research on its implementation is warranted.
The FCTC provisions can be investigated in significantly more detail than what was carried out in this study. There are many points within the various FCTC provisions which could not be given justice within the confines of this study due to the limited resourcing available and an interest in the variables that affect FCTC implementation broadly. In particular, there is considerable scope for more detailed investigation into the implementation of smoke-free environments, price and tax measures, illicit trade, litigation, tobacco growing and country participation in the FCTC process itself. More detailed research on FCTC implementation in the sub-national or community level is needed. Here, rich data giving a more comprehensive account of the variables that affect implementation at a localised level could be provided, which would be useful in conceptualising the implementation environments within SIDS. Future research in all of these areas of the FCTC would significantly supplement the findings of this dissertation.

In exploring how the environments of SIDS affect FCTC and health policy implementation, this study focused on four countries in the Pacific only. Exploring the other Pacific SIDS, as well as SIDS in other areas, such as the Caribbean or Indian Ocean, could validate and add to, the themes on the implementation environments of SIDS found in this study.

The outcome-oriented, quantitative reporting pertaining to FCTC implementation that exists can provide an insight into whether FCTC provisions are being met, but it is more important to answer the questions of how and why they are or are not being achieved, and what can be done to improve implementation. If momentum towards a successful FCTC is to be accelerated, it is crucial that more research analyses FCTC-based policy change globally, particularly in developing countries, many of whose voices are yet to be heard. This dissertation provided an in-depth insight into the implementation of the first international health treaty in small Pacific Island nations. It has answered questions, but many more unanswered questions remain. It is endeavoured that this dissertation not only provides new insights for future researchers investigating similar concepts, but also invokes and
inspires new research questions that direct policy towards the betterment of people’s health.
References


CDC (2009). 'The Republic of Palau Global Youth Tobacco Survey Fact Sheet', CDC: Atlanta, GA.


Cook Islands Ministry of Health & WHO (2011). 'Cook Islands NCD Risk Factors STEPS Report', Cook Islands Ministry of Health, WHO Western Pacific Region, College of Medicine, Nursing and Health Sciences, Fiji National University: Suva, Fiji.


Freeman, B. (2012). 'New media and tobacco control', *Tobacco Control*, 21(2), 139-144.


Gauvin, F.-P. (2012). 'Involving the public to facilitate or trigger governance actions contributing to HiAP', in D. V. McQueen, M. Wismar, V. Lin, C. M. Jones & M. Davies (eds), Intersectoral Governance for Health in All Policies, European Observatory on Health Systems and Policies, WHO: Copenhagen.


Patel, P., Collin, J. & Gilmore, A. B. (2007). "'The law was actually drafted by us but the Government is to be congratulated on its wise actions': British American Tobacco and public policy in Kenya', Tobacco Control, 16(1), e1.


Pollock, N. J. (1991). 'Nauruans during World War II', in G. M. White (ed), Remembering the Pacific War, Center for Pacific Islands Studies, School of Hawaiian, Asian and Pacific Studies, University of Hawai‘i at Mānoa: Honolulu, HI.


Sparks, M. (2010). ‘Governance beyond governments: The role of NGOs in the implementation of the FCTC’, Global Health Promotion, 17(Suppl 1), 67-72.


Toribiong, J. (2011a). 'Re: House Bill No. 8-8-1, HD2, SD2, CD1, PD1', Office of the President: Koror, Palau.


UN Department of Economic and Social Affairs (2010). 'Trends in Sustainable Development: Small Island Developing States (SIDS)', UN Department of Economic and Social Affairs: New York.


Appendix 1: Interview guide

Introduction

In this interview we will refer to the FCTC as a whole, although there may be some emphasis on the articles that are particularly relevant to the country around the time of interview.

I would also like to put some emphasis on the articles with key significance i.e. those in MPOWER. For some of these guidelines and deadlines have been required by the COP secretariat:

- Monitoring tobacco use and prevention policies
- Protection from exposure to tobacco smoke
- Packaging and labelling
- Tobacco advertising, promotion and sponsorship
- Raising taxes on tobacco
- Offering to help quit

You may also want to reflect on some of the general requirements, such as the protection of public health policies from the tobacco industry, and the presence of a national strategy, programmes and action plan, as well as a national coordinating mechanism/focal point for tobacco control.

