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Challenges of Implementation of the WHO Framework Convention on Tobacco Control (FCTC) – a case study of Ghana

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Edith Koryo Wellington (MA)

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ABSTRACT

The WHO FCTC has been an important driving force for the implementation of tobacco control legislation globally. Progress in the implementation of tobacco control legislation varies across countries and policy domains. The FCTC has generally had a positive impact. In spite of some achievements, effort is needed to advance progress to overcome barriers to the effective implementation of the WHO FCTC (1). While there is noteworthy progress in countries around the world, significant challenges remain in the successful implementation of the Treaty's provisions. This study identified and explored 'Challenges of the Implementation of the WHO Framework Convention on Tobacco Control (FCTC)' using Ghana as a case study.

Method: A qualitative case study approach involving documentary analysis, focus group discussions, and in-depth interviews was used. The study sampled officials of government agencies, development partners, professional groups, civil society organizations, and educational and research institutions. The conceptual framework that was used combined the components of two health policy frameworks, namely, the Walt and Gilson framework (2,3) and the Shiffman and Smith framework (4,5). The overlapping and unique components in these frameworks aligned with articles in the WHO FCTC and were used in analysing and discussing this study.

Results: Official documents captured tobacco control under NCDs prevention and control as a priority, but the observed limited funding suggests otherwise. Constraints to FCTC implementation were delay in government release of funds, and competing health programs. Ghana still focuses more on communicable and infectious diseases, and tobacco control is not captured in the medium-term framework. The need for stronger collaboration with stakeholders; developing a policy and strengthening capacity; gathering local data on the incidence of NCDs and mortality rates were issues that were raised to get tobacco control on the agenda as a priority. In order to facilitate access intensified advocacy, clear guidelines on fund disbursement and utilization, prioritization of tobacco control by the government (Ministry of Health/Ghana Health Service); mobilizing funds to overcome constraints to FCTC implementation by the government, and strengthening collaboration between the Ministry of Health and departments and ministries of other sectors.

Conclusion and Recommendations: There is inadequate funding to meet the goals of the FCTC. The government needs to develop a plan of continuous funding of tobacco control through increased budgetary allocations and imposition of higher taxes on tobacco and alcohol (‘Sin tax’). Furthermore, there is a need to undertake effective lobbying for improved prioritization for tobacco control.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Dedication

This dissertation is dedicated

To my late dad (E.K. Amanor) and mom (Mary B. Amarh)

(For everything you've done and taught me to celebrate and embrace life. I could not have asked for better parents);

To my late dear sister Mary Dede Nuer

(For what we share as siblings-You called a week before you passed, promised to attend my graduation but you are no more, gone to be in a better place);

And to the late Sophia Twum–Barima (formally of WHO Ghana)

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“Ebenezer, Thus far the Lord has brought me” (1 Sam. 17:12) **Amen.**

LIST TABLES

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ABBREVIATIONS

AAAA	Addis Ababa Action Agenda
AFRO	Regional Office for African
AFROX	Africa Oxford Cancer Foundation
AIDS	Acquired Immunodeficiency Syndrome
ATSA	African Tobacco Situational Analysis
BAT	British American Tobacco
CAADP	Comprehensive Africa Agriculture Development Programme
CDC	Centre for Disease Control and Prevention
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
COP	Conference of Parties
CSG	Cancer Society of Ghana
CSO	Civil Society Organization
CVD	Cardiovascular Diseases
DALY	Disability Adjusted Life Year
DFID	Department for International Development
FAMRI	Flight Attendant Medical Research
FCTC	WHO Framework Convention of Tobacco Control
FDA	Food and Drugs Authority
GETFund	Ghana Education Trust Fund
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GHPSS	Global Health Professions Students Survey
GHS	Ghana Health Service
GoG	Government of Ghana
GSPS	Global School Personnel Survey
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HIV	Human Immunodeficiency Virus
IDRC	International Development Research Centre
IGF	Internally Generated Funds

INTERPOL	International Criminal Police Organization
IUHPE	International Union for Health Promotion and Education
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle-Bu Teaching Hospital
LMICs	Low and Middle Income Countries
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MOE	Ministry of Education
MOFA	Ministry of Food and Agriculture
MOFE	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MPOWER	Monitor-Protect-Offer-Warn-Enforce-Raise
NCDs	Non-communicable Diseases
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
ODA	Official Development Assistance
SDGs	Sustainable Development Goals
SHS	Second Hand Smoke
STEPS	WHO STEPwise Approach to Chronic Disease Risk Factor Surveillance
SWAP	Sector Wide Approach
TB	Tuberculosis
TDF	Tourism Development Fund
TRIPS	Trade-Related Aspects of Intellectual Property
UN	United Nations
WCO	World Customs Organization
WHO	World Health Organization
WTO	World Trade Organization
WNTD	World No Tobacco Day

CHAPTER 1: INTRODUCTION

Tobacco control is critical to a nation's development and health because of the significant burden of morbidity and mortality associated with the tobacco epidemic. Tobacco use is responsible for the deaths of around six million people every year at the global level. More than five million deaths result from direct use and more than 600,000 from exposure to second-hand smoke (6,7). Importantly, the burden will be considerably experienced by low and middle-income countries where 80 % of the global eight million tobacco related deaths are expected to occur. This represents a striking reversal of the epidemic as smoking rates decline in developed countries where policies and programmes have been implemented as a result of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) (6,8,9).

Because of the high human, social, and economic cost to society over the years, national and international authorities have undertaken actions to reduce tobacco consumption, and promoting the implementation of effective regulations for the production, marketing and consumption of tobacco (10).

The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) (11) is a significant breakthrough in combating the tobacco epidemic. It is the first global public health treaty based on evidence and is an international, legally binding instrument. It reaffirms the right of all people to the highest standard of health and provides new legal dimensions for cooperation in tobacco control. As with any other treaty, the WHO FCTC confers legal obligations to the countries that have signed it and binds them to comply with its regulations. In 2003, member countries of the World Health Organization unanimously endorsed the Framework Convention on Tobacco Control (FCTC), the product of four years of inter- governmental negotiations. Currently, there are 180 signatories to the WHO FCTC (11).

While the overall rate and extent of global progress in the implementation of tobacco control legislation varies across countries and policy domains, the Convention has generally had a positive impact on tobacco control. Yet, significant challenges remain in the successful implementation of the Treaty's provisions. These include trade liberalization, foreign

investment, tobacco advertising, cross-border promotion and sponsorship and illicit trade of tobacco and tobacco products which have both national and global dimensions (11). An important first step is to examine how countries have been able to implement and enforce the FCTC policies, measure the impact of their actions on tobacco control, and then the lessons learned, to enhance tobacco control effectiveness in all countries.

Ghana ratified the WHO FCTC on 29 November 2004 and was among the first 40 countries to do so. The treaty therefore entered into force on 27 February 2005 for the country; the same day that the WHO FCTC became international law. Since signing and ratifying the WHO FCTC, Ghana has made some progress in its tobacco control efforts in terms of engaging actively in the Conference of Parties (COP), and in awareness creation activities such as commemorating the annual World No-Tobacco Day, sensitizing Parliamentarians, health professionals, and notably, passing its tobacco control legislation in 2012. The tobacco control legislation is part of the Public Health Act 581 (12).

In this study, I examine some theoretical and practical questions with regard to tobacco control with Ghana as a case study. As a lower middle income country, Ghana is currently in Stage 1 of the tobacco epidemic. Yet, the risks of increased mortality rates in adults in relation to tobacco use presents a threat to the country (9,13–15). As such, Ghana presents a useful example to examine the opportunities and challenges of the implementation of the WHO FCTC in the context of a lower middle income country with a relatively low level of tobacco use currently.

I used a conceptual framework that combined the components of two health policy frameworks, namely, the Walt and Gilson framework (2,16–18) and the Shiffman and Smith framework (4,19). The overlapping and unique components in these two frameworks focusing on the health policy process (Walt and Gilson) and the shaping of health policy and its priority (Shiffman and Smith) align with the articles in the WHO FCTC framework which are core to achieving tobacco control.

Using the above conceptual framework, I examined the practical issues of health policy development and implementation and its prioritization within the national agenda, in the context of the implementation of the WHO FCTC in Ghana.

The second chapter consolidates the key issues and practices related to the implementation of the FCTC in general and in Ghana specifically. While there are ostensible gaps in the literature on FCTC related practices in Ghana, global practices related the implementation of the FCTC is rich in country case studies and situational analyses. These provide a useful lens to the interpretation of the findings of my study.

The third chapter addresses the Ghana context and the implementation of the WHO FCTC. I conducted a document review specifically on Ghana which involved a thorough study of existing documents to understand their substantive content and deeper meanings which may be revealed by their style and coverage. Public documents like organizations 'annual reports, government papers or publicity materials, procedural documents like the financial accounts of the Ministry of Health (MOH), Ghana Health Service (GHS), and the WHO, and media reports (20,21) were gathered. A further reason for drawing on a range of document sources is that it is not always possible to engage in direct observation or questioning (21,22).

While the fourth chapter discusses the conceptual framework mentioned earlier, the fifth describes the methods used in terms of approach, i.e. the case study method and how it guided the data collection with the stakeholders. It also outlines the process of analysis used.

The results of the research are presented in chapters six to eight. Chapter six highlights and discusses the overall progress and the implementation of the WHO FCTC in Ghana. Next, in chapter seven, I elaborate on the findings related to governance. Focusing on formal and informal actors involved in decision making, I explore the role of funding agencies in relation to the government of Ghana and its policy making and implementation process. The internal challenges of the FCTC demand reduction provisions are examined in relation to the Article 6 of the WHO FCTC in chapter eight.

Chapter nine reviews the findings on the supply reduction provisions in relation to Articles 17 and 18 of the WHO FCTC. Thus, complementary but critical issues of the tobacco industry which are related to tobacco control are presented and discussed here. These include the issues of tobacco farming and alternative cropping.

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Chapter ten examines government strategies to prioritize tobacco control and NCDs in the national agenda. It discusses the issues of resource mobilisation for tobacco control and NCDs, and the implementation of its WHO FCTC commitments. In this section, key stakeholders' role in agenda setting, policy process, and formulation are discussed.

Finally, in chapter eleven I consolidate the findings of the overall research using the conceptual framework that was developed for this study. I contextualize the findings of the study within the national and global discourses, on the topic and make recommendations before concluding the dissertation.

CHAPTER 2: LITERATURE REVIEW

This chapter provides an overview of the global tobacco epidemic and the WHO FCTC. Additionally, the tobacco burden and a detailed description of the tobacco situation globally are provided for contextual background for the study. The chapter ends with a review of research on FCTC implementation.

2.1. History of Tobacco Smoking

Tobacco has been cultivated by the indigenous peoples of the Americas and Cuba since about 5000-3000 BC for medicinal, religious and social purposes. The later migration to and colonization of the American continents and Cuba by explorers resulted in tobacco becoming a commodity of success and pleasure. In 1492 the crew members of Christopher Columbus's ship became the first known Europeans to smoke tobacco. The medicinal purposes attributed to Nicotiana by the Native Americans were the reason that its seeds were taken to Spain and Portugal for cultivation. From Spain, tobacco spread to Great Britain, to the remaining European nations, and then to the rest of the world. Many provinces and nations eventually began to cultivate their own tobacco because it was expensive and because of its claimed cancer prevention property (23,24).

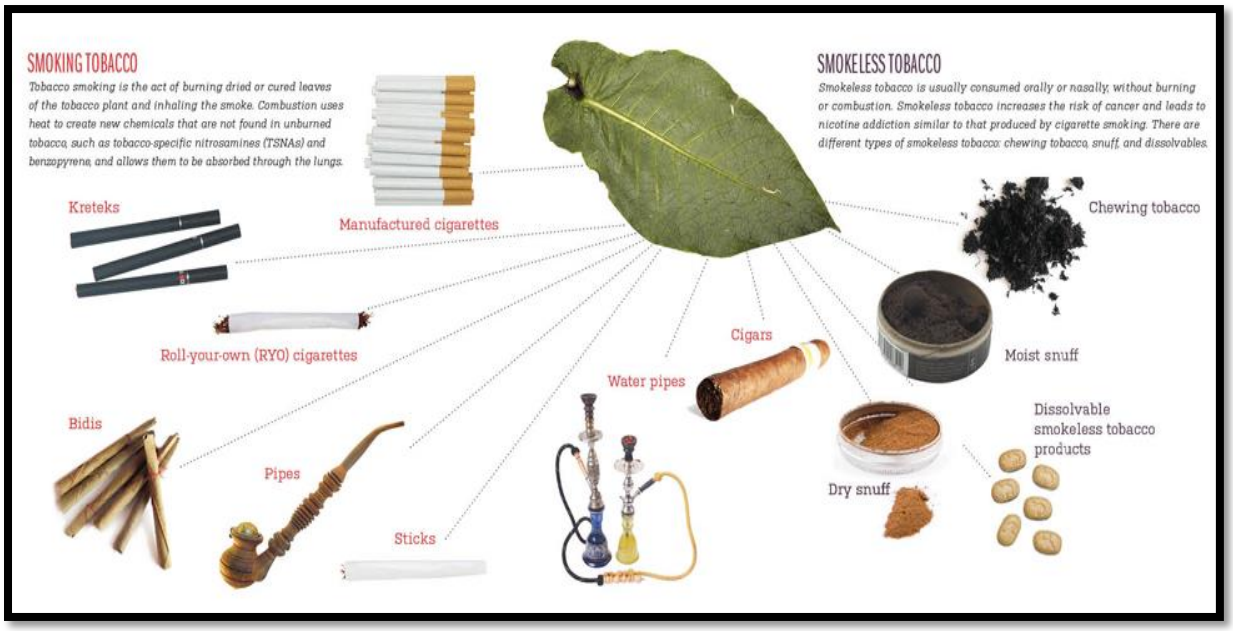
Tobacco was initially used in religious rituals and for medicinal purposes (25) but later on, people smoked for pleasure. Snuff, which is powdered tobacco, was later introduced by the French. When machines were made to produce cigarettes and tobacco farming improved, tobacco became more available and tobacco smoking became very widespread (25).

The use of various tobacco products varies from one region of the world to the other, but the most popular tobacco product used globally still remains the cigarette (15). Other tobacco products which are either smoked or smokeless include kreteks, bidis, roll-your-own (hand rolled) cigarette and pipes, dry or moist snuff (finely ground powdery tobacco leaves already cured), water pipes (also called hookah or shisha), chewable and dissolvable tobacco (15).

New forms of tobacco (and of its component nicotine) - are constantly being invented. Examples of products include nicotine water, lollipops, electronic cigarettes, snus, orbs and lozenges. The use of e-cigarettes and other novel nicotine products, are currently unregulated in most countries, yet these products are growing in popularity (23,24,26,27) and thus pose a grave challenge to countries seeking to reduce the tobacco epidemic among the youth who are prone to experimentation. Besides, older forms of tobacco historically localized to specific regions of the world (such as the water pipe and bidi) are becoming global. Indeed, water pipe use is also on the rise among adolescents and young adults on college campuses and beyond, even among people who explicitly refuse to smoke cigarettes (23,24,26,27).

Despite the introduction of many new forms of tobacco, there is still no safe way of using tobacco - whether inhaled, sniffed, sucked or chewed; whether some of the harmful ingredients are reduced; or whether it is mixed with other ingredients (27). Figure 1 shows some different images of different types of tobacco (28).

Figure 1: Different Types of Tobacco



All forms of tobacco contain nicotine and can be addicted and causes health problems. There is no nontoxic or harmless form of tobacco (33)

2.2. The Problem of Tobacco

The problems related to the tobacco industry link to tobacco farming, tobacco product manufacturing, and tobacco distribution and sales. The overall impact of tobacco-control

policies on the economy depends on the structure of the tobacco industry in each individual country. Countries and regions growing primarily tobacco will face challenges different from those in tobacco manufacturing countries and regions (29).

2.2.1. Tobacco Farming

Tobacco leaf is grown in over 125 countries, three quarters is grown in developing countries (30). Over the past 50 years, tobacco farming has shifted from high to low-and middle-income countries. Tobacco farming is extremely labour-intensive, starting from preparation of seedbeds, transplanting of seedlings, caring for the plants, harvesting of leaves as they mature and the curing of leaves. Tobacco farming also requires expensive inputs such as fertilizers, pesticides and other chemicals. The tobacco crop generates many unique and serious occupational health hazards, due to frequent applications of pesticides, which expose farmers to a range of risks that include genetic damage, nausea, muscle twitching and convulsions, and respiratory problems, kidney damage and skin and eye irritation (31–34).

World production of tobacco leaf has continued to grow since 2003, up 25% from 6.03 million tons in 2003 to 7.5 million tons in 2012. African countries produced 650,000 tons, or 8.7% of the world production of tobacco leaf in 2012, compared to 440,000 tons or 7.3% in 2003. Total area harvested for tobacco in African countries increased by 66% and output increased by 48% (35). Most of the world's tobacco is now grown in low-and middle-income countries, where growth in tobacco consumption is greatest (36).

Many farmers and government officials believe that tobacco is a cash crop essential to their economic success. The short-term benefits of a crop that generates cash for farmers are offset by the long-term consequences of increased food insecurity, frequent sustained debt, environmental damage, and illness and poverty among farm workers. Food insecurity and poverty is a concern in many of the world's largest tobacco-growing countries (34,37,38).

Tobacco farming in most countries makes up a tiny proportion of employment in the agricultural sector. Even in China, the largest tobacco producer in the world, only about 3% of farmers grow any tobacco at all, and tobacco constitutes only about 1% of the value of all agricultural output. However, there are a few countries namely Malawi and Zimbabwe-which are heavily dependent on tobacco farming and raw tobacco and therefore employs a

substantial number of people, the vast majority of whom earn very little, while the big tobacco companies reap enormous profits (31,38).

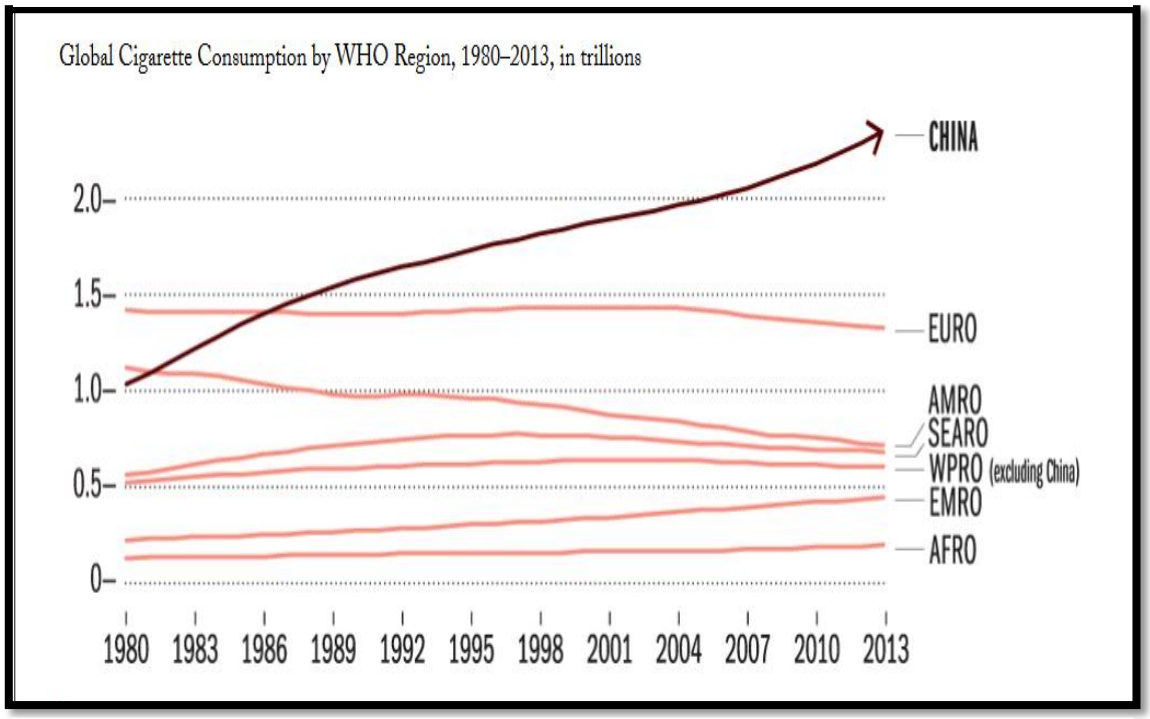
Research indicate that many tobacco farmers would like to switch to alternatives, but they often face considerable challenges, including access to credit, markets, technical assistance, inputs and skills and the roads and other public infrastructure. Initiatives to diminish these barriers, protected from interference by the tobacco industry, will assist small farmers in securing long-term sustainable livelihoods (39–41).

2.2.2. Tobacco Product Manufacturing

There are well over 500 cigarette factories world-wide. The manufacturing side of the tobacco industry is only a small source of jobs, since it is usually mechanized. In most countries, tobacco manufacturing jobs account for well below 1% of total manufacturing employment (31,42). These factories collectively produce nearly 6 trillion cigarettes every year. In recent years, publicly traded tobacco companies have consolidated through privatization and mergers. Today, there are five major private companies: Philip Morris International, Altria/Philip Morris USA, Japan Tobacco International, British American Tobacco and Imperial Tobacco. In addition to these corporations, there are sixteen state-owned tobacco companies that are the leading cigarette manufacturers in specific countries. China National Tobacco Corporation is the largest state-owned tobacco company producing more cigarettes than any other country in the world (42).

The global demand for cigarettes has been steadily growing, both in value and volume. This growth, however, is largely driven by only one region, namely, the Asia Pacific. From 2001 to 2011, the demand for cigarettes grew 5.9% in Vietnam, 41% in China, 34% in Indonesia, 32% in the Philippines, and 15% in India (43).

Figure 2: Consumption of Tobacco by WHO Regions, 2013

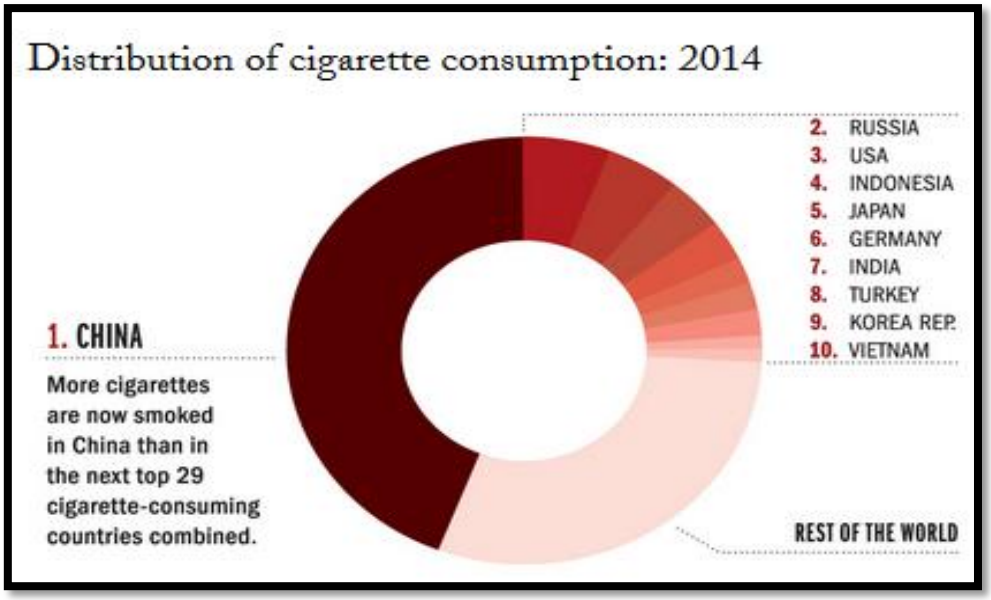


As shown in Figure 2, in the year 2013, a regular smoker in China smoked 22 cigarettes a day. According to the Tobacco Atlas and Ng et al this is almost 50% more than in 1980. The inconsistent increase in the number of cigarettes smoked in China is a combined effect of China's population growth and an increase in smoking intensity (52,53)

Several pull factors have contributed to the shift toward Asia, including a growing consumer class in China and other Asian countries, evolving cultural norms about the desirability of smoking-particularly as a symbol of modern masculinity, and the growing presence and marketing of global tobacco brands in Asia due to trade liberalization (44,45).

Various push factors have contributed to this decline, driven to a large extent by public health concerns regarding the negative impact of smoking, and also by economic factors. These economic factors include more stringent tobacco regulations as a result of the FCTC ratification and implementation, taxation and higher prices (also related to tobacco control) and lower consumer spending power during the economic recession (46).

Figure 3: Top Cigarette Consumers



The largest number of cigarettes consumed by average person per day is in Southern and Eastern Europe, and China. This is due to the smoking intensity and high smoking prevalence (49,52).

2.2.4. Trade, Health and Tobacco

An important dimension of the economic aspects of tobacco control is it is link to trade. The relationship between trade and health forms part of a long history of commercial exchange between human societies, dating from the 19th century BC through the extension of trade to India and China along the Silk Road and the expansion of trade by sea from the 15th century onward (47). As trade has evolved in geographic reach, scale, mode, and type of commodity, so too have the human health implications. Most directly, the coming together of human populations through trade can spread communicable diseases, and commodities exchanged also have the potential to harm (e.g., tobacco) or promote (e.g., fruits and vegetables) health.

Public health advocates argue that trade in goods with the potential to harm, such as arms, tobacco and toxic and hazardous waste (known as "public bads") should be restricted and that such goods should not be included in trade liberalization efforts (48,49). Weissman argues that 'there is no legitimate purpose for inclusion of tobacco products in trade agreements, which are designed to facilitate trade and remove tariff and nontariff barriers to commercial transactions—an inappropriate goal for tobacco products, consumption of which is harmful.

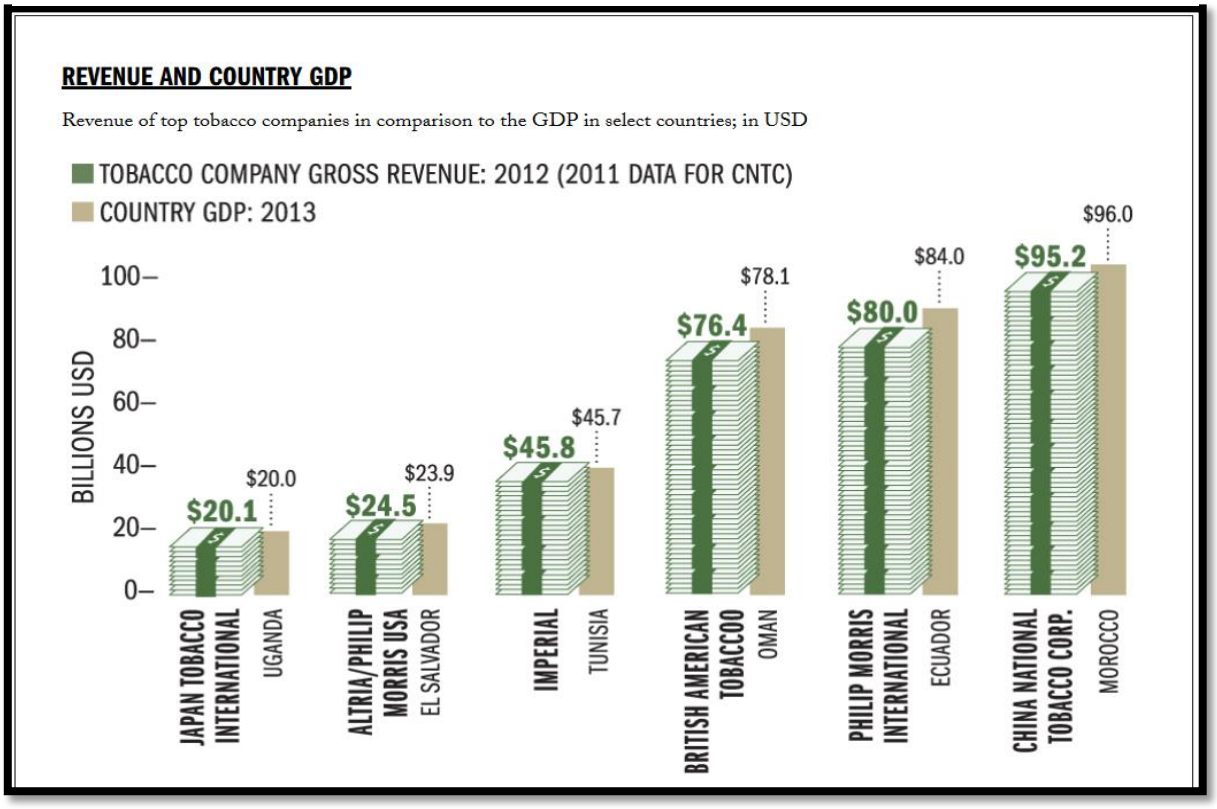
He concludes there is a simple solution to the problems posed by trade agreements to tobacco control: tobacco products should be excluded from their purview (50). However, such arguments have been successfully opposed by the industries behind such trade, often with the support of major governments, in order to protect their economic interests (50,51).

2.2.3.1. Revenues

Estimates of revenues from the global tobacco industry vary widely but likely approach half a trillion dollars annually. In 2013, the total revenue for the six leading tobacco companies was USD35.1 billion (15). This was equal to the combined profits of The Coca-Cola Company, Walt Disney, General Mills, FedEx, AT&T, Google, McDonald's and Starbucks in the same year (27). Although tobacco is ultimately a financial burden on the governments and health-care systems of countries, it is also a source of government revenue, through tobacco taxes and additional profit for those countries with state-owned companies. For example, the tobacco industry in China contributes over 7% of the central government's total revenue each year. In China, the tobacco industry has become a giant state-owned enterprise with annual net profits of USD26.2 billion in 2012, far bigger than the Bank of China or the Petro China Company (15,52).

The Tobacco Atlas in the Figure-4 reveals the billions of dollars made annually in revenue and profit by six top tobacco companies which is equivalent to the in some selected countries. In the lead is Morocco followed by Ecuador, Oman, Tunisia, El Salvador and Uganda (53).

Figure 4: Revenue of top tobacco companies and Countries Gross Domestic Product (GDP)



The positive economic impact of tobacco on the economy cannot be overlooked in developing countries. Tobacco leaf exports in the five African countries- Malawi, Zimbabwe, Mozambique, Tanzania and Zambia, which are among the top 20 tobacco leaf growers, plays an important role in export trade. The total export value of tobacco leaf from these five countries grew more than 70% from around USD 960 million in 2000 to USD 1.65 billion in 2011. The export value for the entire African continent increased from USD 1.03 billion in 2000 to USD 1.79 billion in 2011, marking a74% increase (34).

Malawi is one of the world's leading tobacco-producing countries. But, it is one of the world's most tobacco-reliant countries, and the crop contributes to 60-70% of its foreign exchange earnings (54). Tobacco is also among Malawi's significant contributors to annual national tax revenues (55). Yet, it is also among the poorest countries in the world.

Tobacco is one of Uganda's prime traditional exports and its production contributed about USD 77,000 to the country's foreign exchange earnings between 2011 and 2015 (56).

Zimbabwe has a long history of tobacco growing and in 2013 it was the sixth largest tobacco producer in the world. The Zimbabwean government regards tobacco as the mainstay of Zimbabwe's economy. According to Zimbabwe's Tobacco Industry and Marketing Board, 98% of Zimbabwe's tobacco is exported, making it the country's largest foreign currency generator-accounting for 10-43 % of the country's gross domestic product (57). With the exception of Malawi, Zimbabwe receives a higher percentage of government revenue from tobacco leaf than any other country in the world (58), partly due to a levy system that taxes both growers and buyers (59).

Tobacco is a major source of employment: there are over 90,000 small scale tobacco farmers in Zimbabwe (57,60). Though Zimbabwe's economy is experiencing some economic strains, tobacco growing is likely to continue to be a major income generator for the government (61).

The tobacco industry often uses the aforementioned economic arguments to persuade governments, the media, and public that smoking benefits the economy. It is often claimed that if control measures are introduced then revenues will fall, jobs will be lost, and other such arguments. While governments worldwide generally recognise the health consequences of tobacco smoking, many countries, particularly tobacco producing nations, have been reluctant to implement measures which they fear would have adverse economic consequences (30).

Teh-wei Hu sums up the tobacco industry's major arguments against tobacco control as follows: possible government tax revenue losses, possible industry job loss, possible tobacco farmer revenue loss, possible smuggling and possible regressive burden to low income smokers (62). While the tobacco industry often boasts of the positive economic benefits of growing tobacco, it fails to mention that the overwhelming majority of the profits go to large companies, while many tobacco farmers find themselves poor and in debt (31).

It must be emphasized that anytime it suits the business interests of the tobacco industry, it has closed down its factories, with consequent job losses. Examples include factories that have been closed down by BAT in Australia, Malaysia. Nicaragua, Papua New Guinea, Singapore, South Africa, Spain, Suriname, Switzerland and the United Kingdom (63). The

BAT even relocated to Nigeria from Ghana in 2006 after 42 years of manufacturing cigarettes (64).

In its landmark 1999 report, 'Curbing the Epidemic': Governments and the Economics of Tobacco Control, the World Bank indicated that implementing comprehensive tobacco control policies would have little or no impact on total employment in most countries. Employment would remain about the same or increase in many countries if tobacco consumption were reduced or eliminated, since spending on tobacco products would be shifted to other products and services. This is because when people quit consuming tobacco, the money they previously spent does not disappear. Rather it is redirected to other goods and services, generating demand and new jobs across the economy. Such policies could, in sum, bring unprecedented health benefits without harming-and quite possibly helping-national economies (39).

