



Department
of Health

Business Case

Official Development Assistance Project:
Strengthening tobacco control in low and middle
income countries

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Executive summary

It is estimated that every year around 7 million deaths around the world are linked to tobacco – more than AIDS, tuberculosis and malaria combined. 80% of the 1 billion smokers live in low and middle income countries (LMICs), putting a huge strain on their development.

The UK Government, as a global leader in tobacco control, has invested £15 million of Official Development Assistance funding in the Framework Convention on Tobacco Control (FCTC) 2030 project to support the implementation of tobacco control measures in LMICs in order to reduce the burden of tobacco related death and disease.

The World Health Organisation's (WHO's) FCTC is the world's only public health treaty, aimed at promoting evidence-based action to tackle tobacco-related death and disease, Tobacco control measures include raising taxes on tobacco, enforcing bans on advertising and marketing, regulating products, supporting smokers to quit, education campaigns and monitoring tobacco use.

The 5 year project, which commenced in 2016, is being delivered by the WHO FCTC Secretariat based in Geneva.

“This ambitious programme will promote the accelerated implementation of the WHO FCTC in developing countries that are Parties to the WHO FCTC through tailored assistance by the Convention Secretariat and United Nations agencies”. Dr Vera Luiza da Costa e Silva, Head of the Convention Secretariat, WHO FCTC.

The FCTC2030 project team is working with 15 developing countries directly who were selected from applications received through an open call for expressions of interest. The project will also work with other developing countries who are party to the FCTC to implement its tobacco control measures.

The business case for this project sets out the rationale for this investment.

1. Intervention summary

What support will the UK provide?

This project will improve tobacco control in LMICs through strengthening the implementation of the WHO FCTC. Over time, this support will lead to fewer tobacco users in LMICs and contribute to a reduction of the burden of disease attributable to tobacco as well as a reduction in the economic burden and other societal costs attributable to tobacco use.

The UK will provide a total of £15 million in ODA funding over the period FY2016-17-2020/21 to support LMICs to strengthen tobacco control by:

- implementing the requirements of Article 5 (general obligations) of the WHO FCTC, to improve tobacco control governance,
- increasing tobacco tax,
- implementing the two WHO FCTC time-bound measures on (i) tobacco packaging and (ii) ending tobacco advertising), and
- implementing other Articles of the WHO FCTC according to national priorities.

The project will provide:

- direct support to a selected number of LMICs motivated to advance tobacco control, and
- general support and materials that will be accessible by all LMICs.

The WHO FCTC Secretariat, based at WHO Headquarters in Geneva, will be the primary delivery partner for this project.

Why is UK support required?

Tobacco use is the world's single most preventable cause of disease. If current patterns of use persist, tobacco will kill about 1 billion people in the 21st Century. By 2030, over 80% of the world's tobacco-related mortality will be in LMICs.

The WHO FCTC is an evidence-based "blueprint" for tobacco control strategies and policies at country level. Tobacco use is very likely to reduce if a country has a high level of WHO FCTC implementation. A country needs to have robust tobacco control governance arrangements in place (as set out in Article 5 of the WHO FCTC, included at Annex A) as the foundation of tobacco control.

The UK is highly regarded for achievements in implementing evidence-based tobacco control policy and has a high level of WHO FCTC implementation. For a number of years, the UK has been rated the best country in Europe for tobacco control policy. In 2015, DH was awarded the prestigious Luther L. Terry Prize by the American Cancer Society for exemplary leadership in tobacco control by a government ministry.

The UK has a great deal of experience in implementing the WHO FCTC, including the WHO FCTC "time bound measures" and in the implementation of tobacco taxation policies. The UK is ideally placed to be able to share this experience with LMICs and to support the implementation of similar evidence-based policies in those countries.

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In addition, the new UN Sustainable Development Goals (SDGs)¹ include in Goal 3 on “good health and wellbeing for all”, a specific target relating to strengthening the implementation of the WHO FCTC (SDG target 3.a.). Effective implementation of the WHO FCTC will also help LMICs to achieve many other SDG goals.

The UK is also investing ODA to support Health Systems Strengthening. Reducing the burden on health systems from tobacco-related diseases will enable LMICs to make better use of health system resources to improve health and well-being of their populations.

What are the expected results?

The expected result of the project is the strengthened tobacco control in LMICs through support for the implementation of the WHO FCTC. This will contribute, over the longer term, to reductions in the prevalence in tobacco use.

The project is expected to (i) strengthen tobacco control governance, (ii) increase levels of tobacco taxation and (iii) increase implementation of tobacco control policies (especially relating to tobacco packaging and advertising) in LMICs.

Through the project, direct support will be provided to a number of selected LMICs where the government is motivated to strengthen tobacco control. In addition, general support will be made available to all LMICs to support and encourage WHO FCTC implementation.

As the foundations for future tobacco control, LMICs will be supported to improve tobacco control governance in accordance with Article 5 of the WHO FCTC, to do the following:

- Make and implement effective, evidence-based tobacco control legislation and policies
- Develop and implement comprehensive, multisectoral tobacco control strategies/plans
- Establish a tobacco control unit/department with adequate resources
- Appoint a tobacco control focal point with appropriate training
- Establish/reinforce national multisectoral coordinating mechanisms
- Protect public health policies from the vested and commercial interests of the tobacco industry
- Cooperate with other WHO FCTC Parties to implement the WHO FCTC
- Cooperate with international organisations (such as WHO and UNDP) to implement the WHO FCTC
- Raise financial resources to implement the WHO FCTC

LMICs, in accordance with paragraph 32 of the Addis Ababa Action Agenda on Financing for Development, will be directly supported to raise tobacco taxation, as a public health measure, a means of government revenue and, should a government so wish, as a means of raising finance to implement tobacco control measures.

LMICs will also be supported to implement the two WHO FCTC time-bound measures:

- Packaging: develop and enforce policies to (i) ensure packaging and labelling does not promote tobacco by means that are false or misleading (including banning the use of

¹ Further information about the SDGs is at: <https://sustainabledevelopment.un.org/sdgs>

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descriptors such as “light” and “mild” and (ii) introduce effective health warnings on all tobacco packaging.

- Tobacco advertising, promotion and sponsorship: implement a comprehensive ban on tobacco advertising, promotion and sponsorship.
- On request from an LMIC, support can also be provided to implement other WHO FCTC Articles (such as smokefree laws).

Direct support will be made available to a number of selected LMICs to assist in the implementation of the WHO FCTC, in the areas set out above. LMICs will be selected using a set of criteria to be determined in collaboration with the WHO FCTC Secretariat, which will include the explicit request for support to tackle tobacco use. The project will provide direct support to a minimum of 10 LMICs, but will extend the project to assist a greater number of LMICs if capacity exists. These LMICs will receive intensive support to include expert advice, technical assistance and support to build domestic capacity to improve tobacco control by implementing the provisions in the WHO FCTC.

General support will be available to all LMICs for the implementation of the WHO FCTC in the areas set out above. This will include workshops, toolkits, online training on tobacco control and assistance to governments to implement measures to protect public health policies from the vested and commercial interests of the tobacco industry.

South-South and Triangular Cooperation will be encouraged through the project.

This is the first time that UK ODA funds have been invested in tobacco control. Progress in delivering the project will be tracked through an agreed monitoring and evaluation arrangement between DH and the WHO FCTC Secretariat. An independent evaluation will be undertaken at the end of the project.

2. Strategic case

The Context

Tobacco use in LMICs

Tobacco use is one of the world's most pressing and significant public health concerns. Death and disease from tobacco use is preventable. It is also a major barrier to sustainable development. A major driver of social inequities, tobacco use imposes significant social, economic and environmental harm on individuals, families and national economies. The causes and consequences of tobacco use are endemic to countries at all stages of development.

According to UNDP, the global political push for accelerated implementation of the WHO FCTC is supported by the increasing recognition of tobacco use as a major health and development issue with far-reaching consequences on not just disease burden but also economic growth and poverty, education and gender. Driven by social and economic policies, norms and inequities, tobacco consumption is expected to kill 1 billion people in the 21st century if unabated, and to cost the world economy trillions of dollars in medical expenses and lost productivity. Tobacco use is also infringing on human rights to health, having impeded achievement on every MDG and posing a threat to the achievement of many of the new SDGs. It is, therefore, imperative that countries urgently integrate tobacco control, and more specifically the WHO FCTC, into their development planning processes (UNDP 2014).

Within this section, evidence relating to the harms and impacts of tobacco use are drawn from UK and international research. While the specific evidence-base relating to the harms and impacts of tobacco use is limited with respect to LMICs, the wider international evidence base is so well established that DH is confident that the wider evidence can be extrapolated across to be relevant in the LMIC context.

The onset of mass manufacture of cigarettes precipitated the smoking epidemic. A four-stage model of the epidemic has been described (see figure 1), based on observations of trends in cigarette consumption and tobacco-related diseases in western countries with the longest history of cigarette use, namely the United Kingdom and United States. While the United Kingdom is in the latter stages of the tobacco epidemic, many LMICs are in the early stages. By implementing comprehensive tobacco control strategies (as set out in the WHO FCTC), LMICs will be able to avoid the magnitude of problems relating to tobacco use that have been experienced in other countries.

According to ASH, as well as increased cigarette consumption in east Asia, between 1990 and 2009 cigarette consumption in Africa and the Middle East increased by 57%. A 2013 study projected that the number of adult smokers in Africa is likely to increase from 77 million to 572 million in 2100. Unless current trends are curbed and without taking action to prevent tobacco use, it is projected that Africa could account for 26% of the world's smokers by 2100 (ASH 2015a).