Although there is a broad scope of articles here, many of the determinants that affect their implementation may be the same.

Background information and opening questions

- Occupation (role in FCTC/Tobacco Act implementation)/Organisational structure (i.e. who are you responsible to? who works under you? how many people in your organisation?)
- How long have you been working in this role?
- Start recording
- The current position of the country in relation to the implementation process of the FCTC? (E.g. legislation passed on key articles?)
- Have there been any specific barriers or facilitators in relation to the implementation of the FCTC in the country?

Key Questions

Content: Prescribed goals/causal theory/methods in the FCTC/Tobacco Act and its effect on the domestic implementation of the treaty
• What is your opinion on the goals of the FCTC (i.e. minimising harm associated with tobacco use)? Are they significant for your country with respect to other issues? Why/why not?
• What is your opinion on the methods/strategies of how the FCTC proposes to minimise tobacco use? (e.g. packaging and labelling, advertising, smoke-free environments) – are these methods appropriate in respect to your country? Why/why not?
• Are there any gaps between the demands of FCTC policies, and the ability for them to be written in national legislation? If so, what? How could they be resolved?

Context: The nature of the institutional context – the corridor through which policy must travel, and by whose boundaries it is limited, in the process of implementation

• Who are the significant institutional players/organisations that influence, or are influenced by the process of implementing the FCTC? How does your organisation fit within and/or shape this process?
• Describe your relationships with other key institutions/organisations in this process. For example, how often do you meet? Funding/subsidised? Is there conflict/cooperation?
• How has your organisation been affected by the FCTC? What procedures within your organisation have changed? (e.g. standard operating procedures, funding sources, resource allocation)
• Do any particular challenges/barriers exist within this process by which FCTC policies are implemented? Do any opportunities exist? How may they be addressed?

Commitment: Level of commitment in respect to those who carry out implementation of the FCTC/Tobacco Act

• On a scale, how would you describe the level of commitment* of the [relevant government organisation] to the FCTC and the measures it requires to implement? How committed are the people/organisations above and below you?
  o What is the reasoning behind [relevant government organisation’s] level of commitment? What factors have (or who has) influenced this?
• Are there any specific challenges/opportunities in relation to establishing commitment from key decision makers? Are there any opportunities? How may they be addressed?

* - political support: resource expenditure, mentioning in statements by officials, focal point of issue at [organisation] level, enforcement of key policies.

Scale of 0 to 10 – 0 being no or adverse commitment, 5 being moderate commitment, and 10 being extremely engaged and ready to commit to the FCTC

Capacity: Level of administrative capacity of domestic implementers to carry out desired changes
• How would you describe the current level of capacity* of [relevant organisation] to carry out the changes desired in key articles of the FCTC? Why is this at the level it is?
• Is [relevant government organisation] contending for resources in the same policy arena as other agencies? Why?
• What factors have influenced the current level of capacity? What challenges/opportunities exist? How can the desired level of capacity be realised?

* - size and skill levels of staff, physical facilities, knowledge of issue and access to monitoring information, mandated authority

Clients and Coalitions: Clients and coalitions (interest groups/opinion leaders) enhanced or threatened by the FCTC/Tobacco Act
• What are the interests of [relevant interest group] in respect to key articles of the FCTC? Are they part of an alliance? What is the structure of this alliance?
• <NGOs/advocacy respondents> Describe your relations with, and influence on the key decision makers in respect to the FCTC. / <Government respondents> Describe your relations with interest groups that have sought to influence political decisions on the FCTC.
  o Who is pushing the agenda and advocating for/against the FCTC?
  o How strong is their commitment/action or resistance?
• What challenges or barriers exist that are a hindrance to [relevant interest group]? How may they be addressed?
• How has the public been affected by legislation (relating to the FCTC) that has been put through thus far? How have they reacted to the legislation? (E.g. smokers, public transport users, advertisers, shops, etc.).
• Are there people that have had an active role in to disrupt implementation? Who are they? Why?