2.4. Health Effects of Tobacco – Health and Non-Health Costs

While tobacco provides benefits to the economy in the form of revenues and profits, taxes, and the creation of employment, the health risks associated with continued use of tobacco are large, both in number and in magnitude. Since 1964, the US Surgeon General has repeatedly identified cigarette smoking as the 'most important source of preventable morbidity and premature mortality' in America (65–67).

2.4.1. Health Costs

The World Health Organization has recognised tobacco use as a serious drug problem. Tobacco use is a major risk factor for heart attacks, strokes, chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis and cancer (particularly lung cancer, cancers of the larynx and mouth, and pancreatic cancer) (65–74). It also causes peripheral vascular disease and hypertension. The effects depend on the number of years that a person smokes and on how much the person smokes. Starting smoking earlier in life and smoking cigarettes higher in tar content increases the risk of these diseases. Also, environmental tobacco smoke, or second-hand smoke, has been shown to cause adverse health effects in people of all ages. Tobacco use is a significant factor in miscarriages among pregnant smokers and it contributes to a number of other health problems for the foetus such

as premature birth and low birth weight. Additionally, the chance of sudden infant death syndrome (SIDS) increases by 1.4 to 3 times. With regard to erectile dysfunction, the incidence is approximately 85 percent higher in male smokers compared to non-smokers (65–74).

Furthermore, there is a growing body of evidence that third-hand smoke –which consists of the tobacco residue from cigarettes, cigars and other tobacco products – clings to hair, skin, clothes, furniture, drapes, walls, bedding, carpets, dust, vehicles and other surfaces, even long after smoking has stopped. Infants, children, and non-smoking adults may be at risk of tobacco-related health problems when they inhale, ingest or touch substances containing third-hand smoke (75,76). Third-hand smoke cannot be eliminated by airing out rooms, opening windows, using fans or air conditioners, or confining smoking to only certain areas of a home. The growing understanding of third-hand smoke contamination reaffirms the need for more smoke-free places and for avoiding exemptions in smoke-free laws (77).

The WHO estimates that, globally, tobacco use costs the world an estimated USD500 billion each year in health care expenditures, productivity losses, fire damage and other costs. In the United Kingdom (U.K.), the total estimated costs of smoking to society could be put at GBP13.74 billion. In the United States of America, a much larger economy by population and GDP, the social cost of smoking, USD193 billion (or GBP 114 billion)is more than eight times that of UK,- according to estimates from Kahende et al. (78). About 15% of the aggregate health care expenditure in high-income countries can be attributed to smoking. In the US, the proportion of health care expenditure attributable to smoking ranges between 6% and 18% across different states. In the UK, the direct costs of smoking to the National Health Service (NHS) has been estimated at between GBP 2.7 billion and GBP 5.2 billion, which is equivalent to around 5% of the total NHS budget each year. The economic burden of smoking estimated in terms of GDP reveals that smoking accounts for approximately 1% of the GDP of the United States of America (79). Yang et al estimated the economic burden of smoking for 2008 in China at USD28.9 billion, representing 0.7% of China's GDP and 3% of national health care expenditures. According to the study, mortality costs contributed the most to smoking-attributable costs in China, followed by outpatient expenditures (80). Results from a study in Taiwan reported that the total smoking –attributable expenditures

totalled USD397.6 million, representing 6.8% of the total medical expenditures for people aged 35 years and over (81).

In Brazil, a study undertaken by the state Oswaldo Cruz Foundation and the Alliance for the Control of Tobacco use (ACT), a civil society organisation to measure the economic impact of smoking in Brazil in 2011, reported that Brazil spends some USD 10 billion a year on health care for smokers. On the other hand, the total tax revenue from Brazil's tobacco industry amounted to USD three billion; less than one-third of state expenditure on treating patients with tobacco-related diseases (82,83).

In Indonesia, it is estimated that the annual economic burden for the three-major tobacco-related diseases is at least IDR 39.5 trillion or (USD4.03 billion) in 2011.This represents about 0.74% of the Indonesian GDP of the same year or equals to 29.83% of total health care expenditure. The high proportion of the expense went to COPD treatment, followed by treatment of lung cancer and ischemic diseases (84).

The above statistics indicate that smoking everywhere is very costly in many respects and takes a huge toll on public finances. For most countries, smoking-attributable costs represent the largest single expenditure in total health care costs, with wider implications for the economy (79).

2.4.2. Poverty and Tobacco

According to the WHO, tobacco and poverty are inextricably linked. Many studies have shown that in the poorest households in many low-income countries, spending on tobacco products often represent more than 10% of total household expenditure. Consequently, these families have less expendable income for basic necessities such as food, shelter, education and health care. Tobacco can also worsen poverty among users and their families since tobacco users are at a much higher risk of falling ill and dying prematurely of cancers, heart attacks, respiratory diseases and other tobacco-related diseases, depriving families of much-needed income and imposing additional costs for health care. Several studies from different parts of the world have shown that smoking and other forms of tobacco use are much higher among the poor (31,85–91).

In a study ‘Socioeconomic Implications of Tobacco Use in Ghana, using data from the 2008 Ghana Demographic and Health Survey, a nationally representative survey of 12,323 households, the authors, analysed and explored the association between tobacco use and poverty in Ghana. This analysis indicated that there are more smokers in rural areas than in urban areas. The Northern, Upper East and Upper West regions have a higher prevalence compared with other regions. These are also the regions where chronic food insecurity is widespread and livelihoods are more vulnerable than in the south of Ghana. Regional variation is also manifest in the strong income gradient in tobacco usage as poverty levels are elevated in the three regions. The prevalence of tobacco use increases steadily down the income gradient. The study also found that the odds of having health insurance among current tobacco users was 43% lower than for nonusers. They suggested that this result was most likely due to the diversion of scarce disposable income to meet the needs of addictive behaviour, which crowds out expenditure on health insurance, just like other household expenditures. This finding means that despite having higher health care needs, tobacco users are having lesser access to health insurance and this leads to further impoverishment among them (92).

Tobacco and poverty are linked not only at the consumption level, but also at the production level. Small-scale tobacco farmers in developing countries often depend heavily on the tobacco industry. In a number of countries, the tobacco companies operate a ‘contract system’, whereby the companies provide credit in the form of seeds, fertilizer, pesticides and technical support and farmers usually become obligated to sell all of their tobacco leaf to the company at a set price. Under this system, the selling price of the tobacco leaf sometimes ends up being less than the value of the initial loans, making it difficult for farmers to have any production flexibility or to switch to other crops as they remain condemned to a cycle of indebtedness towards the tobacco industry (31,87,93).

Tobacco not only impoverishes many of those who use it; it also puts an enormous financial burden on countries. The costs of tobacco use to countries include increased health-care costs, lost productivity due to illness and early death, foreign exchange losses, lost revenues on smuggled cigarettes and environmental damage (31).

The negative impact has been acknowledged through various studies over six decades, both in the field of health epidemiology and health economy since the Doll and Hill study in 1950 showing links between smoking and lung cancer (94), followed by the US Surgeon General's report in 1964 which concluded, "cigarette smoking contributes substantially to mortality from certain specific diseases and to the overall death rate", (95) (p.31) it is estimated that there are about 70,000 scientific papers written on the harms caused by smoking (96).

However, the truth of these studies has often been concealed by the tobacco industry as it spelled dire consequences for the global tobacco industry. The tobacco industry prevented the truth on the harm of tobacco use from being known (97). They began to create doubts about the results of these studies using a denialism strategy (98,99). Basically, this strategy creates the impression that there has not been any scientific consensus about the negative effects of smoking. In reality, researchers hired by the tobacco industry themselves knew about the dangers of smoking (100).

2.5. Conflict of Interest between the Tobacco Industry and Public Health

According to the WHO, 'effective tobacco control is, almost by definition, antithetical to the economic interests of the tobacco industry, associated industries, and entities or persons working to further the tobacco industry's agenda. Those interests depend largely on the prosperity of the tobacco industry and its means for ensuring its real or perceived commercial well-being. The primary goal of tobacco control is to prevent tobacco-caused disease and death' (101) (p.1). Furthermore, the objectives of tobacco control which include -preventing uptake, maximizing cessation, and prohibiting smoking in public places-stands in direct opposition to the commercial objectives of the tobacco industry. Thus, when tobacco control succeeds, the tobacco industry fails (101).

The tobacco industry also sabotaged the tobacco control movement from within and created a matching framework to oppose WHO's global health treaty, the FCTC (102–105). The various tactics employed by the tobacco industry to conceal and sabotage the truth about the negative impact of tobacco consumption came to global light in the 1990s after US Attorney-General took the top tobacco companies to court to recoup medical costs. The companies

were ordered to disclose all their internal documents-40 million pages- because they lied to the public. Consequently, numerous publications uncovered how these transnational tobacco companies lied, misled, and subverted the truth about smoking (106–108).

2.5.1. Tobacco Industry versus Tobacco Control

In 2000, the WHO committee of experts on the tobacco industry documents published their report 'Tobacco industry strategies to undermine tobacco control activities at the World Health Organization' This report summarizes evidence obtained from internal tobacco industry documents of actions taken to influence and undermine WHO tobacco control policies and programmes. The committee found that 'the evidence shows that tobacco companies have operated for many years with the deliberate purpose of subverting the efforts of WHO to address tobacco issues. The attempted subversion has been elaborate, well financed, sophisticated and usually invisible. That tobacco companies resist proposals for tobacco control comes as no surprise, but what is now clear is the scale, intensity and most importantly, the tactics, of their campaigns' (109) (p.iii).

In 2001, at the 54th World Health Assembly, the member states unanimously adopted a resolution calling for transparency in tobacco control (110). Resolution WHA 54.18 urges member states to 'be aware of affiliations between the tobacco industry and members of their delegations and be alert to any efforts by the tobacco industry to continue its subversive practice and to assure the integrity of health policy development in any WHO meeting and in national governments. The resolution also calls on WHO 'to continue to inform member states of activities of the tobacco industry that have a negative impact on tobacco control efforts' (111).

The WHO FCTC contains several articles that address the protection of international tobacco control from tobacco industry interference. The Convention emphasizes 'the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts' (11,112).

Under the FCTC treaty's general obligations, the signatories agree to protect tobacco control policies from tobacco industry interference. Specifically, Article 5.3 states: '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'. Article 12.C stresses the importance of public education and awareness about tobacco industry activities, and Parties agree to promote 'public access, in accordance with national law, to a wide range of information on the tobacco industry as relevant to the objective of this Convention.' Article 12.E reiterates the importance of the 'participation of public and private agencies and nongovernmental organizations not affiliated with the tobacco industry in developing and implementing inter-sectoral programmes and strategies for tobacco control (11,112).'

The fundamental conflict of interest that exists between the tobacco industry and public health has been recognised in various fora, including the United Nations Economic and Social Council, through its resolution UN System-Wide Coherence on Tobacco Control, 2013 (113), and in the Political Declaration of the High-Level Meeting of the UN General Assembly on the Prevention and Control of Non-communicable Diseases of September 2011 (114).

2.5.1.1. Tobacco Industry Tactics

The tobacco industry has historically used several tactics to shape and influence tobacco control policies (108,115,116). The tobacco industry has used the same tactics and arguments over time and across jurisdictions, including presenting highly misleading economic arguments, using corporate social responsibility to gain governments' favour, using litigation or threat of litigation (117), and manipulating science through its economic power, lobbying and marketing and manipulation of the media to discredit scientific research and influence governments in order to propagate its sale and distribution. Furthermore, the tobacco industry continues to inject large philanthropic contributions into social programmes world- wide to create a positive public image under the guise of corporate social responsibility and as a way of establishing a dialogue with health authorities and governments (118,119). In 2012, the issue of the tobacco industry's interference was the theme of the WHO World No Tobacco Day (101).

Evidence indicates that the tobacco industry has operated for years with the express intention of subverting the role of governments and WHO in implementing public health policies to combat the tobacco epidemic. Its goal is to maintain the social acceptability of smoking and prevent the adoption of effective tobacco control regulations (15). Since tobacco is a legal

product, the tobacco industry argues that the industry is a legitimate stakeholder and that it should be involved in decisions on the development and implementation of tobacco policies. The Parties to the FCTC are however obliged under Article 5.3 to "safeguard their health policies against tobacco industry interference". It says: "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" (112).

Guidelines for implementation of Article 5.3 were subsequently developed and adopted in 2008 at the Conference of Parties to the FCTC to assist the parties to meet their legal obligations under Article 5.3. The purpose of the Guidelines is to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry are comprehensive and effective. These Guidelines acknowledge that "there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests" (120) (p.2).

The vector of the tobacco epidemic is the tobacco industry, and no campaigns to reduce tobacco can ignore the need to understand and counter this industry. The tobacco industry-whether it be the global corporations, national monopolies, or their local components-remains highly profitable, expansive, adaptive and amoral, and are a formidable opponent of tobacco control. Naively believing it is possible to work with the industry is doomed, as the remit of the industry upon which its very existence depends and its responsibilities to its shareholders, is to sell more cigarettes. The remit of the health professions is to reduce the consumption of cigarettes, which is a diametrically opposite corner of the ring (121). From a health professional's perspective, tobacco consumption is seen as the major modifiable behavioural risk factor for many health problems including cancer, heart and respiratory diseases and results in an enormous health care burden (135).

Tobacco Industry's New Tactics and the Implementation of the FCTC

Challenges to FCTC implementation have been noted in China, India, Ecuador, Ghana, Malawi, Tanzania and the African region in general. The range of challenges experienced include a lack of capacity and resource constraints, tobacco industry interference, limited

anti-tobacco civil society involvement, limited political commitment and awareness in government officials, limited local research and monitoring, and rural-urban disparity (123).

The tobacco industry is using new and more persuasive tactics to promote its image and its product, including new media, neo-libertarian front groups and legal challenges to legislation. This industry will not go quietly into the sunset (121). The conflict between the tobacco industry and tobacco control advocates have to say the least, been intense and acrimonious. From 1996, a decade-long programme by Philip Morris called Project Sunrise attempted to divide and rule the tobacco control movement, in part by attacking them as extremists (124).

There is no sign of weakening of the tobacco industry's resolve to counter control measures (125). The unrelenting nature of the tobacco industry's struggle/fight is clearly demonstrated in the International Tobacco Growers' Association of Africa's letter dated 21st September, 2016 to the UN Secretary General. The letter expresses outrage at the exclusion of tobacco growing country delegates from participation in the Conference of the Parties (CoP7) of the WHO FCTC, in Delhi India in November 2016. They contend that their exclusion 'impinges on the sacred sovereignty of these nations and undermines important principles enshrined by the United Nations Charter' (126).

The extensive documentation of the tobacco industry's tactics has led to widespread exclusion of tobacco companies from policy-making processes, both globally and nationally (127–129).

2.6. Smuggling of Tobacco Products

Cigarettes are the world's most widely smuggled legal consumer product. Smuggling has major implications for tobacco control because maintaining cigarette prices through taxation is one of the most effective ways of controlling cigarettes. Cigarettes are usually smuggled while in transit between the country of origin and the destination country and thus many fail to arrive at their official destination (130). Tobacco companies often argue that smuggling is caused by tobacco taxes being too high. However, countries where taxes are very high and cigarettes very expensive, such as Norway, Sweden and Denmark (and until recently the

United Kingdom) do not have large smuggling problems. By contrast countries in southern Europe with low taxation rates often have high smuggling rates (131).

Smuggling of cigarettes benefits the industry in a number of ways. It stimulates consumption through the sale of cheap cigarettes- (the tobacco industry gains its normal profit regardless of whether cigarettes enter the legal or illegal market). It is used by tobacco companies as a strategy for entering markets which are closed to legal cigarette imports. Smuggling can be a "market softening technique "as it establishes a demand for the smuggled brand, undermines sales of local producers' cigarettes (facilitating the cheap purchase of these companies), and enables the industry to argue the need for the local production of international brands to reduce smuggling (132).

The World Bank emphasizes that the determinants of smuggling are much more than the price alone. Other factors that play a role are insufficient border control policies and the inability of the legal and police system to fight corruption and organized crime. Cigarette smuggling causes major harm. It promotes smoking by lowering cigarette prices, creates unfair competition for legal cigarette sellers and local manufacturers, reduces government tax and import duty revenues and of course promotes corruption (133,134).

The control of cigarette smuggling requires international collaboration and the FCTC has a crucial role to play in this area. In addition to recommending that each country monitor and collect data on cross-border and illicit trade in tobacco products, and exchange such information among appropriate national and regional authorities, the FCTC recommends a series of legislative and other measures to control smuggling (11).

2.7. Global Efforts at NCDs and Tobacco Control

2.8.5. The Challenge of Chronic Non-Communicable Diseases and the Implementation of the WHO FCTC in LMIC

Chronic non-communicable diseases (NCDs) have been defined as diseases or conditions that occur in, or are known to affect, individuals over an extensive period of time and for which there are no known causative agents that are transmitted from one affected individual to another (135,136). The World Health Organization (WHO) includes in the scope of NCDs,

conditions such as cardiovascular diseases, mainly heart disease and stroke; cancers; chronic respiratory diseases; diabetes; and others, such as mental disorders, vision and hearing impairment, oral diseases, bone and joint disorders, and genetic disorders (137). A significant percentage of NCDs are caused by four main behavioural risk factors: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diet. One effective strategy to reduce the global burden of NCDs is to reduce the exposure of individuals and populations to these modifiable risk factors and to prevent emergence of the preventable common risk factors (110,138–141).

Chronic NCDs account for 60% of the estimated 58 million global deaths each year and 44% of premature deaths. The age-standardized disability-adjusted life year (DALY) rates for NCDs are higher in low and middle income countries (LMICs) than in high-income countries. Eighty per cent of chronic NCDs deaths occur in LMICs, where most of the world's population lives. People in these countries tend to develop chronic NCDs at younger ages, suffer longer, and die sooner than those in high income countries (142).

Globally, the World Health Organization (WHO) estimates that mortality from NCDs will increase, overall, by 17% in the next 10 years. The largest increase in mortality will be seen in developing countries - about 27% in the African region. Global cancer deaths are projected to increase from 7.4 million in 2004 to 11.8 million in 2030, and global cardiovascular deaths are expected to increase from 17.1 million in 2004 to 23.4 million in 2030 (137). Non-Communicable Diseases are projected to be the most common cause of death in Africa by 2020, almost equal to communicable, maternal, perinatal, and nutritional diseases. Much of the increase in the NCDs is due to globalization, rapid unplanned urbanization, population ageing, and lifestyle changes such as tobacco use, decreasing physical activity, and increasing consumption of unhealthy foods (138,142).

Non-Communicable Diseases have a high economic burden and have the potential of tipping households into poverty and maintaining them in it. The World Health Organization (WHO) estimates that in developing nations experiencing rapid economic transition, heart disease, stroke, and diabetes alone reduce gross domestic product (GDP) by between 1% and 5% each year (143). In a study of 23 LMICs, it was estimated that USD84 billion of economic

production could have been lost from heart disease, stroke, and diabetes alone between 2006 and 2015 (143).

In spite of this high economic burden, there is very little investment in NCDs. A study of estimated donor spending on NCDs from 2001 to 2008 in developing countries revealed that less than 3% (USD503 million out of USD22 billion) of the overall global development assistance for health was dedicated to NCDs in 2007 (138,141,142,144,145,145–149).

Geneau et al (2010) contend that scientific evidence alone will not change people's hearts and minds, nor will a rise in the number of cost-effectiveness studies produce an increased investment. According to Geneau et al (2010), the way forward is to take concerted and inclusive actions that link closely with the development and global health agendas by addressing the common causes of the high burden of preventable diseases, irrespective of the cause. Indeed, they stress that a focus on chronic disease prevention and control makes both health and development sense for low-income countries where the means of rapid achievement of economic growth are elusive (150) .

2.8.5.1. NCDs: Tobacco as a Risk Factor

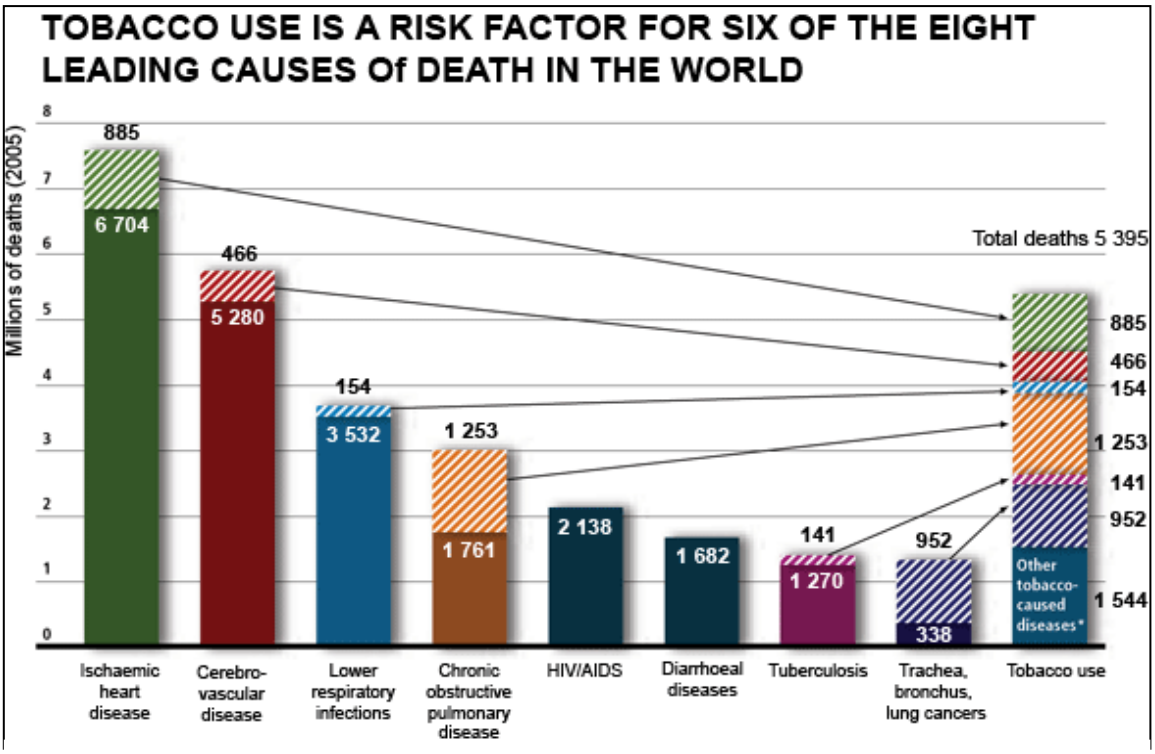
Tobacco use, which includes smoking of cigarettes, cigars, cigarillos and little cigars, dip, bidis and kreteks, pipes, smokeless tobacco chewing, snuf, a hookah (shisha/water pipe), dissolvable tobacco, electronic cigarette or e- cigarette (151) is not only spreading, but its burden shifted from developed to developing nations (24,152). If the current trend continues, tobacco will kill more than eight million people worldwide every year by 2030, with 80% of those premature deaths occurring in low- and middle-income countries (142,153).

Studies have shown that almost 6 million people die from tobacco use each year, both from direct tobacco use and second-hand smoke. By 2020, this number will increase to 7.5 million, accounting for 10% of all deaths. Smoking is estimated to cause about 71% of lung cancer, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease (138,147,152). Globally, tobacco is responsible for the death of 1 in 10 adults (about 5 million deaths each year) with 2.41 (1.80 - 3.15) million deaths in developing countries and 2.43 (2.13-2.78) million in developed countries (39,154–156). Among these, 3.84 million deaths were in men. The leading causes of death from smoking were found to be cardiovascular diseases (1.69

million deaths), chronic obstructive pulmonary disease (0.97 million deaths) and lung cancer (0.85 million deaths) (39,154–157). Fifty per cent of unnecessary deaths due to tobacco occur in middle age (35-69 years), robbing around 22 years of normal life expectancy (158).

As show in Figure-6, in the Global Tobacco Epidemic report of the WHO 2008, tobacco use is a risk factor for six of the eight leading causes of deaths in the world (153,155).

Figure 5: Global Tobacco Burden and its Contribution to NCDs



From the figure above, out of the eight leading causes of death in the world tobacco use is a risk factor that contributes to six of these. They are ischaemic heart disease, cerebrovascular disease, lower respiratory infections, COP disease, TB, bronchus lung cancers among others (237,238)

There is compelling evidence to support a strong relationship between tobacco smoking and various lung diseases. Not only is lung cancer caused by tobacco smoking, but also several other lung diseases such as chronic obstructive pulmonary disease (COPD), bronchial asthma, respiratory infections and some interstitial lung diseases. Some of these problems are also reported in non-smokers who are exposed to second-hand smoke. It is universally accepted now that tobacco smoking accounts for over 80%-90% of cases of COPD (138,154,157).

Reducing tobacco use is one of the most effective strategies to help countries achieve the global targets set out in the Political Declaration on NCDs (2011) by the UN General Assembly to propel the prevention and control of NCDs. Indeed, tobacco use has been described as the most policy-responsive NCD risk factor (159).

2.8.5.2. NCDs: The Biggest Gain from Tobacco Control

Tobacco control is the only NCD intervention thus far backed by an international health treaty. Tobacco control is protected by the WHO FCTC articles and associated guidelines. The first major global commitment to addressing NCDs was the WHO FCTC. Tobacco control has achieved significant successes in terms of policy and legislation change similar to those that will be needed to reduce NCDS. While the WHO FCTC does not address risk factors beyond tobacco use, the approach it takes in terms of addressing fiscal policy (taxation), promotion/marketing, restrictions on use (smoke-free areas), packaging and labelling, are directly applicable to the other key risk factors –alcohol, poor diet and, to some degree, physical inactivity. Full implementation of four of the Framework Convention on Tobacco Control strategies- (i) increasing tax on tobacco products to reduce prevalence, (ii) enforcement of smoke free workplaces, (iii) requirement of FCTC compliant packaging and labelling of tobacco products; combined with (iv) public awareness campaigns about the health risk of smoking; and a comprehensive ban on tobacco advertising, promotion and sponsorship- would avert 5.5 million deaths over 10 year in 23 low income and middle income countries with a high burden of NCDs (160).

These are each considered best buys in reducing tobacco use and preventing NCDs (138). FCTC implementation will have immediate health and economic benefit because reduction in exposure to tobacco smoke, both direct and second hand, will reduce the burden of cardiovascular diseases within one year and thus health expenditure. Smoke free laws are expected to reduce lung cancers, illness from heart diseases and respiratory symptoms (161).

Using the tobacco control model as a foundation to strengthen national public health and programs is too important an opportunity to be missed. Examples of policies that are likely drawn from the tobacco control model not only indicate current successes but also suggest positive developments for the future. The Government of Tonga, for example, has increased

import duties on tobacco, lard and fizzy drinks, and decreased import duties on fresh fish; Nauru and French Polynesia have raised taxes on sugary beverages (162).

Tobacco control also offers a model for surveillance of monitoring of NCD levels and the impact of programs to reduce the incidence of these diseases. Its Global Adult Tobacco Surveillance (GATS) is a practical tool that could be replicated to integrate NCD surveillance into national health information system, as well as strengthening country accountability processes and efforts (163).

The experience of tobacco control provides many useful lessons for the other NCD risk factors in terms of how to deal with industry, the necessity of a policy-based approach, the need for multi-sectoral action, and how to engage a variety of stakeholders (164).

Given that the SDGs through Goal 3 has provided a leverage by recommending the strengthening of the WHO FCTC in all countries (165), major gains for NCDs are possible if progress on the SDGs stays on track. Thus, enabling State parties to implement the FCTC robustly at the national level should be a priority intervention to achieve the goals of the SDGs and reduce the prevalence and incidence of NCDs.

2.7.1. Global Tobacco Control Efforts Prior to the FCTC

Tobacco control is mainly aimed at influencing the behaviour of current and future tobacco users (preventing young people from starting and motivating current smokers to quit; limiting the influence of the tobacco industry on the behaviour of smokers and potential smokers; and reducing harm related to the use of tobacco products both to smokers and non-smokers (166–168).

Legislation is one of the main tools used in public health, and tobacco control is not an exception. In some countries the history of tobacco control laws go back to 17th century (Russia) or the 19th century in some states of the United States of America (169,170) though the history of tobacco control has generally been characterized as " too little too late" (166,168). However, after the health effects of tobacco control were first researched and published, many countries and international organizations have been particularly active to

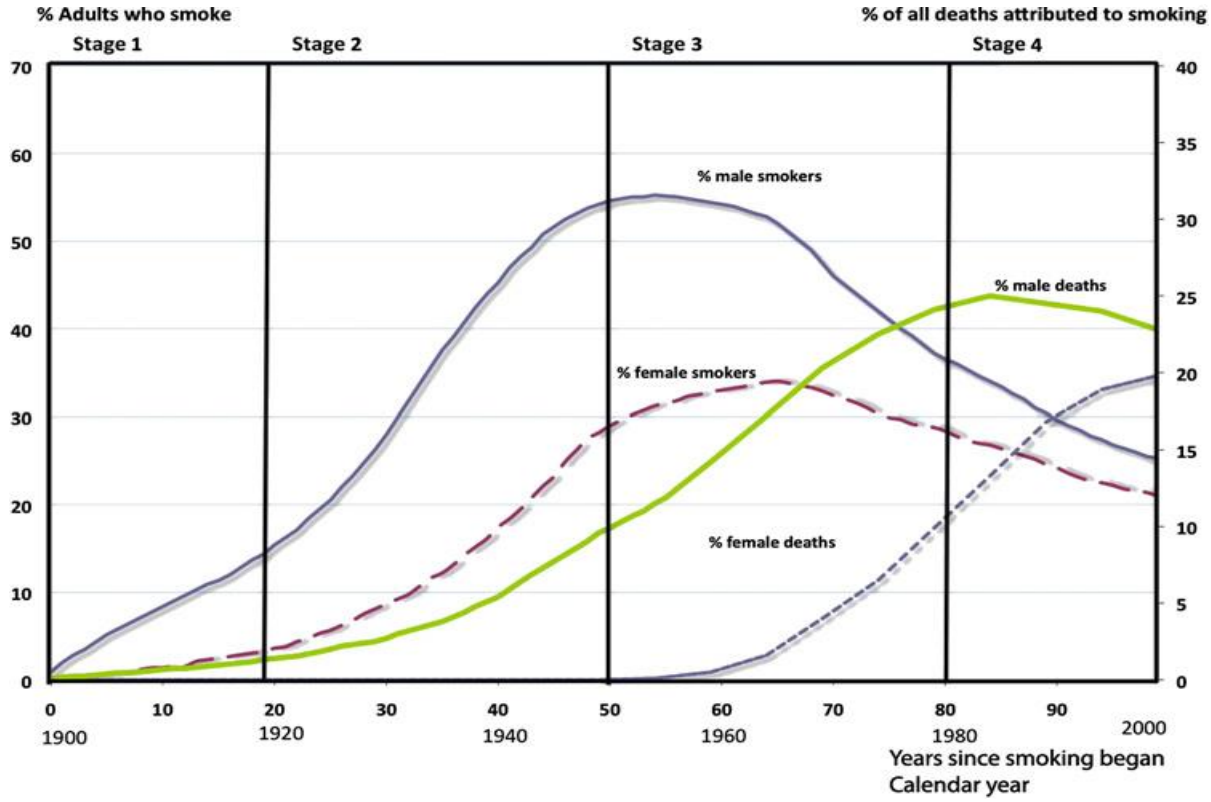
protect population health through tobacco control (169,170) culminating at the international level with the WHO FCTC, which describes principles for developing national tobacco control and guidelines for implementing best practice (11,171).

Along with legislation, tobacco control practice has also included voluntary agreements between tobacco industries and governments (22,172–174).
The focus of global tobacco control took a much-needed turn to the developing world in the 1990s. Two important developments that provided an impetus for policy change in developing countries was a 1995 report by the UN Conference on Trade and Development (UNCTAD) and the World Bank's report entitled, 'Curbing the Epidemic' (39).

The latter highlighted that government fears that tobacco control measures would harm their economies were largely unfounded, and tobacco control could bring unprecedented health benefits without economic consequences (39). The aforementioned health consequences of tobacco use were evident to developing country governments, but these reports provided an economic rationale for tobacco control in these countries and created further momentum towards action in this area. Despite these events, tobacco use remains a leading cause of preventable death globally (175).

In the descriptive Lopez et al 1994 model of the cigarette epidemic (see Figure-5) in developing countries, the four-stage model was proposed to explain progression between the uptake of smoking cigarettes and its consequences on mortality. While in Africa including Ghana, tobacco use and smoking rates attributed to mortality in adults both men and women are low compared to the developed world, this situation will change (Figure-5). Based on the four-stage epidemiology model, if current trends continued, the progression in Africa especially sub-Saharan Africa (e.g. Ghana, Nigeria and Malawi) will increase in mortality attributed to tobacco use. Most sub-Saharan African countries are in the early stages (stage 1) of the Lopez et al model with lower prevalence rates and need to act quickly to prevent them from rising. It is a relatively brief phase, lasting about one to two decades. Eriksen et al has highlighted that there are valuable opportunities for interventions and primary prevention (9,10,13,14,27). "Survey data has misjudged both the number of smokers as well as of cigarettes smoked in particularly in the younger age group. Especially consumption figures consumed by younger adults 15 years and older" (9).