The recently published UNDP report Tobacco Control Governance in Sub-Saharan Africa, makes the following conclusion:

Sub-Saharan Africa is at a major crossroads in tobacco control. Unlike other regions, most countries in SSA are in the early stages of the tobacco epidemic. However, tobacco use is rising dramatically in SSA, in large part due to the tobacco industry's aggressive efforts to expand its markets. If these efforts go unchecked, and if current projections come to fruition, many of the region's hard-won health and development gains will be in serious jeopardy. This situation presents both an urgent need and enormous

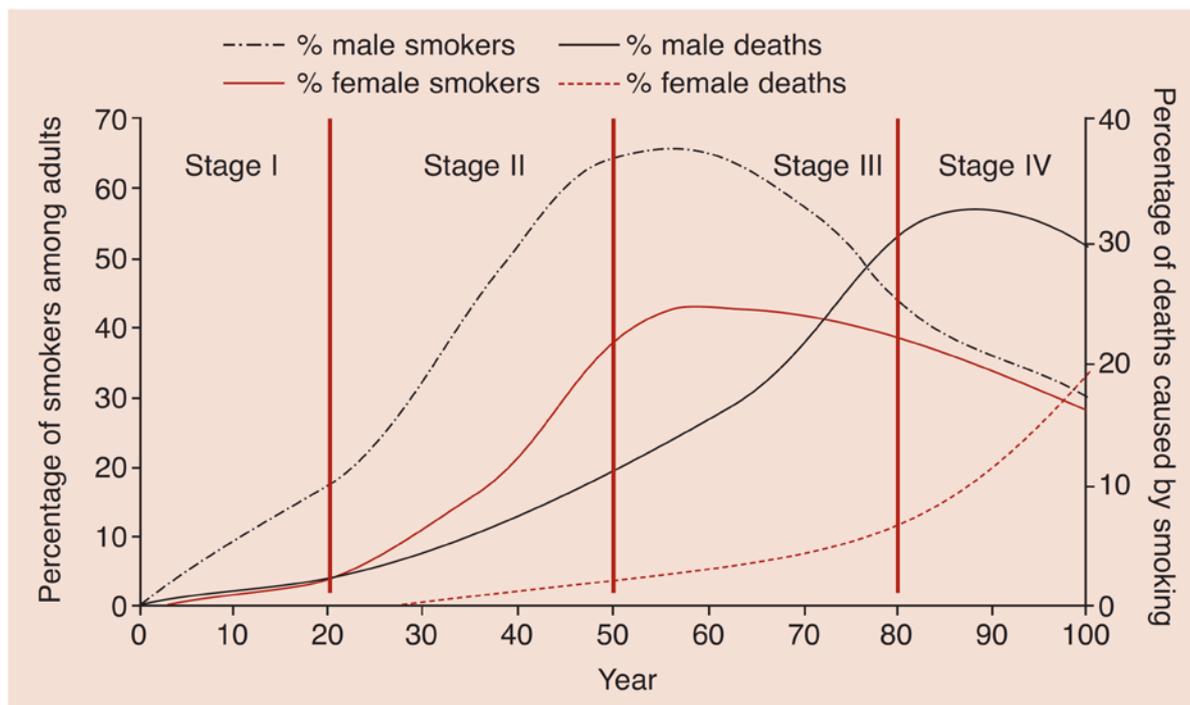
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opportunity for countries to prevent and control the tobacco-related death, disease and developmental consequences that have plagued other regions (2016).

Tobacco use is the world's most preventable cause of death. If current tobacco use patterns persist, tobacco will kill about 1 billion people in the 21st Century. By 2030, over 80% of the world's tobacco-related mortality will be in LMICs. High rates of tobacco use are projected to lead to a doubling of the number of tobacco-related deaths between 2010 and 2030 in low- and middle-income countries. As smoking continues to rise in developing countries, so too will the number and range of smoking related diseases and premature death. By 2030, a projected 8 million people in developing countries will be killed by tobacco every year (WHO 2011).

The number of tobacco users is increasing in LMICs and tobacco use is already high in a number of DFID priority countries. A recent report by the Network of African Science Academies, Preventing a Tobacco Epidemic in Africa: A Call for Effective Action to Support Health, Social, and Economic Development, concluded that without concerted action to introduce and enforce tobacco control, smoking prevalence in the African region will increase by nearly 39 percent by 2030, from 15.8 percent in 2010 to 21.9 percent. This is the world's largest expected regional increase in smoking prevalence by 2030. Similarly, American Cancer Society estimates that the implementation of proven tobacco control policies could prevent 139 million premature deaths in the region by 2100 (World Lung Foundation 2014).

Figure 1: Model of the tobacco epidemic (from RCP 2007)



Non-communicable diseases (NCDs) have surpassed communicable diseases (e.g. HIV, malaria, tuberculosis, diarrhoea, pneumonia) as the leading causes of death in all but the lowest-income nations. Even in low-income countries, deaths from NCDs are rapidly approaching those of communicable diseases. Tobacco is a causal factor in the development of most of the leading NCDs, including lung disease, cardiovascular disease, stroke and cancer. Tobacco use is a shared risk factor for the four leading NCDs in the world. According to Islam et al:

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In recent years, non-communicable diseases (NCDs), such as cardiovascular diseases (CVD), diabetes, chronic obstructive pulmonary diseases (COPD) and cancers have become an emerging pandemic globally with disproportionately higher rates in developing countries. The World Health Organization (WHO) estimates that by 2020, NCDs will account for 80 percent of the global burden of disease, causing seven out of every 10 deaths in developing countries, about half of them premature deaths under the age of 70. According to WHO, it is estimated that the global NCD burden will increase by 17% in the next ten years, and in the African region by 27%. Almost half of all deaths in Asia are now attributable to NCDs, accounting for 47% of global burden of disease. Over 80% of cardiovascular and diabetes deaths, 90% of COPD deaths and two thirds of all cancer deaths occur in developing countries. The transition from infectious diseases to NCDs in LMICs has been driven by a number of factors, often indicative of economic development: a move from traditional foods to processed foods high in fat, salt and sugar, a decrease in physical activity with sedentary lifestyles, and changed cultural norms such as increasing numbers of women using tobacco. The impact of globalization and urbanization in low-and-middle-income countries (LMICs) has accelerated the growing burden of NCDs. However, governments in LMICs are not keeping pace with ever expanding needs for policies, legislation, services and infrastructure to prevent NCDs and poor people are the worst sufferers.

NCDs are a barrier to development. In LMICs, poverty exposes people to behavioural risk factors for NCDs and in turn, resulting NCDs become an important driver for poverty (2014).

Tobacco also causes long-term morbidity in high-, middle- and low-income countries. Disability adjusted life years (DALYs) are a measure of healthy life lost as a result of an individual being in a state of poor health or disability. One DALY can be thought of as a one lost year of healthy life. Estimates have been made using DALYs to quantify the impact of risk factors on morbidity. Smoking was identified as the leading cause of disability in high-income countries, where it is responsible for 13% of DALYs lost. In LMICs, it is responsible for 4% of DALYs lost (see figure 2). Globally, smoking in 2001 was responsible for the loss of 72.9 million DALYs, almost 5% of the total. Along with mortality, the global burden of morbidity from tobacco is expected to increase. The 2001 figures are almost double the estimated DALYs lost globally to tobacco use in 1990. A further rise to over 120 million DALYs lost to tobacco—just over 9% of the total—is predicted by 2020 (RCP 2007).

Smoking affects the health of non-smokers, particularly children, because of secondhand smoke. While evidence relating to the health impact of secondhand smoke exposure in LMICs is limited, the UK context is relevant in terms of illustrating the magnitude of the health risk of secondhand smoke exposure. For instance, secondhand smoke in the home presents a substantial health risk for adults and in the UK, over 12,000 deaths among people over 20 years of age each year are estimated to be attributable to exposure to secondhand smoke. These deaths will be concentrated in groups where smoking rates are the highest. According to the RCP (2010), among children in the UK, exposure to secondhand smoke has been found to cause the following each year:

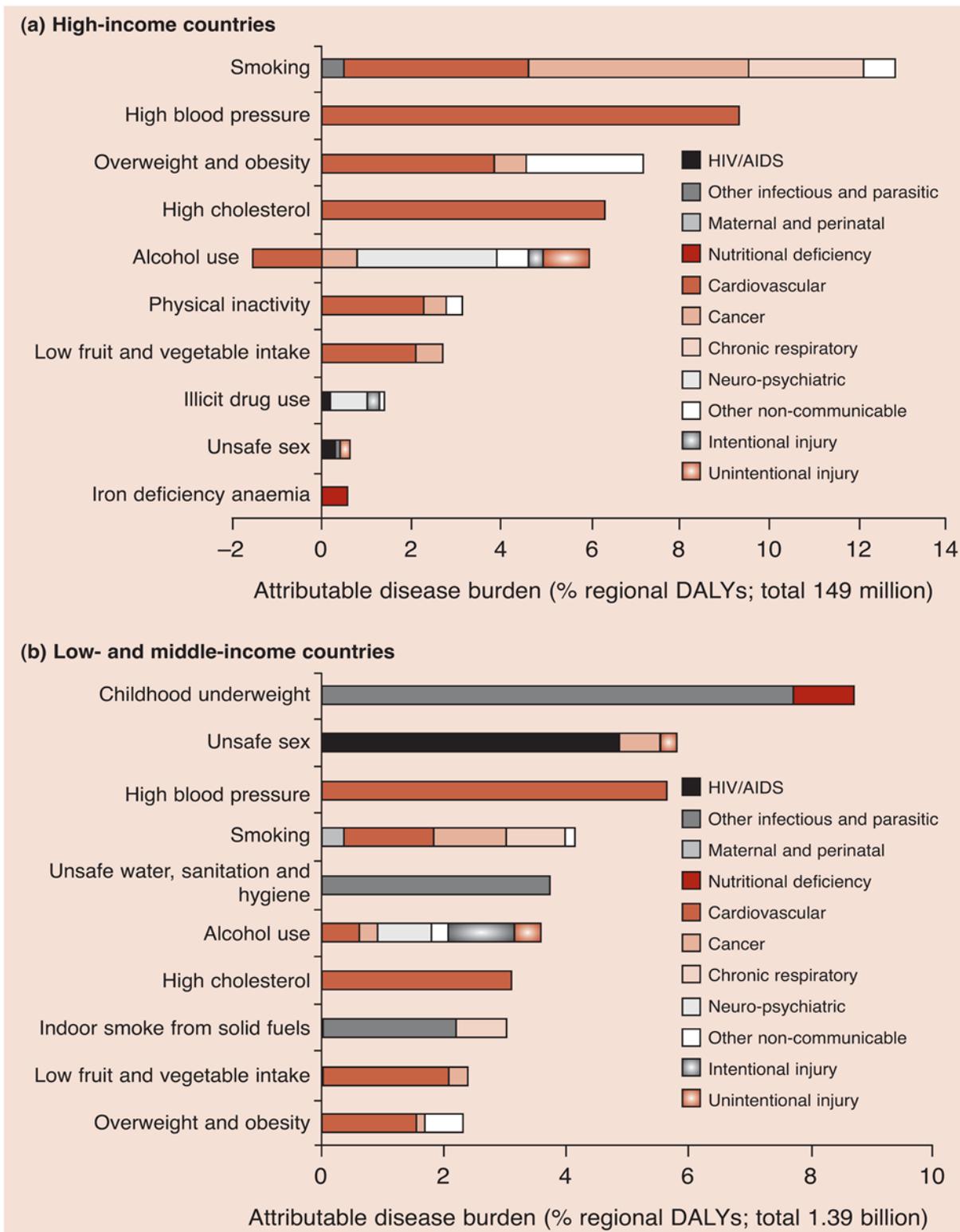
- over 20,000 cases of lower respiratory tract infection (in children under 3 years);
- 120,000 cases of middle ear disease;
- at least 22,000 new cases of wheeze and asthma;
- 200 cases of bacterial meningitis; and
- 40 sudden infant deaths (one in five of all sudden infant deaths are caused by smoking).

In terms of diseases that are relevant to wider development work undertaken by DFID:

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- Tuberculosis: passive or active exposure to tobacco smoke is significantly associated with tuberculosis infection and tuberculosis disease. Active smoking is significantly associated with recurrent tuberculosis and tuberculosis mortality. Over a fifth of tuberculosis cases in adults are attributable to tobacco. As most patients with tuberculosis are relatively young, excess morbidity and mortality from tobacco-related tuberculosis takes a toll on people in their most economically productive years.
- HIV/AIDS: people with HIV are more susceptible to tobacco-related illnesses, and have been found to lose more than twice as many years of life than non-smokers.