Closing questions

• Are there any further comments you would like to add about implementation of the FCTC in your country [and/or the Pacific region]?
• Do you have any questions to ask me?
• Thank the respondent for participating and close interview

List of Coalitions:

For Health/anti-tobacco For tobacco/trade

Data/reports/literature referred to:

Technical notes:
Appendix 2: Plain language statements and consent forms (for participants and organisations)

PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Participants

Plain Language Statement

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.

Principal Researcher: Prof. Evelyne de Leeuw

Student Researcher: Erik Martin

Associate Researcher(s): Dr. Hans Lofgren, Dr. Simon Barraclough

Research on the Framework Convention on Tobacco Control (FCTC)

The World Health Organisation’s Framework Convention on Tobacco Control (FCTC), responds to the global tobacco epidemic. The Treaty is now being implemented by many nations in the World. Like most other countries, Pacific
Island nations have been burdened significantly by diseases associated with tobacco use. However, they represent a challenging environment to implement the FCTC. Some of these challenges relate to geography, others to institutional contexts.

The purpose of this project is to identify and explore what influences the domestic implementation of the FCTC in small island countries of the Pacific. With this knowledge, we anticipate that the research will provide direction as to how to overcome barriers to implementation. This may also include utilisation of advantages associated with small island nations. This is a student project and the research is being conducted as a part of a Doctor of Philosophy degree. The results of the research may be used to help the researcher, Erik Martin, fulfil the requirements of this degree.

**Data collection**

This project is a multiple-case study involving several Pacific Island nations. Key informants are selected based on roles they may have in implementation parameters for the implementation of the FCTC in Pacific Island countries. You were selected because your role and/or responsibility has been deemed very relevant to the substance of this study. This assessment was made based on reviews of the literature and consultations with regional experts.

Data are generated from multiple sources. These include primarily in-depth interviews and documentation, and to a lesser extent questionnaires and observation. Data will be transcribed and entered into NVIVO, which is a computer program that facilitates systematic analysis of qualitative data.

You will be asked to participate in an in-depth, semi-structured, audio-recorded, face-to-face (or telephone) interview lasting approximately one-hour at either your workplace/office, or another public location of your choice. For a number of reasons you may want to speak undisturbed and in private – an effort will be made to conduct the session in such an environment. Interview questions will involve topics such as

- an exploration of the content of the FCTC;
- the institutional context through which the FCTC is being implemented in;
- the commitment and capacity of implementers;
- and the people and coalitions affected by the treaty.

Examples of questions are ‘what is your opinion on the goals of the FCTC?’, and ‘how would you describe the commitment of your organisation to the key articles of the FCTC?’.

Recorded data will be transcribed and you will have an opportunity to review the transcript before analysis takes place. You may be asked to provide further documentation such as reports, evaluations, proposals, etc. that relate to the implementation of the FCTC in your country. You will have an opportunity to indicate the nature of such documentation and the extent to which it can be used for the research project. As a result of the review of materials you may be asked for
further clarification. The conditions under which this clarification is generated will not differ from the above encounter.

The research results will be produced in the form of a doctoral thesis submitted to Deakin University. It is also anticipated that several publications in academic journals will result from this research, and key findings may also be presented in seminars and/or conferences.

Risks and benefits
Personal risk of involvement in this research is minimal. There may be some risk involved in revealing information that may be confidential to the organisation that you may be a part of, as well as any associated consequences in relation to this matter. Such risk can be reduced by reviewing your transcript and removing sensitive information in this regard. No other risks are foreseen, apart from some anxiety that is associated with any interview session. Also, there may be some inconvenience of you donating your valuable time to this project, and filling out the consent form. If you do experience any discomfort associated with this research, you can suspend, or end participation in the project at any time.

Possible benefits in taking part in this project include the ability to express your specialised views on how the implementation of the FCTC is affected in your specific role or area of expertise, and the personal satisfaction of assisting in the generation of knowledge in regards to a study topic that has not been researched before.

Benefits to the wider community may include a better understanding of what may determine the ultimate success or failure of the implementation of the FCTC in respect to your country. This may contribute to overcome barriers, challenges and how to utilise advantages in implementing a global health treaty in such countries in the future, ultimately leading to positive outcomes for populations related to the study.