Figure 6: The Four-Stage Model of Cigarette Epidemic or the Tobacco Epidemic Continuum



The figure above describes four distinctive stages which projects the Lopez et al model. There are different countries at different levels as showed above. This explains the relationship between the smoking prevalence and smoking mortality. It further summaries the different points of the smoking epidemic (10,13,14,32).

By the end of the 20th century, it remained imperative for health promotion and public health efforts to continue to focus on minimising the burden of tobacco control. The globalisation of the tobacco epidemic and its growth in developing countries required a massive impetus for action on a global scale (176,177). The WHO had not previously utilised its treaty-making power, enshrined in its constitution in 1948; however, the tobacco epidemic called for radical measures (74,178).

The WHO made use of this power by adopting the FCTC in a substantial effort to enhance tobacco control policy internationally. Tobacco control has evolved over the last 30 years from sporadic acts by activists and isolated actions by some governments to a mainstream public health issue, with known, proven, cost-effective measures. Needed now is a coherent public health strategy designed to reduce tobacco consumption, involving international,

regional, national and local actors involved in strategic planning, policy-oriented research, capacity building, funding, enforcement and evaluation (42).

2.8. Tackling the Tobacco Problem: Origins and Objectives of the WHO FCTC

The Globalization of the tobacco epidemic reduces the capacity of individual countries to regulate tobacco through domestic measures alone. Thus, a coordinated, international response is essential. The early 1990s saw the first steps toward developing an international legal approach to tobacco control, formalized in a resolution, the WHA 49.17 of the World Health Assembly (WHA) in May 1996 (178).

In 1999, the WHA called for work on the WHO FCTC to begin. Thus, it established an Intergovernmental Negotiating Body (INB) for the purpose. The INB held six sessions between October 2000 and February 2003 (179). The text agreed at the final session was referred to the World Health Assembly, which unanimously adopted it in May 2003.

After the WHA adopted the WHO FCTC, it was opened for signature. The WHO FCTC came into force on 28th February 2005; 90 days after the necessary 40 countries had completed ratification procedures. As of May 2016, there were 180 parties to the WHO FCTC of 194 WHO member states. These countries cover about 90% of the world's population (179). The WHO FCTC articles and associated guidelines set out a mix of interrelated tobacco control measures that should all be implemented comprehensively. Every country that is a party to the WHO FCTC has an accepted a legal obligation to implement these various provisions in its own territory. This requires political commitment, strategic planning, reasonable funding, partnership working, and the sharing of experiences and lessons learned both within and between countries (179).

2.8.1. Scope of the WHO FCTC

The WHO FCTC is the first treaty negotiated under the auspices of the WHO. It establishes the international public health template for national tobacco control activities (42).
The objective of the FCTC is stated in Part II, Article 3:

The objective of this Convention and its protocol is to protect present and future generations from the devastating health, social, environmental, and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties (countries) at the national, regional and international levels in order to continually and substantially reduce the prevalence of tobacco use and exposure to tobacco smoke (11).

The FCTC consists of a wide range of articles on ways in which to minimise the health burden associated with tobacco use. These articles are grouped into those measures relating to the reduction of demand; those relating to the reduction of supply; scientific and technical cooperation and exchange; and communication of information (11).

The main articles are described below:
Measures relating to the reduction of demand for tobacco (11):

- Article 6 Price and tax measures
- Article 8 Protection from exposure to tobacco smoke
- Article 9 Regulation of the contents of tobacco products
- Article 10 Regulation of tobacco product disclosures
- Article 11 Packaging and labelling of tobacco products
- Article 12 Education, communication, training and public awareness
- Article 13 Bans on tobacco advertising, promotion and sponsorship
- Article 14 Promote the cessation of tobacco use and treatment for Tobacco dependence

Measures relating to the reduction of supply of tobacco (11):

- Article 15 Illicit trade in tobacco products
- Article 16 Sales to and by minors
- Article 17 Provision of support for economically viable alternative activities

In addition to the above mentioned articles, Article 5 specifies some important general obligations that assist with the FCTC overall which includes:

- Cooperating to raise resources for effective implementation through bilateral and multilateral funding (Article 5.6) (11).

2.8.2. International Governance of the WHO FCTC

The Conference of the Parties (COP) is the governing body of the WHO FCTC and is comprised of all Parties to the Convention. The COP keeps under regular review the implementation of the Convention and takes decisions necessary to promote its effective implementation. The COP may also adopt protocols, annexes and amendments to the Convention according to its priorities and ensure that the Guiding principles are addressed in its decisions. The work of the COP is governed by its Rules of Procedure. Starting from COP 3, the regular sessions of COP are held at two-year intervals (180) .

The COP has so far adopted eight guidelines covering the provisions of nine articles of the Convention: Articles 5.3,6, 8, 9 and 10,11,12,13 and 14. The COP also adopted at its sixth session (2014) a set of policy options and recommendations on economically sustainable alternatives to tobacco growing (in relation to Articles 17 and 18 of the WHO FCTC) (180).

The Convention Secretariat is a global authority concerning the implementation of the WHO FCTC. It also works to promote the Protocol to Eliminate Illicit Trade in Tobacco Products. Its main functions aim at:

- Supporting Parties in fulfilling their obligations under the Convention, its protocols and guidelines;
- Providing the necessary support to the Conference of the Parties (COP), the governing body of the WHO FCTC;
- Translating the decisions of the COP into programme activities.

The Convention Secretariat is an entity hosted by the World Health Organization in Geneva and cooperates with relevant departments of the WHO and other competent international organizations and bodies, and non-governmental organizations accredited as observers to the Conference of Parties (180).

2.8.3. National Governance of FCTC

It is important to consider the governance role that various sectors and institutions play at the national level in order to implement the FCTC. Although the national ministries of health

within governments are central actors, many provisions/articles of the FCTC require significant collaboration with and the commitment of other government departments (181).

Passing FCTC provisions into national tobacco control legislation typically requires parliamentary approval and whole-of-government approach. Legal departments will have a significant influence on the development of regulations to enforce the tobacco control legislation. Tax policies on tobacco products, the allocation of extra-budgetary funding, and earmarking funds for tobacco control or health promotion purposes tend to be governed by the ministries of finance or their equivalent. Ministries responsible for foreign affairs and trade also have significant clout on decisions relevant to the trading of tobacco. Furthermore, the enforcement of FCTC-based provisions is performed by police officers and health inspectors/environmental health officers, and prosecutions tend to be performed by the ministry of justice or department of the attorney-general (182).

Departments responsible for customs and border control typically oversee illicit trade, import duties and the sale of duty-free tobacco products. Ministries of agriculture and finance may have responsibilities for the provision of sustainable alternatives to tobacco for tobacco growers. The ministry of education support is often important in running awareness programmes in schools and monitoring tobacco use and control among youth. This complex web of actors is complicated further when some countries (such as China, Japan and Thailand) have tobacco companies that are totally or partially owned by government entities (182).

To effectively control tobacco, it is clear that FCTC implementation requires a whole-of-government and multi-sectoral approach that is not subject to undue tobacco industry influence.

2.8.4. Review of WHO FCTC Implementation research and the rationale of the study

A study conducted in 2007 on Ghana's readiness for tobacco control measures in relation to the WHO FCTC explored a cross-sectional descriptive study using both quantitative and qualitative methods. The study showed a high level of support for various strategies in

controlling smoking and the use of tobacco products – ban of smoking in public places, non-sale of cigarettes and other tobacco products by minors and to minors. There was also support for tax increases on tobacco products, ban on advertisements and disclosure of all ingredients in cigarettes on packs. The study also identified some perceived obstacles to the implementation of the FCTC in Ghana such as the lack of human and financial resources, lack of political will on the part of government, smokers lobbying for their rights and the influence of tobacco companies (183).

In a study, 'Challenges of Tobacco Control in Low and Middle-Income countries', Ournar Ba sought to identify barriers to the effective implementation and enforcement of the tobacco control in Mongolia. The law is in line with the FCTC. This case study was carried out through examination of national policy documents on tobacco control and through key interviews with government officials and representatives of non-governmental organizations (184). According to Ournar, a number of barriers undermine the effective implementation and enforcement of the law, including the lack of human and financial resources. At the National Centre for Health Development (NCHD), there is only one person working full time on tobacco control for the whole country. The NCHD focuses its efforts on educational programmes on the hazards associated with tobacco and second-hand smoke, particularly during the World No Tobacco Day (WNTD). The country lacks stable and sustainable funding for tobacco control. Their tobacco control programme relies exclusively on external funding (184). Other barriers identified were that retailers were legally not obliged to verify the ages of buyers though the sale of cigarettes to and by persons under the age of 18 years of age was prohibited. Besides, cigarettes were easily accessible to minors through unlicensed vendors and the informal sector (184).

Dhavan and Reddy in a lecture on 'Implementing the FCTC in Developing Countries', notes that as with any international treaty, the success of the FCTC hinges on the effective implementation of its provisions. They contend that both developed and developing country parties experience challenges in implementing the FCTC. They enumerate a list of challenges which include economic arguments by tobacco industry in campaigning against tobacco control; lack of capacity for development of tobacco control legislation and weakness of enforcement systems; insufficient financial resources for FCTC implementation, conflicting priorities in the health sector, the lack of dedicated funds or a regular budget for tobacco

control programmes; insufficient human resources for FCTC given that very few or no dedicated staff work on tobacco control implementation at various levels of governance, lack of strong networks of well-funded nongovernmental organizations; poor monitoring and surveillance systems; lack of operational research to inform implementation of FCTC measures; availability and use of a wide range of tobacco products other than cigarettes; and inadequate coordination among multiple sectors relevant to tobacco control (185).

Tumwine in a study in 2011 set out to describe the status of tobacco control legislation in Africa and identify obstacles to FCTC implementation in Africa. The three areas chosen as focus for the study were Article 8-protection from exposure to tobacco smoke; Article 11-packaging and labelling of tobacco products; and Article 13-tobacco advertising, promotion and sponsorship. These articles were chosen because of their centrality in tobacco control campaigns in Africa and also because they were the first three articles to have guidelines adopted for their implementation. Tumwine's study was conducted through a review and analysis of tobacco control legislation in Africa, media reports, journal articles, tobacco industry documents and data published in the 2011 WHO Report on the Global Tobacco Epidemic (186).

According to the report, majority of countries was found to have legislative provisions that permit designated smoking rooms. Designated smoking rooms are in violation of the FCTC Article 8 and the FCTC Article 8 Guidelines. On Article 11 she reported little progress on packaging and labelling of tobacco products, with few countries having legislation meeting the minimum standards of FCTC Article 11 and its guidelines. On Article 13, the study found that slightly better progress in banning tobacco advertising, promotion and sponsorship has been shown by African countries, although the majority of legislation falls short of the standards of FCTC Article 13 and its guidelines (186).

As regards obstacles to FCTC implementation in Africa, Tumwine concluded that one of the challenges of getting African countries to adopt and implement packaging and labelling requirements including health warning labels that meet the standards of the FCTC and its Guidelines is the popularity of selling single stick cigarettes as opposed to selling them in a complete unopened packet. A similar challenge is the common practice of selling smokeless tobacco in unconventional packaging especially among rural dwellers who may not afford the

more expensive cigarettes and among women who due to cultural reasons might prefer to be seen consuming smokeless tobacco products as opposed to cigarettes (186).

Another obstacle to the implementation of Article 11 of the FCTC and its Guidelines is the interference of the tobacco industry. In Mauritius, the tobacco industry carried out delay tactics to undermine the implementation of the law. The industry took advantage of the loophole in the law that did not specify a supply date of the tobacco products that was required under the new law. The tobacco industry therefore stockpiled many tobacco products manufactured before the entry into force of the law and was able to supply the non-complaint tobacco products several months after the law had entered into force (186).

Sinha et al, in their review article "WHO Framework Convention on Tobacco Control and its Implementation in South-East Asia Region", note that member countries have enacted comprehensive national tobacco control laws and regulations which cover some important provisions such as tax and price measures, smoke-free places, health warnings, a ban on tobacco advertising and promotion and a ban on tobacco sales to minors. Member countries are at various stages of implementing the provisions of the Framework Convention. Member countries have been doing their best to enforce those legislations and regulations as effectively as possible. While the countries are making concerted efforts at achieving the goals of the Convention, there are still huge gaps to meet the goals of the WHO FCTC via effective implementation of the provisions of the Convention. Major challenges in the implementation of tobacco control measures include: weakness in tobacco control policy, weak enforcement of tobacco control legislation, weak public awareness campaigns on the adoption of legislations, limited human and financial resources dedicated to tobacco control, tobacco industry influence on policy makers, farmers and other stakeholders, and social and cultural acceptance of tobacco use as a norm (187).

McCool et al, in a paper examined the factors that have assisted Pupua New Guinea and Solomon Islands to make progress in implementing Article 5.3.A document analysis was undertaken. They found that key determinants of progress included a motivated and engaged Ministry of Health, active civil society group and access to media to prepare tobacco industry related material to stimulate public and policy sector debate. They concluded that though

there has been considerable progress in legislation and policy in the tobacco control area, challenges in relation to adequate enforcement still remain (188).

Studies from other island States indicate that reasons for the impeded progress of the FCTC vary by country; though some argue that it is due to lack of funding and technical support to advance legislation (189,190).

Martin and Leeuw undertook a qualitative case study of the implementation of the FCTC in four small island developing states of the Pacific. The multiple case study used documents review/analysis and key informant interviews to determine the variables which influence the implementation of the FCTC in the Pacific Islands, particularly in the Cook Islands, Vanuatu, Palau and Nauru. The documents reviewed included legislative proceedings, FCTC implementation reports, tobacco monitoring studies and reports, organizational reports, media reports, newsletters, presentations, meeting notes and personal communications from a variety of relevant individuals and organisations (123).

The authors found out that each country has made a significant progress towards FCTC implementation. Overall, strong policy content, public support and limited pro-tobacco coalition activity were conducive to FCTC implementation. The challenges found in the study were limited capacity, limited anti-tobacco coalition and limited political commitment outside the ministries of health in each country. The study concluded that further efforts are needed for full FCTC implementation, through building capacity and using resources effectively, growing commitment to the FCTC beyond the health sector, fostering growth in anti-tobacco coalition activity, exploiting the limited pro-tobacco activity that may be present and garnering public support for tobacco control (123).

Piotie of Consultancy Africa Intelligence's Public Health Unit in an article 'Protection of populations from exposure to second-hand smoke in Africa: Implementation challenges' identified a number of challenges faced by the tobacco control community in Africa in the literature in relation to implementation of Article 8. Piotie noted that tobacco industry interference, insufficient financial and human resources, lack of support from government officials and legislators and poor involvement of civil society are among the barriers to achieving a smoke-free Africa. However, poor compliance, as well as poor, often non-

existent enforcement and monitoring and surveillance systems are the real threats to smoke-free laws in Africa (191).

Lee in his article “What hinders implementation of the WHO FCTC Article 5.3? The case of South Korea”, set out to identify what hinders the implementation of the WHO FCTC Article 5.3 there. The author reviewed official government documents on tobacco control and reviewed news articles. He identified three factors that hindered Article5.3’s implementation, namely, the tobacco industry’s lobby and active interference in the policymaking process (192).

The global progress report provides an overview of the status of implementation on the FCTC based on information submitted by Parties using a core questionnaire adopted by the COP in 2010. The 2014 Global Report showed variability in implementation rates across FCTC provisions. In general, implementation of the Convention has progressed steadily since entry into force in 2005, with the average implementation rate of its substantive articles approaching 60% compared with just over 50% in 2010. Progress is, however, uneven between different articles, with implementation rates varying from less than 20% to more than 75%. Implementation is also uneven between parties and regions (193).

The most frequently mentioned challenges were interference by the tobacco industry, insufficient political support and weak inter-sectoral coordination. Other constraints reported were limited expertise, lack of awareness of the importance of tobacco control, low priority given to tobacco control in non-health sectors and institutions, paucity of data, weak monitoring, discrepancies between policies and the implementation guidelines adopted by COP and lack of research systems. Other challenges concern specific articles, for example, difficulties in enforcing smoke-free measures or lack of national testing capacity (193).

The WHO Regional Office for Africa report, “The WHO FCTC: 10 years of implementation in the African Region”, documents progress and challenges in implementing the Convention in the African Region. According to this report, recent years have witnessed significant achievements, innovative approaches and positive trends, which demonstrate the strong commitment of countries in the region to achieving full implementation of the Convention.

Member States are making huge efforts to develop and implement tobacco control policies and programmes, despite the challenges they face (194).

The challenges and barriers that remain, despite the significant progress made in implementing key provisions of the WHO FCTC in the African Region, include slow integration of the WHO FCTC into national law: not all countries have enacted comprehensive national legislation to implement the WHO FCTC. Some have not yet issued regulations or administrative instructions to enable effective implementation of existing tobacco control laws. Suboptimal enforcement of existing laws and inadequate enforcement of existing tobacco control laws has resulted in only a small impact at the country level. Intensified marketing by the tobacco industry and interference with policy-making; and inadequate funding for tobacco control has resulted in slower implementation of the WHO FCTC at the country level. There is also insufficient human capacity. According to the report, to fully implement the WHO FCTC, more human resources are required. These human resources need to be adequately trained to tackle the challenges posed by full implementation of the Convention (194).

The African Union in a status report on "The Impact of Tobacco Use on health and Socio-Economic Development in Africa noted that while the global community has committed to tobacco control through the FCTC, obstacles remain for adequate implementation and provision. Financial hurdles such as the economic benefit of production and the high cost of cessation programmes, have stymied some efforts. Poverty and lower income are also barriers to accessing cessation programmes. They also inhibit access to knowledge about the harms of smoking which, despite considerable evidence, has not disseminated fully to the general public and sometimes even to policy makers. At the same time behaviour and knowledge of health care providers, particularly those who smoke themselves, together with the influence of policy makers and politicians can be an impediment to successful tobacco control. A significant amount of misinformation also persists regarding the effects of tobacco control on the economy and development (195).

Panda et al examined the Implementation of Tobacco Control Policy at the District Level: A Case Study Analysis from a High Burden State in India. In a study amongst senior health programme managers to understand current implementation practices and the challenges

faced in mainstreaming tobacco control programs in Andhra Pradesh in India. A qualitative study design was used to conduct the case study analysis of 42 in-depth interviews. The findings of this study highlighted lack of resources, low prioritization of tobacco control and lack of monitoring and evaluation of smoke-free laws as limiting factors implementation of tobacco control policy (196–198). It was evident from the results of Persai's study that tobacco control was not on a high priority agenda of the health department as compared to other programmes such as reproductive health, child health, and AIDS control programmes. The study noted that tobacco being a low priority issue, is a concern not only in India but also in many other developing and even developed countries (196–198).

Programme managers reported lack of resources, i.e. the inadequacy of both financial support and manpower- as the biggest hurdles for effective implementation of the programme. Similar barriers of finances and costs have also been highlighted in other studies conducted in different parts of the world (199). Another significant barrier reported by a few respondents was lack of interdepartmental coordination and motivation within the government (200).

A study by Owusu-Dabo and colleagues used qualitative methods to explore the awareness of policy makers of the FCTC, as well as the achievements and challenges to the process of implementation of FCTC, in Ghana's bid to control tobacco use. Semi-structured interviews with 20 members of the national steering committee for tobacco control in Ghana, the official multi-disciplinary team with responsibility for tobacco control advocacy and policy formulation, were conducted. According to the study, the challenges of implementation of the FCTC in Ghana as indicated by respondents were: absence of a clear strategy and legal framework for tobacco control; lack of enforcement of existing directives for tobacco control from the Ministry of Health and other agencies of state, limited resources, lack of prioritization of tobacco control policy, lack of capacity to effectively deal with the global epidemic and slow implementation of the FCTC (201).

Lv et al conducted a review of various sources of information to determine the current status of FCTC implementation in mainland China with respect to five policies and interventions of the WHO MPOWER policy package (with the exception of monitoring tobacco use). The authors concluded that even though China has made considerable efforts to implement the FCTC, there is still a significant gap between the current state of affairs in China and the

requirements of the FCTC. The authors concluded that China faces many challenges in implementing the FCTC. For example, smoking serves an important social function in reinforcing friendships and relationships in China. Misconceptions and lack of awareness concerning the health risks of smoking are common. The routine budget for tobacco control only accounts for 0.5% of the total budget for disease prevention and control, which is quite insufficient compared with the harm caused by tobacco. The professional capabilities for tobacco control are weak. Smoking bans lack powerful enforcement and monitoring. In the final analysis, however, the most crucial obstacle to the implementation of the FCTC is the tobacco monopoly (202).

Hu et al undertook a study to analyse the barriers in the implementation of the FCTC in China. They reviewed the available literature on progress and explored the barriers and challenges that impede a speedier pace in the adoption of effective tobacco control measures and present recommendations based on in-depth knowledge of decision-making process on the implementation of the FCTC in China. The results of the study showed that the pace of progress is too slow. China faces intractable political, structural, economic and social barriers in tobacco control, which make the whole-hearted implementation of FCTC measures a painstaking process (203).

Xiao et al in a review article “Implementation of the World Health Organization Framework Convention on Tobacco Control in China: An Arduous and Long-term Task”, summarize the epidemic of tobacco use and the progress made in implementing the WHO FCTC including the promotion of legislation for smoke-free public places; smoking cessation assistance; labelling of tobacco packaging, enforcement of bans on tobacco advertising, promotion and sponsorship; increases in taxes on tobacco products and in the price of tobacco; and improvements in public awareness of the dangers of smoking, and defining the barriers to implementing effective tobacco-control measures (204).

The researchers noted that China has taken some important steps, including increasing public awareness of the hazards of tobacco use, changing social customs and habits, offering smoking-cessation services and promoting legislation for smoke-free public places. However, some tobacco-control policies suggested in the WHO FCTC have not yet been implemented in China. Some of the issues include the lack of official legislation at the national level for a

smoke-free environment and the fact that most cigarettes are still very cheap. They concluded that because tobacco permeates the fabric of society, business, commerce and politics in China, commitments and actions from the government are crucial and implementing the WHO FCTC in China will be an arduous and long-term task (204).

In 2010, civil society groups developed a report on the implementation of the Framework Convention on Tobacco Control (FCTC) in countries from Latin America and the Caribbean. The main objective was to provide a regional overview of the progress achieved and the obstacles encountered in the ratifying countries regarding the implementation of the FCTC measures. The report indicated that great progress has been achieved in the fight against tobacco in Latin America and the Caribbean. The report observed significant achievements in the implementation of Article 11 (packaging and labelling of tobacco products) and Article 8 (protection against tobacco smoke) (205).

The main obstacle for the implementation of the FCTC has been the interference of the tobacco industry. The tobacco industry and its front groups have litigated against several member states with the aim of hindering progress in tobacco control policies. The lack of governmental technical capacity to approach certain matters such as tax policies on tobacco products, complete bans on tobacco advertising, promotion and sponsorship, the elimination of illicit trade and economically sustainable alternatives to tobacco growing and the lack of official epidemiological data about the tobacco epidemic, are extended problems for the States in the region (205).

2.8.4.1. Structural and Systemic Factors Related to the Implementation of the WHO FCTC: The UNDP Report

The Conference of the Parties (COP) to the WHO FCTC, the UN General Assembly, the UN Economic and Social Council (ECOSOC) and the 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 the 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 (206).

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. UNDP's engagement on WHO FCTC implementation aligns fully with the UNDP Strategic Plan 2014-2017, which emphasizes: strengthening institutions and sectors to progressively deliver universal access to basic services; the importance of social, economic and environmental co-benefit analysis and planning; inclusive social protection; whole-of-government and whole-of-society initiatives; and addressing inequalities. All of these priorities characterize UNDP's approach to addressing the social determinants of NCDs and health outcomes more broadly. Within this context, a research was undertaken to identify lessons and recommendations for further action on integrating the WHO FCTC into national development plans (NDPs) and UNDAFs (206).

The research first reviewed the current status of such integration for the 120 countries (out of 176 Parties at the time of data collection) that had reported on WHO FCTC activities for the 2012 cycle. Second, 48 countries were selected for an in-depth desk analysis. Subsequently, key personnel from the Ministries of Health, UNDP Country Offices and WHO were interviewed from 10 of these 48 countries, to provide a more focused case study assessment. The results of the study from the sample of 48 countries showed a low level of inclusion of tobacco in the development planning documents. About 30 % of the NDPs retrieved support action on tobacco control and fewer than 25 % of the UNDAFs included any commitments to support WHO FCTC implementation or tobacco control. Just four countries were found to include commitments to tobacco control in both their NDPs and UNDAFs (206).

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

economic impacts and make a case for inclusion of tobacco control in the NDP and UNDAF as well as to decrease the influence of the tobacco industry (206).

The lack of technical and financial resources has long been recognized as an impediment to full implementation of the WHO FCTC; more recently, the 2012 global progress report on implementation of the WHO FCTC revealed it as one of the most pressing barriers o implementation (206).

2.8.4.2. Structural and Systemic Factors Related to the Implementation of the WHO FCTC: Other Studies

Chung-Hall et al conducted a global evidence review across all 17 substantive articles of the WHO FCTC where impact assessment was appropriate. The articles were Article 5.3, 6, 8 and from 9 to 22. This was part of the International Tobacco Control Policy Evaluation project. The authors indicated that the WHO FCTC has played an important role in driving global progress in the implementation of a wide range of tobacco control policies over the last decade, much progress is still needed in several areas (1). According to Chung-Hall et al the ongoing challenges to the global implementation of the WHO FCTC include the following:

- Tobacco industry interference- The tobacco industry continues to rely on the use of strategies that are explicitly prohibited by Article 5.3 guidelines. The industry also uses strategies that are not directly covered by Article 5.3 guidelines to interfere with policymaking.
- Lack of guidelines- Formal guidelines have not yet been adopted to assist
  Parties to meet their Treaty obligations for several key Articles of the WHO FCTC (Articles 9,10,15,17 to 22)
- Ineffective implementation of existing guidelines allows the tobacco industry to take advantage of loopholes in tobacco control legislation.
- Insufficient capacity- In many countries, there is limited capacity (e.g. administrative, technical, testing) for tobacco control at the national level
- Lack of financial support- There is a lack of funding to support the implementation of effective measures for several WHO FCTC Articles.

- Poor enforcement. The enforcement of tobacco control policies remains challenging. For examples, many Parties continue to report difficulties in enforcing smoke-free laws, tobacco advertising, promotion and sponsorship bans and measures to limit youth access to tobacco products (1).

At its fifth session in Moscow, Russia, 13-18 October 2014 the Conference of Parties (COP) adopted the decision FCTC/COP6 (13), entitled "Impact assessment of the WHO FCTC", to conduct an overall assessment and analysis of the effectiveness of implementation of the WHO FCTC. Following this decision, the Bureau of the COP selected seven independent experts to undertake the assessment. The Expert Group gathered information from three main evidence sources: 1) a global evidence review of scientific studies by the International Tobacco Control (ITC) Project; 2) commissioned reports, government documents and other relevant literature; and 3) missions to the 12 selected countries by Expert Group members; these included meetings with a broad range of stakeholders, including ministers, government departments, parliamentarians, civil society, academic experts, media and others (207).

The Expert Group in its conclusions stated that the ten years since the FCTC entered into force have seen remarkable developments in global tobacco control. While it will never be possible to identify precisely how many measures are directly or indirectly attributable to the Convention, and inevitably the extent of implementation has been uneven across the Parties, with partial implementation of some Articles, the FCTC has undoubtedly played a critical role as an authoritative and agreed catalyst and framework for action. Furthermore, the Expert Group postulated that evidence from the scholarly literature, reports from Parties, WHO and other health authorities, and further sources show that the FCTC has made a powerful contribution to tobacco control policy development and implementation, strengthening existing strategies, and contributing to denormalising smoking (207).

In spite of encouraging progress in implementation of the FCTC, remaining obstacles include:

- Aggressive action by the global tobacco industry to oppose tobacco measures and to undermine Article 5.3
- Need for continuing recognition of the urgency to act by all stakeholders, with a focus on measures that will have most population-level impact;

- There is still often not full recognition that the Convention applies to all sectors of government, not only health departments;
- Insufficient support for low and middle-income countries;
- Insufficient special action on vulnerable groups, which are often specifically targeted by the tobacco industry;
- Exploitation by the tobacco industry of concerns about growers' livelihoods;
- Lack of sustainable national tobacco control surveillance systems;
- Little research examining the FCTC's impact by gender and among disadvantaged groups;
- Low awareness that non-cigarette tobacco products should also be a priority for action by government (207).

The WHO, with funding from the New Zealand Agency for International Development (NZAID), released a best practice report on overseas development assistance programmes for tobacco control. This features a case study report by Allen (2009) on building the tobacco control capacity of six Pacific island states. Allen (2009) presents several opportunities and threats to tobacco control in the Pacific Islands (208). The opportunities include:

- Small populations resulting in one level of government mandated to set legislation and policy and an ability to reach and influence decision-makers more readily;
- A culture of chiefs, elders and religious leaders where they are potential supporters for tobacco control programmes; and
- A rapid increase in NCDs in the region meaning that adopting mechanisms to reduce this have become palpable (208).

The threats to tobacco control in the Pacific Islands include:

- A relatively small workforce available for tobacco control efforts, with many staff members being stretched thin with competing demands for their time;
- A lack of sustainable funding for tobacco control programmes due to small national budgets and more immediate funding needs;
- Tobacco companies' strong endorsement of "sensible regulation" resonating with decision-makers in the Pacific;
- Lack of a domestic evidence base; (208)

This research was conducted largely before (or while) comprehensive tobacco control legislation passed through parliaments in the various countries. Although its primary focus was overseas development assistance for tobacco control, it provides insight into some of the factors that may affect FCTC implementation in six Pacific Island countries (190).

Cussen and McCool (2011) explore one provision of the FCTC, the status of advertising bans in Pacific islands countries. They suggest that there is need for improvement in this provision and for resources to support the introduction of effective policies in low-income countries in the Pacific region (190). A study conducted by Hale and colleagues (2012) in Niue outlines five elements to ensure the progress of tobacco control in the country, which include leadership and political support, engaged communities, a step-wise (incremental) approach, the potential for novel supply-side restrictions, and utilising the FCTC as a lever for action. Capacity building and outside technical assistance to support tobacco control have also been suggested (189).

2.8.7. Financing Tobacco Control

Tobacco use imposes a substantial economic burden on both individuals and societies (24,209). Yet, investments in tobacco control are extremely small compared to other global health challenges, in both absolute and relative terms. Data on funding for both domestic and international tobacco control are not readily available (210).

Attempts to determine the level of investment in tobacco control have been made, including by the WHO Secretariat for the Framework Convention on Tobacco Control (FCTC), but the conclusion was that this task is very difficult, if not impossible (11,211). The last conference of the parties to the FCTC in Uruguay 2011 requested the FCTC Secretariat to track tobacco control resources and to update them on a continuing basis (212). Publications from major funders do not include information about tobacco control (166). They reveal, however, that while non-communicable diseases pose a higher death burden than infectious diseases in developing countries, less than 3% of overall development assistance for health in 2007 was allocated to combating them (144). A study reported that the total amount available for development assistance in tobacco control was probably no greater than USUSD 240 million in 2008 (210), representing about 1% of development assistance for health. Earlier sources of

funding for tobacco control in LMICs became available in the late 1980s and the 1990s as a result of cancer charities based in the USA, UK, Canada, Australia and from the Union for International Cancer Control (167).

This was followed by the 9th World Conference on Tobacco or Health in Paris, France in 1994, where the International Tobacco Initiative was established to support research, knowledge management and tobacco control funding. International Tobacco Initiative soon became Research for International Tobacco Control disbursing about USUSD 100 000 per year towards research, funded primarily by the Canadian government.

In 2000, some NGOs and foundations began to invest in global tobacco control, which increased Development Assistance to Control Tobacco (DACT) to USUSD1 million that year, reaching nearly 40 countries. DACT refers to resources available to low-income and middle-income countries for tobacco control. This amount doubled two years later, when more funds were invested in tobacco control focusing on advocacy and networking between tobacco control advocates.

Since then, other organizations, both private and public, have stepped in to support global tobacco control. However, their contributions represent only a small share of their investment portfolio, leaving tobacco control in low-resourced countries underfunded and vulnerable. In 2004 one foundation, which funded about 16% of Development Assistance to Control Tobacco, discontinued its tobacco control funding in order to cope with stock market losses.

The need for funds and the relatively small number of entities funding global tobacco control motivated an effort to coordinate projects and to collaborate on funding. Thus, Research for International Tobacco Control organized meetings to discuss such coordination as well as funding to support Development Assistance to Control Tobacco (169).

The data for the 2000-2009-time period showed that the funding grew from USUSD 1.2 million in 2000 to USUSD 44.2 million in 2009. The field of global tobacco control is characterized by a high degree of collaboration among the funding agencies, since about 39% of awards were classified as collaborative. There was almost an equal number of institutional (35%), research (32%), and advocacy (32%) projects funded between 2000 and 2009, but the

value of funding favours research (USUSD 47 million), and institutional support (USUSD 43 million) over advocacy (USUSD36 million). The value distribution reflects the different cost structure of these project types (e.g. research projects tend to be more expensive) (169).

Setting health priorities involves making decisions about which health needs are most important and what programs will be funded to address them. There are no universally agreed set of decision-making rules for setting priorities. Dominant approaches prioritize health economics, and have favoured expert knowledge drawn from technical-rational methodologies rather than consumer involvement and community action (171). However, research reveals that setting priorities is complex, difficult, contentious and often controversial (172).