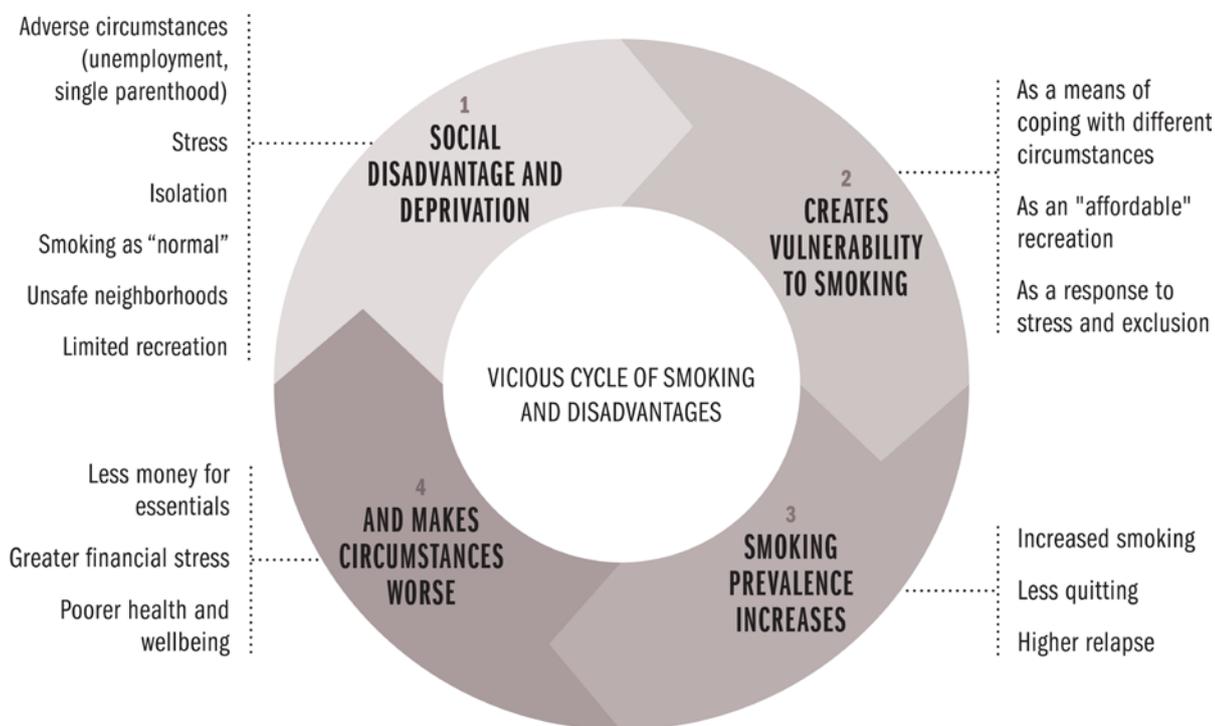
Figure 2: Burden of disease attributable in 2001 to 10 leading regional risk factors, by disease type in (a) high-income countries and (b) low- and middle-income countries (from RCP 2007)



Economic impact of the tobacco epidemic

Tobacco is a driver of poverty around the world, and those living on lower incomes are more likely to smoke. Tobacco-related illness and premature death impose high productivity costs on smokers, their families and the wider economy. One in two long term smokers will die from a smoking-related disease, and many smokers die in middle-age. Poor families are particularly vulnerable when a family member becomes ill or dies young. Medical costs associated with treating heart diseases and cancer can further impoverish families. The American Cancer Society’s Tobacco Atlas describes an inextricable and pernicious relationship between tobacco and poverty, a vicious cycle, where disadvantage increases smoking likelihood, and smoking increases likelihood of disadvantaged circumstances (see figure 3).

Figure 3: The vicious cycle of tobacco and poverty (from Eriksen et al 2015)



According to evidence compiled by ASH:

In developing countries, many of the poorest smokers spend significant amounts of their income on tobacco instead of basic human requirements such as food, shelter, healthcare and education. A 2011 WHO systematic review found an inverse relationship between income level and tobacco use. The study found that in low income countries, a median of 10.7% of home expenditure was spent on tobacco in low income households.

- In India, one study estimated that tobacco consumption impoverished approximately 15 million people while a separate study found that homeless people in India often spend more on tobacco than on food.
- Similar evidence in Sri Lanka shows that the expenditure of the poor on tobacco compromises their ability to meet basic needs.

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- Extensive evidence, highlighted by a 2011 review, suggests that tobacco use in Vietnam wastes household and national financial resources and widens social inequalities.
- A study in Cambodia found a cycle of deprivation: low education results in an increased likelihood of smoking which in turn leaves less money for education.

Contrary to the claims of the tobacco industry that tobacco farming brings positive economic benefits to developing countries, most of the profit goes to the large multinational companies, while many tobacco farmers remain poor and in debt (2015a).

Tobacco consumption poses a barrier to economic development at household, national and global levels. At the household level, money spent on tobacco costs poorer families a significant percentage of income – income that may otherwise have been spent on food, health care or education, all of which are vital to economic advancement. The poor health outcomes caused by tobacco result in medical costs (often out-of-pocket in LMICs) that can financially cripple a household. Furthermore, illness, disability and premature death render people and their caregivers unable to work, depriving families of income and driving households further into poverty.

Tobacco consumption also has an economic impact at both national and global levels and the burdens from tobacco are much greater than just costs to health systems. For instance, the overall economic burden in the United Kingdom of tobacco use is estimated at £13.74 billion a year. These costs comprise not only treatment of smoking-related illness by the NHS, but also the loss in productivity from smoking breaks and increased absenteeism, the cost of cleaning up cigarette butts, the cost of smoking-related house fires and the loss in economic output from people who die from diseases related to smoking or exposure to secondhand smoke (Nash and Featherstone 2010). In addition to addressing poverty and social inequalities, reducing tobacco use has other economic benefits to local and national economies in LMICs. Research found that Russia lost \$24.7 billion in productivity in 2006 (more than 3 percent of GDP in 2005) due to premature deaths caused by smoking, while another estimated that smoking costs the world 1–2 percent of its GDP each year. The pathway to these devastating losses is clear: tobacco use and resultant NCDs strike people in their most productive years in LMICs, which inhibits a country's productivity, burdens already weak health care systems and displaces scarce national resources. A 2012 analysis found that tobacco use results in approximately \$500 billion globally in annual expenditures related to health care costs, productivity losses, fire damage and other costs (Ross et al 2008).

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

Meanwhile, tobacco production also carries harmful individual and societal health impacts, including environmental destruction (e.g. from pesticides and deforestation), which lead to a loss of biodiversity, land resources and food insecurity as well as green tobacco sickness among those harvesting the tobacco plant, often women and children. Finally, because the

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tobacco industry manipulates the costs of production as well as sale prices, small-scale tobacco farmers are often not economically rewarded so much as forced into debt-bonded labour.

Most smokers begin smoking in childhood and are addicted before they become adult. According to the UNDP, recent evidence suggests that women in LMICs are taking up smoking at “alarming rates” and the WHO FCTC sets out the need for Parties to take measures to address gender-specific risks when developing tobacco control strategies. According to Mackay and Amos:

Smoking prevalence is lower among women than men in most countries, yet there are about 200 million women in the world who smoke, and in addition, there are millions more who chew tobacco. Approximately 22% of women in developed countries and 9% of women in developing countries smoke, but because most women live in developing countries, there are numerically more women smokers in developing countries. Unless effective, comprehensive and sustained initiatives are implemented to reduce smoking uptake among young women and increase cessation rates among women, the prevalence of female smoking in developed and developing countries is likely to rise to 20% by 2025. This would mean that by 2025 there could be 532 million women smokers. Even if prevalence levels do not rise, the number of women who smoke will increase because the population of women in the world is predicted to rise from the current 3.1 billion to 4.2 billion by 2025. Thus, while the epidemic of tobacco use among men is in slow decline, the epidemic among women will not reach its peak until well into the 21st century. This will have enormous consequences not only for women's health and economic wellbeing but also for that of their families. The health effects of smoking for women are more serious than for men. In addition to the general health problems common to both genders, women face additional hazards in pregnancy, female-specific cancers such as cancer of the cervix, and exposure to passive smoking. In Asia, although there are currently lower levels of tobacco use among women, smoking among girls is already on the rise in some areas. The spending power of girls and women is increasing so that cigarettes are becoming more affordable. The social and cultural constraints that previously prevented many women from smoking are weakening; and women-specific health education and quitting programmes are rare. Furthermore, evidence suggests that women find it harder to quit smoking. The tobacco companies are targeting women by marketing light, mild, and menthol cigarettes, and introducing advertising directed at women. The greatest challenge and opportunity in primary preventive health in Asia and in other developing areas is to avert the predicted rise in smoking among women (2003).

Global response to tobacco epidemic

WHO FCTC

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the world's first public health treaty and promotes the implementation of comprehensive tobacco control strategies to tackle the tobacco epidemic around the world. At present, there are 179 countries that are Parties to the treaty (including 24 DFID priority countries) as well as the European Union. The WHO FCTC is well supported throughout LMICs.

The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health and was developed by countries in response to the globalization of the tobacco epidemic. It aims to tackle some of the causes of that epidemic, including complex factors with cross-border effects, such as trade liberalization and direct foreign investment, tobacco advertising, promotion and sponsorship beyond national borders, and illicit trade in tobacco products. The preamble to the Convention shows how countries view the need to develop such an international legal instrument. It cites their determination “to give priority to their right to protect public health” and the “concern of the international community about the

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devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke”. It then notes the scientific evidence for the harm caused by tobacco, the threat posed by advertising and promotion, and illicit trade, and the need for cooperative action to tackle these problems.

The UK is a Party to the WHO FCTC, which includes obligations for Parties to cooperate “in the scientific, technical and legal fields and provision of related expertise”.

WHO policy recommendations

According to the WHO, the following four key elements of the WHO FCTC constitute “best buys” for countries seeking to tackle non-communicable diseases (NCDs):

- tobacco tax increases,
- comprehensive legislation creating smoke-free indoor workplaces and public places,
- health information and warnings about the effects of tobacco, and
- bans on tobacco advertising, promotion and sponsorship, particularly to prevent uptake of tobacco use by women and young people.

If they were implemented, the WHO estimated that these best buys could have saved more than 5 million deaths in 23 large low- and middle-income countries alone during the period 2006-2015. Tobacco control measures are also extremely cost effective.

WHO FCTC implementation is an SDG goal

Goal 3.a of the Sustainable Development Goals (SDGs), under “Ensure healthy lives and promote well-being for all at all ages”, is to “strengthen implementation of the Framework Convention on Tobacco Control in all countries as appropriate”. Effective implementation of the WHO FCTC will also help LMICs to achieve many other SDG goals (see Annex B for an assessment made by a coalition on NGOs on this topic).