In any publication, information will be provided in such a way that you cannot be identified. Any identifiable variables such as names, role or occupation, age and geographical location will be removed to protect your confidentiality. This may even include your country of origin where small populations exist. Despite this, the purpose of the research and countries of interest may lead to those with good knowledge or networks within the field being able to speculate to some extent as to who might be participating in the project. Data files and/or transcripts of research material generated through interviews or otherwise will not be made available by the research team to the organisation that you work in. Identifiable information that is given to the researcher (e.g. occupation, name the organisation you work in) will be encrypted, and stored in a different place to the location of the data itself. Potentially identifiable data will be stored in computer files, and a locked filing cabinet at Deakin University, for a minimum of 6 years after final publication using the data collected, after which time the data will be destroyed. Computer files will
be password protected. The only personnel who will have authority to access the information will be the student researcher and principal researcher.

**Cultural context**

As the student researcher is from a country other than your own, this research has been approved at the national level of your country by <Permit authority name> and a research permit (<Permit #>) has been issued to the student researcher in order for him to conduct the study.

The researcher is aware of cultural differences between the countries of interest and has received training in this regard, as respect for local beliefs, customs, laws and cultural heritage is of great significance in the undertaking of this research.

The research will be monitored by regular contact with the principal researcher. The student researcher will provide a weekly report while he is conducting the research, where any appropriate advice and feedback relating to the research and its progress will be given by the principal researcher, based on their vast expertise in the field.

**Funding and logistics**

You will not be paid for your participation in this project. However, if you incur any transport costs to meet with the researcher, you will be reimbursed for the amount of this cost (to a maximum of AU$30).

This research is funded by the School of Medicine at the Geelong Campus of Deakin University. The researchers have no competing interests or financial incentives in relation to this project.

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage until the data is processed. Any information obtained from you to date will not be used and will be destroyed.

Contact details for the student researcher and principal supervisor are as follows:

**Student researcher**

Name: Mr. Erik Martin
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: emart@deakin.edu.au
Phone: +61 403 xxx xxx (mobile), +61 3 5227 2630 (office)

**Principal supervisor**

Name: Prof. Evelyne de Leeuw
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: evelyne.deleeuw@deakin.edu.au
Phone: +61 3 5227 2845

Please note that the student researcher will be located in your country at the time of data collection. Email contact is recommended, to avoid international calling costs.
(Note: Local contacts were also provided in each country, which consisted of an ethics officer or government representative that approved the research.)

Complaints

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: +61 3 9251 7129, Facsimile: +61 3 9244 6581; research-ethics@deakin.edu.au

Please quote project number 2010-103.
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Participants

Consent Form

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.
Reference Number: 2010-103

I have read and I understand the attached Plain Language Statement. I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

It is recommended that the interviews be audio-taped. However, if you do not want them to be recorded and are otherwise happy to participate in the interview, you can circle the ‘do not’ option below:

I DO / DO NOT allow the interview to be audio-taped.

Participant’s Name (printed) ……………………………………………………………………

Signature ……………………………………………………… Date  …………………………

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Student researcher details
Name: Mr. Erik Martin
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: emart@deakin.edu.au
Phone: +61 403 xxx xxx (mobile), +61 3 5227 2630 (Deakin office)
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Participants

Revocation of Consent Form

(To be used for participants who wish to withdraw from the project)

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.

Reference Number: 2010-103

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University.

Participant’s Name (printed) .................................................................

Signature ................................................................. Date ................

Please mail or fax this form to:

Name: Prof. Evelyne de Leeuw
Address: School of Medicine
          Faculty of Health, Medicine, Nursing and Behavioural Sciences
          Deakin University, Geelong Campus, Victoria, Australia
Email: evelyne.deleeuw@deakin.edu.au
Fax: +61 03 5227 2945 (School of Medicine)
TO: Organisations

Plain Language Statement

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.

Principal Researcher: Prof. Evelyne de Leeuw

Student Researcher: Erik Martin

Associate Researcher(s): Dr. Hans Lofgren, Dr. Simon Barraclough

Research on the Framework Convention on Tobacco Control (FCTC)
The World Health Organisation’s Framework Convention on Tobacco Control (FCTC) responds to the global tobacco epidemic. The Treaty is now being implemented across many nations in the World. Like most other countries, Pacific Island nations have been burdened significantly by diseases associated with tobacco use. However, they represent a challenging environment to implement the FCTC. Some of these challenges relate to geography, others to institutional contexts.