The funding for both infectious and non-communicable diseases in low-resourced countries is inadequate and therefore the solution is not to shift funding among public health priorities, but to increase the total amount of funding (169). Pokhrel et al in a paper noted that "the level of funding provides a good proxy for the level of commitment or prioritization given to a particular issue" (22). This observation is true of the global tobacco control situation. There are mechanisms that could increase tobacco control funding, but they are not used to their full potential.

2.8.8. Summary of review

According to Martin and de Leeuw (2013) (123) earlier studies on FCTC implementation have remained largely post hoc descriptive (123). This explains the limited use of theoretical frameworks in studies exploring WHO FCTC implementation.

The review also showed that many of the studies that explored the implementation of the FCTC were carried out in developing countries. Some of the studies were undertaken by individuals with information from single countries (183,184,188,196,201,202,204). However, other studies commissioned by the WHO and other reports were based on data from multiple countries (1,123,186,187,191,193–195,205–207). Many studies explored the implementation of the FCTC in broad terms by including all substantive articles (123,186,187,191,193–195,207). Other studies examined the implementation of specific articles of the WHO FCTC

such as Article 5.3, (188,192) Article 8 (186,191) Article 11 (186) and Article 13 (186). In many of the studies and reports, effort was made to include information on ways in which the identified challenges have been or could be overcome in practice to improve the level of implementation of various articles of the WHO FCTC.

Many studies used a qualitative research design. Some of the studies used the single-case study approach, while one study used the multiple case study design. Other studies used qualitative methods such as interviews and document reviews but did not describe their research as case studies. Many of the studies used mixed methods to gather data.

The data for many of the studies were collected from in-depth interviews with the relevant stakeholders and a review of documents. These documents included policy documents on tobacco control, tobacco industry documents, and legislative proceedings. Others were newsletters, journal articles, media reports and WHO FCTC global progress reports. However, a few of the reports made use of quantitative methods particularly survey questionnaires to elicit information. Most of the studies provided more descriptive information than analytical.

Generally, qualitative studies in the review used purposive sampling to select informants. The informants included government officials from various ministries, academics, legislators, media personnel, personnel from non-governmental organizations. Others were personnel from UNDP and WHO country offices and the donor community. The interviewees in the studies reflected the range of stakeholders involved in the WHO FCTC implementation.

The review revealed a diversity of research methods in the studies, samples and study locations. Yet, significantly, there was consistency in the findings across many studies.

In general, this review found limited research on FCTC implementation at the country level. Lencucha and others (2016) suggest that researchers need to focus better on examining the barriers and facilitators to WHO implementation at the country level (213) . This is echoed by Hammond and Assunta (214). Similarly, in the literature, there is limited research that focuses on FCTC implementation in Ghana (201).

Thus, the contribution of my research on the challenges of WHO FCTC implementation in Ghana, addresses a gap in the literature and underscores the importance of the study. Moreover, the extensive use of both primary and secondary data sources as identified in summary of methods- table 2, in my study in lieu of the singular use of document review or interviews with stake holders is another key contribution of this thesis.

An important opportunity was interviewing a wider range of policy makers including the political actors. The involvement of stakeholders at various health levels, including the community, strengthened the triangulation of data through use of multiple data sources and the rich contextualization of experience.

2.8.9. Summary of the rationale of the study

A variety of challenges to the success of the WHO FCTC implementation have been reported in this review. The review reveals that challenges to FCTC implementation vary across countries, although there are some barriers that are common to many countries. The most commonly cited challenges are lack of financial support or resources, limited human resources, poor enforcement of laws/regulations and tobacco industry interference.

This research makes a unique contribution to the body of knowledge on the implementation of the WHO FCTC because it focuses on Ghana, a country where very few studies have been done on the issue. Moreover, the use of triangulation of different data sources by involving a wide range of stakeholders and extensively reviewing the academic and grey literature on the topic strengthens the consideration of the multiple perspectives in this multi-dimensional issue which lends a fruitful contextualization of praxis.

CHAPTER 3: THE GHANA CONTEXT AND THE IMPLEMENTATION OF THE WHO FCTC

3.1. Ghana: Country Description

According to the 2010 national census, Ghana has an estimated population of 24.2 million. About 41.3% of the population is aged less than 15 years and 5.3% are older than 64 years. Life expectancy is estimated at 60 years. There is rapid urbanization. The population living in urban areas increased from 32% in 1984 to 44% in 2000, and to 51% in 2010. Ghana has recently been categorized as a low middle-income country. According to the World Bank, Ghana has a per capita GDP of USD1,190 and about 28.5% of the population lives below the poverty line. Per capita health expenditure in 2009 was about USD45. Official development assistance (grants and loans) constitutes 24% of Government spending in Ghana (135,139,142).

3.2. NCDs in Ghana

Analysis of institutional data in Ghana suggests that several NCDs have been increasing in both absolute and relative terms. WHO estimates that NCDs account for an estimated 34% deaths and 31% of disease burden in Ghana. There is an estimated 86,200 NCD deaths each year with 55.5% occurring in persons aged less than 70 years and 58% of males being affected. The age standardized NCD death rate is 817 per 100,000 for males and 595 per 100,000 for females (135).

Cardiovascular diseases (CVDs) accounted for 8.9% of institutional deaths (excluding teaching hospitals) in 2003 compared to malaria which accounted for 17.1% of the deaths. In 2008, CVDs were reported as the leading cause of institutional deaths accounting for 14.5% compared to malaria which accounted for 13.4% of the deaths (135).

Hypertension has ranked in the top five outpatient diseases for more than 15 years, accounting for 3.0%-5.0% of all new outpatient diseases across all ages. It ranks as the third most common newly diagnosed outpatient disease among adults (135). The prevalence of adult hypertension in Ghana appears to be increasing and ranges from 19% to 48%. The reported outpatient cases of hypertension in public and mission facilities other than teaching

hospitals increased from about 60,000 cases in 1990 to about 600,000 cases in 2009. Up to 70% persons identified to have hypertension are not on treatment and only 0%-13% of those with hypertension have their blood pressures well controlled (135,139,142).

The burden of NCDs in Ghana is projected to increase due to ageing, rapid urbanization and unhealthy lifestyles. Studies show that the proportion of women aged 15-49 years who are overweight or obese more than doubled from 13% in 1993 to 30% in 2008. It is refreshing to note that according to the Ghana Demographic and Health Survey 2008, the prevalence of tobacco consumption in males 15 – 49 years reduced from 11% in 2003 to 9% in 2008. However 15% of adult males aged 35 years and above reported using tobacco 24 hours preceding the survey (135).

Current data suggests that Ghana appears to be in an early or stage one of the smoking epidemic model. Stage one of this model is characterized by a low prevalence –below 20%- of cigarette smoking, principally limited to males (9,215). The overall cigarette smoking rates for Ghana are low, 1 - 4 per cent among women and 5 -10.8 per cent among men (215). As a developing but rapidly growing country, Ghana is therefore a prime tobacco industry target (216).

Ghana was one of the first countries to ratify the WHO FCTC. This provides a key opportunity to stem the growing epidemic of tobacco-related death and disease. However there are significant barriers to the long term success of tobacco control programmes in many developing countries including Ghana. Among the barriers are (217,218):

- Lack of policies and legislation to regulate environmental tobacco smoke;
- Tobacco advertising and marketing and the use of tobacco in public and private places;
- Lack of reliable information on prevalence of smoking across the general population of Ghana;
- Sources of tobacco products, price, promotion and other aspects of the market and finally inadequate knowledge about the health effects of tobacco use and cessation programmes and
- Lack of funding for tobacco control.

However, the issue of tobacco control is complex because it involves the agricultural sector, employment, development, behavioural changes, regulation of tobacco use and health systems in terms of prevention, promotion, treatment and long term management. FCTC was meant to cut across sectors and provide a powerful instrument to drive policy development and implementation across. A critical aspect of this is funding. An exploration of funding gives an indication of where the drivers are for tobacco consumption and control, mechanisms for monitoring progress towards tobacco control. Although there are restrictions in the level of funding available for tobacco control, there is also some indication that development funding available for tobacco control to Low Countries is underutilized. As such, it is vital to examine the linkages between development assistance for health and funding for tobacco control in Ghana. Equally significant is the link between development assistance for healthcare, NCDs and tobacco control.

3.3. Development Aid and Development Assistance for Health in Ghana

It is useful to scrutinise the links between development assistance for health in Ghana and finding for tobacco control in the context of the dynamics of overall development aid to the country.

3.3.1. Development Aid in Ghana

Since the reform of the health sector under the 1997 Sector Wide Approach, development partners have provided financial and technical support and participated in developing sector plans. Most of the development partners give grants to the health sector. The implementation of the Paris Declaration on Aid Effectiveness and the Ghana Harmonization and Alignment Plan has provided many options for health sector support, including:

- General Budget Support, via the Ministry of Finance and Economic Planning, not linked to health;
- Sectorial Budget Support, via Ministry of Finance and Economic Planning, linked to health;
- Loans, via Ministry of Finance and Economic Planning, linked to health;
- Health fund or Basket Funding, via Ministry of Health

- Program /project approach including capital development with different mechanisms like:
    I. Earmarked health fund;
    II. Earmarked program funds, via MOH but restricted in use;
    III. Programmes/project funds, notified to MOH but passed via other channels and levels;
    IV. Other unnoticed aid funds (including NGO expenditure and other Projects, which the MOH is not informed about);
    V. Silent partnership with financing;
    VI. Silent partnership without financing;
- Active but not funding

Development Assistance for Health in Ghana

Development assistance for health has generally followed the same trends as overall development assistance, but it is worthwhile to note three key recent trends: the increases in funding, the growing number of actors and institutions, and the overwhelming focus on a single health condition, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) (219,220).

According to one estimate, development assistance for health increased four-fold from 1990 to 2007, from USD5.6 million to USD21.8 billion per year, with more than half of this increase coming after 2000 (166). This increasing volume of aid comes from and is funnelled through an ever more complex set of actors: In a 2008 article, McColl (221) estimated that there are more than 40 bilateral donors, 26 United Nations agencies, 20 global and regional funding mechanisms, and 90 distinct initiatives involved in development assistance for health (221).

Developmental partners providing assistance in the health sector have a number of processes and mechanisms including a monthly government partners meeting chaired by MOH. The monthly government partners meeting is the forum where decisions on the allocation of funds, including funds required for tobacco control are taken. This meeting discusses topical issues in the sector, initiates responses and serves as an information dissemination forum for partners. There is also an annual joint review and reporting mechanism which culminates in a

formal, biannual health summit for all stakeholders in the sector. Each summit ends with a business meeting and the signing of an aide memoire by the key partners and government (222).

In Ghana, a 2010 Needs Assessment of the implementation of WHO FCTC observed that the Ministry of Health and the Ghana Health Service do not have a budget line for tobacco control activities. Besides, other relevant ministries which have obligations to implement the FCTC do not have dedicated budget in this area in particular (217) and there is very little investment in NCDs in general. A study of estimated donor spending on NCDs from 2001 to 2008 in developing countries revealed that less than 3% (USD503 million out of USD22 billion) of the overall global development assistance for health was allocated to NCDs in 2007 (144).

As a country in the early stage of the epidemic, there is a critical dearth in basic information to support the development, implementation and monitoring of effective tobacco control programmes. Little is also known about the funding situation of NGOs and other agencies working to implement the provisions of the FCTC in Ghana.

3.3.2. Health Care Financing and Development Assistance to Ghana

Financing is a critical factor in the realization of a viable health system. Financing is the mechanism by which plans and policies are translated into action through the allocation of resources. Without adequate financing, plans remain in the realm of rhetoric and good intentions. Financing is a fundamental building block on which the other critical aspects of the health system rest. As such, financing is not only a major driver of the health system but is also a powerful tool with which policy-makers can develop and shape health services and their impact.

Ghana pursues an agency model in the health sector, which separates policy making from service delivery. The Ministry of Health is responsible for the overall health strategy and the monitoring of health outcomes; the Ghana Health Service co-ordinates health care delivery and disease surveillance. The Ministry follows a five-year Program of Work which spells out long-term objectives, strategies and targets for the health sector. It aims at partnership with

donors, other ministries, departments and agencies, the private sector, NGOs, communities and individuals. An update of the Program is developed annually to integrate lessons learned and re-adjust policy objectives (222) .

The policy environment on financing the sector is changing gradually as there is a shift from Sector Wide Approach (SWAp) "basket funding" to Multi-donor Budget Support and Sector Budget Support which aims at long-term development in partnership with government in conformity with the Paris Declaration. The government of Ghana has signed a memorandum of understanding with nine development partners namely African Development Bank, Canada, Denmark, Germany, the EU, the Netherlands, Switzerland, the UK and the World Bank, to support the Multi-donor Budget Support (222).

Sources of funds for the health sector include Government of Ghana through the regular budget (45%), tax based National Health Insurance Fund (23%), Health Fund and Earmarked Funds (13% each), Internally-Generated Funds from out-of-pocket payment to facilities (3%) and Heavily Indebted Poor Countries (HIPC) inflows (3%). Since its inception in 2005, the National Health Insurance Fund is increasingly a major funding source for the health sector, contributing a quarter of the available revenue in 2006 (222) while coverage of the National Health Insurance Scheme (NHIS) expands. The increased coverage of the NHIS has been found to put a financial strain (223) as the healthcare system struggles with shortages of medicines (224) and economic and financial barriers persist (223) Simultaneously, the third Ministry of Health Five-Year Program of Work identifies challenges facing the health sector as: slow improvements in health outcomes; persistent under-nutrition; persistence of some diseases that could easily be controlled; neglect of other diseases which intensify poverty; growing burden of NCDs; uneven performance and productivity; and missed opportunities for mobilizing resources for health development (222). Given the growing NCD burden in the country and challenges faced by the health care system, tobacco control becomes an important strategy in reducing the burden of disease and disability.

3.4. Calendar of Events on tobacco control in Ghana

1930's – 1940's:

Cultivation of tobacco began. Tobacco use accelerated by servicemen from World War II.

1948:

Veterans returning from WWII brought some tobacco products to Ghana and started to demand for tobacco products in the country. Subsequently the British American Tobacco (BAT) partnered with local group to establish a tobacco warehouse and began selling cigarettes imported into the country.

1951:

The Gold Coast Tobacco Company was established in Ghana.

1952

Pioneer Tobacco Company was established to promote domestic tobacco leaf cultivation and manufacturing of cigarette and the official manufacturing of cigarettes began in the country.

1954:

First buildings of PTC completed.

1957:

Gold Coast Tobacco changed its name to Ghana Tobacco Company.

1959:

The Pioneer Tobacco Company took over Gold Coast Tobacco Company.

1962:

Nkrumah's government passed a law to take over tobacco marketing, but the private companies returned after the overthrow of his government in 1966.

1971:

The government established the Ghana Tobacco Leaf Company in order to manage the marketing of tobacco products.

1976:

The Acheampong government passed a law to take over ownership of private cigarette manufacturing and tobacco leaf companies. The government also established the international Tobacco Ghana to take over the marketing and production of all tobacco products in the country.

1980:

The government issued directives to prohibit smoking in government facilities, offices and public places, including restaurants and cinema canters.

1982:

The Ministry of Health issued a directive to ban tobacco advertisements on TV, radio and the print media.

1988:

The Leaf Development Company was established in 1988 to produce tobacco leaf for the local market and to lay the basis of a future export industry.

1989:

The government privatized the International Tobacco Ghana.

July 1, 1989

Labelling Requirements for Cigarette Packs

1991:

International Tobacco Ghana sold to Meridian Tobacco Company, MTC (Joint venture between SSNIT, Ghana and Rothmans UK)

1992

Standard 105-1:1992 on Specifications for Cigarettes

1993:

Ghana Committee on Tobacco Control was established

1999:

BAT merged with Meridian Tobacco Company and became the sole local manufacturer of tobacco products in Ghana. Ghana also signed the Lomé, Togo Declaration on the Contribution of Parliamentarians to Tobacco Control in the African Region in the same year.

2000:

Ghana joined Global Tobacco Surveillance System (GTSS) and the first national Global Youth Tobacco Survey (GYTS) was conducted to determine prevalence of tobacco among youth.

2001:

The immediate Director General of Ghana Health Service complained about the painting of the Kaneshie Market, the biggest market in Accra with BAT products, and this generated a national debate about tobacco control.

2002:

Ghana became a member of Quit and Win International Smoking Cessation Program and the Ghana National Tobacco Control Steering Committee (GNTCSC) was inaugurated the same year.

2003:

The National Tobacco Control Steering Committee drafted the first national tobacco bill for approval by cabinet. A demography and health survey was also conducted the same year to assess the prevalence of tobacco among adults in the country.

2004:

Ghana signed and ratified the framework convention Tobacco Control (FCTC)

2005:

A second national GYTS survey was conducted to determine tobacco prevalence among the youth and the tobacco bill was re-drafted to reflect the FCTC provisions and sent to Cabinet for consideration

2006:

The Ministry of Health issued another directive to ban smoking in all Ministry of Health Facilities. In addition, the Ministry of Transportation issued a directive to ban smoking in public in private commercial transport including the Ghana Private Roads Transport Union (GPRTU) and Inter City Buses and also on both domestic and international flights, transports, buildings, ports and stadia. Ghana also chaired one of the committee meetings of the first session of the FCTC Conference of Parties held in Geneva. Lastly, the British American Tobacco Company closed down its manufacturing company and relocated to Nigeria.

2007:

The Ministry of Health issued another directive to compel all importers of tobacco products to register their products and comply with the Food and Drugs Board (FDB) regulatory requirements in addition, the Ministry, the GNTCSC, and the Ghana Tourist Board reached voluntary agreement with owners of the entertainment industry to create smoke free areas for non-smokers. Ghana also chaired one of the committee meetings of the second session of the FCTC Conference of Parties meetings held in Thailand. The GNTCSC instituted a five-year plan of action to control tobacco in the country in the same year.

2007

Customs and Excise (Duties and Other Taxes) (Amendment) Act, 2007 (excerpt)

2008:

The Ghana National Tobacco Control Steering Committee reached an agreement with importers requiring the importers to disclose the content of tobacco products to be imported

into the country. Ghana Demographic Health Survey (GDHS) conducted other survey to determine national tobacco prevalence among adults in the country.

2009:

GYTS conducted another national survey to determine tobacco prevalence among the youth in the country. The Ministry of Education also developed a School Health Education Policy to promote healthy lifestyles and prohibit the use of tobacco by children in educational complexes. In addition, the Ghana Food and Drugs Board directed all tobacco imported into Ghana to have approved health warnings and cover the required sizes.

2010:

Ghana hosted the Second Meeting of the Working Group of the FCTC on Article (17) and (18).

2011:

The Ministry of Health issued additional directives to mandate the posting of no smoking signs on the premises of all health facilities to strengthen its effort to prevent tobacco smoking on health facilities.

2012:

The National Parliament unanimously passed a tobacco control law as part of the Public Health Bill to protect public health - Public Health Act, 2012 (Act 851)

2013

Food and Drug Authority Guidelines for the Labelling of Tobacco Products

2016

Tobacco Control Regulations, 2016 (L.I.2247)

Source: Compiled from various sources (54,64,225,226)

3.5. Tobacco Market in Ghana

There is no manufacturing of tobacco products in Ghana since December 2006 when BAT shut down its production plant and relocated to Nigeria. The closure of the factory has resulted in the decline of commercial tobacco farming since tobacco growers no longer have access to the market provided by BAT. However some form of tobacco farming still continues across five regions of the country whereby small farmers plant small plots of tobacco for sale or consumption (301).

Since Ghana's sole tobacco producer British American Tobacco (BAT) halted production of cigarettes in Ghana in December 2006, it has shifted focus to distribution and marketing of its brands – Rothman's King Size, Pall Mall, London, 555, Embassy, Diplomat and Tusker. These products of BAT are mostly imported from Nigeria. The Vietnam Tobacco Import Export Company (Vinataba) cigarettes reach Africa including Ghana through Oriental General Trading INC-OGT (Dubai) under an arrangement negotiated in 2001. TargetLink is OGT's main distributor in Ghana with its imports coming from Vietnam. BAT Ghana and TargetLink limited are the two major registered importers in Ghana. There are other companies which import smaller quantities of tobacco products into the country (301).

The FDA of Ghana requires all importers of tobacco products into Ghana not only to register as importers but also to register the tobacco product and/or products they want to import. The registration for both the importer and the product is valid for one year. Furthermore, for products to be allowed in Ghana, they must have the inscription 'For Sale in Ghana Only' on the packets and the country of origin (301).

ILLICIT TRADE

According to the Financial Action Task Force (FATF), a global inter-governmental body, illicit trade in tobacco 'is the production, import, export, purchase sale or possession of tobacco goods, which fail to comply with legislation'. The share of the illicit cigarette trade in the global cigarette market is estimated at 9 per cent to 11 per cent (37).

In Ghana the volume of cigarettes smuggled into the country is estimated at between 10 per cent and 19.9 per cent of the total product. Apart from posing health risks to consumers, illicit tobacco trade deprives government of its much-needed revenue through taxes and import duties among others (37). Cigarettes are usually smuggled from Togo, Ghana's eastern neighbour.

The Ghana Revenue Authority and the FDA carry out frequent market surveillance and enforcement operations in the market to seize and destroy substandard products. Indeed there are several media reports of seizures and destruction of illegal tobacco products. The FDA constantly issue warnings to the citizenry especially the young population to be wary of illicit use of tobacco products, which is impacting negatively on health, legal and economic, governance and corruption (301).

The FDA has put in place measures in place to eliminate illicit trade such as strengthening regulations at the ports of entry, registration of tobacco importers and tobacco products, permit authorization systems and monitoring tobacco products on the market through FDA's post market surveillance activities. However combatting the illicit trade is a herculean task due to the porous border entry points between Ghana and its neighbouring countries that allow traders to bring in their products piecemeal on motor bikes and other modes of transport using unapproved routes (288).

In response to the threat posed by illicit trade, the international community negotiated and adopted in November 2012 the Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to the WHO FCTC. Ghana signed the Protocol on24 September 2013 but is yet to ratify it (288).

SMOKELESS TOBACCO

In Ghana, local snuff is prepared by mixing the dried tobacco leaf with chemicals such as saltpeter (potassium nitrate) and the grinding it into a fine powder. Dried tobacco leaves are also a form of smokeless tobacco which users chew. Snuff is consumed mostly by older adults in Ghana, but the youth are reportedly becoming more interested in using it as indicated by findings from the Global Youth Tobacco Survey (GYTS) from Ghana (GYTS).

In Ghana smokeless tobacco products are consumed in a variety of ways – sniffed, chewed, sucked or applied to teeth and gums. Products are largely locally made by cottage industries, but limited number of premade manufactured brands are also available. Smokeless tobacco is sold on the open market (302). Figures from the 2012 Tobacco Atlas indicates that the prevalence of adult smokeless tobacco use in Ghana is less than one per cent (37).

Shisha

Shisha smoking a traditional method of smoking tobacco products mainly prevalent in the Mediterranean region, North Africa and parts of Asia but now spreading around the world (37) has found its way to Ghana. Many establishments selling shisha are now open in many urban areas especially the national capital as shisha smoking becomes a popular method of tobacco smoking in Ghana. The increasing popularity of shisha smoking among the younger population has raised concerns among tobacco control advocates in Ghana. The Ghana Health Services focal person on tobacco control has indicated to the media that "the ministry of health is raising awareness on the dangers of shisha- an emerging tobacco product patronized in some public entertainment joints across the country (288)."

CHAPTER 4: CONCEPTUAL FRAMEWORK

A number of studies evaluating the implementation of the WHO FCTC undertook the assessment in terms of the provisions of the articles of the Convention.

Martin and de Leeuw (123) used Najam's 5C Protocol, a theoretical framework from political science, which posits that five critical interlinked variable clusters affect implementation. These variable clusters that affect implementation are: the content of the policy-the goals, causal theory and methods in the policy (i.e. FCTC and national tobacco control legislation; the institutional context through which the policy travels and by whose boundaries it is limited; the commitment of those entrusted to carry out implementation to the policy content; the capacity of implementers to carry out the desired changes and the clients and coalitions whose interests are enhanced or threatened by the policy and the strategies they may employ to influence (123).

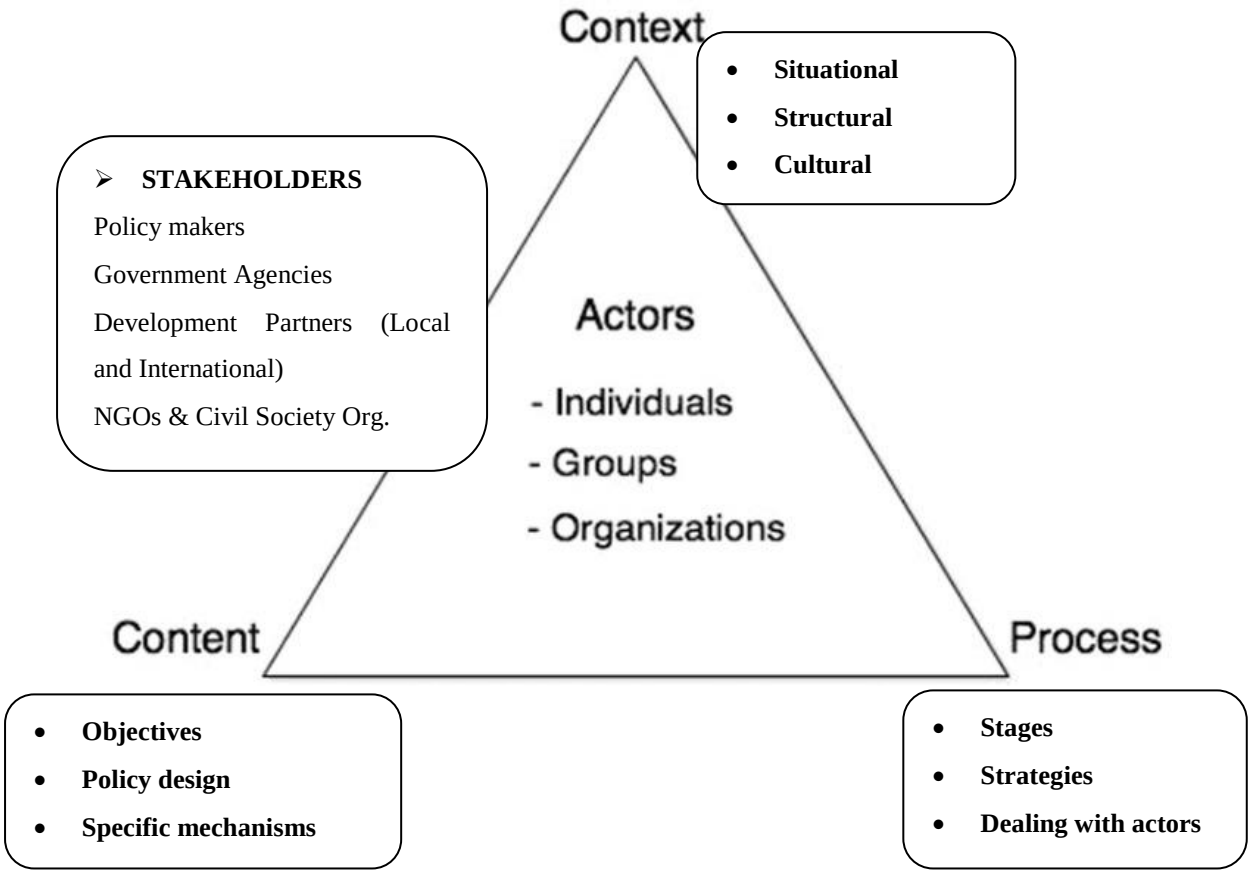
Others such as Tomson and colleagues (2009) in their study on stakeholders' opinions about a tobacco control policy in Lao PDR, used Walt and Gilson's framework. Their policy analysis was in the frame of context, content and actors with focus on the latter (227). Lunze and Migliorini (228) also used the Walt and Gilson policy triangle as the analytical framework to examine content, context, and processes of the Russian tobacco control policy.

CONCEPTUAL FRAMEWORK

As a public health researcher, I chose to combine the Walt and Gilson Health Policy Analysis Framework (2,17,18) with the Determinants of Political Priority for Global Initiatives Framework developed by Shiffman and Smith (4,19,229) to guide the conceptual framework for this study. The two frameworks can assistance to inform public health policy processes. To this end it is important when using an adequate descriptive policy analysis to apply one of the policy process frameworks.

The Walt and Gilson Health Policy Analysis Framework comprises four components, namely, actors, context, process, and content (2,17,18). See Figure -7. It can be applied to analyse or understand a particular policy which is generally retrospective, or it can be applied to plan a particular policy which is prospective (2,230).

Figure 7: Walt and Gilson Health Policy Analysis Framework



Walt and Gilson, 1994

The components of the Shiffman and Smith Framework include actor power, ideas or the way in which the issue is understood and portrayed, political contexts, and the characteristics of the issue (4,19,229). Four elements outlines what factors affect global and national agenda setting: The interaction between actors and they power, ideas, context of the political environment and characteristics of the issues. Each of these four elements is described in the table 1. Furthermore, there are eleven factors shaping political priority which are policy community cohesion, leadership, guiding institutions, civil society mobilization, internal and external frame, policy windows, global governance structure, credible indicators, severity, and effective interventions. The Shiffman and Smith framework argues that a health issue gains political priority when the following three conditions are met: A country's political leaders as well as international leaders publicly (as well as privately) express support for the

issue, and do so in a sustained fashion; policies are enacted to address the problem; and resources (appropriate to the disease burden) are allocated to the issue (2–4,17–19,229,230).

Table 1: Framework on Determinants of Political Priority for Global Initiatives

Category	Description	Factors shaping political priority
Actor power	Strength of the individuals and organizations concerned with the issue	1. Policy community cohesion 2. Leadership 3. Guiding institutions 4. Civil society mobilization
Ideas	Ways in which actors understand and portray the issue	5. Internal frame 6. External frame
Political contexts	Environments in which actors operate	7. Policy windows 8. Global governance structure
Issue characteristics	Features of the problem	9. Credible indicators 10. Severity 11. Effective interventions

Common to both frameworks are the components of actors, contexts, and content (Walt and Gilson) or ideas (Shiffman and Smith) related to health policy (2,4,17–19,229,230). These components are discussed below.

4.1. Actors

In every public policy, actors play various roles in all the stages of policy process, such as policy formulation, planning, implementation, monitoring and evaluation. Some refer to actors as policy elites and decision makers (18), while others prefer to call them stakeholders (231,232). Sabatier (1998) has developed a framework in which the role of individual actors and interest groups play a central role (233,234).

In analysing the role of actors, some scientists tend to limit their focus of attention only to the actors within government hierarchies. Others argue that actors outside the government should also be included because many actors outside the governmental hierarchies directly and indirectly influence health policy process (235). Researchers have highlighted the role of actors in different regions of the world. Some reviewed work demonstrates that civil servants play an important role in policy making due to their greater expertise and continuity. Others included political, traditional and religious leaders, civil servants and foreign donors in analysing the role of actors in Africa. They concluded that - besides the political leaders and civil servants – traditional leaders, religious leaders and donors significantly influence the policy process in Africa. Researchers have suggested that relationships between various actors should also be considered in analysing the role of actors. Various studies, argue for analysing the role of actors as “Individuals” and as members of “Groups” within and outside the government (17,18).

International agencies and donors such as the World Bank, IMF, WHO and many others also influence overall policy environment, health policy and health in various ways. They constitute an important part of the actor analysis. For example, there are international NGOs who affect policies in several countries. Some studies (236) have argued that in the international system there are networks of scientists, policy experts, economists, and other non-state actors who work with states and international organizations to influence public policies in countries. In tobacco control, transnational groups have become active in calling for restrictive policies from the WHO and its member states. For instance, groups such as International Development Research Centre (IDRC), American Cancer Society (ACS), the International Union Against Cancer (UICC), the World Heart Federation (WHF), and the International Union for Health Promotion and Education (IUHPE) have been active in

tobacco research and the lobbying of the WHO to require member states to adopt and implement the FCTC. In this relation, Shiffman and Smith found that having a group of no more than 15 persons leading the initiative was a significant factor contributing to the rise of global attention (4). The Shiffman and Smith describe it as the strength of the individuals and organizations concerned with the issue. They further explain it in the first four of the factors (4).

4.2. Content

Content is an element of a particular policy which details its essential parts and most often reflects some or all the dimensions. It examines details such as the objectives, the design of the policy, the specific mechanisms and the plan for implementation. It supports in finding solutions for health problems by considering not only health care services but also other determinants of health, which can be influenced, particularly environment and lifestyle. Furthermore, it improves the understanding of policy outcomes and provides information for policy makers regarding the technical skill, reliability, and effectiveness of various means and the interrelations between different goals (237). The Shiffman and Smith postulate that some health campaigns are easier to promote than others because the diseases they address are seen to be more harmful. The Shiffman and Smith elaborates it in the category as ideas with its description as ways in which actors understand and portray the issue as tobacco control with its factors within internal and external frame (4).

4.3. Context

Health policy does not take place in a political vacuum but is embedded within a political, administrative, economic, socio-cultural, and demographic context. Contextual factors are considered critical elements in influencing the policy process and the overall health of a population directly and indirectly. The economic context significantly influences the health policy process and health outcomes. A well-functioning health care system and successful health policy implementation need a regular flow of resources (235).

The success of tobacco control under the WHO FCTC and overall NCDs prevention and control efforts will depend on adequate and long term financing. Context involves the environment in which the actors operate and includes the ability of the global actors to take advantage of policy windows to influence decision makers. The United Nations High Level Meeting on Non-Communicable Diseases was such a policy window (4). The Shiffman and Smith continue to examine political contexts and describe it as the environment in which these actors operate. Their framework addresses the seven and eight factors such as the policy windows and the global governance structure (4).