Tobacco control within Financing for Development

The recently agreed Addis Ababa Action Agenda of the Third International Conference on Financing for Development states:

32. We note the enormous burden that non-communicable diseases place on developed and developing countries... We recognize, in particular, that, as part of a comprehensive strategy of prevention and control, price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and health-care costs, and represent a revenue stream for financing for development in many countries.

The United Nations Interagency Task Force on the Prevention and Control of NCDs and WHO Global Action Plan for the Prevention and Control of NCDs

The United Nations Interagency Task Force (UNIATF) on the Prevention and Control of NCDs coordinates the activities of relevant UN organizations and other inter-governmental organizations to support governments to meet high-level commitments to respond to NCD epidemics worldwide. The commitments were made by Heads of State and Government in the

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2011 Political Declaration on NCDs. The Task Force was established by the UN Secretary-General in June 2013 and placed under WHO's leadership.

To realise these commitments, the World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 in May 2013. The Global Action Plan provides Member States, international partners and WHO with a road map and menu of policy options which, when implemented collectively between 2013 and 2020, will contribute to progress on nine global NCD targets to be attained in 2025, including a 25% relative reduction in premature mortality from NCDs by 2025. One of the nine global NCD targets to be attained in 2025 is for all countries to achieve 'a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years'. The WHO Global Action Plan recommends that countries implement the WHO FCTC in order to achieve this target.

UK and international tobacco control

The UK is highly regarded for achievements in implementing evidence-based tobacco control policy and has a high level of WHO FCTC implementation. For a number of years, the UK has been rated the best country in Europe for tobacco control policy. In 2015, DH was awarded the prestigious Luther L. Terry Prize by the American Cancer Society for exemplary leadership in tobacco control by a government ministry. The UK's experience and achievements in tobacco control includes:

- effective national coordination and cross government cooperation and working across on tobacco control;
- evidence-based legislation made and effectively implemented across a variety of areas to stop young people taking up smoking, reduce adult smoking rates and protect people from secondhand smoke;
- trained and experienced tobacco control focal points in post in DH;
- ambitious and financed national strategies in place in England (and DAs) for over a decade;
- robust action to protect public health from the vested and commercial interests of the tobacco industry;
- functional and positive relationships with civil society;
- a wealth of experience in supporting other countries to implement tobacco control, bilaterally and through multilateral settings (such as the WHO FCTC and WHO); and
- crucially, impressive results, with long-term reductions in smoking rates, with over a 1 million fewer smokers in England now, compared to a decade ago.

Many other countries that have prioritised tobacco control and have a high level of implementation of the WHO FCTC have also seen smoking prevalence reduce significantly. Evidence and experience shows that a long-term policy approach and commitment from governments is needed to maximise reductions in smoking rates.

DH's SDP includes the "aim to reduce the impact on society and the economy of unhealthy lifestyle choices (e.g. through lost productivity), and the many premature deaths and illnesses which could be avoided by improving lifestyles, through policies on tobacco, alcohol, drugs and diet".

DH is currently leading the development of a new cross-government tobacco control strategy, which is expected to include a chapter on how the UK will encourage and support tobacco

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control internationally, and will emphasise the UK's ongoing commitment to the WHO FCTC. This project will be a key "deliverable" within the new strategy.

Tobacco control in LMICs: current limitations

Tobacco use has a devastating impact on public health, as well as social, economic and environmental consequences for all countries. The WHO FCTC represents an evidence-based "blue print" for countries to tackle tobacco use. Nevertheless, significant gaps and weaknesses remain in the implementation of the WHO FCTC in LMICs, for a variety of reasons.

According to UNDP:

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

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

The Conference of the Parties (COP) to the WHO FCTC, UN General Assembly, UN Economic and Social Council (ECOSOC) and UN Secretary-General's successive reports on the meetings of the Ad Hoc Inter-agency Task Force on Tobacco Control (IATF) have recognized the urgent need to integrate WHO FCTC implementation into countries' health and development plans and called upon the UN agencies, programmes and funds to provide coordinated support in the pursuit thereof. At the country level, the prioritization of tobacco control in national development planning would facilitate its inclusion in the UN system response as articulated through the UN Development Assistance Frameworks (UNDAFs), which are the strategic programme frameworks jointly agreed between governments and the UN system outlining priorities in national development (2014).

The tobacco industry is the "vector" of tobacco-related disease. The tobacco industry is becoming increasingly active in LMICs, where tobacco control measures are limited. Tobacco use is promoted as a desirable "western" lifestyle and the tobacco industry has a history of aggressively promoting tobacco use, especially to young people. According to the WHO, the tobacco industry has historically employed a multitude of tactics to shape and influence tobacco control policy. The tobacco industry has used its economic power, lobbying and marketing machinery, and manipulation of the media to discredit scientific research and influence governments in order to propagate the sale and distribution of its deadly product (2012). The WHO FCTC obliges Parties to protect public health policies from the vested and commercial interests of the tobacco industry.

Tobacco governance

Tobacco control governance² acts as the foundation on which LMICs can go on to develop and implement effective tobacco control policies and legislation. Collectively, the requirements of countries under Article 5 (general obligations) of the WHO FCTC are referred to as tobacco control governance, encompassing the following actions for governments:

- Making and implementing effective, evidence-based tobacco control legislation and measures
- Developing and implementing comprehensive, multisectoral tobacco control strategies/plans/programmes
- Establishing/reinforcing cross government national coordinating mechanisms
- Appointing a trained tobacco control focal point
- Protecting public health policies from the vested and commercial interests of the tobacco industry
- Cooperating with other WHO FCTC Parties to implement the WHO FCTC
- Cooperating with international organisations (such as WHO and UNDP) to implement the WHO FCTC
- Raising financial resources for tobacco control

In the latest WHO FCTC Global Progress Report, over 90% (119) of the Parties stated that they have at least one priority area for implementation of the WHO FCTC. More than half of the Parties reported a priority under the scope of Article 5 (general obligations) of the WHO FCTC, with over a third mentioning adoption of new or strengthening of existing tobacco control legislation. Several other Parties reported that they focus on preventing interference by the tobacco industry and reinforcing their national coordinating mechanisms or focal points for tobacco control. Other priorities cited in relation to Article 5 were development and strengthening of a national tobacco control strategy, enforcement of penalties, and capacity building of stakeholders.

The WHO FCTC Global Progress Report found a number of issues relating to the implementation of Article 5 of the WHO FCTC, including weaknesses in multisectoral coordination and insufficient support for treaty implementation from sectors outside health in a large number of Parties. Not all Parties have designated a national tobacco control focal point, and even fewer Parties have increased the number of staff working full time in tobacco control. In addition, the WHO FCTC report set out that interference by the tobacco industry remains significant and loopholes in Parties' legislation often allows such interference to take place.

The WHO FCTC Secretariat has undertaken more than 40 detailed "needs assessment" missions, which are provided at the request of the health minister of a country. From these assessments, the areas of greatest need identified are in the areas of Article 5 (general obligations) of the WHO FCTC. The needs assessment process has revealed that significant gaps remain in WHO FCTC implementation among LMICs, especially at the most basic level.

² UNDP (1997) defines "governance" as 'the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises the mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences'

Strategic case

This will impair the effectiveness of tobacco control and means that the reduction of smoking rates will be sub-optimal.

WHO FCTC “time-bound” measures

The WHO FCTC includes two critical “time-bound” measures, which many LMICs have not yet fully implemented:

- Packaging: (i) Ensure packaging and labelling does not promote tobacco by means that are false or misleading (including banning the use of descriptors such as “light” and “mild” and (ii) introduce health warnings on all tobacco packaging.
- Tobacco advertising, promotion and sponsorship: implement a ban on tobacco advertising, promotion and sponsorship.

The WHO FCTC Global Progress Report found that only around half of WHO FCTC Parties have health warnings on packs that make use of picture health warnings and even fewer meet the recommendation that warnings should be greater than 50% of the principal display area of the pack.

Some 30% of WHO FCTC Parties do not yet have comprehensive tobacco advertising, promotion and sponsorship bans in place. Ending tobacco advertising is a vital measure to stop young people taking up smoking. According to ASH, research shows that children in developing countries are influenced by tobacco industry marketing. A 2013 study showed that the majority of young children in low- and middle-income countries could correctly identify cigarette brand logos, and nearly a third of children in India reported that they wanted to smoke when they grow up (ASH 2015a). Eriksen et al report that one-third of youth experimentation occurs as a result of exposure to tobacco advertising, promotion, and sponsorship, and 78% of youth aged 13–15 report regular exposure to tobacco marketing worldwide (2015).

In addition, although there is no timeline imposed in the treaty itself, non-binding guidelines for the implementation of Article 8 of the WHO FCTC that were agreed unanimously by WHO FCTC Parties recommend that comprehensive smokefree policies be put in place within five years of entry into force of the Convention for that Party. To date, fewer than half of WHO FCTC Parties report having comprehensive smokefree requirements in place.

Addressing the problem

To reduce rates of tobacco use, there is a clear need for LMICs to:

- improve tobacco control governance through the full implementation of the general obligations in Article 5 of the WHO FCTC;
- implement the two time-bound measures in the WHO FCTC (packaging and advertising); and
- consider the benefits of increasing tobacco tax

LMICs have also expressed need for support and assistance to implement the other Articles of the WHO FCTC.

This project will address the needs in LMICs to strengthen tobacco control through:

- Direct support to selected LMICs: the provision of direct expert advice, technical assistance and peer support to build domestic capacity to improve tobacco control and to support their

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implementation of the WHO FCTC, focusing on tobacco governance (as set out in Article 5 of the WHO FCTC) and the WHO FCTC time-bound obligations.

- General support to all LMICs: to be made available to all LMICs to support implementation of the WHO FCTC in the areas set out above. This will include workshops, toolkits, online training on tobacco control, networking, South-South and Triangular Cooperation, promotion of tobacco control in the wider UN system, and assistance to governments to implement measures to protect public health policies from the vested and commercial interests of the tobacco industry (including examining the feasibility of creating a WHO FCTC knowledge hub to support LMICs implement Article 5.3).

Direct support will be made available to a number of selected LMICs to assist in the implementation of the WHO FCTC, in the areas set out above. LMICs will be selected using a set of criteria to be determined by the WHO FCTC Secretariat, which will include political motivation by governments to reduce rates of tobacco use, as well as explicit requests for assistance. Over the course of the project, direct, intensive support to a minimum of 10 LMICs will be provided. These LMICs will receive intensive support to include expert advice, technical assistance and support to build domestic capacity to improve tobacco control. The project is designed to be scalable and a greater number of LMICs will be supported, if capacity and resource exists.

DH will ask WHO and the WHO FCTC Secretariat to develop a set of selection criteria for countries and produce a suggested list. DH will agree the selection criteria and always be asked to approve on the countries that are proposed to be supported through this project.