The purpose of this project is to identify and explore what influences the domestic implementation of the FCTC in small island countries of the Pacific. With this knowledge, we anticipate that the research will provide direction as to how to overcome barriers to implementation. This may also include utilisation of advantages associated with small island nations. This is a student project and the research is being conducted as a part of a Doctor of Philosophy degree. The results of the research may be used to help the researcher, Erik Martin, fulfil the requirements of this degree.

Data collection
This project is a multiple-case study involving several Pacific Island nations. Key informants are selected based on roles they may have in implementation parameters for the implementation of the FCTC in Pacific Island countries. Your organisation was selected because its role and/or responsibility has been deemed very relevant to the substance of this study. This assessment was made based on reviews of the literature and consultations with regional experts. Within your organisation, participants will be selected on the basis of their workplace role and its relevance to the research interests of this study.

Data are generated from multiple sources. These include primarily in-depth interviews and documentation, and to a lesser extent questionnaires and observation. Data will be transcribed and entered into NVIVO, which is a computer program that facilitates systematic analysis of qualitative data.

Participants will be asked to participate in an in-depth, semi-structured, audio-recorded, face-to-face (or telephone) interview lasting approximately one-hour at either their workplace/office, or another public location of their choice, in the absence of any other people. Interview questions will involve topics such as

- an exploration of the content of the FCTC;
- the institutional context through which the FCTC is being implemented in;
- the commitment and capacity of implementers;
- and the people and coalitions affected by the treaty.

Examples of questions are ‘what is your opinion on the goals of the FCTC?’, and ‘how would you describe the commitment of your organisation to key articles of the FCTC?’.

Recorded data will be transcribed and participants will get the chance to review their transcript before analysis takes place. Participants may be asked to provide further documentation such as reports, evaluations, proposals, etc. that relate to the implementation of the FCTC in your country. Participants will have an opportunity to indicate the nature of such documentation and the extent to which it can be used for the research project. As a result of the review of materials, participants may be asked for further clarification. The conditions under which this clarification is generated will not differ from the above encounter.

The research results will be produced in the form of a doctoral thesis submitted to Deakin University. It is also anticipated that several publications in academic journals will result from this research, and key findings may also be presented in seminars and/or conferences.

**Risks and benefits**

Personal risk of involvement in this research is minimal. There may be some risk involved in participants revealing information that may be confidential to your organisation, as well as any associated consequences in relation to this matter. Such risk can be reduced by participants reviewing transcripts and removing sensitive information in this regard. No other risks are foreseen, apart from some anxiety that is associated with any interview session. Also, there may be some inconvenience of participants donating their valuable time to this project, and filling
out the consent form. If your organisation and/or study participants do experience any discomfort associated with this research, you can suspend, or end participation in the project at any time.

Possible benefits in taking part in this project include the ability for members of your organisation to express specialised views on how the implementation of the FCTC is affected in your organisation’s specific role or area of expertise, and the personal satisfaction of assisting in the generation of knowledge in regards to a study topic that has not been well researched before.

Benefits to the wider community may include a better understanding of what may determine the ultimate success or failure of the implementation of the FCTC in respect to your country. This may contribute to overcome barriers, challenges and how to utilise advantages in implementing a global health treaty in such countries in the future, ultimately leading to positive outcomes for populations related to the study.

In any publication, information will be provided in such a way that individuals cannot be identified. Any identifiable variables such as names, role or occupation, age and geographical location will be removed to protect their confidentiality. This may even include one’s country of origin where small populations exist. Despite this, the purpose of the research and countries of interest may lead to those with good knowledge or networks within the field being able to speculate to some extent as to who might be participating in the project. Data files and/or transcripts of research material generated through interviews or otherwise will not be made available by the research team to the organisations where participants work. Identifiable information that is given to the researcher (e.g. occupation, name of their organisation) will be encrypted, and stored in a different place to the location of the data itself. Potentially identifiable data will be stored in computer files, and a locked filing cabinet at Deakin University, for a minimum of 6 years after final publication using the data collected, after which time the data will be destroyed. Computer files will be password protected. The only personnel who will have authority to access the information will be the student researcher and principal researcher.