4.4. Health Policy Process

Aside from the common components of actors, content, and contexts which have been discussed in the two frameworks above, Walt and Gilson Framework uniquely highlights the stages of policy development in its component on process. Through health policy process, a government, society, institutions and/or professionals set their activities and allocate their resources. Generally, the policy process is divided into different stages or phases such as agenda building, planning, implementation, monitoring, evaluation and feedback (2,18,233).

However, policy planning and implementation are not always interlinked; often disconnects occur. Policy elites in developing countries often build the health agenda and formulate health policies without recognizing important health problems (235,238). Consequently, many health problems do not effectively get on the policy agenda (239–241). In developing countries, health planning repeatedly leads to health plans that do not appear to be implemented at all or are only partly implemented. Planning documents often offer health objectives without providing enough details on how objectives will be realized. Health planning is often not flexible, participative or integrated with other decision-making processes (235).

The weak links between planning and implementation (235) is also evidenced in many health policies in developing countries which are not implemented properly due to power conflicts, lack of political support, lack of resources and lack of reliable data (18,231,232,240). For example, the issue of Tobacco control and the implementation of the WHO FCTC in Low and Middle Income Countries (LMIC).

4.5. Characteristics of the Issue

One key difference in the two frameworks is that the Shiffman and Smith Framework have a fourth component namely 'Characteristics of the Issue' which the Walt and Gilson Framework does not have (4,19,229). The Characteristics of the Issue' underscores the significance of the dimensions of the severity of the problem burden, the availability of credible indicators to measure the severity of the problem and that can be used to monitor progress, and the existence of effective interventions to address the problem, in shaping political priority for the health policy under consideration (2,4,17–19,229,230).

The Shiffman and Smith Framework, which was developed to assess why some global health issues achieve political priority while others do not have been applied to several issues including global health networks, tuberculosis (TB), pneumonia, alcohol harm, maternal and new born/ child mortality, safe motherhood, HIV/AIDS, malaria, tobacco use, NDCs and violence against children (242–244).

Many of these studies which this researcher reviewed have examined factors that shape political priority which looks at the eleven key features of the framework. Political priority is considered when political leaders identify an issue with the provision of financial, human and technical resources been aligned with the severity of the problem. These issues are spoken about and showed concern for publicly and privately by the leaders, and policies and programmes which are enacted and implemented to address the issues. Additionally, funds are allocated and released to the cause (4,242,243,245).

It is very important to examine political priority because sometimes though policy makers are aware of the severity of the problem and potential solutions are known, there is no guarantee of them acting or implementing the face of several competing challenging issues and limited resources (242,243).

The factor nine that addresses clear indicators expands on the credible measures that demonstrate severity of the challenge. These are important because numbers can alarm the politicians, policymakers and convince them of progress that is being made. On the issue of severity, factor ten, it matters because other things being equal policy makers prefer to devote

resources to causes they perceive to be serious. And the final factor eleven, effective interventions means addressing the problem backed by evidence and explained clearly. These the policy makers are likely to act on in terms of what they think they can do something about (4).

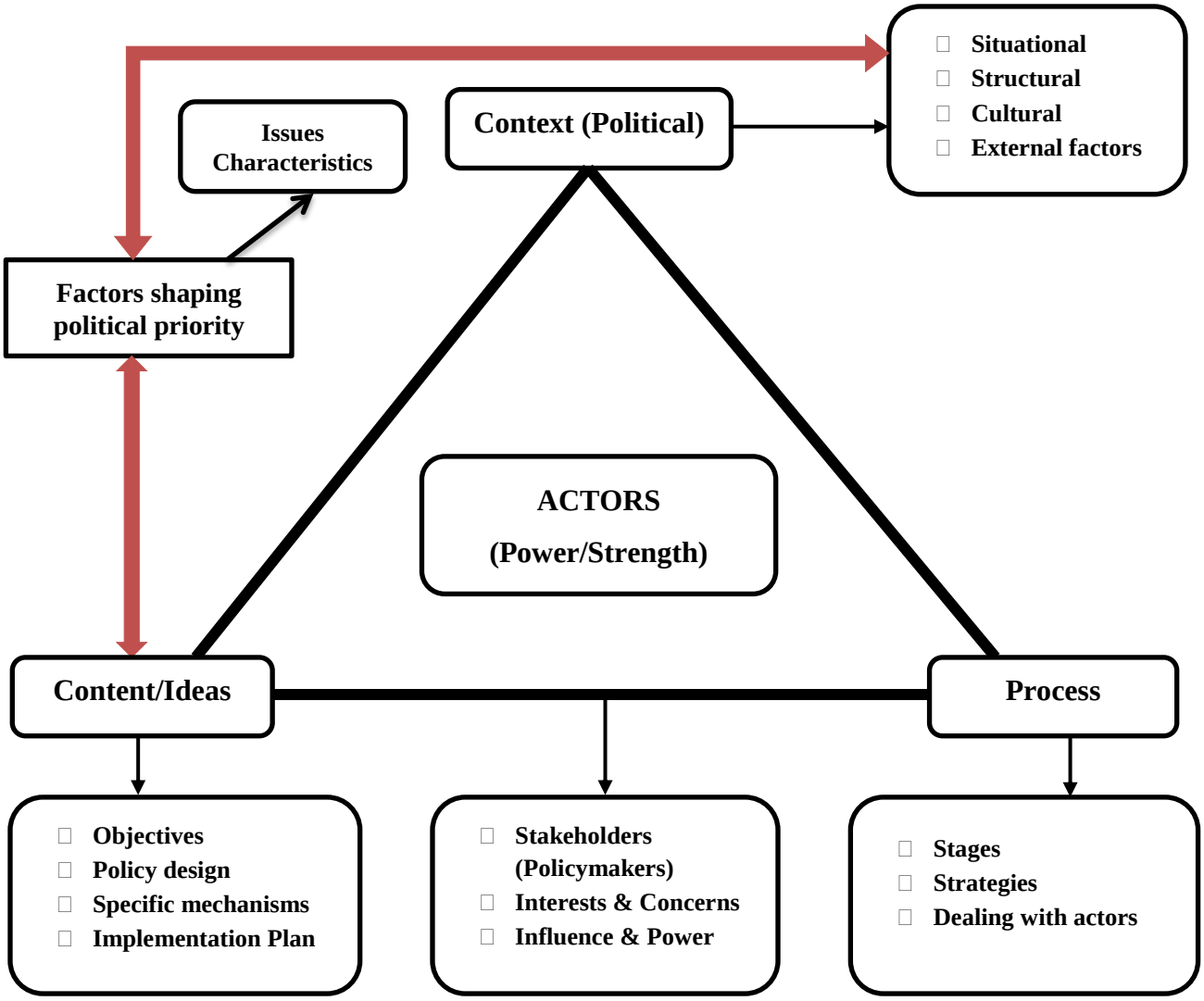
One key issue with the severity is that “network emergence and effectiveness are more likely surrounding problems that are perceived to have high mortality, morbidity or socioeconomic costs. An issue can be framed in multiple ways, some resonate more than others (244,246).

The characteristics of the issue are important for two reasons. Some challenges are essentially more complex than others and not all are given attention and support (244). With respect to diseases, some are communicable and non-communicable and tobacco is a risk factor to the NCDs. Although tobacco is associated with about twice the global mortality burden it has been second among all risk factors with regards to lost disability-adjusted life years (DALYs). Tobacco control has experienced much greater progress. The major accomplishment is the WHO FCTC (110,244,247).

Shiffman and Smith has argue that “problems that are easily measured, cause substantial harm, and have simple evidence-based solutions available are more likely to gain political support than are ones that do not have these features” (4,248). In the same way, some issues with low priority possess many of these characteristics while others with significant political attention lack several (246).

4.6. Conceptual Framework of the Study

Figure 8: Conceptual Framework



Given the importance of the health policy process (3,17,18) as well as issue characteristics (4) in the shaping of health policy and its prioritisation, this thesis has combined these components of both the Walt and Gilson (17,18) and the Shiffman and Smith (4) frameworks with common components of actors, contexts, and content. The overlapping and unique components in these two frameworks align with the articles in the WHO FCTC framework which are core to achieving tobacco control.

The literature reviewed on frameworks indicated that policy frameworks can facilitate understanding the process for public policy. It is the expectation that this thesis conceptual framework can be used to inform subsequent policy engagement strategies on tobacco control (3). The combined Walt and Gilson and the Shiffman and Smith frameworks used in this thesis will henceforth be called the ‘conceptual framework’ and is portrayed in Figure-8 above.

CHAPTER 5: RESEARCH DESIGN

This section outlines the research problem and describes the research methods in terms of approach (case study), and how it has guided data collection (stakeholder identification and analysis, focus group discussions, in-depth interviews, and document review) and the process of data analysis.

5.1. Research Problem

Tobacco use is an important modifiable risk factor to major non-communicable diseases (NCDs) - cancer, cardiovascular diseases, chronic respiratory diseases and diabetes, causing one in six of all deaths. Almost 6 million people die from tobacco use each year, both from direct tobacco use and second hand smoke. By 2020, this number will increase to 7.5 million, accounting for 10 million deaths (138).

The research problem remains fundamentally as defined earlier. Ghana is a country in the early stage of the epidemic. There is a critical dearth of basic information to support the development, implementation and monitoring of effective tobacco control programmes. It is against this background that this study focuses on funding mechanisms for tobacco control and the challenges of the implementation of the WHO FCTC. In view of the limited data on funding and the challenges of tobacco control, this study proposes to extend the understanding of the issues as indicated in the research questions and objectives.

5.2. Research Questions

The research had the following research questions:

1. What are the existing and potential funding sources (both local and international) and activities funded for tobacco control to address WHO FCTC commitments in Ghana?
2. What are the attitudes and perceptions of key stakeholders (government ministries - Health, Finance, Trade, and Agriculture etc.; CSO-NGOs and key corporate organizations) towards tobacco control?

3. What are the constraints in implementing the WHO FCTC?
4. What are the factors that would facilitate greater access to Official Development Assistance (ODA) for tobacco control in Ghana?

5.3. Objectives

5.3.1. General Objective

The general objectives of this study are to identify and explore: (i) the overall challenges of the implementation of the WHO Framework Convention of Tobacco Control (FCTC), and (ii) the existing and potential funding sources as well as activities funded for tobacco control in Ghana.

5.3.2. Specific Objectives

Specifically, the study's objectives include:

1. To explore the priority given to tobacco control in Ghana.
2. To identify current and potential funding sources for tobacco control while addressing the WHO Framework Convention for Tobacco Control commitments (FCTC).
3. To determine the attitudes and perceptions of key Stakeholders (government ministries - Health, Finance, Trade, Agriculture etc.; Civil Society Organizations – NGOs; and key corporate organizations - excluding Tobacco industry) toward funding for tobacco control and the Implementation of the FCTC.
4. To identify constraining and enabling factors to the implementation of the WHO FCTC in Ghana.

5.4. Research Approach and Method

The research was exploratory in nature. A qualitative case study was conducted for this study. The case study approach is known to enrich the examination of complex contextual issues where contextual conditions are very relevant to the phenomenon of the study (20,249). As such, the case study approach was used in order to gain an in-depth contextualised examination of the strategies for and barriers to accessing funding for tobacco control and

overall NCDs prevention and control efforts in Ghana. An article reviewing stakeholder theory provides convincing justification for the use of case studies as a research method. It argues that "small" sample, case based studies can be a source of rich data (20,250,251). The case study approach also permits the utilization of several data collection methods. Thus, adopting the case study approach, this study used triangulation through multiple qualitative methods and multiple sources of data.

The range of qualitative methods used include stakeholder identification and analysis, focus group discussion, in-depth interviews, and document review. These are discussed in more detail later in this chapter.

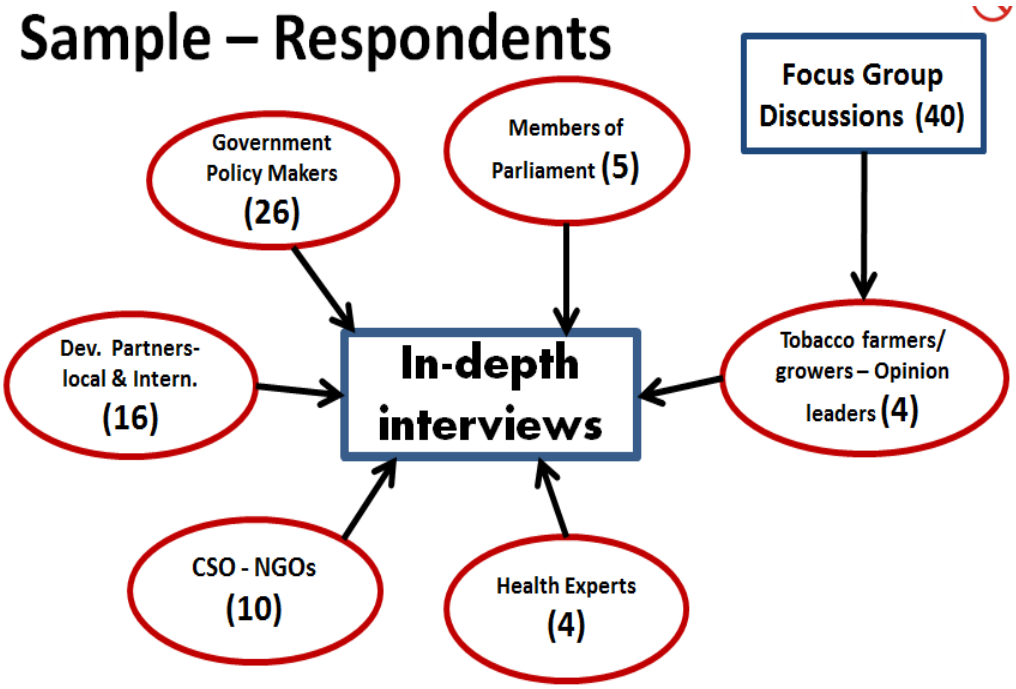
5.4.1. Triangulation

Methodological triangulation and data triangulation was applied to gain the most detailed picture of stakeholders' experiences and further validate the results. Methodological triangulation, implies that several methods in different combinations are used to facilitate the development of emerging themes and critical perspectives (252). It also enables the researcher gain the most detailed picture of stakeholders' experiences (253–255). All the different methods and the processes (including the seminar/ workshop) enable the establishment of a fuller and holistic picture. In this study, the prior brainstorming, consultation, interviews, and focus group discussions provided very rich information. These preliminary brainstorming sessions, consultations and workshops data allowed me to extract emerging themes and to have them discussed in the group discussions. In a research study triangulation adds validity to the findings (255,256).

5.5. Sample

A non-probability purposive sampling approach was used to recruit study participants. The individual participants and organisations/ agencies/ Institutions were selected deliberately for their specific characteristics, such as development partners that are of importance to the study. The aim was to ensure that all the key characteristics of relevance to the subject under study are covered, and to ensure that within each key category of stakeholders some diversity is included so that the impact of the characteristic concerned can be explored (257).

Figure 9: Sampled Respondents



5.6. Stakeholder Identification and Analysis

The stakeholder identification was undertaken at the outset of the research. Stakeholders were defined as individuals, groups, or institution/agency/organization that has a vested interest in tobacco control (250,258–265). The researcher identified all stakeholders who needed to be considered in achieving research objectives and whose participation and support are crucial to its success (250,258–265).

The research sources of information included governmental agencies - ministries, departments and agencies, development partners (local and international), and non-governmental organizations, and key informants within them. Other sources were educational and research institutions as well as professional bodies and individuals.

The researcher started off with a small team of four trained (on tobacco control and NCDs) research assistants who went through a brainstorming section. Different types of stakeholders were engaged in different ways in various stages of the study, from gathering and giving

information, to consultation and dialogue. This method provided a preliminary identification of key stakeholders, using a set criteria (importance, influence, involvement, dependence on the resources, authority, responsibility etc.) in the tobacco control programme in Ghana (250,258–265).

5.6.1. Rationale for Stakeholder Analysis

A stakeholder analysis can assist the tobacco control programme in Ghana identify: the interests of all stakeholders who may affect or be affected by the research; potential conflicts or risks that could jeopardise the study and implementation; opportunities and relationships that can be built on during implementation; groups that should be encouraged to participate in different stages of the study and implementation stage; and appropriate strategies and approaches for stakeholder engagement; (257–260).

5.6.2. Stakeholder Identification Process

The stakeholder identification and analysis was implemented by interviews and group discussions, matching the technique to the evolving needs of the study. Whatever approaches that was used; there were three essential steps in this stakeholder analysis:
1) Identifying the key stakeholders and their interests (positive or negative) in the project;
2) Assessing the influence of, importance of, and level of impact upon each stakeholder; and
3) Identifying how best to engage stakeholders.

I identified the key stakeholders and their interests (positive or negative) in the research by brainstorming all possible stakeholders (257–260).

I then researched the human environment. I talked to various stakeholders, face to face with the majority, and with a few by phone and emails. I subsequently asked them who they would see as potential stakeholders for the initiative in question. The list of stakeholders shrunk as our interviews progressed and our understanding deepened (257–260).

I tried to learn about each stakeholder group in as much depth as possible. With a team of four, I filled out a matrix which had the list of stakeholders. I numbered them for easy reference. This was to enable us to describe the stake or mandate of each stakeholder. The

mandate refers to the nature and limits of each stakeholder's stake in the resource and the basis of that stake (250,258–265). Key questions focused on assessing the influence and importance (Vision and Mission) of each stakeholder as well as the potential impact of the research upon each stakeholder (250,258–265).

Different types of stakeholders were engaged in different ways in the various stages of the study, from gathering and giving information, to consultation, and dialogue, determining who needs or wants to be involved, and when and how that involvement in this research can be achieved (250,258–265).

Stakeholder analysis is an important approach to apply in order to enhance the political viability of any policy related research.

- Doing stakeholder analysis requires patience and careful judgment, and particular attention to the contextual influences shaping policy actors' interests, positions on new policy proposals and relative power.
- Given the dynamic nature of policy change, repeated stakeholder analyses are likely to offer clearer insights to support policy change than a single analysis representing experience at only one time (266).

5.7. In-Depth Interviews

I planned the recruitment process for the in-depth interviews, negotiated the date and time of in-depth interviews, and chose venues for the project that were mutually suitable and acceptable. Data collection instruments were pretested and interviewing techniques that facilitate validity and reliability were used (267). The research questions for in-depth interviews focused on describing the 'why' and 'how' of tobacco control funding in Ghana (which type, how often) how it has come about (causes, strategies), and how it is maintained (structure) (257).

The research mainly used two types of interviews, unstructured and semi-structured. Semi-structured interviews are characterized by topic guides containing major questions that are used in the same way in every interview, although the sequence of the questions might vary as well as the level of probing for information by the interviewer (20,257). Follow up

interviews were negotiated where it was required. It was expected that data from other sources such as websites, official documents, and interviewing others would help enhance the viability of the research results. A total of 66 key stakeholders were interviewed comprising 26 Government Policy Makers, 16 Development Partners (Local & International), 10 Civil Society Organizations, five Members of Parliament, five Health Experts, and four Opinion Leaders among former tobacco farmers.

5.8. Document Review and Analysis:

I conducted a document review which involved a thorough study of existing documents to understand their substantive content and further illuminate deeper meanings which may be revealed by their style and coverage. Public documents like, organizations' annual reports, government papers or publicity materials, procedural documents (financial accounts of the Ministry of Health, Ghana Health Service, and the World Health Organization) and media reports (20,21) were gathered. A further reason for drawing on document sources is that it is not always possible to engage in direct observation or questioning (21,22).

5.9. Focus Group Discussions (FGD)

This study included focus group discussions (FGDs) as one of the data collection methods. A focus group discussion (FGD) is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. FGDs are a form of group discussion with the aim of capturing the interaction between the participants based on topics that are supplied by the researcher. The main purpose of group discussions is to evoke the level of respondents' attitudes, feelings, beliefs, experiences and reactions (268–270).

Focus group discussions (FGD) are normally held with 6-8 persons guided by a facilitator. During an FGD, group members talk freely and spontaneously about a topic. The purpose of an FGD is to obtain in-depth information on concepts, perceptions, and ideas of the group. It helps to focus the study and develop relevant information by exploring the topic in greater depth. Preparing and conducting an FGD involves identification of a contact person, recruitment of participants, identification and arrangement of the venue, and preparation of the FGD guide. There is also note taking and recording Taking notes of the session, and

getting as much details as possible writing verbatim are imperative. Researchers must also write down what they are sure about. The researcher is not supposed to make own judgements, only document what participants say (268–270) .

Four focus group discussion (FGDs) were held in two towns in Ghana, Kintampo North and South Districts of Brong-Ahafo Region. These are major tobacco growing communities in Ghana. The FGDs were held with 50 former tobacco farmers (15 females 35 males) who were recruited from the above communities. They were purposively selected for the four FGDs.

The summary of methods used for the four research objectives, and their corresponding data sources and instruments are given in Table 2.

Table 2: Summary of Methods

Research Objective	Data Source	Method	Instrument
1. Explored priority given to tobacco control in Ghana. 2. Identified current and potential funding sources for tobacco control while addressing the WHO FCTC commitments.	❑ Documents ❑ Policy makers (MOH/GHS) ❑ Government Agencies/ Inst. (eg. Finance/ Trade/ Agric/ Environ.) ❑ Development Partners ❑ NGOs & Civil Society Org. ❑ Programme managers (NCDs & Tob. Control)	❑ Documents Analysis ❑ Stakeholder Identification and Analysis ❑ In-depth interviews ❑ Focus Group Discussions ❑ Internet-Email	❑ Matrix ❑ In-depth interview guide ❑ FGD guide
3. To determine attitudes and perceptions of key stakeholders (government ministries-Health, Finance, Trade, Agriculture, etc.; CSO-NGOs & key corporate organizations) towards funding for tobacco control. 4. To identify constraining and enabling factors to tobacco control in Ghana.	❑ Documents ❑ Policy makers (MOH/GHS) ❑ Government Agencies/ Inst. (e.g. Finance/ Trade/ Agric) ❑ Development Partners ❑ NGOs & Civil Society Org. ❑ Programme managers (NCDs & Tob. Control) ❑ International Dev. Partners	❑ Documents Analysis ❑ In-depth interviews ❑ Internet-Email	❑ Matrix ❑ In-depth interview guide

5.10. Data Analysis

This section describes the data analysis approach (case study), how it has guided data collection (stakeholder analysis, in-depth interviews, document review, and focus group discussions), and the process of data analysis.

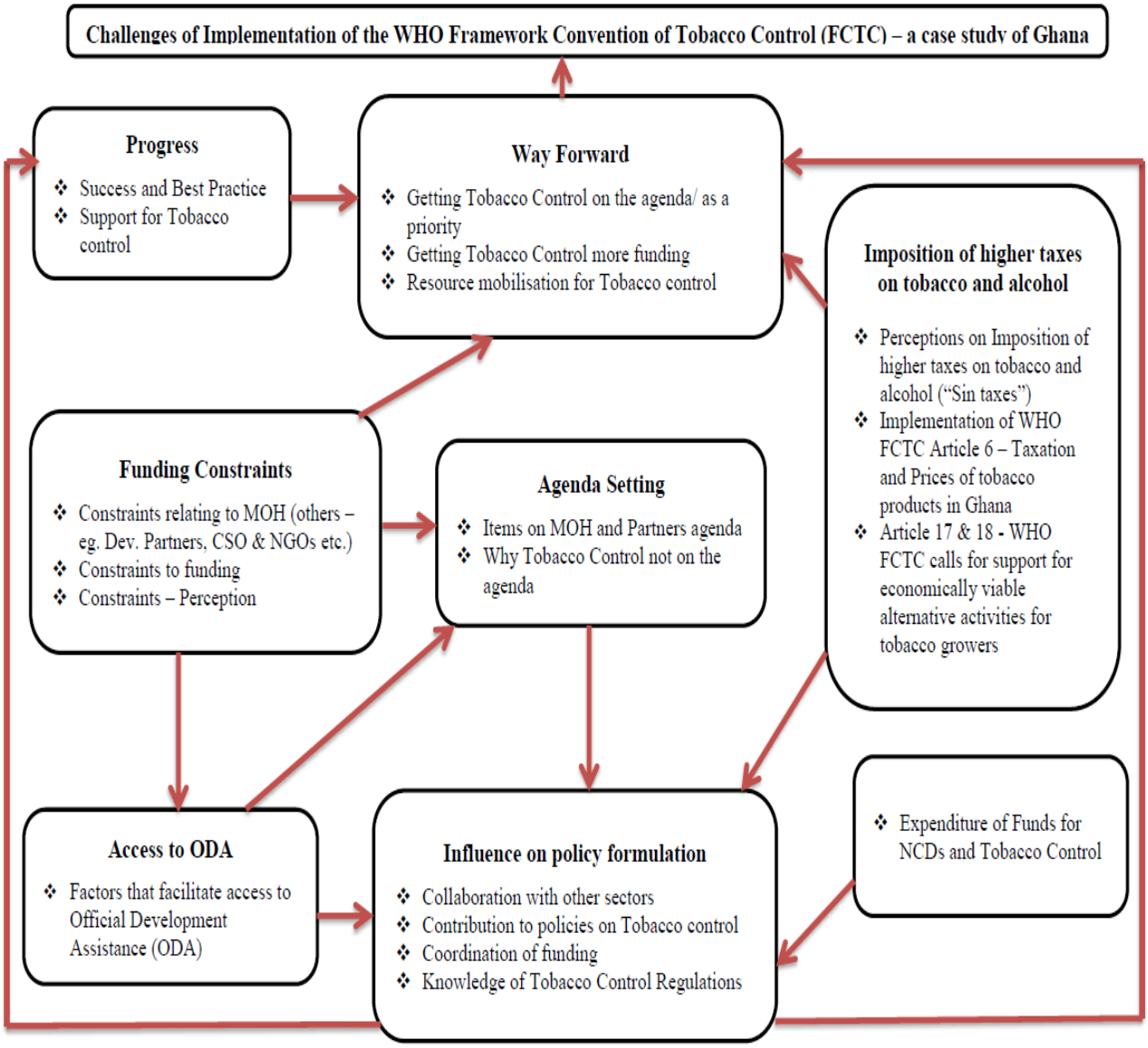
Data were reduced and developed into codes or categories. This was followed up by selective coding which involves selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development (271–273). Methodological triangulation was applied to gain the most detailed picture of stakeholders' experiences and further validate the results.

This section discusses the process of indexing/coding/labelling the data. The process of coding or more accurately (in the case of qualitative research) the indexing and linking of those elements of the data that are conceived of as sharing some perceived commonality, is an essential first step in managing the analytical process. Codes were used to simplify or reduce transcript data to manageable levels, the purpose being to achieve a simple conceptual schema. This involved the exclusive index coding of segments of data text in order to be able to eventually retrieve segments sharing a common code. Coding can be used as a method to open-up the data so enabling the researcher to think or conceptualise beyond the data itself (274,275).

Data was analysed using NVIVO computer data analysis program version 10. NVIVO is a computer software data analysis programme that was used to manage the qualitative data. It has clear advantages when analysing a large text data-base. NVIVO was used to do a systematic search for 'themes' in the data (273,276–278).

The summary of the data analysis and results are given in Figure 9.

Figure 10: Data Analysis and Results Plan



CHAPTER 6: OVERALL PROGRESS IN THE IMPLEMENTATION OF THE WHO FCTC

This chapter examines the history, current status, and challenges on tobacco control and the implementation of the WHO FCTC in Ghana, the support for tobacco control and the role of civil society organizations, i.e. and other stakeholders.

This will be in line with selected Articles of the WHO FCTC analysing the obligations that Ghana has to the Convention; the progress the country has made in implementation; and the challenges that exist. These articles are key elements which need to be put in place to enable the government of Ghana to meet its obligations to the Convention.

Ghana ratified the WHO FCTC on 29th November 2004 and was among the first 40 countries to do so (217,222,279). The Convention entered into force for Ghana on 27 February 2005 (218,280). Having ratified this treaty, Ghana is obliged to implement its provisions through national law, regulation, or other measures. There is therefore need to examine how far Ghana has implemented these, identify all obligations in the substantive articles of the Convention, link them with the relevant agencies, avail the required resources, and seek support internationally where appropriate (54,183,281).

The Convention recognizes the need to generate global action so that all countries are able to respond effectively to the implementation of the provisions of the Convention. Article 21 of the WHO FCTC calls on Parties to periodically submit to the Conference of Parties (COP) implementation reports, including any challenges they may face during implementation of the treaty. Article 26 of the Convention recognizes the importance that financial resources play in achieving the objectives of the treaty (217,282,283). The COP further directed that detailed needs assessment be done at the country level, especially in developing countries and countries with economies in transition, to ensure that lower resource Parties are supported to fully meet their obligations under the treaty.

At its second session (July 2007), the COP asked the Convention Secretariat (Decision FCTC/COP 2 (10)) to actively seek extra budgetary contributions specifically for the purpose

of assisting Parties in need to carry out needs assessments and develop project and programme proposals for financial assistance from all available funding sources. At its third session (November 2008), the COP adopted the work plan and budget for the biennium of 2010–11. The work plan, inter alia, stressed the importance of assisting developing country Parties and Parties with economies in transition, strengthening coordination with international organizations, and aligning tobacco control policies at country level to promote the implementation of the Convention. Needs assessments, combined with the promotion of access to available resources, the promotion of treaty tools at country level, the transfer of expertise and technology, and south-to-south cooperation were outlined as major components of this work.

The assessment of needs was necessary to identify the objectives to be accomplished under the WHO FCTC and resources available to a Party for the implementation and any gaps thereof. It should therefore be comprehensive and based on all substantive articles of WHO FCTC with a view to establishing a baseline of needs that a Party requires to fulfil its obligations under the Convention. The needs assessment was also expected to serve as a basis for assistance in Programme and Project development for meeting the obligations under the Convention, particularly to lower resource countries to promote and accelerate access to internationally available resources for implementation of the Convention.

In Ghana, the needs assessment was carried out in three phases: (a) initial analysis of the status, challenges and potential needs deriving from the latest implementation report of the Party and other available sources of information; (b) visit of an international team to the country for a joint review with government representatives representing both the health and other relevant sectors; and (c) follow up with country representatives for further details and clarifications, review of additional materials jointly identified, and the development and finalization of the needs assessment report in cooperation with the government focal point(s) (217,218).

With the above objectives and process in view, a joint assessment of the needs concerning the implementation of the WHO FCTC was conducted by the Government of Ghana and the Convention Secretariat, with the participation of the WHO Tobacco-Free Initiative (WHO-

TFI) and WHO Representative in Ghana in 2010. The assessment involved various relevant ministries and agencies of the Government of Ghana.

The report contains a detailed overview of the status of implementation of substantive articles of the treaty and also identifies gaps therein and areas where further actions are needed to ensure full compliance with the requirements of the treaty and the implementation of guidelines adopted by COP when relevant. This is followed by specific recommendations concerning that particular area. The Executive Summary provides an overview of the joint needs assessment exercise, and an outline of key findings and recommendations.

6.1. Current Status of Implementation in Relation to the International Status

6.1.1. Guiding Principles

In Article 4, Guiding Principles of the FCTC, the Preamble emphasizes "the special contribution of nongovernmental organizations and other members of civil society not affiliated with the tobacco industry to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts" (217,284).

ROLE OF NGOS /CSOS

Civil society action is paramount to the success of tobacco control efforts in Ghana. Civil society groups aim to: influence policy change; sensitizes communities to tobacco issues; create awareness about the dangers of second-hand smoke and mobilize society for action to compel government to issue directives, as well as speed up the passage of the tobacco control law. The Coalition of NGOs in Tobacco Control (CNTC), an organization made up of over 15 NGOs, is the key civil society group that leads the effort from the nongovernmental side. Specific NGOs include Vision for Alternative Development (VALD), Network for Community Planning and Development (NECPAD), Healthy Ghana, the Movement Against

Tobacco and Substances of Abuse (MATOSA), the Communication for Development Centre (CfDC), Healthpage Ghana, the Future Rescue Foundation, the Integrated Social Development Centre (ISODEC). The coalition has so far sensitized stakeholders – including the media, the hospitality industry, the Ghana Actors Guild and others on the need for smoke-free ruling.

Healthy Ghana has played a pivotal role in tobacco control in Ghana .It is a health –based NGO created to establish a healthy population and healthy environment and to support comprehensively its identified social determinants of health. The executive director of Healthy Ghana, Professor Agyeman Badu Akosa, has been the pillar of tobacco control activities in Ghana. He is a past director of the GHS Ghana Health Service, a position he held for five years, during which time he raised advocacy efforts on tobacco control. VALD was established to promote alternative initiatives and development at all levels of society. It engages in health promotion and information about tobacco control. The organization – particularly via Executive Director Issah Ali and Programmes Directory Labram Musah – has been very vocal about tobacco control generally, but also specifically about it being FCTC-compliant. MATOSA headed by Oscar Bruce, has been a fervent advocate against anything related to tobacco (54). VALD and the other NGOs have been influential in pushing for the passage of the Public Health Act 581 of 2012. Besides VALD and the other NGOS also lobbied for the passage of the legislative instrument. VALD has over the years received support from the Bloomberg Foundation to undertake advocacy programmes. Therefore it is reasonable to state that advocacy networks and the activities of interest groups influenced the adoption of tobacco control instruments in the country (225).