The WHO FCTC Secretariat will be the primary delivery partner for this project, and will use its convening power to involve other key members of the UN family to support delivery, including UNDP. UNDP has already made important advances in promoting tobacco control as a development issue, and has a history of working positively in partnership with the WHO FCTC Secretariat to promote WHO FCTC implementation. The project will also encourage WHO's Tobacco Free Initiative and Regional Tobacco Coordinators, the World Bank and UN in-country teams to participate in the project, and to resource and assist with WHO FCTC implementation in LMICs

Impact and Outcome that we expect to achieve

The Theory of Change outlines the outputs, outcomes and impact expected from this investment.

Theory of change

Inputs	Process	Outputs in LMICs	Outcomes	Impact
£14.4m funding to WHO FCTC Secretariat (FY16-17 to 20-21, ODA Programme funded)	Support by WHO FCTC Secretariat to LMICs reinforced	National Coordinating Mechanisms for tobacco control established/strengthened	Strengthened implementation of the WHO FCTC in LMICs	Reduced prevalence of tobacco use in the longer term
	WHO FCTC implementation needs in LMICs assessed	Focal points for tobacco control (with appropriate training) in post		

Strategic case

1 x DH G7 (five years, DH ODA Admin funded)	Direct intensive technical support provided to selected LMICs	Multisectoral tobacco control strategies developed and implemented (could be as part of a wider governmental strategy)		
	Intensive, direct capacity building support in a minimum of 10 selected LMICs	Multisectoral tobacco control strategies developed and implemented (could be as part of a wider governmental strategy)		
	“Global Public Goods” generated, including general support, tools and materials available to all LMICs	New sources of finance for tobacco control identified and activated		
	Assistance to all LMICs to protect public health from vested and commercial interests	Tobacco taxes policies reviewed in light of WHO FCTC guidelines		
	Intergovernmental organisations activated to support tobacco control by LMICs	WHO FCTC time-bound measures implemented		
Other WHO FCTC Articles implemented, according to national priorities				

Impact

The expected impact is reduced prevalence of tobacco use over the longer term.

To maintain consistency with the new SDGs, impact will be measured using the same indicator and methodology that is put in place for measuring the new SDGs Goal 3.a target on the implementation of the WHO FCTC (age-standardised prevalence of current tobacco use among persons aged 15 years and older). The impact is also aligned with the WHO Global Action Plan for the Prevention and Control of NCDs voluntary global target on smoking for ‘a 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years’. Countries will be supported separately to improve impact monitoring to assist with SDG and NCD target monitoring.

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While reducing smoking prevalence is the aspiration for the impact of this project, it is recognised that action that reduces or arrests the rise in smoking prevalence in LMICs where use of tobacco is currently expanding should also be considered as a highly beneficial step towards longer term achievement of declines in tobacco prevalence.

As set out by DFID, the impact for this project is not intended to be achieved solely by this project. It is also recognised that prevalence of tobacco use can sometimes take many years to reduce after the implementation of evidence-based policies, and can be influenced by a range of factors, including the actions of the tobacco industry. There is also other work in place to support effective tobacco control, including work funded by private philanthropies and NGOs. This project will complement other tobacco control projects in LMICs through supporting the creation of robust tobacco control governance foundations on which tobacco control policies and projects can be built.

Outcome

The outcome will be the strengthened implementation of the WHO FCTC in LMICs. A key source of data relating to outcome achievement is the Global Progress Report on Implementation of the WHO Framework Convention On Tobacco Control, which reports on the average implementation of each of the WHO FCTC Articles.

The Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control is based on self-reporting by Parties. The level of implementation of Articles 5, 11 and 13 within the LMICs that receive direct support through this project will be also be validated using independent sources of data. The project will be subject to ongoing monitoring and an evaluation report will be produced at its conclusion, which will also provide an assessment of progress made by the project countries.

Outputs

The project has the following seven main outputs (each specifically relating to LMICs):

- National Coordinating Mechanisms for tobacco control established/strengthened
- Focal points for tobacco control (with appropriate training) in post
- Multisectoral tobacco control strategies developed and implemented (could be as part of a wider governmental strategy)
- New sources of finance for tobacco control identified and activated
- Tobacco taxes policies reviewed in light of WHO FCTC guidelines
- WHO FCTC time-bound measures implemented
- Other WHO FCTC Articles implemented, as appropriate according to national priorities

The achievement of these outputs will put LMICs into a strong position to go on to make further progress on tobacco control, particularly by having the foundations in place to introduce policies to implement the other Articles of the WHO FCTC. Given the evidence on reducing smoking rates, the achievement of these outputs in LMICs should lead to the project making a contribution to the desired impact.

3. Appraisal case

What are the feasible options that address the need set out in the Strategic case?

There are two options for this intervention:

1. Strengthen the implementation of the WHO FCTC in LMICs in partnership with the WHO FCTC Secretariat:

Strengthening the WHO FCTC’s capacity and resources to provide (i) direct intensive support to motivated LMICs to strengthen tobacco control governance and implement the WHO FCTC and (ii) provide general resources and materials to all LMICs via the WHO FCTC Secretariat, in partnership with other UN bodies such as UNDP.

2. No additional support to implement the WHO FCTC:

No further support other than the technical support and cooperation DH already provides to other WHO FCTC Parties (on request), and to the WHO and WHO FCTC Secretariat.

Assessing the strength of the evidence base for each feasible option

Option	Evidence rating
1.	Strong
2.	Medium

The WHO FCTC is an evidence-based treaty. A vast evidence-base demonstrates the harms to health that are caused by tobacco use, and that a sustained policy response by governments can significantly reduce the prevalence of tobacco use (the UK, as well as many other countries, demonstrates this). There is strong evidence relating to tobacco taxation as a public health measure. The WHO FCTC time-bound measures are important in reducing demand for tobacco products.

Without this project, it is unclear whether LMICs will be able to take the necessary and sustained action necessary to reduce tobacco use. The project will also enable LMICs to be better placed to withstand the likely actions of the tobacco industry to undermine action intended to improve public health.

What is the likely impact (positive and negative) on climate change and environment for each feasible option?

Option 1 (Strengthen the implementation of the WHO FCTC in LMICs in partnership with the WHO FCTC Secretariat) is likely to make a positive environmental impact, if tobacco consumption is reduced as expected.

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Clearing of land for the cultivation of tobacco and the large amounts of wood needed for curing tobacco causes massive deforestation, estimated at a rate of approximately 200,000ha per year, with the subsequent effects on climate change. Dangerous pesticides are used in the cultivation of tobacco. Litter from smoking fouls the environment, including cigarette filters from the 6 trillion cigarettes consumed annually (cigarette filters are generally not biodegradable). Smoking materials are also a known cause of wildfires, which can devastate vast areas of land and cause death. Many of the environmental consequences of the tobacco industry and the use of tobacco products are summarised by Eriksen et al:

The tobacco industry damages the environment in many ways, and in ways that go far beyond the effects of the smoke that cigarettes put into the air when they are smoked. The harmful impact of the tobacco industry on deforestation, climate change, litter, and forest fires is enormous and growing. Tobacco farming is a complicated process involving heavy use of pesticides, growth regulators, and chemical fertilizers. These can create environmental health problems, particularly in low- and middle-income countries with lax regulatory standards. In addition, tobacco, more than other food and cash crops, depletes soil of nutrients, including nitrogen, potassium, and phosphorus. As a result, in many low- and middle-income regions of the world, new areas of woodlands are cleared every year for tobacco crops (as opposed to re-using plots) and for wood needed for curing tobacco leaves, leading to deforestation. This deforestation can contribute to climate change by removing trees that eliminate CO₂ from the atmosphere.

Litter from cigarettes fouls the environment as well. Internationally, cigarette filters (which are not generally biodegradable) are the single most collected item in beach cleanups. Material that leaches out of these filters is toxic to aquatic life. To combat this, a bill to ban the sale of single-use filtered cigarettes was submitted to the California Legislature in 2014. Damage to people and the environment by fires caused by cigarette smoking is considerable and deadly... (2015)

The reduction in tobacco use across the globe would be very likely to have a positive impact on climate change and the environment. This project is intended to ultimately result in reductions in smoking prevalence which would result in a decline in the amount of tobacco product manufactured and consumed.

What are the costs and benefits of each feasible option?

Option 1: Strengthen the implementation of the WHO FCTC in LMICs in partnership with the WHO FCTC Secretariat

Costs

The following will be the primary costs of delivering this project:

- national level capacity building and technical support in a minimum of 10 selected LMICs, deployed flexibly according to country need (delivered by WHO FCTC Secretariat);
- development of toolkits, materials, training packages, communications and running workshops for the benefit of all LMICs (delivered by WHO FCTC Secretariat);
- if feasible, the establishment of an Article 5.3 “knowledge hub” to assist all LMICs protect public health policy from the vested and commercial interests of the tobacco industry (delivered by WHO FCTC Secretariat); and
- staffing costs (WHO FCTC Secretariat, DH (DH ODA Admin funded))

Benefits

The benefits of this investment will be in strengthened tobacco control through WHO FCTC implementation in LMICs which, according to the evidence base, should deliver reductions in prevalence of tobacco use over time.

Improving tobacco governance

The WHO FCTC acknowledges that most well-proven tobacco control measures require the meaningful engagement of sectors beyond health, such as finance, tax, justice, agriculture, trade, labour, education, youth and others. Effective tobacco control and strengthened WHO FCTC implementation require governance arrangements that can facilitate multisectoral coordination and cooperation, while protecting against tobacco industry interference in policymaking. Strong tobacco control governance depends considerably on whether countries have a well-functioning and reliably financed tobacco control focal point and national coordinating mechanism, in line with WHO FCTC Article 5.2(a) obligations. The exact form of these entities can and should vary based on country context. Both entities should be established or reinforced with clear and significant legitimacy, sufficient technical expertise in tobacco control and the ability to coordinate and engage with key stakeholders, including possibly disputatious ones. Also, both entities must prioritise transparent, comprehensive and accurate reporting. According to UNDP:

Effective tobacco control and strengthened WHO FCTC implementation require governance arrangements that can facilitate multisectoral coordination and cooperation, while protecting against tobacco industry interference in policymaking. Strong tobacco control governance depends considerably on whether Parties have a well-functioning and reliably financed tobacco-control focal point and NCM, in line with WHO FCTC Article 5.2(a) obligations (2016).

This ODA project would invest in supporting LMICs to get robust foundations for tobacco control into place. The full implementation of Article 5 of the WHO FCTC will enable LMICs to work across their governments to tackle tobacco use, including through the establishment of intersectoral capacity development, functional mechanisms in country to advance tobacco control and the development and implementation of national tobacco control strategies.

In addition to improving public health, LMICs will be encouraged to put tobacco control in their national development agenda, highlighting the role that tobacco control has in terms of a country's economic development and as an effective measure to reduce poverty.

The project will offer LMICs assistance to undertake analysis and build the economic case for tobacco control. By generating collaboration from other ministries (particularly those responsible for finance and economy) and with the UN system, LMICs will be able to define returns on investments in tobacco control (with associated policy scenarios), the real and projected costs of inaction, identify and secure new sources of development-related funding for tobacco control.

LMICs will also be supported to take action to protect public health policies from the vested and commercial interests of the tobacco industry. The WHO sets out that the tobacco industry is known to employ a variety of methods to slow or stop progress on beneficial public health policies.