Cultural context
As the student researcher is from a country other than your own, this research has been approved at the national level of your country by <Permit authority name> and a research permit (<Permit #>) has been issued to the student researcher in order for him to conduct the study.

The researcher is aware of cultural differences between the countries of interest and has received training in this regard, as respect for local beliefs, customs, laws and cultural heritage is of great significance in the undertaking of this research.
The research will be monitored by regular contact with the principal researcher. The student researcher will provide a weekly report while he is conducting the research, where any appropriate advice and feedback relating to the research and its progress will be given by the principal researcher, based on their vast expertise in the field.

**Funding and logistics**

Your organisation will not be paid for its participation in this project. However, if your staff incur any transport costs to meet with the researcher, they will be reimbursed for the amount of this cost (to a maximum of AU$30).

This research is funded by the School of Medicine at the Geelong Campus of Deakin University. The researchers have no competing interests or financial incentives in relation to this project.

Participation in any research project is voluntary. If you do not wish for your organisation to take part in this research, then it is not obliged to contribute. If on behalf of your organisation, you decide to take part and later change your mind, you are free to withdraw from the project at any stage until the data is processed. Any information obtained from your staff to date will not be used and will be destroyed.

Contact details for the student researcher are as follows:

**Student researcher**

Name: Mr. Erik Martin  
Address: School of Medicine  
Faculty of Health, Medicine, Nursing and Behavioural Sciences  
Deakin University, Geelong Campus, Victoria, Australia  
Email: emart@deakin.edu.au  
Phone: +61 403 xxx xxx (mobile), +61 3 5227 2630 (office)

**Principal supervisor**

Name: Prof. Evelyne de Leeuw  
Address: School of Medicine  
Faculty of Health, Medicine, Nursing and Behavioural Sciences  
Deakin University, Geelong Campus, Victoria, Australia  
Email: evelyne.deleeuw@deakin.edu.au  
Phone: +61 3 5227 2845

Please note that the student researcher will be located in your country at the time of data collection. Email contact is recommended, to avoid international calling costs.

(Note: Local contacts were also provided in each country, which consisted of an ethics officer or government representative that approved the research.)
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The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: +61 3 9251 7129, Facsimile: +61 3 9244 6581; research-ethics@deakin.edu.au

Please quote project number 2010-103.
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Organisations

Organisational Consent Form

(To be used by organisational Heads providing consent for staff/members/patrons to be involved in research)

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.

Reference Number: 2010-103

I have read and I understand the attached Plain Language Statement. I give my permission for staff of ............................................................. to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal the participants’ identities and personal details if information about this project is published or presented in any public form.

I agree that
1. The institution/organisation MAY / MAY NOT be named in research publications or other publicity without prior agreement.

2. I / We DO / DO NOT require an opportunity to check the factual accuracy of the research findings related to the institution/organisation.

3. I / We EXPECT / DO NOT EXPECT to receive a copy of the research findings or publications.

Name of person giving consent (printed) .................................................................

Signature ................................................................. Date  ................................

Student researcher details
Name: Mr. Erik Martin
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: emart@deakin.edu.au
Phone: +61 403 xxx xxx (mobile), +61 3 5227 2630 (Deakin office)
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Organisations

Revocation of Consent Form

(To be used for participants who wish to withdraw from the project)

Date:

Full Project Title: The Implementation of a Global Health Treaty in Small Island Developing States of the Pacific.

Reference Number: 

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University.

Participant’s Name (printed) ……………………………………………………………………………

Signature ……………………………………………………………………………………………………… Date ……………………

Please mail or fax this form to:

Name: Prof. Evelyne de Leeuw
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: evelyne.deleeuw@deakin.edu.au
Fax: +61 03 5227 2945 (School of Medicine)
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

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Participant’s Name (printed) ...........................................................

Signature .......................................................... Date ..................

Please mail or fax this form to:

Name: Prof. Evelyne de Leeuw
Address: School of Medicine
Faculty of Health, Medicine, Nursing and Behavioural Sciences
Deakin University, Geelong Campus, Victoria, Australia
Email: evelyne.deleeuw@deakin.edu.au
Fax: +61 03 5227 2945 (School of Medicine)