The coalition could do well to engage other NGOs involved in public education and awareness, including community-based organizations that address issues pertinent to women, children, youths, and the environment. These organizations could be very helpful in the dissemination of information and to help conduct the public education and awareness campaigns for tobacco-related issues.

General Obligations

Article 5 of the FCTC covers tobacco control governance and related general obligations. Article 5.1 calls upon Parties to "develop, implement, update and review comprehensive multi-sectoral national tobacco control strategies, plans and programmes in accordance with this Convention." Furthermore, Article 5.2 requires countries to establish or reinforce and finance a national coordinating mechanism or focal point for tobacco control. Ghana's experience with tobacco control precedes the creation of the WHO FCTC. In the 1980s, the government, through directives instituted various tobacco control measures before the international tobacco treaty was adopted in 2005 (201).

Many tobacco control activities have been conducted such as Quit and Win, observation of the annual World No Tobacco Day, raising public awareness and updating policy makers on tobacco control issues.

There is several government agencies involved in fulfilling the government's various obligations to the Convention. Thus, there is a need to develop a national strategy in implementing the WHO FCTC to enable better coordination of the policy making process related to tobacco control to maximize effectiveness. Meeting the treaty obligations is mainly seen as the task of the Ministry of Health and the Ghana Health Service rather than the whole government's responsibility. It is important to ensure that all actors (governmental and non-governmental) can bring their contributions to the implementation of a national tobacco control action plan.

The first National Tobacco Control Steering Committee (NTCSC) was established by the Minister of Health in January 2002. Members of the committee were tasked to support the Ministry in its policy development, advocacy for tobacco control and to advise on effective intervention strategies for the successful implementation of a National Tobacco Control Program. The Minister also expected the committee to develop a national policy on tobacco control. The Ghana Health Service was appointed the Secretariat of the Committee. Other relevant government agencies were invited as members of the Committee. After Ghana ratified the Convention in 2004, the first NTSCS continued to play some coordination role and in consultation with key stakeholders, drafted tobacco control measures which

eventually became PART SIX of the Public Health Act of 2012 (ACT 581). A second NTSCS has now been established and inaugurated with the same mandate (217).

In 2010, during the needs assessment, the Ministry of Foreign Affairs committed to support coordination from the treaty implementation angle and make efforts to ensure the obligations under the Convention were fully met. Interest was also expressed by the Ministry of Finance to learn more about the international experience of using earmarked tobacco taxation to fund the national coordination mechanism and tobacco control activities. Members of the Health Committee of Parliament also suggested the establishment of a health promotion fund through earmarked tobacco taxation. The 2010 needs assessment report recommended that a specific budget line be allocated to support the work of the national coordination mechanism with dedicated staff in place (217).

The Research and Development Division (RDD), formerly the Health Research Unit of the Ghana Health Service under Ministry of Health has since the year 2000 been coordinating tobacco control and a staff was appointed the focal point for tobacco control in Ghana. This tobacco control focal point also covered other research responsibilities apart from tobacco control. In the absence of a national coordination mechanism, the tobacco control focal point also played the coordination role in preparing the country's WHO FCTC implementation report with input from the relevant agencies but this relied more on personal effort rather than a systematic mechanism. In 2010 it was recommended that a full time focal point be established in the Ministry of Health to work full-time on the implementation of the Convention. This office could then better coordinate all relevant units in Ghana Health Service (such as non-communicable disease, health promotion, research etc.) and the Food and Drugs Board (FDB) now Food and Drugs Authority (FDA) to integrate implementation of the WHO FCTC in all health care programmes. Other staff from within the Ministry and its agencies could support tobacco control on a part-time basis. More staff time shall be realized from other ministries and agencies of government who have a role in the implementation of the Convention (54,217,285). However, since 2010 till now there continues to be a focal person at the Ghana Health Service who has other responsibilities to perform in addition to the numerous tobacco control activities. The focal person in the discharge of his duties is assisted by others who also have their core functions to perform.

In Ghana successive governments have adopted measures concerning tobacco control through executive or administrative directives that have demonstrated some effectiveness. For example, the Ministry of Health (MOH) has prohibited smoking in all its healthcare facilities, a measure that remains in force, the Ministry of Education (MoE) prohibits the smoking of cigarettes by both students and staff at the pre-tertiary educational level during school hours and the Ministry of Transport restricts smoking on public and private commercial transport. Additional directives by government officials in the 1980s placed restrictions on smoking in government offices and other public places, including restaurants and cinemas (54).
In January 2002 the government set up the National Tobacco Control Steering Committee to draft a Tobacco Control Bill. The country's ratification of the FCTC gave the need for this legislation a further boost. The ratification led to the redrafting and editing of the draft bill in 2005 before submitting it to the cabinet by the then minister of health. In 2008-9, the draft bill was reviewed by local and international experts and resubmitted to the attorney general's office for onward submission through the health minister to the cabinet. For a variety of reasons, progress on the bill stalled and it was not clear when the bill would be passed from the cabinet to the legislature, as is the legislative process in Ghana (54).

However, as a result of persistent public pressure for new tobacco control measures the drafted bill became part of the Public Health Bill which was ultimately approved by cabinet and submitted to parliament. The bill was debated and unanimously passed into law in July 2012 and assented to by the President on 9th October, 2012.The passage of the Public Health Act, 2012 (Act 581) PART SIX of which covers tobacco control measures is the culmination of a lengthy process of policy development. The MOH which led the policy development process collaborated with various ministries, members of parliament, particularly the Select Committee on Health and other agencies from both the public and private sectors including civil society organisations.

PUBLIC HEALTH ACT 2012 ACT 581

PART SIX of the Public Health Act 2012 covers the tobacco control measures. It has provisions on prohibition of smoking in public places, advertising in relation to tobacco and tobacco products, tobacco sponsorship, promotion of tobacco and tobacco products, packaging and labelling. Other provisions are on health warning on package, point of sale

health warning, minimum age restrictions, public education against tobacco use, treatment of tobacco addiction, and sale of tobacco products. The Act also has administrative and miscellaneous provisions on appointment of inspectors and analysts, their powers and functions, the testing of tobacco and tobacco products, the power of the Food and Drugs Authority to prosecute and collaborate with relevant bodies, regulations, and offences. There are also transitional provisions and interpretation of terms used in the text of the tobacco control measures of the Public Health Act 581 of 2012.

The researcher's analysis of the provisions of the Act indicate they are largely consistent with the FCTC and its guidelines with some exceptions such as the inclusion of designated smoking areas. There are some new provisions. The law now provides legal support to existing tobacco control measures in Ghana.

Since the passage of the law in 2012 the Minister responsible for Health in exercise of the power conferred on him by section 76 of the Public Health Act, 2012 (Act 851) and in consultation with the Food and Drugs Authority, has developed a set of tobacco control regulations (L.I.2247) which was promulgated on 19 September, 2016. It is instructive to note that these regulations are in furtherance of " a) provisions on tobacco control specified in the Public Health Act, 2012 (Act 851) and b) the objectives, principles and provisions of the Framework Convention on Tobacco Control and its Guidelines for Implementation in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke.(REF Republic of Ghana Tobacco Control Regulations, 2016 (286).

The WHO Needs Assessment report of 2010 clearly indicated that a national coordination mechanism on implementation of the WHO FCTC had not yet been established and financed. A national coordination mechanism is needed because tobacco control requires a whole-of-government approach and system-wide co-ordination (287).

However, in line with Article 5.2 Ghana inaugurated a Tobacco Control Inter-Agency Coordinating Committee (TA-IACC) in December 2013. The TA-IACC is chaired by the Minister of Health who delegates to the Chief Director. The tobacco focal point is Secretary to the committee. The committee includes representatives from the different sectors of government namely health, finance, education, local government, environment, justice, food and agriculture, trade and industry. Other members are from the tourism authority, the police

service, revenue authority, teaching hospitals and health training institutions, the WHO Country Office and representatives of the media and civil society organizations. The committee shall review progress of implementation of activities, enforcement of regulation and resource mobilization and its efficient use (288).

Although there is no manufacturing of tobacco products in Ghana since 2006, tobacco products importers are regularly engaged in lobbying government so as not to increase tobacco taxation. (54,120,217). The 2012 public health law has no clear policies on how to engage with the tobacco industry in protecting public health policy from influence by vested interests though international guidelines have been developed for parties to adopt and implement (Art. 5.3).

However, the recently passed tobacco control regulations (L.I. 2247) have two provisions which are in line with implementing Article 5.3 and its guidelines among government officials. Section/Article 17 of L.I.2247 indicates that 'any interactions or meetings between public authorities or public officers with a role in tobacco control and the tobacco industry shall be limited to the extent strictly necessary for effective tobacco control and enforcement of relevant laws.' Furthermore, the Minister may issue a code of conduct prescribing standards for public officers, service providers, contractors and consultants involved in setting or implementing public health policies for effective tobacco control (54,120,217).

In 2014 and 2016 Ghana reported that it was in the process of developing an appropriate code of conduct for public officials in their interactions with the tobacco industry (288).

Article 5.2 does not just oblige Parties to establish or reinforce focal points and national coordinating mechanisms – it also obliges Parties to finance them (288). Ghana now has both a focal point and national coordinating mechanism working on attaining various FCTC obligations. However, Ghana reports that inadequate funding affects efforts to attain FCTC objectives (288).

6.1.3. Price and Tax Measures to Reduce the Demand for Tobacco

Article 6 of the FCTC recognizes that "price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular

young persons". It is not clear if the Government of Ghana at the time of the needs assessment recognized from a policy perspective that tobacco taxes were an effective means to reduce tobacco use. It is clear, however, that an excise tax was and continues to be imposed on tobacco products (as well as alcohol) partly because those products are considered harmful to health. It is important that in the enforcement of the Public Health Act 2012 on tobacco control, Ghana develops a national strategy for implementation of the Convention. This is an obligation in that it stipulates that "each party should take account of its national health objectives concerning tobacco control and implement tax policies and, where appropriate, price policies on tobacco products should be instituted so as to contribute to the health objectives aimed at reducing tobacco consumption" (217,218).

Up until 2008, Ghana imposed a flat ad valorem rate of 140% (of the Cost, Insurance and Freight - CIF - value) on all tobacco products. In 2008, the taxation structure was changed for cigarettes to a specific excise tax. The rate varied depending on the type of cigarette imported (217,289).

The following rates were imposed during 2008 and 2009:

- Premium cigarettes: 0.0275 cedis per stick
- High quality cigarettes: 0.0235 cedis per stick
- Medium quality cigarettes: 0.0175 cedis per stick
- Low quality cigarettes: 0.01 cedis per stick

The other types of taxes imposed on tobacco products:

- Import duty: 20% of CIF value (cigarettes produced within ECOWAS (Economic Community of West Africa States) and imported to Ghana are exempt from the import duty);
- National Health Insurance Levy: 2.5% of CIF + Import duty value (this levy is imposed on all products in the market which are subject to VAT, it is collected at the same time as VAT);
- ECOWAS levy: 0.5% of CIF value (imposed on most imported products);
- Economic development and investment fund: 0.5% of CIF value (imposed on most imported products);
- Processing fee: 1% of CIF value (only imposed on products benefiting from the import duty waiver above);

- Value-added tax (VAT): 12.5% of CIF + Import duty value +excise tax (initially, the enforcement agency - Customs - used only CIF + Import duty as the base, but the Ministry of Finance sent a note to Customs to make sure that the excise value was also taken into account in the base for the VAT tax. This happened only 5 months ago) (54,217,289).

The main reason why the tax structure was changed in 2008 was for revenue generation purposes and affected all non-petroleum excisable products (tobacco, alcoholic and non-alcoholic drinks). The Government assumed tax neutrality, i.e. follow the one tax policy approach for all non-petroleum excisable products. This meant that the government looked at the effect of tax change as a whole and not by product ,and the purpose was to increase revenue from those products taken altogether (54,217,289).

After two years of imposition of the new tax structure introduced in 2008, the government noted a decrease in their total tax revenues from non-petroleum excisable products. The reduction in revenue was mainly driven by the decrease in revenues from alcoholic beverages. However, revenues from tobacco taxes actually increased. Unfortunately, because of the tax neutrality approach and the fact that total revenues went down, the government decided to go back to the old regime with the rates applied on the excisable products before 2008. For tobacco products, in particular cigarettes, this meant basically a reduction of the tax rate (54,217,289).

In 2010 the Ministry of Finance decided to impose the flat ad valorem rate of 140% of CIF value. Even though the rate seems like a high rate, when converted as a percentage of the retail price, excise tax only represents 22% of the price and the total tax (excise + import duty + VAT + other levies) share is 31% of the retail price (54,217,289).

It was then recommended that the government considers increasing excise taxes on tobacco products. However, the increase should not only cover cigarettes but all tobacco products in order to avoid substitution of consumption to other tobacco products as in Article 6.2 (b) of the FCTC which requires Parties to prohibit or restrict, as appropriate, sales to and/or importations by international travellers of tax- and duty free tobacco products. The quantity limit for importation of tobacco products by international travellers is not clearly stated in the

Customs law and is left to the discretion of each customs officer. It is important that the Customs law clearly sets the limit for the sale and/or importation of tobacco products by international travellers entering the country (54,217,289).

Chapter 6.1.3 page 100 reports on tax measures up to 2010 reforms below covers the increase made: In the 2014 budget and economic policy of the Ghana government, the Finance Minister announced an increase in the excise duty rate of tobacco products from 150 per cent to 175 per cent. The Minister argued that the increase will improve compliance by Ghana with Article 6 of the Convention and be in line with guidelines for implementation of Article 6, adopted at the sixth session of the COP in October 2014. The increase in tobacco excise also addressed the recommendation of the report of the joint needs assessment conducted with the assistance of the Convention Secretariat. The increase was effected after the Parliament of Ghana approved it through the passage of the Excise Duty (Amendment) (No2) Act, 2015 (Act 903) (289).

Furthermore, a Tariff Interpretation Order issued by the Commissioner-General of the Ghana Revenue Authority to explain and amplify the changes in tariffs arising from the 2016 Budget Statement and Economic Policy and captured in the Excise Duty (Amendment) (No2) Act 2015 (Act 903) stipulates/indicates 175 per cent levy for cigarettes and cigars, 175 per cent for snuff and other tobacco and for Negrohead is 12 Ghana cedis per kilogram (288,289).

6.1.4. Protection from Exposure to Tobacco Smoke

Article 8 requires countries to adopt and implement effective measures to protect their people from exposure to tobacco smoke in indoor workplaces, public transport, indoor places and as appropriate, other public places. The Article 8 guidelines emphasize that “there is no safe level of exposure to second-hand smoke” and calls on “each Party to strive to provide universal protection within five years of the WHO Framework Convention’s entry into force for that Party”. The corresponding date for Ghana was 27 February 2010 (217,284,290,291).

Ghana was unable to meet the five year timeline; several efforts were made to protect the public from exposure to tobacco smoke. Various Ministries and government agencies issued administrative directives on protection from exposure to tobacco smoke. The Ministry of

Health for example, prohibits smoking in all its health care facilities and other premises. The Ministry of Education prohibits the smoking of cigarettes by both students and teachers at the pre-tertiary level within the school premises and enforce stiff punishment for those students caught smoking. The Ministry also developed School Health Education Policy in 2009 to promote a child friendly school framework and healthy lifestyles which includes avoiding the use of tobacco. Emphasis is also given to the provision of counselling service to the students who want to quit (217). The school health education programme still continues at the pre-tertiary level.

The Children's Act 1998 protects the right to education and well-being of children and stipulates that no person shall deprive a child access to education, immunisation, adequate diet, clothing, shelter, medical attention or any other thing required for their development. As exposure to tobacco smoke poses serious health consequences to the child's development, the right to clean air without tobacco smoke can be effected under this Law. The Ministry of Transport restricts smoking in public and private commercial transport, including the Ghana Private Road Transport Union and Inter City Buses, and on both domestic and international flights (217).

Ghana Tourism Board is the government's regulatory body to develop, promote and coordinate all tourism activities. It is responsible for issuing licenses to the hospitality industry. The Board has been promoting smoke free public places and provided some hotels in the Greater Accra Region non-smoking signs and encouraged the hospitality industry to create smoke free places within their facilities (217).

Since the needs assessment of 2010 Ghana has enacted the Public Health law, section 58 of the law provides a list of workplaces and place places where smoking is prohibited. This list includes factories, health and educational institutions, offices and office buildings, indoor public places, premises in which children are cared for, shopping malls and any other facilities accessible to the public. The law prohibits smoking in public places; the ban is not 100% complete since the law allows smoking in specially designated areas. L.I. 2247 provides requirements for areas designated for smoking. However, where the requirements cannot be met for an area designated for smoking inside an enclosed workplace or public

place, including a means of public transportation the entire indoor or enclosed public place or workplace shall be declared smoke-free (286).

An interesting provision in the tobacco control regulations is the right of owner to prohibit smoking throughout the entire indoor and outdoor premises of that public place or workplace (286). There is also prohibition of smoking in a private vehicle where a child or a pregnant woman is on board.

Under the Act and the regulations a person who contravenes or facilitates the contravention of these regulations commits an offence and is liable on summary conviction to the penalty specified under the Act. While it is a good sign to have the Law and the tobacco control regulations in place, how to enforce them across the country would be very challenging. In 2015 a study assessed the perceptions of owners or managers of selected smoking and non-smoking public places and the compliance of tobacco control law in selected places in two cities in Ghana. The study also measured the extent of air pollution caused by tobacco smoke in public places in 2007 (pre) and 2015(post) legislation era by using Sidepak monitors to measure Particulate Matter (PM 2.5) in 60 smoking and 10 non-smoking public places. The results showed significant differences in manager perceptions of the law in 2007 and 2015. Managers of non-smoking establishments had a better perception of the law than their smoking counterparts. About one-third of pre-legislative smoking locations did not allow smoking and PM2.5 levels were 25% lower than pre-legislative era. The study concluded that smoking is still allowed in many places in Accra and Kumasi (292).

While it is good to have the law and tobacco control regulations in place, how to enforce them across the country to protect people from exposure to tobacco smoke would be a daunting task in view of the huge numbers of public places. Allowing for designated smoking areas in public places could also be a challenge since there is no safe level of exposure to tobacco smoke and even brief periods of exposure to low levels of tobacco smoke is harmful (293).

6.1.5. Regulation of Contents of Tobacco Products

In implementing Article 9 on regulation of the contents of tobacco products, the FCTC requires Parties to "adopt and implement effective legislative, executive and administrative or

other measures for the testing and measuring of the contents of tobacco products" Ghana has two institutions whose mandates are relevant for the implementation of Articles 9 of the Convention. These are the Food and Drugs Board (FDB) and the Ghana Standards Board (GSB). FDB - The Food and Drugs Law established FDB in 1992. Although the Food and Drug Law did not directly cover regulation on tobacco, the Minister of Health's Directive of 2007 gave the Board the mandate for tobacco regulation. As there is no manufacture of tobacco products in Ghana, FDB requires all importers to register their tobacco products with the agency and submit analytical reports on contents. For cigarettes, the ignition propensity test is also required. The Ghana Standards Board (GSB) was established by the Standards Decree, NRCD 173, 1973 to promote standardization in industry and commerce and promote standards in public health and industrial welfare. Health and safety is taken into consideration for setting standards and conducting conformity testing. Some tobacco products standard (GS 105-1:1992) has been set up. It details the specifications for cigarette including tar and nicotine levels and the methods for sampling procedure required to ensure compliance to the standard (54,217,294).

The FDB does not at the moment do any confirmatory testing themselves and rely on the importers to do that and present the results. GSB's laboratory has very limited capacity to test tobacco products and for example cannot test nicotine level. Therefore, there is to include testing and measurement of the contents and emissions of tobacco products. An assessment and review of the testing and laboratory capacity among the existing facilities in the country will help to later decide whether Ghana should develop its own testing capacity or utilize capable laboratories in the Region through bilateral arrangement (217,294).

6.1.6. Regulation of Tobacco Products Disclosures

Article 10 requires Parties to "adopt and implement effective measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities' information about the contents and emissions of tobacco products." FDB currently requires importers to disclose information about active ingredients, other ingredients and reasons for inclusion, additional raw materials used but not in the final product, more than 20 constituents of whole/unburned tobacco and more than 40 toxic emissions in both mainstream and side stream smoke when the importer registers for their products. FDB gets the

information on tobacco product disclosures through the importer's registration form. (217,294).

Currently there are no measures in place on public disclosure of information about toxic constituents and emissions when it comes to Article 10 which also requires a Party to “further adopt and implement effective measures for public disclosure of information about toxic constituents of the tobacco products and the emissions they may produce (217,284).”

6.1.7. Packaging and Labelling of Tobacco Products

Article 11 of the FCTC obligates countries to adopt and implement effective measures to ensure that tobacco product packaging and labelling do not promote the product; ensure that each unit packet and package of tobacco products and any outside packaging and labelling of such products also carry health warnings and messages that cover at least 50% of the principal display area. The health warnings and messages may include pictures (295).

Before 2010, the health warnings on cigarette packages in Ghana covered only 5% of the display area. The message ‘tobacco may be harmful to your health’ was rather ambiguous and did not communicate the health and other effects of tobacco use. In 2007 the Ministry of Health issued a directive for the registration of all tobacco and tobacco products with the then Food and Drugs Board (FDB) now Food and Drugs Authority (FDA). The FDA the agency responsible for tobacco control regulation in Ghana developed and approved for use three pairs of rotational messages covering 50% of the front and back panels of the principal display area (296).

Despite the absence of comprehensive tobacco control legislation in 2010, Ghana had however made some progress in meeting the obligations under Article 11 through the contractual arrangement with the tobacco product importers and distributors during product registration. FDB requires that all imported tobacco products should be registered with the agency and the importer signs an agreement that includes requirements on packaging and labelling of tobacco products. Article 11.1 (a) prohibits misleading tobacco packaging and labelling. FDB requires all imported tobacco products registered to comply with these requirements through contractual arrangement. Misleading descriptors are banned. In addition, the Article 11 guidelines recommend that Parties implement pictorial health

warnings and give specific recommendations on message contents and the design elements such as location, size and colour (217,285).

FDA requires that a tobacco product manufactured in, imported into or sold in the country shall carry the recommended health warnings determined by the Minister responsible for health. There are three sets of rotational textual health warnings (Annex IV) required on both the front and back panels of the principal display area. The size of the warnings is 50% on both the front and the back as recommended by the Article 11 guidelines and is greater than the minimum 30% size required by the Article 11. The health warnings should be black on a white background and clear, visible and legible (217,285).

All these measures put in place by the FDA were complied with even without national legislation. FDA currently does not have any requirement related to Article 11.2 which requires "Each unit packet and package of tobacco products and any outside packaging and labelling of such products shall, in addition to the warnings specified in paragraph 1(b) of this Article, contain information on relevant constituents and emissions of tobacco products as defined by national authorities" (217,285). Similarly, pictorial health warnings recommended in the Article 11 guidelines have not yet been implemented at this time.

With the coming into force of the Public Health Act of 2012 (Act 581), the FDA in pursuance of Sections 62 to 65 of the Act produced a set of guidelines for the labelling of tobacco products in February 2013 to provide prospective importers of tobacco products with information on the general requirements for the labelling of tobacco products.

The Public Health Act of 2012 consolidates all the directives that the FDA used in relation to product registration, product packaging and labelling of tobacco products. The Public Health Act also requires that a unit packet or package of tobacco products for retail or wholesale in the country shall carry the statement 'for sale in Ghana only' and also state the country of origin. The recently passed tobacco control regulations L.I.2247 (2016) mandates a person who manufactures, imports or sells tobacco or a tobacco product shall ensure that for a unit packaging, the warning and message consisting of the pictorial images and accompanying text as shall be determined by the FDA shall cover fifty per cent of the principal display at the front and sixty per cent at the back. Furthermore, a sign on the product pack shall specify

‘eighteen years’ as the lowest age for the sale of tobacco and tobacco products. All tobacco companies which supply tobacco products in Ghana are obliged to comply with these provisions within eighteen months from the time the FDA makes the source document containing the electronic images of the health warnings, messages, constituents and emissions information statement available to the public.

Ghana has seen a lot of progress in the implementation of packaging and labelling of tobacco products and of health warnings on tobacco product packages. However, there is still work to be done particularly in the area of packaging and labelling of local smokeless tobacco to become fully compliant with the FCTC provisions.

6.1.8. Education, Communication, Training, and Public Awareness

One very key and important Article of the FCTC is Article 12 on education, communication, training and public awareness. It requires each Party to adopt and implement effective measures to promote broad access to effective and comprehensive educational and public awareness programmes on health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke”.
In Ghana several ministries, government agencies and civil society organizations have undertaken various informational, educational and communication programmes across the country. These activities have aimed that raising awareness of the harmful effects of tobacco use among the general population. For example, the Ghana Health Service in collaboration with the WHO Country Office organise the annual World No Tobacco Day with public educational events. These events are usually addressed by high ranking government and/or health officials. The celebration of World No Tobacco Day generates a lot of media coverage and discussions. The Ghana Health Service organized three Quit and Win campaigns which promoted the benefits of cessation of tobacco use as well as tobacco free lifestyle. GHS staff has provided some education on tobacco control issues at events organized by educational institutions and religious groups.

The dissemination of tobacco related survey results such as Global Youth Tobacco Survey in Ghana also created opportunities to secure resources to conduct advocacy campaigns and raise awareness of the harmful effects of tobacco use (281,297–299).

The Ghana Education Service through the school health programme carry out tobacco control education programme in the schools with the technical input from the Ghana Health Service. The "Smoker's body" posters have been distributed to many schools to raise awareness among students and teachers about the dangers of tobacco use. Civil society groups have also used their platforms individually and severally to provide some education against tobacco use and its harmful effects to segments of the population.

A media group representing the main print, radio and television outlets in the country has been mobilized to cover tobacco related issues and play a key role in communication and raising public awareness. This media group is committed to advocate for the passing of the Tobacco Control Bill. Ghana has performed well in public education on tobacco control but such campaigns have not been on a sustainable basis with the exception of the celebration of World No Tobacco Day when campaigns appeared to be intensified (201).

The 2010 Ghana FCTC needs assessment showed a lack of systematic and comprehensive educational and public awareness programme as well as lack of effective and appropriate training, sensitization and awareness programme among key target groups.

Section 66 of the Public Health Act 581 calls for public education on the effects of tobacco use, it also requires the Minister of Health in collaboration with the Minister responsible for Education, Youth and Sports, the National Commission for Civic Education and other related agencies to incorporate education against smoking in their programmes. The Minister shall ensure that each health facility has a unit or department that provides education against smoking.

As indicated elsewhere in the chapter, the Ghana Education Service, an agency of the Ministry of Education provides education on the dangers of smoking to discourage the youth from tobacco use. The Ministry of Health and her various agencies particularly the Ghana Health Service and the Food and Drugs Authority have organised several activities that provide knowledge and warn the general population about the risks of tobacco use, exposure to second-hand smoke and the tactics used by the tobacco industry and their front groups to derail the efforts being made by tobacco control advocates both at the national and

international levels. Since 2012 the Ghana FCTC Implementation reports have indicated increased education, communication, training and public awareness raising activities across the country. For example, there have been sensitization programmes for key frontline health workers who interact with communities and schools such as disease control officers, community health officers and public health workers. Additionally, pre-service training for some students of health training institutions have been undertaken. The FDA has also carried out media sensitization programmes to create awareness on the provisions of the Tobacco Control Measures as specified by the Public Health Act 581.There have been training programmes for officials of the FDA. Ministry of Health has carried out sensitization activities for Customs and Immigration Officers at all entry points to create awareness about Tobacco Industry tactics and interference and how to prevent them (288).

Civil society organisations have also organised information, education and communication activities in various communities. Media houses have also contributed to the awareness creation through the various programmes on their networks (288). These educational and public awareness programmes have targeted the general public, young people and the youth. These activities have provided information on the health risks of tobacco consumption and exposure to tobacco smoke and the benefits of cessation of tobacco use and tobacco-free lifestyles. Furthermore, health workers, media professional and other professionals have had appropriate special training and awareness programmes on tobacco control (194).

In spite of the increased educational and public awareness and special training programmes on tobacco control, some of the concerns that the needs assessment report of 2010 raised remain.

These are the:

1. There is no clear strategy on improving public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption. The 2014 and 2016 country reports indicated the development of a national comprehensive strategic plan for tobacco control and education, training and communication as some of the priorities to be implemented (288).

2. There is no information yet available on the overall level of knowledge of the members of the society on matters related to tobacco use or on the level of public support for stronger tobacco control legislation. Limited research has been done so far in Ghana. Some of the respondents comments ‘much of what we know about public health issues and tobacco control campaigns come from global level statistics-national level data is needed’(development partner).
3. There is no sufficient financial support to carry on the resource-demanding activities in meeting the obligations under Article 12 (217). This study found for example, in 2011 the total requirement for selected activities in tobacco control was budgeted at GH cedis 50,000, but however the actual amount received was 5,000. In 2012, except WHO support of US$ 2000 and Convention Secretariat support of US$ 15000, no additional funding was received from local sources for tobacco control activities though a programme of work and budget had been prepared. In the 2016 country report ‘very low financial support for public health activities in general was reported as one of the constraints for implementing the FCTC (288).

Some of the study respondents indicated that

> *“getting money to do advocacy is one of our major challenges…so there’s a problem and it’s got to do with the issue of funding to get the structures properly placed…”NGO*

> *“our constraint, the first one is lack of government funds to carry out our own work plan. The second one has to do with logistics…we have a lot of newly appointed coordinators who need capacity building but because we don’t have money, we haven’t been able to do it for them. We need more of the smokers’ body and leaflets to support teaching and learning of tobacco control…” (education official)*

> *“finances also a challenge. NCDs and tobacco control do not tend to attract financing” (development partner)*

It is therefore necessary that the Ministry of Health and other relevant government agencies such as Ministry of Education, Ministry of Information, National Media Commission, etc.

should continue to work together to educate and raise awareness of the harmful effectiveness effects of tobacco consumption and exposure to tobacco exposure. Effort should also be made to organise more training on tobacco control in both pre-service and in-service training for the health professionals (217).

6.1.9. Tobacco Advertising, Promotion and Sponsorship

Article 13 requires countries to legislate a comprehensive ban on all tobacco advertising, promotion and sponsorship, both within the country and that originating from and entering the territory.

Each country was expected to undertake appropriate measures to ban tobacco advertising, promotion and sponsorship within five years after entry into force of the Convention for that country. In 1982 the Government banned all cigarette advertisements on state television, radio and in print media. The National Media Commission's Guidelines for Broadcasting also stipulates that liquor consumption and smoking should be shown only when consistent with plot and character development (217).

FDB requires the importers and distributors of tobacco products to accept the following conditions when applying for registration as an importer of tobacco product: (i) prohibits direct and indirect advertising including brand stretching activities, (ii) prohibits tobacco advertising on a billboard, wall mural, vehicle, transport stop or station; (iii) prohibits organized activities and sponsorship and (iv) prohibits promotional offers and items to youth through all kinds of media (217).

FDB requires that posters containing health warning shall be placed at all distribution points and retail outlets. The text of the warning is as follows:

"Ministry of Health Warning: Cigarette smoking is harmful to your health."

The Code of Advertising Practice developed by Adverting Association of Ghana requires health warnings on packs of tobacco products and reaffirms the non-press tobacco advertising rules. Currently Ghana has not implemented any measures beyond the obligations set out in Article 13.4 (217).

Article 13.7 reaffirms Parties' sovereign right to ban those forms of cross-border tobacco advertising, promotion and sponsorship entering their territory and to impose equal penalties as those applicable to domestic advertising, promotion and sponsorship originating from their territory in accordance with their national law. Currently Ghana has not implemented any measures to ban cross-border advertising, promotion and sponsorship entering into its territory. The various regulations or contractual arrangements on banning tobacco advertisement, promotion and sponsorship developed by different agencies in Ghana have been consolidated into the Public Health Act 581 and its accompanying L.I.2247. This has thus provided a legal framework to ensure a total ban on brand stretching and brand sharing, corporate responsibility, depictions of tobacco in entertainment media recommended in the Article 13 guidelines.

The existing regulations and contractual arrangements still have loopholes such as point of sales advertisement and are not comprehensive. For example, L.I. 2247 requires that a person who sells or offers for sale tobacco or a tobacco product may, display at the point of sale, an inscription that tobacco products are available for sale. There shall also be a health warning of a required size conspicuously displayed at the point of sale. Furthermore, there shall be a sign with a statement

> *'WE CANNOT, BY LAW, SELL TOBACCO PRODUCTS TO ANYONE UNDER THE AGE OF 18 YEARS'.*

FDA has no regulation or contractual arrangements to require the disclosure to relevant governmental authorities of expenditures by the tobacco industry on advertising, promotion and sponsorship not yet prohibited. There is lack of regulation to ban cross boarder advertising, promotion and sponsorship originating from and entering into its territory (217).

The public health law when enforced will ensure 100% ban on tobacco advertising, promotion and sponsorship. The FDA is to provide the enforcement mechanism to ensure compliance. Media reports indicate that the FDA has already pulled down billboards or signboards advertising the availability of shisha at certain entertainment centres in some of the major cities in the country. It is further necessary that cross-border advertising, promotion

and sponsorship originating from and entering into its territory should be banned according to provisions of Article 13.2 and 13.7 (217).

The Global Progress report of FCTC implementation has cited Ghana as one of the countries with the highest level of achievement in TAPS (193).