Through supporting the strengthening of tobacco governance, including anti-corruption measures, LMICs will develop the leadership and capacity necessary to drive forward tobacco

Business Case

control and achieve outcomes to improve public health and tackle the wider costs of tobacco use.

Increased tobacco tax

The investment will support and encourage LMICs to raise tobacco tax. According to the WHO, evidence from countries of all income levels shows that price increases on cigarettes are highly effective in reducing demand. Higher prices promote cessation and prevent initiation of tobacco use. They also reduce relapse among those who have quit and reduce consumption among continuing users. On average, a 10% price increase on a pack of cigarettes would be expected to reduce demand for cigarettes by about 5% in low- and middle-income countries, where lower incomes tend to make people more sensitive to price changes. Even so, high tobacco tax is a measure that is rarely implemented. Only 33 countries, with 10% of the world's population, have introduced taxes on tobacco products so that more than 75% of the retail price is tax (WHO 2016).

Children and adolescents are also more sensitive to price increases than adults, allowing price interventions to have a significant impact on this age group. Tobacco excise taxes are a powerful tool for protecting public health while at the same time an efficient source of government revenues. LMICs have the option to dedicate some or all tobacco tax to improve public health.

WHO FCTC time-bound measures

LMICs would be supported to implement the WHO FCTC time-bound measures, to:

- end tobacco advertising, promotion and sponsorship (TAPS), and
- require tobacco packs to be stripped of misleading elements as well as displaying health warnings.

Many LMICs are in the initial phase of the tobacco epidemic. Tobacco companies are aggressively fighting for market share in LMICs, including through the use of advertising and promotion. Tobacco advertising and promotion is a powerful mechanism by which tobacco companies recruit new smokers (usually children and young people), and the industry has refined its methods over the past century. The WHO FCTC says that each Party shall introduce comprehensive bans on TAPS on radio, television, print media and other media such as the internet.

According to ASH, there is a clear relationship between tobacco advertising and consumption. A review commissioned by the UK Government found that “the balance of evidence supports the conclusion that advertising does have a positive impact on consumption” (i.e. it increases consumption). The same review also found that in countries that had banned tobacco advertising the ban “was followed by a fall in smoking on a scale which cannot reasonably be attributed to other factors”. An international overview of the effect of tobacco advertising bans on tobacco consumption concluded that “a comprehensive set of tobacco advertising bans can reduce tobacco consumption but a limited set of advertising bans will have little or no effect”. This is because tobacco companies respond to partial bans by diverting resources from the restricted to the non-restricted media (DH 1992). There is also evidence that children and young people are more receptive than adults to tobacco advertising and that young people exposed to tobacco advertising and promotion are more likely to take up smoking. Research suggests that very young children understand that tobacco promotion is promoting smoking

Appraisal case

rather than a particular brand and that as they get older they can differentiate the brand messages (ASH 2015b).

During the process of introducing a tobacco advertising laws in the UK, DH considered evidence from other countries and conservatively estimated that the tobacco advertising ban would result in a 2.5% fall in consumption and save 3,000 lives a year in the long term. Research conducted before and after the TAPA reveals that, overall, young people's awareness of tobacco marketing and brand recall has declined since the ban. Levy et al. reviewed studies on the effects of different tobacco control policies on smoking rates, and found that a comprehensive ban on TAPS would reduce smoking prevalence by 4% and reduce initiation by 6% (2004).

Regarding tobacco packs, the tobacco industry is known to use elements, including terms such as "light" and "mild", which are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions. The WHO FCTC requires Parties to end the use of such elements to reduce the opportunities that tobacco companies have to promote their products. The WHO FCTC also requires Parties to require that all tobacco packs carry health warnings. Such a requirement helps to increase public awareness of the risks of tobacco use at nil cost (the costs fall to the tobacco manufacturer). Picture health warnings are particularly effective in countries where low literacy rates may prevent textual warnings from being understood. Picture health warnings in use in the UK are sourced from an EU library, which is also available for the use of LMICs at no cost. The Levy et al. review found that large, graphic health warnings may reduce smoking prevalence and increase cessation rates by 2% (2004).

Other Articles of the WHO FCTC as appropriate:

The WHO FCTC is a blueprint for a country to implement a comprehensive programme of tobacco control, covering measures relating to demand and supply of tobacco. The UK has a wealth of experience across the different measures in the WHO FCTC and can provide technical support, on request, to LMICs that wish to also implement other tobacco control policies. Assistance to LMICs to implement other Articles of the WHO FCTC will be offered, according to national priorities of LMICs, in areas such as legislation to protect people from exposure to secondhand smoke or measures to assist tobacco users to quit.

Through the project, the UK will also be able to support South-South and Triangular Cooperation to strengthen the implementation of the FCTC in LMICs.

The Levy et al. review of studies on the effects of different tobacco control policies on smoking rates, and reported:

- Smokefree laws: reduction of 11% in smoking prevalence from comprehensive smokefree laws (like those in place in the UK) implemented with strong enforcement and media publicity.
- Media campaigns: reduction of 7% in smoking prevalence from well financed, long-term media programmes.
- Age of sale requirements: maximum 25% reduction in youth smoking prevalence with strong enforcement, stiff penalties and heavy community participation.
- Access to cessation treatments: a 2% relative reduction in prevalence rates after 5 years and 3.5% reduction after 10 years (2004).

Analysis of costs and benefits of the project

The economic costs and benefits for the introduction of tobacco control measures have been considered in detail by the DH, in the impact assessments (IAs) that have been prepared in advance of the implementation of new tobacco control legislation over the past decade or more. The latest IAs on tobacco control (including for the implementation of standardised packaging of tobacco) has found that in the UK, for every young person who no longer takes up smoking, there is a lifetime benefit through increased life expectancy of 2.1 years, valued at around £60,000. For every additional UK adult smoker who quits, there is a lifetime benefit through increased life expectancy of 2.0 years, valued at around £70,000.

In the UK context, the primary economic cost of tobacco control is the loss of tax take for the government as people stop smoking. The DH tobacco control IAs above estimate that £15,000 in tax is lost for every young person who no longer takes up smoking, and £11,000 for every additional UK adult smoker who quits. Therefore when considered together the net economic benefit for every young person who no longer takes up smoking is around £45,000, and £59,000 for every additional UK adult smoker who quits.

By using this existing analysis, we find that this project would need to stop 330 children from taking up smoking or encourage 250 adults to quit across all LMICs that are being supported, for the project to “break even” in economic terms. Given the expected impact of the various tobacco control measures that would be supported through this project, there is a high level of confidence that this number of adult quitter or children not starting smoking in the first place (or a combination of either) would be delivered.

This calculation uses the UK context (note all values are discounted except life years and are quotes to two significant figures). For example, it is assumed that most smokers quit over time, and that all smokers consume 11 cigarettes per day. Work by Doll et al (2004) suggests these benefits could be increased about 5 fold if it is assumed smokers do not quit (more likely where stop smoking support services are not available) and if more cigarettes are smoked by smokers each day (which may be more likely in settings with weak implementation of the WHO FCTC). Furthermore, the analysis is based on the UK setting where tax rates are very high compared to LMICs, and so the overall benefit could be much higher in LMICs where tax rates are lower compared to the UK. Another example is that the UK assigns a value of £60,000 to a Quality Adjusted Life Year (QALY), and different countries will use different values, which would alter the estimate for other countries. Therefore, while there is uncertainty of the direct comparability of these UK data to other countries, the estimates clearly suggest that the project would need to deliver very few young people not taking up smoking or adult quitters (i.e. hundreds) to “break even”.

UK data is used to undertake this appraisal. DH recognises that UK data might not be directly transferrable to contexts in other countries. Nevertheless, UK data is used to demonstrate the magnitude of the cost effectiveness of investment in tobacco control.

The WHO FCTC is entirely funded by Parties. While extrabudgetary funding has been provided to the WHO FCTC Secretariat by other Parties for specific work in the past, no work relating to the areas that this project would cover is currently being funded by other Parties. There is, therefore, no reason to believe that this project would displace work to support tobacco control in LMICs that is otherwise being undertaken. Nevertheless, it will be necessary for the WHO FCTC Secretariat to maintain a close understanding of the other programmes and projects underway to support tobacco control in LMICs (for example by philanthropies) at local, regional and global levels, and identify ways of working together to maximise public health and development outcomes.

Appraisal case

The WHO FCTC Secretariat and UNDP work closely together to support the implementation of the treaty, particularly in LMICs. The continued involvement of UNDP in WHO FCTC implementation will bring new perspectives and different parts of the UN system to strengthening tobacco control. The WHO FCTC Secretariat will encourage UNDP involvement in this project.

Option 2: No additional support to implement the WHO FCTC

Costs

No additional financial costs. Costs in terms of lost opportunities to support improvement in public health and promote development in LMICs.

Benefits

There are no definable benefits that would arise from not supporting LMICs to implement the WHO FCTC, either from a public health or development perspective.

What measures can be used to assess Value for Money for the intervention?

According to DFID, the main components of “value for money” (VfM) are the four “Es”:

- Economy: what are the cost of inputs for a given level of outputs?
- Efficiency: how are inputs transformed into outputs?
- Effectiveness: are outputs adequate to achieve the desired outcome?
- Equity: are benefits reaching populations groups most in need?

DFID guidance sets out that the appraisal case needs to focus on efficiency and effectiveness.

Efficiency

It will be possible to monitor and assess efficiency in the project through:

- Regular report of achievement against the project plan by WHO FCTC Secretariat to DH.
- Maintenance of good records so that the cost of different types of support that are provided can be understood.
- Measuring levels of participation and understanding the type of participant for all events.
- Seeking regular feedback from LMICs on the types of support provided (including feedback after events).

Effectiveness

It will be possible to monitor and assess effectiveness of the project through:

Business Case

- An independent evaluation exercise to be undertaken at the end of the project, to include if possible, an economic analysis to estimate the likely impact of the project on smoking rates and economic benefits of measures that are introduced (based on existing evidence of likely impacts of tobacco control interventions).
- Progress relating to the achievement of the outputs and outcomes of the project
- Understanding how support that is provided is translated into action by LMICs to implement the WHO FCTC.
- Levels of participation in the WHO FCTC by LMICs, such as participation in the biennial WHO FCTC Conferences of the Parties and in South-South cooperation projects relating to tobacco control.
- Evidence on the economic costs and benefits of WHO FCTC implementation at LMIC country level.
- Revisions to tobacco tax policies and any increases in tobacco prices.
- Identification and activation of new sources of funding for tobacco control in LMICs.
- New capacity and human resources for tobacco control in LMICs.
- Quality of reporting on WHO FCTC implementation by LMIC Parties.
- New laws that are introduced in LMICs to implement the WHO FCTC.
- Effectiveness of compliance and enforcement of new and existing tobacco legislation.
- In country visits and evaluation by DH, independent experts and/or tobacco control NGOs.