6.1.10. Demand Reduction Measures Concerning Tobacco Dependence and Cessation

Article 14 of the WHO FCTC requires countries to develop and disseminate comprehensive, integrated guidelines for cessation of tobacco use and to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence. Countries should provide cessation support and treatment in all health care settings by all health care providers. Additionally, countries should consider providing cessation support and treatment in non-health care settings by sustainably trained non-health care providers.

Ghana served as one of the key facilitators to the Article 14 Working Group and actively participated in the drafting of the guidelines on implementation of this Article of the WHO FCTC.

Ghana attempted some cessation efforts by organising the Quit and Win Cessation competition three times. Quit and Win sought to encourage smokers to quit smoking for thirty days. Prizes were awarded to those who won the competition. The organizers of Quit and Win Ghana organised some groups counselling sessions for interested smokers especially in Accra. A draft manual on cessation was developed by the Ghana Health Service in 2007 but was not officially published. Nevertheless, some community psychiatric nurses provided some limited counselling and cessation services based on their training on substance abuse rather than tobacco dependence treatment.

Ghana still lacks a comprehensive and integrated programme concerning tobacco dependence and cessation. However, in some of the media campaigns and World No Tobacco Day celebrations information have been given about the benefits of quitting. There are partial cessation services on-going in some health facilities. In 2013 an in-service training on

cessation was organized for 40 health professionals including physicians, psychiatrists, pharmacists, mental health nurses from regional hospitals and regional health directorates. The training was funded and facilitated by the WHO Africa Regional Office. More importantly, Ghana now has a Cessation Manual that was officially launched at this year's World No Tobacco Day celebrations (288).

Meanwhile pharmaceutical products for treatment of tobacco dependence are not widely available and also not covered by the National Health Insurance. It is important that a national programme and services on diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco use should be established and provided in health care facilities, educational institutions, workplace and sporting environment. It should be integrated into the national health and education system. The cost of treatment of tobacco dependence and cessation services should be covered by the National Health Insurance. It is also recommended that Ministry of Health and its FDA should ensure to include Nicotine Replacement Therapy in the National Essential Drug List (217).

According to the 2016 Ghana Report there are plans to form cessation clubs, establish Quit Hotline and procure nicotine replacement medicines. The efforts that have been made so far in addressing the issue of cessation are encouraging but Ghana has a long way to go attain the objectives of the article (288).

6.1.11. Illicit Trade

Article 15 on illicit trade in tobacco products requires Parties to adopt and implement measures to ensure "the elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting, and the development and implementation of related national law, in addition to sub regional, regional and global agreements, are essential components of tobacco control."

The Ministry of Finance and Economic Planning and the Customs, Excise and Preventive Services (CEPs) estimate that illicit tobacco products consist 20-30% of the market share in Ghana. Even though tobacco products are not explicitly mentioned, the CEPs Law is the legal basis for combating illicit trade including of tobacco products. CEPs have confiscated illicit

tobacco products where Ghana is used as a transit point for neighbouring countries. CEPs has also signed MOUs with BAT and Phillip Morris to facilitate seizure of counterfeit products (217).

Ghana does not restrict duty-free sales of tobacco products. However Ghana restricts imports of duty-free tobacco by international and also limits the quantity of tobacco products that can be carried into the country duty-free. (217).

Similarly, the same article calls on each Party to "adopt and implement effective legislative, executive, administrative or other measures to ensure that all unit packets and packages of tobacco products and any outside packaging of such products are marked to assist Parties in determining the origin of tobacco products." Article 15.2 (a) requires that "unit packets and packages of tobacco products for retail and wholesale use that are sold on its domestic market should carry the statement: "Sales only allowed in (insert name of the country, sub national, regional or federal unit)" or "carry any other effective marking indicating the final destination or which would assist authorities in determining whether the product is legally for sale on the domestic market (217)."

In 2010, the FDA required tobacco product importers to provide information on the country of origin during the registration of a tobacco product. It also required that a tobacco product shall bear the inscription "For SALE IN GHANA" which shall cover not less than 5% of the principal surface of the package. This requirement is now part of the tobacco control section of Act 581of 2012 (12,217).

Customs, Excise and Preventive Service (CEPS) has an electronic system of tracking and tracing transit goods under the Ghana Management System (GCMS) and Ghana Community Network (GCNet). Importers are required to process clearance of goods by electronic declarations and the system can detect fraud or smuggling. Article 15.2 (b) calls on all Parties to "consider, as appropriate, developing a practical tracking and tracing regime that would further secure the distribution system and assist in the investigation of illicit trade (217)."

Ghana has met some obligations under Article 15.3 and 15.5. All labels are required in official language-English or translated into English. Data are collected through the GCMS

and GCNet systems. Ghana has met the obligations under this Article. The Article emphasizes "the packaging information or marking specified in 2(a) shall be presented in legible form and/or appear in its principal language or languages." and calls on Parties to "monitor and collect data on cross-border trade in tobacco products, including illicit trade, and exchange information among customs, tax and other authorities, as appropriate, and in accordance with national law and relevant applicable bilateral or multilateral agreements (217)"

CEPS (Management) Law 1993 prohibits all forms of smuggling. Penalties range from seizure, fine of 300% of the tax evaded and or a maximum jail of 10 years. The FCTC calls on Parties to "enact or strengthen legislation, with appropriate penalties and remedies, against illicit trade in tobacco products, including counterfeit and contraband Cigarettes (217,300)."

Confiscated counterfeit and contraband tobacco products are destroyed under the supervision of the Environmental Protection Agency but it is not very clear whether the methods used are environmentally-friendly. Article 15.4 (c) calls on Parties to "take appropriate steps to ensure that all confiscated manufacturing equipment, counterfeit and contraband cigarettes and other tobacco products are destroyed, using environmentally-friendly methods where feasible, or disposed of in accordance with national law" The FDA,CEPS and EPA would have to work together and establish environmental-friendly methods to destroy confiscated counterfeit and contraband tobacco products (217,300).

In the Ghana customs regulations, goods from the port of discharge are covered by Removal Bonds to ensure that they are not diverted into the market until they are safely delivered into bonded warehouses and secured all taxes collected. Article 15.4 (e) calls Parties to "adopt measures as appropriate to enable the confiscation of proceeds derived from the illicit trade in tobacco products" (217,281,300).

In 2008, Ghana passed the Anti-Money laundering Act (749) where proceeds from unlawful activities such as proceeds derived from illicit trade in tobacco products are frozen on the orders of a court. Parties are to "adopt and implement measures to monitor, document and control the storage and distribution of tobacco products held or moving under suspension of taxes or duties within its jurisdiction." And similar "provide information collected pursuant to

sub paragraphs 4(a) and 4(d) of this Article in their periodic reports to the Conference of the Parties, in accordance with Article 21 (217)."

Ghana continues to provide information through its reports to the Conference of the Parties and therefore has so far met the obligations under Article 15.5. Parties are to "promote cooperation between national agencies, as well as relevant regional and international intergovernmental organizations as it relates to investigations, prosecutions and proceedings, with a view to eliminating illicit trade in tobacco products. Special emphasis has been placed on cooperation at regional and sub-regional levels to combat illicit trade of tobacco products."

Ghana as a member of the International Criminal Police Organization (INTERPOL) and the World Customs Organization (WCO), shares information with INTERPOL and WCO and has active cooperation with them on anti-smuggling. Ghana has signed MOUs with its immediate neighbours Togo, Burkina Faso and Cote d'Ivoire on customs cooperation including combating smuggling (217).

CEPS and FDA were collaborating to tighten border patrols against tobacco illicit trade and regularly check the market to uncover and seize illicit tobacco products as one of the requirement of the FCTC. This is according to the FCTC article 15.7 which calls Parties to "adopt and implement further measures including licensing, where appropriate, to control or regulate the production and distribution of tobacco products in order to prevent illicit trade.'
The FDA has established a licensing system in which to control and regulate the distribution of tobacco products in Ghana. It further requires importers to commit to not selling tobacco or tobacco products to a person under eighteen. Selling in an education institution and in a facility with a significant portion of youth clientele including an amusement park, a movie theatre and sports stadium is also prohibited. This is according to Article 16 which requires "measures at the appropriate government level to prohibit the sales of tobacco products to persons under the age set by domestic law, national law or eighteen (54,217)."

Ghana was actively engaged in the process of drawing up the Protocol on Illicit Trade in Tobacco Products (54,217). It is the first protocol which builds on and complements Article

15. Ghana has signed the Protocol but is yet to ratify it. The Protocol shall enter into force after ratification by 40 countries.

6.1.11. Sales to and By Minors

Article 16 obligates countries to adopt and implement measures to prohibit the sales of tobacco products to and by persons under the age set by the law. In Ghana the minimum age restriction relates to a person below the age of eighteen years. The current law prohibits the sale of tobacco products to and by a child, it also prohibits a person to request a child to light tobacco or a tobacco product and expose a child to tobacco or tobacco product. The law requires any person in doubt of the age of the purchaser to demand a valid picture identification (300). The recently passed tobacco control regulations L.I.2247 require that an inscription 'we cannot by law, sell tobacco products to anyone under the age of 18 years' be displayed at the point of sale.

The law prohibits the sale of a tobacco product except in unopened packages containing a minimum of ten sticks of smoked tobacco product or thirty grams of smokeless tobacco products. Cigarettes are sold individually on the open market and therefore are easily accessible to minors (300). While the law fulfils the requirements of the Article a lot of public education will have to take place among the general population and tobacco dealers before these provisions of the law can be optimally enforced.

Ghana currently has no vending machines. However, FDA has asked importers to commit not to sell or offer to sell tobacco products through a vending machine. The law prohibits the manufacture and sale of sweets, snacks, toys or any other object in the form of tobacco products that might appeal to minors.

6.1.12. Alternative Provision for Support for Economically Viable Alternative Activities

Article 17 calls on Parties to promote, as appropriate, "in cooperation with each other and with competent international and regional intergovernmental organizations, economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers".

There is no large-scale tobacco growing in Ghana. Moreover, the last factory for tobacco products was closed in 2006, and therefore there is no longer cigarette manufacture in the country. With the consequent drastic reduction in demand for tobacco leaves, tobacco farmers are now facing major difficulties in finding alternative livelihoods. The Ministry of Food and Agriculture provides limited credit to farmers and very limited extension services to tobacco farmers. The government has however, through the Ministry of Food and Agriculture committed to work closely with the Ministry of Health in finding feasible solutions to implement obligations under Article 17 (217).

The Comprehensive Africa Agriculture Development Programme (CAADP) is an initiative by African governments to accelerate growth and eliminate poverty and hunger. In aligning with CAADP in October 2009, the Ministry of Food and Agriculture committed to achieve the Maputo Declaration of allocating at least 10% of annual expenditure to the agriculture sector. CAADP also provides a framework for partnership and development assistance. The World Food Programme could play a key role in providing support for the small tobacco farmers to shift to economically viable and sustainable alternative livelihoods. Ghana hosted the second meeting of Working Group on Articles 17 and 18 from 21-23 April 2010 in Accra. This was the very first time that a Working Group meeting was held in Africa and the meeting should have a significant impact by proposing policy recommendations to the Conference of Parties on the implementation of the Articles 17 and 18 (217).

During this meeting the Brazilian delegation shared its experience in field testing a framework for economically sustainable alternative livelihoods to tobacco growing. In the context of south-south collaboration, the Brazilian delegation offered to consider any request to provide technical support to Ghana in exploring alternative livelihoods to the tobacco farmers (217).

There were very promising opportunities for the government to take advantage of the potential technical (south-to-south collaboration) and financial support (with CAADP and the World Food Program) that can be provided to affected tobacco farmers. It was very evident that there was no policy and mechanism in place to support the small-scale tobacco farmers to adjust to the withdrawing of tobacco industry from the country and shift to alternative livelihood. The Ministry of Food and Agriculture would be very effective and appropriate if

they take the lead in promoting economically viable alternatives to smaller scale tobacco farmers and integrating its support into the government's overall food and agriculture programme. The Ministry of Food and Agriculture, in collaboration with the Ministry of Health, could follow up with World Food Programme and the Brazilian government for possible cooperation in helping to meet the obligations under this Article (217).

6.1.13. Protection of the Environment and the Health of Persons

Ghana until this study does not have any data or information documented on Articles 18 which expands on "Protection of the environment and the health of persons" Parties have agreed to "have due regard to the protection of the environment and the health of persons in respect of the environment in respect of tobacco cultivation and manufacture." Ghana has also not reported to the FCTC Secretariat about Ghana in meeting its obligation. The attention of the Environmental Protection Agency has been drawn to this Article. Subsequently, that the Environment Protection Agency, Ministry of Food and Agriculture and Ministry of Health would have to work together and make joint efforts in meeting this treaty obligation (217).

6.1.14. Research, Surveillance, and Exchange of Information

With support from WHO and US Centre for Disease Control, Ghana has conducted the Global Youth Tobacco Survey (GYTS) in 2000, 2006 & 2009, Global School Personnel Survey (GSPS) in 2006 & 2009 and Global Health Professional Students Survey (GHPSS) in 2006. The STEPwise approach survey (STEPS) was conducted in one region of Ghana in 2008 and is expected to provide prevalence data for adults aged 15-64 for the Region. In implementing FCTC Article 20, Parties are required to "develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control." Ghana has no national system for epidemiological surveillance of tobacco consumption and related social, economic and health indicators. (217) The Ghana Statistical Service is responsible to collect data on important vital statistics through household and other types of surveys. Current expenditure survey does not include information on tobacco consumption. In 2010, a formal request was made to the Ghana Statistics Services to add on two more questions on smoking prevalence to the already existing questions. They

were happy to collaborate but said the request was coming too late at a time when they were about to start data collection (217). Since then no concrete effort has been made to follow up on that.

With support from WHO and US Centres for Disease Control, Ghana has conducted the Global Youth Tobacco Survey (GYTS) three times in 2000, 2006 & 2009, Global School Personnel Survey (GSPS) in 2006 & 2009 and Global Health Professional Students Survey (GHPSS) in 2006. The STEPwise approach survey (STEPS) was conducted in one region of Ghana in 2008 and was expected to provide prevalence data for adults aged 15-64 for the Region (288,297,303).

Ghana first participated in the GYTS, a school-based tobacco specific survey which focuses on adolescents aged 13-15 in 2000 and repeated in 2006 and 2009. Data from the 2000 GYTS facilitated Ghana's signing and ratifying of the WHO FCTC in November 29th, 2004. The GYTS applied the same standard methodology where self-administered questionnaire, consisting of a set of core questions, were completed by students of Junior High School forms 1, 2, and 3 in all public and private schools. Students were between the ages 13 – 15 years old. The survey aimed to document and monitor the prevalence of tobacco-use such as smoking cigarettes, cigars, pipes and the use of smokeless tobacco. It assessed learners' knowledge, beliefs and attitudes related to tobacco-using behaviour, as well as smoking cessation, environmental tobacco smoke, minor's access to tobacco, school curriculum, media and advertising. The survey was completed by 4,171 pupils aged 13-15 years (2009), 4,185 pupils in 2006 and 1,008 pupils in 2000 within the same age group (288,297,303).

Ever smokers (smoked a cigarette, even a puff or two) made up 10.2% of the sample in 2000 and decreased to 9.2% in 2006 and then to 8.9% in 2009. Current smokers (smoked cigarettes on one or more days in 30 days preceding the survey) made up 4.2% of the sample in 2000 but decreased to 2.7% in 2006 and increased slightly to 3.6% in 2009.14.6% of the sample had used tobacco products other than cigarettes such as chewing tobacco and snuff in 2000 but only 10.4% in 2006 and 10.6% in 2009. 11% of pupils were offered free cigarettes by a tobacco representative across the three surveys (288,297,303).

The percentage of current smokers who expressed a desire to stop smoking in the past year remained high (ranging from 80% to 92%). A significant number of current smokers who said that they had made an attempt to stop smoking in the past year was noted from 2000 (84%) to 2006 (61%) and 77.4% in 2009. A significant decrease in the number of pupils who had bought cigarettes from a store has been noted from 2000 (49.3%), to 34.3% in 2002 and then 26.9% in 2009. A significant number of pupils across the three surveys wanted smoking banned in all public places (288,297,303).

Prevalence of tobacco – using behaviour

In 2009, 8.9% of respondents were classified as ever smokers, lower than the prevalence obtained in the 2006 GYTS survey (9.2%) and 10.2% in the 2000 survey. For the three surveys males were more likely to smoke than females. Of ever smokers, 55.6% (2009), 44.4% (2006) and 40.2% (2000) indicated that they had initiated smoking before age 10. In 2009, current smokers were 3.6% while in 2006 was 2.7% and 4.2% in 2000. Use of other tobacco products was significantly more than cigarettes in each of the three surveys (see Fig 1). Among never smokers, 15.9% of respondents (2009) were likely to initiate smoking in the next year, whereas 14.2% (2006) and 14.8% (2000) were likely to initiate smoking in the next year (288,297,303).

The Global Surveillance Survey (GTSS) adds to bridge the gap of dearth of youth tobacco use information in developing countries including Ghana, which is necessary to document the extent of the problem; to formulate tobacco prevention and control programmes and to promote tobacco control at country, regional and global levels (288,297,303).

The GYTS is a comprehensive first and only National Representative data on tobacco use among the GYTS provides data on tobacco use among in-school youth from a national representative sample. Results from the GYTS indicate that Ghana may have a potential tobacco problem as the rate of use of tobacco products are rather high in-school youth in Ghana. Results from this GYTS study indicate that Ghana can enhance the country's capacity to monitor tobacco use among the youth with the major goal of making the information available to tobacco control programme and policy makers throughout the world (288,297,303).

Global School Personnel Survey (GSPS)

The Ghana GSPS includes data on prevalence of cigarette and other tobacco use as well as information on attitudes on school policy toward tobacco use, access to teaching materials and training, and attitudes toward tobacco use. These factors are components Ghana could include in a comprehensive tobacco control program. The Ghana GSPS was a school-based survey of school personnel from the schools that participated in the 2009 Ghana GYTS. The GYTS was conducted in schools having students in JHS 1-3. For the GYTS, a two-stage cluster sample design was used to produce representative data for Ghana. At the first stage, schools were selected with probability proportional to enrolment size. The GSPS, 70.7% of the school personnel completed the survey, for a total of 391 teachers and administrators (288,297,303).

The GSPS survey results showed 6.6% of school personnel currently use any tobacco product whilst 2.7% currently smoke cigarettes and 4.0% currently use other tobacco products. Nearly seven in 10 schools have a policy prohibiting tobacco use among students. There were more than three in five schools that have a policy for personnel while almost all schools enforce their school policies. One-half of the schools include tobacco use prevention in school curriculum. And nearly one-quarter of the teachers have access to teaching materials on tobacco use. Fifteen percent (15.7%) of teachers have ever received training on youth tobacco use prevention. Almost two in five of the schools use non-classroom programs to teach youth tobacco use prevention, while nine in 10 think smoking should be banned from public places more than nine in 10 think smoking should be banned from public places. Similarly nine in 10 think teacher tobacco use influences youth tobacco use (288,297,303).

In relation to school policies prohibiting tobacco use, 98.6% agreed schools should have policy prohibiting tobacco use among students. 69.3% of personnel reported that their schools have a policy prohibiting tobacco use among students. 98.2% of the school personnel agreed that schools should have a policy prohibiting tobacco use among personnel and 63.5% reported their schools have a policy prohibiting tobacco use among personnel, with 96.3%

mentioning their schools enforce policies on tobacco use for students and personnel (288,297,303).

Concerning the attitudes of the school personnel, 95.7% thought smoking should be banned from public places, whilst 97.7% thought smoke from others was harmful to them. The results showed that 93.3% think teacher tobacco use influences youth tobacco use and 88.9% think tobacco product advertising should be completely banned. Eighty one (81.1%) thinks the price of tobacco products should be increased and 62.1% mentioned they think the tobacco industry deliberately encourages youth to use tobacco (288,297,303).

Global Health Professions Students Survey (GHPSS)

Health professionals have a prominent role to play in tobacco control. They have the trust of the population, the media and opinion leaders, and their voices are heard across a vast range of social, economic and political arenas. At the individual level, they can educate the population on the harms of tobacco use and exposure to second-hand smoke. They can also help tobacco users overcome their addiction. At the community level, health professionals can be initiators or supporters of some of the policy measures described above, by engaging, for example, in efforts to promote smoke-free workplaces and extending the availability of tobacco cessation resources (288,297,303).

Studies have shown that even brief counselling by Health Professionals on the dangers of smoking and the importance of quitting is one of the most cost-effective methods of reducing smoking (ref). The Global Health Professionals Survey (GHPS) was developed to collect data on tobacco use and cessation counselling among HPs students in all WHO member states. Ghana used the GHPS to explore the role and knowledge of smoke cessation approaches among health professionals in relation to Ghana's compliance to article 14 of the FCTC (288,297,303).

GHPS is a school based survey of third–year students pursuing advanced degree in medicine, nursing and pharmacy. A multi stage sample design was used to select schools proportional to enrolment size. Classrooms were chosen randomly in selected schools. All students in selected classes were eligible for participation. In all 425 HPs answered a self-administered questionnaire using computer scanable answer sheets (288,297,303).

Over 68% of students think HPs serve as role models for their patients whereas 99.1 % think HPs have a role in giving advice about smoking cessation to patients. Nearly all think HPs should get specific training on cessation techniques to use with patients. However, only 21.7% received formal training to provide smoking cessation approaches. Majority of the students who participated were supportive of tobacco control efforts. HPs play an integral role in tobacco control. Need to empower and challenge HPs to intensify advocacy, education and other activities that could help smokers quit and prevent non-smokers from smoking; provide training to HPs to enable them provide counselling services; educate HPs about WHO FCTC (288,297,303).

Ghana STEPS Survey (Chronic Non-communicable Disease Risk Factor Surveillance in the Greater Region of Ghana)

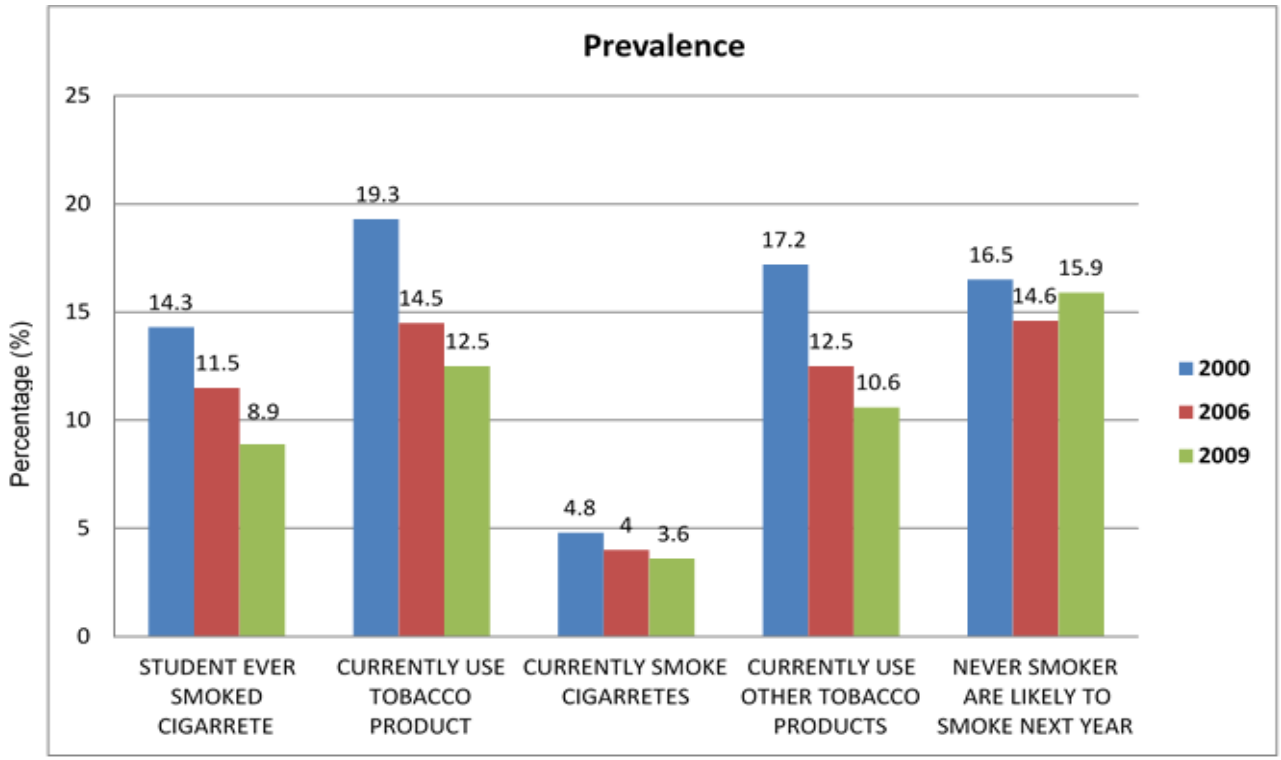
The STEPS survey of chronic disease risk factors in Accra-Ghana was carried out in 2006. Ghana carried out Step 1, Step 2 and Step 3. Socio demographic and behavioural information, such as age, sex, level of formal education, employment status, current exposure to tobacco and alcohol products, diet and physical activity during working hours, during transportation and at leisure was collected in Step 1. Physical measurements such as height, weight, waist circumferences, hip measurements and blood pressure were collected in Step 2. Biochemical measurements were collected to assess fasting blood glucose and lipid profiles (total cholesterol and trigylcerides) levels in Step 3. The STEPS survey in Accra-Ghana was a population-based survey of adults aged 25 years and above**.** A cross-sectional survey was conducted in the Greater Accra Region of Ghana. The survey covered all the five districts in the Greater Accra Region. In each province, four districts were randomly selected and in each district, four rural health facilities were randomly selected. The health facilities were used as the operation point for the survey team. A total of 2,662 adults were selected using a modification of the probability proportion to size cluster sampling technique. The overall response rate was 100% for STEP 1, 99.4% for STEP 2 and 84.6% for STEP 3.

The STEP 1 results on tobacco use for adults revealed that the weighted prevalence of former tobacco use was 10.6% and 1.1% respectively. The weighted percentage male current tobacco users comprised 6.3% who used tobacco daily and 5.0% who did not use it daily. About 0.8% of men used both smoked and smokeless tobacco products (304).

According to Owusu-Dabo et al (2009) the survey was carried out in the Ashanti region involving 7,096 respondents in a sample household. The survey reported current smoking prevalence as 3.8% (males 8.9% and females 0.3%), and ever smoking 9.7% (male 22.0% and female 1.2%) (305). Most of the findings of these studies including the GDHS in all the 3 (2002/3, 2008, 2014) national surveys are consistent with previous studies in Ghana and elsewhere in in Africa where the prevalence of smoking in Ghana are one of the lowest in sub-Sahara Africa (305).

Other studies has reported different rates of smoking prevalence, but overall, all the surveys point to the fact that smoking prevalence is quite moderate/ low in Ghana (297,303).

Figure 11: Tobacco use by the youth - a surveillance report from the Ghana Global Youth Tobacco Survey: 2000 – 2009



Tobacco use by the youth - a surveillance report from the Ghana Global Youth Tobacco Survey: 2000 – 2009 (Ref. Unpublished report of the GYTS report

In implementing the FCTC Article 20, Parties are required to "develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control." Ghana has no national system for epidemiological surveillance of

tobacco consumption and related social, economic and health indicators. The Ghana Statistical Service is responsible to collect data on important vital statistics through household and other types of surveys. Current expenditure survey does not include information on tobacco consumption. In 2010, a formal request was made to the Ghana Statistics Services to include two questions on smoking prevalence. They were happy to collaborate but said the request was coming too late at a time when they were about to start data collection (217).

It is expected that Ghana would:

- Develop and promote national research capacity and cooperate with competent international and regional organizations to conduct research addressing the determinants and consequences of tobacco consumption and exposure to tobacco smoke as well as research for identification of alternative crops.
- Strengthen training and support for all those engaged in tobacco control activities, including research, implementation and evaluation.
- Establish progressively a national system for the epidemiological surveillance of tobacco consumption and related social, economic and health indicators and integrate it into national, regional and global health surveillance.
- Promote and facilitate the exchange of publicly available scientific, technical, socioeconomic, commercial and legal information, as well as information regarding practices of the tobacco industry and the cultivation of tobacco.
- Progressively establish and maintain an updated database of laws and regulations on tobacco control and information about their enforcement and jurisprudence.

6.1.15. Reporting and Exchanging of Information

The Article 21 of the WHO FCTC obligates parties to report to the convention secretariat. Ghana began reporting on the implementation of the Convention in 2007. Since then, four more reports have been submitted biennially in 2010, 2012, 2014 and 2016. Ghana has been very punctual in its WHO FCTC reporting. The prescriptive nature of the initial reporting instrument did not allow the presentation of data from sub-national activities and as such was not an accurate representation of Ghana. The Parties and the Convention Secretariat agreed to make minor updates to the data collection initiatives in the area of tobacco control, to develop

an indicator compendium and to develop a voluntary reporting instrument on the implementation of the WHO FCTC guidelines (288).

Since the 2012 report Ghana has always provided information on both the obligatory and optional parts in the reporting instrument. These improvements have helped to generate a more comprehensive national report. The reports over the years have noted some progress in the implementation of some WHO FCTC especially articles 6, 8,12,13,14 20,21 (288).

In relation to the tax measures (Article 6) there has been an increase in the excise duty from 150% to 175% since the 2012/2014 report. In spite of this increase, retail prices of cigarettes have remained relatively low across the country. With regard to Article 8 on Protection of Exposure to Tobacco Smoke, the Public Health Act 851 of 2012 now places a ban on smoking in public places and workplaces except in designated places with the FDA as regulator. Fines have been instituted to deal with those who offend the law. Ghana now has a much more comprehensive smoking ban than the 2012 reporting period (288).

Similarly, Ghana has moved from the administrative order banning tobacco advertising, promotion and sponsorship in 2010 to legislative measures since 2012. Ghana has been recognized as one of the highest achieving countries in 2016 that enforce bans on tobacco advertising (153,288).

From 2010 demand reduction measures concerning tobacco dependence and cessation have included some media campaigns emphasizing the importance of quitting tobacco use, training some health professionals till 2016 where Ghana has developed a Cessation Manual. The guidelines provide for health workers, the structures and the medicines to be used for treating tobacco dependence and cessation. From the time of the first report till 2016 there has been steady progress improvement in the provision of education, communication, training and public awareness activities. There has been sensitization programmes for health professionals, students at all educational levels, media personnel and civil society groups. There have been more radio and television programmes now than when reporting started in 2007/2010 (288).

Since 2010 the FDA has required tobacco importers to display FDA approved text based health warnings covering 50% of the principal areas of tobacco product packaging and labelling. Till now Ghana has not used pictures or pictograms as part of the health warnings despite evidence that these are more effective in developing countries though the 2016 report that FDA is in the process of instituting pictorial warnings in the very near future (284,288).

Since reporting began Ghana has never provided information for tobacco-related mortality and information on the economic burden of tobacco use in the population. It is necessary to gather such relevant mortality and economic data to enhance the public health argument for tobacco control to policymakers (54). Though there is some small scale tobacco growing in the country, Ghana has not adopted and implemented any measures for economically viable alternatives or protection of the environment and health of persons. Ghana's reports have focused primarily on activities at the national level and indicated some progress in the implementation of some articles of the WHO FCTC. Ghana now consults with sectors outside the health sector to gather data for the WHO FCTC reports. Efforts must be made to include more tobacco activities at sub-national level as well gather data on those articles for which no information has been provided in previous reports (288).

6.1.16. Cooperation in the Scientific, Technical and Legal Fields and Provision of Related Expertise

In implementing Article 22, Parties are required to cooperate directly or through competent international bodies to strengthen their capacity to fulfil the obligations arising from this Convention, taking into account the needs of developing country Parties and Parties with economies in transition. Such cooperation shall promote the transfer of technical, scientific and legal expertise and technology, as mutually agreed, to establish and strengthen national tobacco control strategies, plans and programmes.

The Government of Ghana has received from WHO at various times support in tobacco control training and conducting advocacy campaigns in accordance with Article 12. Ghana also got support from WHO and the United States Centre for Disease Control for various surveys under the Global Tobacco Surveillance System. WHO also supported the sub national STEPs survey (304). Broader international cooperation on implementing the Convention has not been fully utilized. The hosting of the second meeting of the Articles 17

and 18 provided potential opportunity to cooperate with other Parties and competent international organizations and development partners. United Nations Development Assistance Framework (UNDAF) is the strategic programme framework for the UN Country Team (UNCT) to have collective response to the priorities in national development. The Current UNDAF covers the period of 2006 to the end of 2011. The six outcomes are health, education, sustainable livelihood, HIV/AIDS, data management and governance. Health as the very first outcome currently does not include work related to the implementation of the Convention. In 2010 the UNCT was in the process of developing new UNDAF (2012-2016). The Ghana Joint Assistance Strategy was developed every five years by the major development partners to identify key areas of support such as HIV/AIDS, malaria and maternal and child mortality are identified as priority areas in the Strategy (217).

6.1.17. Financial Resources

One key area that the WHO FCTC Articles highlights is Article 26 which calls on Parties to "provide financial support in respect of its national activities intended to achieve the objective of the Convention, in accordance with its national plans, priorities and programmes". Some Parties and development partners recognize "the important role that financial resources play in achieving the objective of this Convention". Though Ghana has benefited from some support from nationally and internationally donors, Ghana still consistently lack funds for implementation nationally and internationally partners. This is not making Ghana meet all its obligations under the Convention (217).