Summary Value for Money Statement for the preferred option

Given that this project would only need to stop 330 children from taking up smoking or enable 250 adults to quit across all LMICs to “break even” in economic terms, strengthening the implementation of the WHO FCTC in LMICs in partnership with the WHO FCTC Secretariat (option 1) is the preferred option. The impact is likely to be vastly higher, which will deliver significant benefits for LMICs.

4. Commercial Case

Indirect Procurement

Why is the proposed funding mechanism/form of arrangement the right one for this intervention, with this development partner?

The WHO FCTC is the world's only public health treaty and sets out an evidence-based blueprint for countries to follow to implement effective tobacco control measures and reduce prevalence of tobacco use. At present, 180 countries are Parties to the treaty (including 24 DFID priority countries). The WHO FCTC is well supported throughout LMICs.

The WHO FCTC Secretariat and its work is entirely funded by contributions from Parties. The WHO FCTC Secretariat is based within the WHO HQ in Geneva, and is subject to WHO's financial, procurement and HR arrangements.

Working in partnership with the WHO FCTC Secretariat presents an efficient mechanism to support the implementation of the WHO FCTC in LMICs. The WHO FCTC Secretariat has existing relationships with governments of all Parties, and has been working with key UN organizations in the pursuit of tobacco control, including UNDP, World Bank and the World Trade Organization.

The WHO FCTC Secretariat has undertaken a series of WHO FCTC implementation "needs assessment" missions to LMICs. This project would follow-up on those missions to provide comprehensive support to LMICs on bottlenecks, capacity deficits and WHO FCTC Article implementation priorities that have been identified.

The project is designed to be delivered under the auspices of an arrangement to be agreed between DH and the WHO FCTC Secretariat, which is closely based on DFID's framework arrangement with the WHO. The arrangement would bring into place the same arrangements for this project as those in place for the delivery of other DFID-funded, WHO-delivered projects.

In addition to providing funding, DH will work closely with the WHO FCTC Secretariat to deliver this project, including through the mobilisation of UK experts and the provision of a DH secondment to support the management and delivery of the project.

Value for money through procurement

No major procurements by DH or the WHO FCTC Secretariat are envisaged under this project.

Any procurement would be undertaken by the WHO FCTC Secretariat, following normal WHO procedures. WHO procurement is managed through competitive procedures which include limited international bids and some long term framework arrangements.

In the last published DFID Multilateral Aid Review, WHO scored satisfactorily on procurement with the conclusion that the organisation's approach to procurement is driven by value for money. In 2007, the European Commission contracted Ernst and Young to assess whether WHO offered guarantees equivalent to internationally accepted standards in four areas - accounting, auditing, internal control and procurement. The report concluded that WHO offered guarantees equivalent to internationally accepted standards in all four areas, including procurement.

Business Case

The recruitment of any staff into the WHO FCTC Secretariat would be on a short-term basis, and managed in a streamlined and flexible manner so that maximum use can be made of DH funds. Any staff would not be permanent members of the WHO cadre.

In the first year of the project, the WHO FCTC Secretariat will undertake detailed scoping of the technical support needed to deliver this project. Through this scoping work, the WHO FCTC Secretariat will engage with DH to identify how public health expertise might be sourced from within the UK to support the delivery of this project in a manner that maximises VfM.

In that case that the WHO FCTC Secretariat will need to draw on consultant expertise, the negotiated cost of consultants will affect the number of consultant days that would be used. The WHO FCTC Secretariat would be encouraged to engage the best consultants at the lowest cost to ensure VfM. Consultants can only be deployed when required services cannot be met within the staff resource of WHO. They are usually selected from a roster of pre-qualified candidates. According to WHO regulations, clear terms of reference are agreed in advance, including objectives, measurable outputs and delivery dates, as well as performance indicators for evaluation of results. They are subject to performance reviews. Through the project, UK experts from within government would also be mobilised and should be available to the project free of charge (travel and subsistence would be funded by the WHO FCTC Secretariat).

The WHO FCTC has a number of knowledge hubs that provide advice and support to Parties to implement specific Articles of the WHO FCTC. Through the project, the WHO FCTC Secretariat and DH will examine the feasibility of creating a knowledge hub on Article 5.3, to support LMICs to protect public health from the vested and commercial interests of the tobacco industry and invest in the creation of such a knowledge hub if it would be useful in supporting LMICs. In addition, existing knowledge hubs are also available to assist with the delivery of the project in their areas of specialism

5. Financial Case

What are the costs, how are they profiled and how will you ensure accurate forecasting?

HMT have approved ODA funding of £15m for this project. The £15m budget will be profiled as follows:

Year	Funding to WHO FCTC Secretariat (£m)
2016/17	1
2017/18	3
2018/19	3
2019/20	4
2020/21	4

Cost components

The primary cost and likely cost components for the WHO FCTC Secretariat will be as follows:

Primary costs	Possible cost components – examples of the types of work and support that can be funded
National level capacity building and technical support in selected LMICs, deployed flexibly according to country need	<ul style="list-style-type: none"> -Provision of direct to support to a minimum of 10 LMICs (the project will be scaled upwards to support addition countries, depending on available resources) -Needs assessment exercises to LMICs to assess needs and follow-up missions -Provision of necessary commodities -Provision of technical support (UK experts and/or consultants) for policy advice, strategy development etc. -Provision of additional capacities for tobacco control (such as HR capacity) -Development of investment/business cases, economic impact assessments for tobacco control and modelling -Institutional context analyses

	<ul style="list-style-type: none"> -Review of tobacco control legislation, legal environment and enforcement capacity -Support for data collection, analysis and monitoring -Support for developing national tobacco control strategies -Study visits -Training for tobacco control focal points and other key government officials (for example, in finance ministries) -Assistance to create and operate a national coordinating mechanism for tobacco control -Awareness raising with UN country teams in LMICs -Promote WHO FCTC implementation among key stakeholder groups, such as health professionals -Work to include tobacco control into UNDAFs and sustainable development frameworks
<p>Development of “global public goods” to strengthen WHO FCTC implementation in all LMICs</p>	<ul style="list-style-type: none"> -Toolkits, manuals and checklists for WHO FCTC implementation -Training packages (including e-learning) -Workshops on WHO FCTC implementation (such as tobacco tax and law enforcement) -IT platforms to facilitate exchange of information and to promote communication between LMICs -Awareness raising of WHO FCTC implementation with WHO, other UN organizations and intergovernmental bodies such as the World Bank, Global Fund and PEPFAR/USAID -Promotion of tobacco tax in work of intergovernmental organisations -Promote WHO FCTC implementation among key stakeholder groups, such as health professionals -Coordination of support between WHO FCTC Parties, through collection and dissemination of good practices in WHO FCTC implementation -South-South and Triangular cooperation, including demonstration projects
<p>If feasible, the establishment of an Article 5.3 “knowledge hub” to assist all LMICs protect public health policy from the vested and commercial interests of the tobacco industry</p>	<ul style="list-style-type: none"> -Provision of training to tobacco control focal points and other government officials -Collection and dissemination of good practice in the implementation of Article 5.3 -Support to LMICs, including Q&A capacity -Support to WHO FCTC Secretariat on the implementation of Article 5.3 in LMICs -Research into the implementation of Article 5.3 in LMICs -Systems assessments regarding transparency and

Financial Case

	corruption
Staffing costs	<ul style="list-style-type: none"> -Secondment of DH official to assist with management and delivery of the project -Dedicated staff resources for tobacco control in the WHO in-country offices in LMICs selected for intensive support -Additional WHO fixed term professional and/or general staff necessary to deliver the project, as agreed with DH

The first year of costs will be primarily for set up, as well as piloting a number of different ways of providing support to countries. In the first year of the project (April 2016-March 2017), the WHO FCTC Secretariat will:

- Undertake a detailed programme of fact-finding and outreach with DH, LMICs, relevant sections of the WHO, UN agencies (including UNDP), civil society (including academia) and other relevant stakeholders to understand the needs of LMICs, so as to inform the development a detailed plan for delivery of the project for the years April 2017-March 2021.
- Develop a detailed monitoring/evaluation strategy for the project.
- Pilot different forms of delivering support to LMICs, to learn lessons for years 2-5 of the project.
- Arrange and fund workshops and conferences to stimulate motivation for tobacco control in LMICs, including on tobacco taxation.
- Commence the development of toolkits and manuals to support the strengthening of the WHO FCTC in LMICs.
- With DH, examine the feasibility of establishing an Article 5.3 Knowledge Hub.
- Establish a clear understanding of the technical support that will be necessary to deliver the project, and develop proposals for sourcing this technical support in a cost effective manner.

Direct support will be made available to a number of selected LMICs to assist in the implementation of the WHO FCTC, in the areas set out above. LMICs will be selected using a set of criteria to be determined by the WHO FCTC Secretariat, which will include political motivation by governments to reduce rates of tobacco use, as well as explicit requests for assistance. From year 2 of the project, direct, intensive support to a minimum of 10 LMICs will be provided. These LMICs will receive intensive support to include expert advice, technical assistance and support to build domestic capacity to improve tobacco control. The project is designed to be scalable and a greater number of LMICs will be supported, if capacity and resource exists.

DH will ask WHO and the FCTC Secretariat to develop a set of selection criteria for countries and produce a suggested list. DH will agree the selection criteria and always be asked to approve on the countries that are proposed to be supported through this project.

Business Case

It is difficult to produce specific costings for the different work that the FCTC Secretariat will carry out, as it will be very specific to the needs of the specific countries that are selected to work intensively with. The arrangement between DH and the FCTC Secretariat will include a requirement for a specific budget and work plan for years 2-5 of the project to be signed off by DH before budgets are provided for that year. During year one of the project (ie, FY 16/17), the countries that will be supported through the project will be identified and work to scope out the requirements of those countries undertaken so that detailed budgets can be produced for each subsequent year.

Staff resources

DH will provide staff resources (1 x G7 and 1 x HEO) to oversee governance aspects of the ODA project, undertake liaison between DH and the WHO FCTC Secretariat, arrange HMG experts to participate in the project, lead on the UK's contributions to the WHO FCTC sustainable measures working group and provide direct support to LMICs as necessary. These staff will be funded from a separate DH ODA Admin budget, meaning that they would also be available to support wider ODA work.

In the first year of the project, the WHO FCTC Secretariat will undertake detailed scoping of the technical support needed to deliver this project. Through this scoping work, the WHO FCTC Secretariat will engage with DH to identify how public health expertise might be sourced from within the UK to support the delivery of this project in a manner that maximises VfM.

How will it be funded: capital/programme/admin?

Funds will be available to DH as a programme budget line, under the responsibility of the DH Healthier Lives Division.

How will funds be paid out?

The funds will be released annually to WHO, at the beginning of the DH budget year.

The budget is profiled to enable the project to start up in the first year, in which the WHO FCTC Secretariat to develop detailed implementation plans. The WHO FCTC Secretariat will be asked to present to DH for agreement a high-level project plan for the delivery of the project for the years April 2017-March 2021 by 1 March 2017, to include a monitoring and evaluation plan. The WHO FCTC Secretariat will also be asked to present a detailed annual delivery plan and budget for agreement by DH, according to the following schedule:

- By 1 March 2017: Detailed annual delivery plan and budget for the period April 2017-March 2018.
- By 1 March 2018: Detailed annual delivery plan and budget for the period April 2018-March 2019.
- By 1 March 2019: Detailed annual delivery plan and budget for the period April 2019-March 2020.
- By 1 March 2020: Detailed annual delivery plan and budget for the period April 2020-March 2021.

Financial Case

The payment of the initial financial contribution to the WHO FCTC Secretariat will be made as soon as possible after 1 April 2016. The payment of the respective financial contributions from DH will be subject to the agreement by DH of the annual delivery plan for the respect period in advance of the payment being made. WHO and the FCTC Secretariat require funds in advance of projects being set up and made operational, as the WHO finance and administration model does not provide payments to be made in arrears.

The WHO FCTC Secretariat will be responsible for allocating, managing and reporting on the utilisation of funds provided, under the terms set out in the agreement, to achieve agreed annual delivery plans.

What is the assessment of financial risk and fraud?

The risk is judged to be low. The WHO FCTC Secretariat is located within the WHO, which has clear systems and procedures relating to financial management and procurement.

Under the agreement with DH, the WHO FCTC Secretariat will be required to take all necessary precautions to prevent fraud corruption and other financial irregularities in line with its and WHO's regulations and rules and, in particular, its and WHO's policies for combatting fraud and corruption. The agreement will specify expectations relating to fraud, including the investigation of any allegations or suggestions of inappropriate behaviour/activity in detail. If the project is affected by suspected or actual fraud or corruption DH will reserve the ability to suspend or terminate financial disbursements with immediate effect.

The secondment of a DH official to lead the project within the WHO FCTC Secretariat provides a high level of assurance that the project will be managed in line with DH expectations.

The WHO FCTC Secretariat will provide regular reports on financial aspects of the project, and will be asked to provide detailed information to DH on request.

How will expenditure be monitored, reported, and accounted for?

The WHO FCTC Secretariat will submit the following reports to DH:

- Every six (6) months, a report summarizing project performance and results for the duration of the project. This report will include a breakdown of uncertified financial information on the budget amount and expenditure reported by staff and activity costs.
- An annual financial statement as of 31 December every year, certified in accordance with the WHO FCTC Secretariat's standard procedures for certification, to be provided no later than 30 June of the following year.
- Within three months after the date of completion or termination of the project, a final report summarizing programme/project performance. This report will include a breakdown of uncertified financial information on the budget amount and expenditure reported by staff and activity costs.
- On completion of the project, a final financial statement certified in accordance with the WHO FCTC Secretariat's standard procedures for certification, to be submitted no later than six months following the financial closing of the project.

The WHO FCTC Secretariat may agree to provide additional reporting at the expense of DH. The specific nature and frequency of this additional reporting will be agreed with DH.

Business Case

The WHO FCTC Secretariat will, in a timely manner, inform DH of any delays, obstructions or events which, in the opinion of the WHO FCTC Secretariat, interfere or threaten to interfere with the successful implementation of any part of the project. In the event that DH reasonably believes that timely and appropriate corrective action has not been taken to remove the delay or obstruction it may request consultations at senior level between DH and the WHO FCTC Secretariat and, where applicable and appropriate, the relevant authorities of the Government in the country or region in which the project is implemented to determine the appropriate action to ensure that the programme or project achieves the results as defined in the project document or annual work plan.

Financial records, including documentation to support entries on accounting records and to substantiate charges against contributions, will be maintained in accordance with the WHO FCTC Secretariat's usual accounting procedures, financial regulations, rules, policies, procedures and directives, including as to the retention period.

This project, funded by contributions from DH, will be exclusively subject to the external and internal auditing procedures provided for in the financial regulations, rules and policies of the WHO FCTC Secretariat. In the event that DH becomes aware of information that would indicate a need for further and closer scrutiny of the project funded by contributions from DH under this Arrangement, DH agrees to bring this information promptly to the attention of WHO's Office of Internal Oversight Services (IOS) for examination.

The reports to be provided to DH by the WHO FCTC Secretariat, will be prepared in accordance with the WHO FCTC Secretariat's accounting and reporting regulations, rules, policies, procedures and directives. Narrative reports will describe how value for money and results have been achieved against the indicators contained in the relevant Contribution Arrangement and shall relate to the financial reports. The financial reports will be prepared in US\$.

If commodities are made available through this project to support LMICs, those assets will be recorded in an asset register and will be monitored and managed by the WHO FCTC Secretariat. At the end of the project, DH and the WHO FCTC Secretariat will agree on the disposal of the assets in such a way that WHO FCTC implementation to LMICs can continue to be supported.

DH is currently establishing a governance structure for ODA programmes of work, of which this project will also report.

We are satisfied that the project is affordable and achievable, as set out in this business case. The project is scalable depending on (a) the number of countries we are working with, (b) wider support provided to LMICs and (c) the amount of money available in any particular year.

DH will make arrangements with the WHO FCTC Secretariat that the project can be terminated by either party on the basis of a reasonable period of notice being provided.

Why this project meets the definitions for ODA

According to DFID guidance, the key decisive criteria in determining ODA eligibility is establishing "economic development and welfare of developing countries" as the main objective

ODA eligible activities must demonstrate specific welfare or development outcomes rather than merely creating the conditions where development might occur.

This project will improve tobacco control in LMICs through strengthening the implementation of the WHO FCTC. Over time, this support will lead to fewer tobacco users in LMICs and contribute to a reduction of the burden of disease attributable to tobacco as well as a reduction

Financial Case

in the economic burden and other societal costs attributable to tobacco use. Strengthening the implementation of the WHO FCTC is a specific SDG goal.

The WHO FCTC represents an evidence-based blueprint of the actions that countries need to take to reduce prevalence of tobacco use. Many countries that have high levels of implementation of the WHO FCTC have demonstrated significant declines in tobacco use in their populations.

Given the vast costs of tobacco use on public health, poverty, welfare, the environment and the economy of LMICs, this project will deliver tangible welfare and development outcomes.

6. Management Case

What are the Management Arrangements for implementing the intervention?

The Deputy Director, Tobacco Control & Physical Activity (Healthier Lives Division, DH) will be the senior responsible owner of the project and will lead DH governance oversight. To assist in this task, DH will provide staff resources (likely 1 x G7 and 1 x SEO/HEO) to be funded through the ODA Admin budget. These staff will under a number of other tasks in support of this project and in support of DH's wider ODA programme of work.

As the WHO FCTC Secretariat will be the primary delivery partner for this project, the Head of the WHO FCTC Secretariat will be responsible for the management and delivery of the project plan that is agreed with DH before funds are dispersed.

To support the Head of the WHO FCTC Secretariat, a DH secondment to the WHO FCTC Secretariat will be facilitated, to be funded through the project. The WHO FCTC Secretariat, with the agreement of DH, will be able to employ additional professional or general staff on a fixed term basis to support the delivery of the project.

What are the risks and how these will be managed?

Risks	Probability (3 high, 1 low)	Impact (3 high, 1 low)	Mitigation strategy
Fiduciary	1	3	-DH will monitor through oversight reporting, and will investigate irregularities closely.
Lower level of commitment by countries to WHO FCTC implementation than expected	1	3	-LMICs for direct, intensive support to be selected on the basis of criteria to include a high level of motivation for tobacco control in the government -Continued dialogue with governments, including through UK diplomatic routes. -Continued advocacy, including through WHO and UN in-country teams and civil society -DH will review progress annually and withhold payment if there is insufficient progress
Insufficient funds	1	2	-Level of funding likely to be sufficient -WHO FCTC Secretariat to adjust work plan to take into account available

Management Case

			funds
Insufficient capacity within WHO FCTC Secretariat	3	3	<ul style="list-style-type: none"> -Secondment of one DH official to the WHO FCTC Secretariat to bolster capacity -WHO FCTC Secretariat able to employ additional staff on a fixed term basis, with agreement of DH -UK experts to be made available, as required -Consultants can be engaged
Insufficient national capacity	2	2	<ul style="list-style-type: none"> -LMICs to receive direct, intensive support -LMICs able to access support to build capacity through project -Depending on need, additional resources from organisations such as VSO can be considered
Insufficient co-ordination between WHO HQ, regions and countries	2	2	<ul style="list-style-type: none"> -Key stakeholders to be mapped -WHO FCTC Secretariat to develop an engagement and communications strategy -WHO TFI and WHO Regional Tobacco Coordinators to be involved in project design

What conditions apply (for financial aid only)?

Not applicable.

How will progress and results be monitored, measured and evaluated?

Progress will be assessed through use of a detailed monitoring and evaluation plan to be agreed between DH and the WHO FCTC Secretariat. Every six months, the WHO FCTC Secretariat will provide a report to DH summarising project performance and results for the duration of the project. Detailed reporting requirements will be included in the Arrangement that will be in place between DH and the WHO FCTC Secretariat.

DH ODA Admin funded staff will closely monitor project performance and delivery.

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ANNEX A

Article 5 of the WHO FCTC

Article 5

General obligations

1. Each Party shall develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with this Convention and the protocols to which it is a Party.
2. Towards this end, each Party shall, in accordance with its capabilities:
 - (a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and
 - (b) adopt and implement effective legislative, executive, administrative and/or other measures and cooperate, as appropriate, with other Parties in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke.
3. In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.
4. The Parties shall cooperate in the formulation of proposed measures, procedures and guidelines for the implementation of the Convention and the protocols to which they are Parties.
5. The Parties shall cooperate, as appropriate, with competent international and regional intergovernmental organizations and other bodies to achieve the objectives of the Convention and the protocols to which they are Parties.
6. The Parties shall, within means and resources at their disposal, cooperate to raise financial resources for effective implementation of the Convention through bilateral and multilateral funding mechanisms.

ANNEX B

Tobacco: A barrier to sustainable development

Fact sheet by Framework Convention Alliance, World Lung Foundation, The NCD Alliance and Campaign for Tobacco Free Kids.

Available at:

http://www.fctc.org/images/stories/Tobacco_sustainable_development_190315.pdf

ANNEX C

Acronyms and abbreviations

ASH	Action on Smoking and Health (UK)
COP	WHO FCTC Conference of the Parties
DALY	Disability adjusted life years
DFID	Department for International Development (UK)
DH	Department of Health (UK)
GDP	Gross domestic product
HR	Human resources
IA	Impact assessment
LMICs	Low- and middle-income countries
NCD	Non-communicable diseases
NCM	National Coordinating Mechanism
NHS	National Health Service (UK)
NGO	Non-governmental organisation
ODA	Official development assistance
QALY	Quality Adjusted Life Year
Q&A	Questions and answers
RCP	Royal College of Physicians
SSA	Sub-Saharan Africa
SDG	Sustainable Development Goals
SDP	Shared Delivery Plan (DH)
TAPS	Tobacco advertising, promotion and sponsorship
UNDP	United Nations Development Programme
UK	United Kingdom
UN	United Nations
UNIATF	United Nations Interagency Task Force
VfM	Value for Money
WHO	World Health Organization
FCTC	Framework Convention on Tobacco Control