It is significant for Ghana to proactively seek opportunities to cooperate with other Parties, competent International Organizations and development partners present in the country. Also the government of Ghana should advocate for the implementation of the Convention as a priority area in the future collaborating with UNDAF and Ghana Joint Assistance Strategy (217).

The FDB has a unit dedicated to tobacco regulations and it collect registration fees from the tobacco importers and registered tobacco products. The registration fees are used for tobacco control activities but are not sufficient to cover all the expenses on tobacco control at this time. With no comprehensive Tobacco Control Bill in place, FDB finds it a challenge to

make sure all importers and tobacco products registered and collect new fees from tobacco importers on testing constituents and emissions (217).

One main challenge is the Ministry of Health and Ghana Health Service currently do not have a budget line for tobacco control activities. Other relevant ministries which have obligations to implementation of the Convention do not have dedicated budget or staff to work in this area. These resources should be availed by the responsible ministries and government agencies.

It is therefore suggested that the Government of Ghana could take the following actions:

- Establish within the budget of the Ministry of Health and relevant agencies, a dedicated line for implementation of the Convention.
- Urge the other relevant ministries to provide in their budgets, funds to support implementation of the relevant provisions of the Convention as their responsibility towards meeting obligations of the treaty.
- Collate the sums in the various Ministry budgets to estimate the total government financing of implementation of the Convention.
- Consider the establishment of a specific fund for tobacco control using a determined part of the collected tobacco tax (earmarking).

Many international organizations and development partners are present and active in Ghana. The UN Health Theme Group plays an instrumental role in providing support to Ghana's health sector and the members are WHO, UNICEF, UNAIDS and UNFPA. WHO has been working very closely with the government in providing technical assistance in helping the country to implement the WHO FCTC and conduct various surveys on tobacco use in conformity with Article 26.3 which elaborates that the Convention requires Parties to "promote, as appropriate, the utilization of bilateral, regional, sub regional and other multilateral channels to provide funding for the development and strengthening of multi-sectoral comprehensive tobacco control programmes of developing country Parties and Parties with economies in transition" (217).

Ghana may not have fully utilized the bilateral, regional, sub regional and other multilateral channels to provide funding for the development and strengthening of multi-sectoral

comprehensive tobacco control programmes yet. It is important that, in the spirit of Article 26.3 of the Framework Convention, the Government of Ghana takes advantage of the presence of international development partners in the country and promotes the inclusion of implementation of the WHO FCTC in bilateral and multilateral agreements and action plans worked out with these agencies. The Ministry of Foreign Affairs, Ministry of Finance and Ministry of Health will have key roles in meeting obligations under this Article (217).

Ghana does not currently have a policy and project to address the issue of economically viable alternatives to tobacco production, including crop diversification. The Article 26.3 specifically points out, that projects promoting "economically viable alternatives to tobacco production, including crop diversification" should be addressed and supported in the context of nationally developed strategies of sustainable development. The Ministry of Food and Agriculture should initiate discussions with relevant development partners and explore possible assistance in meeting this obligation under the Convention (217).

Ghana has not met this provision in encouraging regional and international organizations and financial and development institutions to provide financial assistance to developing countries including Ghana for assistance in meeting their obligations under the Convention. The Ministry of Foreign Affairs is however committed that Ghana will take a proactive and leading role in promoting implementation of the Convention in the relevant bilateral and multi-lateral forums. It is therefore suggested that Ghana would take leadership role in meeting this provision and become a strong advocate for putting the WHO FCTC higher in the international development agenda. This is in line with Article 26.4 which calls on Parties represented in relevant regional and international intergovernmental organizations, and financial and development institutions shall encourage these entities to provide financial assistance for developing country Parties and for Parties with economies in transition to assist them in meeting their obligations under the Convention, without limiting the rights of participation within these organizations (217).

CHAPTER 7: GOVERNANCE

In this chapter, the results address the issue and concept of governance. It focuses on the formal and informal actors involved in the decisions-making and implementing the decisions made and the formal and informal structures that have been set in place in relation to funding of tobacco control (306,307). Specifically, the chapter addresses three objectives of the research study, namely, (i) to what extent do funding agencies (development partners) influence policy formulation and implementation on tobacco control; (ii) to identify factors which would facilitate greater access to Official Development Assistance (ODA) for tobacco control; and (iii) to identify constraints to funding for tobacco control.

The chapter is divided into four Sections as identified in Figure-9 previously on data analysis and results plan. All stakeholders were identified as possible key informants to this study. Majority were contacted and those that were available were interviewed as key informants.

7.1. Influence on Policy Formulation

Section one: Influence on policy formulation - Stakeholder Analysis, Working across agencies (examining Collaboration with other sectors, Contribution to policies on and Tobacco control), Coordination and disbursement of funds and the Knowledge of Regulations (Public Health Act – Tobacco Control).

Stakeholder identification and analysis was the primary method guiding this research. Stakeholder analysis is an important approach to apply in order to enhance the political viability of any policy related research. The research sources of information included governmental agencies - ministries, departments and agencies, development partners (local and international) civil society organization and non-governmental organizations. Other sources were educational and research institutions as well as professional bodies and individuals.

The stakeholder identification was undertaken at the outset of the research. Stakeholders are defined as individuals, groups, or institution/agency/organization that has a vested interest in tobacco control (250,258–265). I identified all stakeholders who needed to be considered in

achieving the research objectives and whose participation and support are crucial to its success (250,258–265).

I started off with a small team of four trained research assistants who assisted this researcher went through a brainstorming section. It provided a preliminary identification of key stakeholders, using a set criteria (importance, influence, involvement, dependence on the resources, authority, responsibility etc.) in tobacco control programme (250,258–265).

Table 3: Background of Respondents – According to Organization

Respondents	No.	Percentage
Development Partner	16	20
Governmental Organization	26	40
CSO & Non-Governmental Organizations	10	10
Individuals Experts (MPs, Experts, Opinion leaders	13	15
TOTAL	**65**	**100%**

The above table (10) summaries the number of people who were interviewed and which category/ group they belong to.

I then researched the human environment. Talk to various stakeholders, majority individual in-depth interviews, a few by phone and emails. I subsequently asked them who they would see as potential stakeholders for the initiative in question. The list of stakeholders shrink as my interviews progressed and my understanding deepened (257–260).

I tried to learn about each stakeholder group in as much depth as possible. This was to enable me describe the stake or mandate of each stakeholder. The mandate refers to the nature and limits of each stakeholder's stake (mission and vision) in the resource and the basis of that stake (250,258–265).

Key questions were assessing the influence and importance of each stakeholder as well as the potential impact of the research upon each stakeholder, this stakeholder analysis were looked

at decisions on issues important to the study (250,258–265). Different types of stakeholders were engaged in different ways in the various stages of the study, from gathering and giving information, to consultation, and dialogue. Determining who needs or wants to be involved, and when and how that involvement in this research can be achieved (250,258–265).

Document review: This research method involved the study of existing documents, either to understand their substantive content or to illuminate deeper meanings which may be revealed by their style and coverage. The research collected public documents like, organisations yearly or annual reports, government papers or publicity materials, procedural documents (financial accounts – MOH, GHS and WHO) and media reports (20,21) A further reason for drawing on document sources is that it is not always possible to engage in direct observation or questioning.

The results of the stakeholders and documents review have all been incorporated into the following results of the analysis. The table below shows all organisations, agencies and institutions supporting NCDS and tobacco control in Ghana till the year 2013. This information was gathered from the documents review and interviews.

Table 4: Organizations / Agencies Supporting NCDs and Tobacco Control

Type of Organisation /Agency/ Institution	Name of Organizations/ Agencies/ Institution
1. Private Sector - International	1. Bloomberg Philanthropies 2. Bill and Melinda Gates foundation 3. American Cancer Society 4. Canadian Public Health Association 5. National Cancer Coalition (NCC) – USA 6. Krebsallianz of Germany 7. Johnson & Johnson of the US 8. National Institute of Health and National Cancer Institute - US 9. Direct Relief International - California, US) 10. Carrie's Touch Incorporated 11. Africa Oxford Cancer Foundation (Afrox) – UK 12. Roche Pharmaceuticals 13. Pfizer and Astrazeneca 14. World Child cancer organization - UK charity
2. Private – local (Ghanaian)	15. UT Bank 16. Uni Bank Ghana Ltd

Type of Organisation /Agency/ Institution	Name of Organizations/ Agencies/ Institution
	17. Forever Easy company 18. Societe Generale Ghana Limited 19. Kasapreko company limited 20. First Allied Savings & Loans 21. Stanbic bank 22. First Capital Plus 23. Ecobank Ghana Ltd 24. Toyota Ghana company limited 25. Ghana Textile Printing 26. Ghana Mineworkers Union 27. Cocoa Processing company limited
2.2: Hospitality Industry - Hotels	28. King's court hotel 29. Grand View hotel 30. African Reagent hotel 31. Labadi Beach hotel
2.3: Tele communications companies	32. Vodafone Ghana Foundation 33. MTN Ghana Foundation
2.4: Charity Foundations	34. Samsung Electronics Ghana 35. Chirano Gold Mines Limited
2.5: Local Foundations	36. Ghana Heart Foundation 37. Children's Heart Foundation 38. Melcom Care Foundation 39. Global Cervical Charity Foundation 40. Sweden Ghana Cancer Foundation 41. Lordina Foundation 42. Ghana Parents Association for Childhood Cancers 43. Lebanese Women in Ghana
2.6: Local faith based organizations (Religious organizations)	44. International Central Gospel Church (ICGC) 45. Immanuel Methodist Society – Church
2.7: Others	46. Golden Star Resources Limited a gold mining company 47. Ghana National of Teachers 48. Sweden Ghana Cancer Foundation (SGCF) 49. Individuals (celebrities - sports, film, & music personalities)

7.2. Coordination and Disbursing of Funds

Government of Ghana (GoG):

Government funding is provided to the sector in four areas; personal emoluments (salaries), Administration, Service and Capital projects. Personal emoluments are paid directly from government to individual staff accounts. The money for administration goes through the treasury. Funds for services and the capital projects or investments are also done directly by the government as and when there is the need. The personal salaries, maintenance and supplies are paid through the recurrent budget while expenditures on construction of buildings are paid through the capital budget.

Loans/grants:

On occasions the government contracts loans or receive grants from various sources. The government of Ghana received a loan from the Arab Bank for Economic Development of Africa (BADEA) and OPEC Fund for International Development (OFID) towards the upgrading of Radiotherapy and Nuclear Medicine Services at two of the country's teaching hospitals namely Korle Bu Teaching hospital in Accra and Komfo Anokye Teaching Hospital in Kumasi.

Internally Generated Funds (IGF):

IGFs are obtained from user fees charges for drugs, consumables and consultation fees. These funds are discretionary funds to be used at the facility level. Generally, they are used for expenditures such as social mobilization, transport and purchase of supplies.

Donations - Development Partners/ Donors:

The study found out that unlike previously where donors used to give ear-marked funding to various health sectors, donors now give their funds to the health sector through a donor pool. This means that government decides with development partners in the health sector which areas of health deserve priority and which areas such monies from donors should be sent to.

Over the years donors have included multilateral institutions such as World Bank, Department for International Development (DFID), Canadian government's International Development Research Centre (IDRC), Centers for Disease Control and Prevention - Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, World Health Organization (WHO) among others. Some international/ external financial assistance has been received from a multiplicity of sources-bilateral channels of multilateral channels to support both tobacco control and NCD prevention and control activities.

The FCTC endorses such assistance of greater financial support to developing countries including Ghana. For example, for tobacco control IDRC and CDC Bloomberg Philanthropists have provided both financial and technical assistance for various activities including other sources such as research and commendations. The US government, through the Global Tobacco Surveillance System GTSS) has supported Ghana to collect data through three surveys: the Global Youth Tobacco Survey (GYTS) GTSS entrance. All the research projects have one way or another enhanced the country's capacity to design, implement and evaluate tobacco control interventions, while monitoring key articles of the WHO Framework Convention on Tobacco Control and MPOWER strategies (308).

Although Ghana's current investments in health are notable more can be done to ensure that investments meet the public need for expanded access to quality health services to promote prevention and effectively respond to critical needs. However, Ghana's new stations as a lower middle income country has implications for foreign assistance in the medium to long term, given that roughly 40% of Ghana's budget comes from development partners, and in the health sector, donors currently account for some 22 % of the sector budget. Ghana rebased its GDP figures in 2010, which elevated the country into lower middle income status, according to widely- used UN status. It is worthy of note, that Development Partners and the GOG have begun discussions about Ghana's lower middle-income stations, new oil revenues and the potential implications regarding development assistance in the medium to long term (308–311). However, Ghana's new National Policy on Private Public Partnership could leverage private sector resources to fund important public health infrastructure projects in the medium to long term. Other funding sources the study identified include the international private sector and local private sector.

Private Sector-International

A number of private sector organisations contribute to the response to NCDs and tobacco control. These include corporate donors, individual philanthropists, foundations, religious groups and non-governmental organisations (NGOs). Some of the donors include Bloomberg Philanthropies, Bill and Melinda Gates foundation, American Cancer Society, Canadian Public Health Association, Krebs Allianz of Germany, Johnson & Johnson and the National Cancer Coalition (NCC), National Institute of Health as well as the National Cancer Institute of the United States of America. Others are Direct Relief International (based in California, US), Carrie's Touch Incorporated, Africa Oxford Cancer Foundation (Afrox) of the UK, Pharmaceutical companies (Roche, Pfizer and AstraZeneca) and World Child cancer organization (a registered UK charity).

Private – Local

Locally based/Ghanaian organizations make contributions both financially and in kind to various activities related to NCDs and tobacco control. Some of the agencies are UT Bank, Unibank Ghana limited, Forever Easy company, Societe Generale Ghana Limited, Kasapreko company limited, First Allied Savings & Loans, Stanbic bank, First Capital Plus Bank, Ecobank Ghana limited, Toyota Ghana company limited, Ghana Textile Printing, Ghana Mineworkers Union and Cocoa Processing company limited. Other contributors come from the hospitality industry such as King's court hotel, Grand View hotel, African Reagent hotel, Labadi Beach hotel and telecommunications companies and their charity foundations such as the Vodafone Ghana Foundation, MTN Ghana Foundation, Samsung Electronics Ghana, Chirano Gold Mines Limited.

Other local foundations which have contributed to NCDs/tobacco control includes the Ghana Heart Foundation, Children's Heart Foundation, Melcom Care Foundation, Global Cervical Charity Foundation, Sweden Ghana Cancer Foundation, Lordina Foundation, Ghana Parents Association for Childhood Cancers and the Lebanese Women in Ghana.

On some occasions, such as anniversaries, employee organisations or unions and/or clubs make donations to support some aspect of NCDs prevention. For example, the Ladies Club of

Golden Star Resources Limited–a gold mining company–donated an amount of 13,000 Ghana cedis to support activities of Breast Care International and the Ghana National Association of Teachers paid 100,000 Ghana cedis to the Sweden Ghana Cancer Foundation (SGCF).

Local faith based organizations (Religious organizations) make periodic donations to pay for care and treatment of patients with chronic diseases. For example, since 2011, the International Central Gospel Church (ICGC) has committed itself to supporting the Childhood Cancer Unit of the Korle Bu teaching hospital with funds towards medications and treatment drugs every month. By the end of 2014, ICGC would have provided a total amount of 300,000 GH cedis. The Immanuel Methodist Society of the Accra North Circuit of the Methodist Church has established a cancer assistance fund to support needy cancer patients in Ghana.

Another source of funding has come from individuals particularly celebrities such as sports, film and music personalities and others make periodic donations in cash and in kind to patients. Both foundations and individuals organize various fund raising activities such as musical shows, fashion shows, funfairs, fun walk throughout the year to support various organizations provide the needed assistance to patients. For example, SGCF a non-profit making organization incorporated in June 2012 is working to raise an amount of USD five million. The SGCF will use the money raised to initiate free treatment of Ghanaian patients who cannot afford cost of cancer treatments.

Over the years, the Ghana Heart Foundation has supported Ghanaian patients undergoing heart surgery with 50% subsidy from their Trust Fund. For example, in 2010 the Ghana Heart Foundation spent about USD 300, 000 to assist needy patients undergo surgery. Corporate organizations provide support to NCDs/tobacco control as part of their Corporate Social Responsibility initiatives.

Private sector institutions in partnership with the Ministry of Health and Ghana Health Service have mobilized resources to sponsor multifaceted promotional campaigns to reinforce healthy behaviours, including mass media, community interventions and other means to raise interest, understanding and use priority interventions. These private sector organisations have funded NCDs and tobacco control related activities as part of their corporate social

responsibility programmes. Some of these activities have coincided with international days such as World Cancer Day (February 4) World No Tobacco Day (May 31) World Heart Day (September). Indeed, there is increasing awareness and concern in the business sector about the impact of NCDs on both worker health and on the under developed community. A number of companies have implemented workplace health programmes and engage in keep fit exercises at weekends and on some public holidays. Sometimes, they support health screening exercises as well. Through these programmes they play a role in influencing individual behaviour and social norms. Indeed, encouraging companies to invest in their employees' health care is a possible area of resource mobilization. It must be noted that through these preventive activities and donations both in cash and in kind, the private sector make substantial.

However, these contributions are difficult to track and bypass the Ministry of Health and Ghana Health Service. This is because the organisations have independent budgets and are not captured by national statistics. It will be prudent to strengthen links with the private sector so as to improve resource tracking mechanisms of their contributions to NCDs in order to have much more comprehensive data on corporate funding.

7.3. Collaboration with Other Sectors

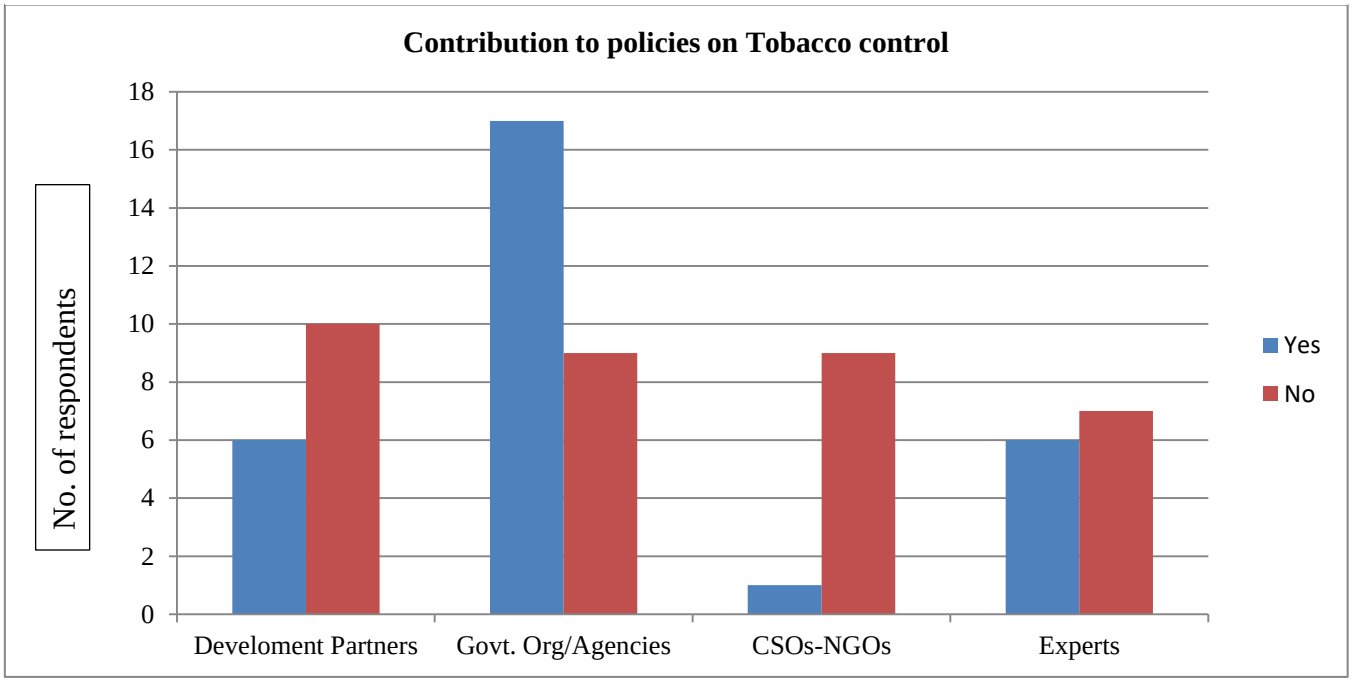
For all respondents, they iterated that they also work with other agencies and departments. This is because health issues are not stand alone issues and as such need to be tackled from all directions. In the case of NGOs, only two of them collaborate by sharing funds in the implementation of activities. For the rest, collaboration is more of provision of technical knowledge and staff to support in activities. This is what some respondents had to say on coordination of funding:

> *"The development partners financial supports are coordinated by the Ministry of finance, they coordinate it so the multi donor budget support system is coordinated by Ministry of Finance and Economic Planning (MOFE)."*
>
> *"That can be done through the development of the LI, when you are developing the legislative instrument and you insert in such a clause, the*

LI will be approved by parliament so that will be where they'll be discussing that at parliament so I think it should part of it rather than a separate discussion with parliament, it's difficult to get parliament to argue on something."

The figure (11) below shows that most respondents from the government sector mentioned yes they contribute to policies on tobacco control. There were quite a number of key informants who also said no they don't within the same category of key informants.

Figure 12: Contribution to policies on Tobacco Control



7.4. Awareness of Tobacco Control Regulations (Public Health Act)

All respondents are aware of tobacco control regulations. Respondents had been informed by the MOH of the Public Health Act and the tobacco control regulations. Others had the information via the media. Some of the respondents were at the fore-front in pushing government to pass the bill on banning tobacco smoking in public places.

7.4. Agenda Setting – Items on MOH and Partners Agenda

Most of the respondent complained that MOH (Government) does not see Tobacco control as a priority. They iterated that by the actions of the ministry, tobacco control is not on the agenda as seen in the words of a respondent; "As at now, we are supposed to have offices at the MOH for tobacco control but its non-existent. These are very vital and that we have to make impact and headway in tobacco control but look at how long it even took us to get the bill passed. From their actions, I don't think these are their priorities".

Other respondents added that tobacco control and NCDs in general are not on the agenda due to limited resources–material and human.

7.4.1. Why NCDs and Tobacco Control Not on the Agenda of MOH

Majority of the respondents mentioned among other reasons that there has been a long list of diseases over the past years and now Ghana still focuses more on communicable and infectious diseases as main on the agenda. They gave other reasons such as the limited budget allocation which makes it impossible to capture all issues or outright unavailability of funding. They emphasised that issues are reflected on the agenda and priorities are according to the MDGs and most of these are infectious diseases. Respondents further mentioned limited organisational capacity, identification of responsible agencies and the nonappearance of NCDs and tobacco control in the medium term framework thus cannot be funded.
Some of the reasons given as to why NCDs and tobacco control are not on the agenda include the following:

> *"funding was not available" "it is the responsibility of other agencies"*
> *"it was not captured in the medium term frame work; as such it cannot be funded"*

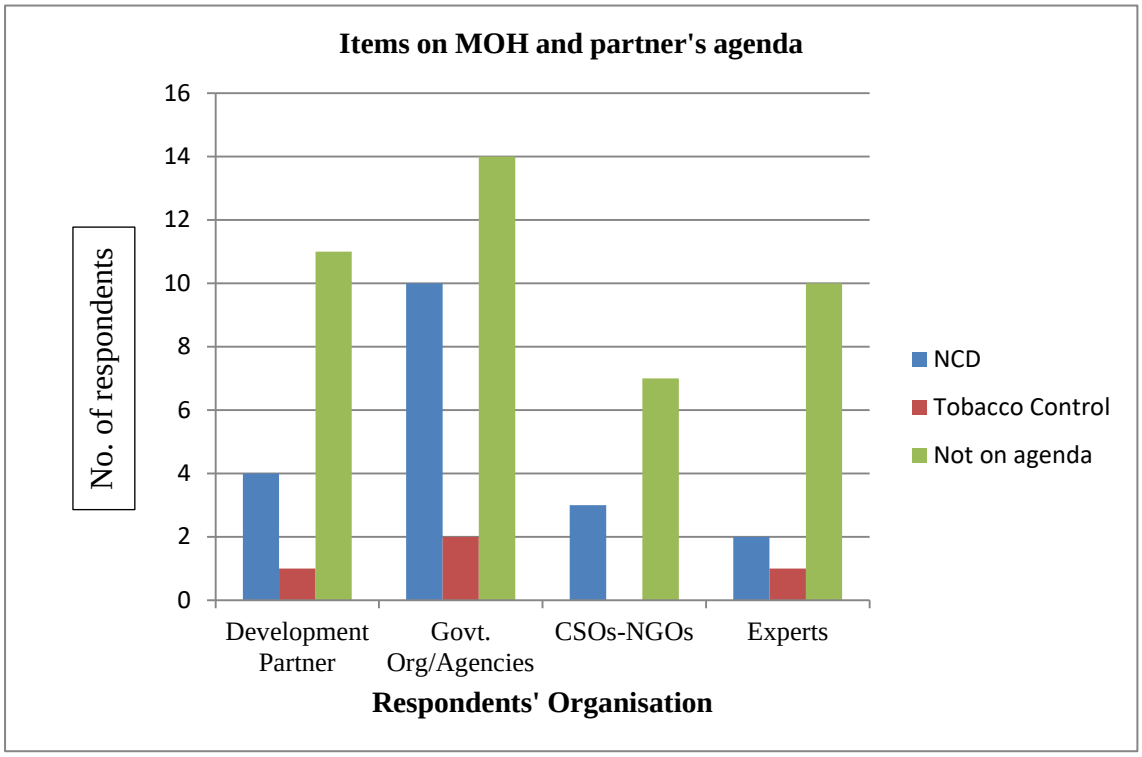
A few respondents mentioned that NCD featured most on the agenda of MOH and partners. This is so because for most of the stakeholders, NCDs have now become a priority area as attested to by the GHS that;

"NCDs generally is a priority area, it's one of the ten top priorities of the MOH and GHS".

Tobacco control was not specifically mentioned as being on the agenda but was captured under NCDs. The Health Promotion of the MOH/GHS was the only respondent who attested to the fact that tobacco control is very high on the agenda because of the 'World No Tobacco Day (WNTD)' and the WHO FCTC.

For the development partners, the agenda setting for the health sector is from the strategic objectives of the MOH and stakeholder meetings are organized to develop these strategic objectives. They added that although NCDs and tobacco control are not on their agenda now, it is a priority and will receive necessary attention in the coming years. Respondents concluded that since the international community has specified NCDs as a main focus, they will pay attention to its implementation next year. Table 2 shows respondents' response to whether or not NCDs and Tobacco control are on their respective agenda.

Figure 13: Items on MOH and Partners' Agenda



How to get NCDs and Tobacco Control on the Agenda/as a Priority

Stakeholders interviewed were of the view that, stronger collaboration, strong advocacy and lobbying featured most alongside making NCDs and tobacco control a priority in strategies to get NCDs onto the agenda. Others include having a policy, increasing commitment to work effective leadership and strengthening capacity.

Some views of the respondents are:

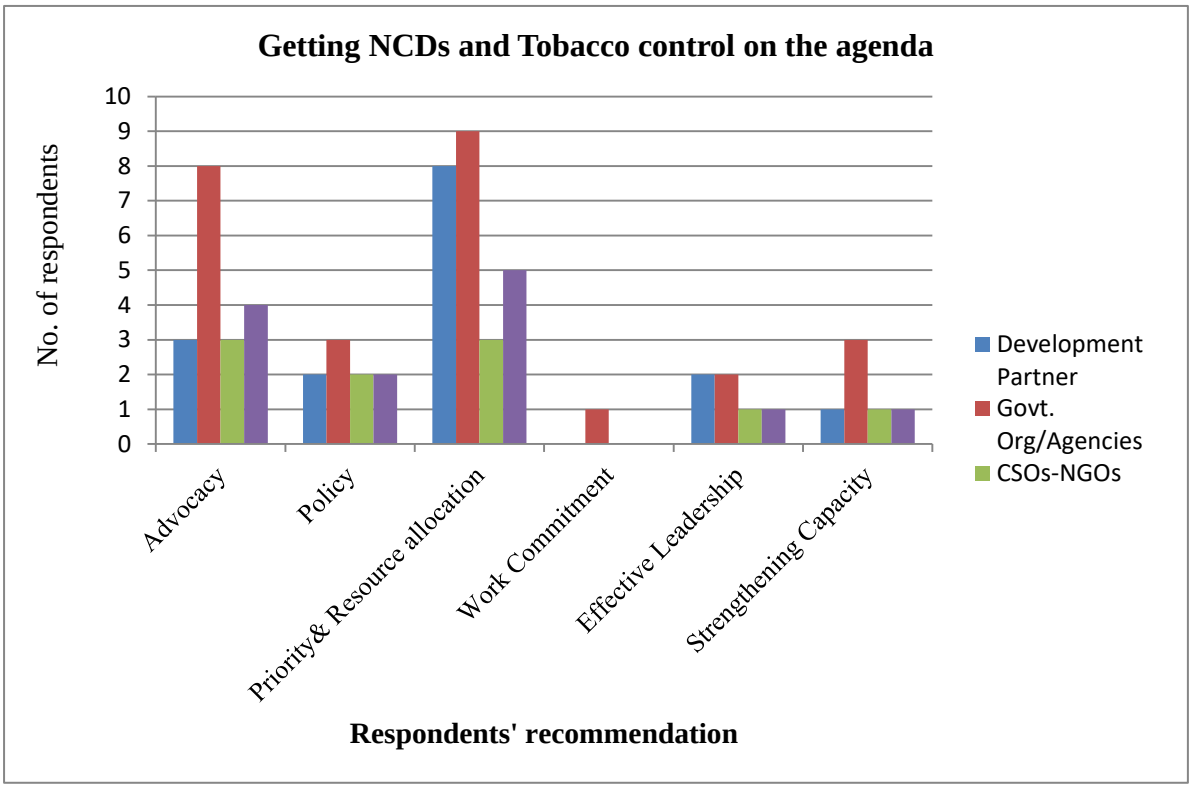
> *"NCDs and tobacco control are a responsibility of government, if any government will sit down and allow donors to fund NCDs then what are they going to do because NCDs are the diseases either communicable or non-communicable, every society has ill-health and that is the ill-health of society so if a government says that I want to control your health conditions then they must be prepared to take up NCDs and CDs but you see issues like maternal health and others, have some other areas that will warrant a donor come in and help"*

> *"Donors are saying that if the country identifies it as a priority they'll come in but once the country doesn't see it as priority..."*

> *"If we are committed to doing our work and we do it very well and we look at the people we are serving and not ourselves, we can do a good job."*

7.5. Access to Official Development Assistance (ODA)

Figure 14: Getting NCDs and Tobacco Control on the agenda



7.5.1. Access to Official Development Assistance (ODA)

Official Development Assistance (ODA) remains a key measure used as practical aid and benefit from countries of donor governments (312,313). Although listed as a lower middle income country, Ghana still needs to facilitate access ODA specifically NCDs and Tobacco control funding.

Majority of the stakeholders suggested; intensified advocacy, clear guidelines on fund disbursement and utilization, identification of focal persons, establishing a competent and strong coordinating body, and government (MOH/GHS) prioritizing NCDs and tobacco control would facilitate access to ODA.

> *"having a focal person in charge of NCDs and probably tobacco control or…" "better still having separate personnel manning them putting in place a strong coordinating body with competent personnel who will be responsible for the management of funds and*

the institution as a whole government prioritizing NCDs and tobacco control"

7.5.1.1. Funding Constraints

Constraints to funding of NCDs and Tobacco Control

Constraint to funding of NCDs and tobacco control is a limiting factor to an organization's performance, an obstacle to the MOH/GHS and Ghana as a whole in achieving her goal or objective. Some respondents identified delay in release of funds from government and some donors as well as inadequate amounts as constraints.

7.6. Insufficient Budgetary Allocations of the Government of Ghana

While it is true that the central government provides funds to support the NCDs and tobacco control activities, its budgetary allocations to effectively implement interventions are inadequate.

Delay in the release of funds is an administrative bottleneck that undermines many health programmes including NCDs and tobacco control activities. The delays in budget releases from the Ministry of Finance and Economic Planning to MOH and then to GHS, subsequently has a rippling effect on disbursements through the various levels of the health delivery system and consequently affecting quality of services. This constraint can be overcome through effective resource allocation system which allows for funds from government for health programmes to be released at the beginning of the year.

Another constraint is that sometimes the funds released are lower than the budget allocations. Further, budget releases are at variance with cash flow plan and monthly releases are far too small to enable departments deliver continuous services to make meaningful impact to the sector programmes.

The funding challenges to the health sector in Ghana, are compounded by the fact that the 'sector does not receive its entire share of budget allocations'

The following issues were raised by the Government Policy makers as constraints to funding of NCDs and tobacco control:

- Lack of GOG funds to implement work plans
- Will power of the government to fight NCDs and control tobacco
- Priority and importance attached to control of NCDs and tobacco
- Weak collaboration between MOH unit and departments and other ministries
- Lack of team work
- Inadequate number of trained personnel and staff
- Non-involvement of media due to funding issues
- Office space
- Resource mobilization

Issues raised by Development partners as constraints to funding of NCDs and tobacco control include;

- Slow coordination and implementation of activities
- The headquarters monitoring control and authority over management of funds by regions because the funds are directly released to the regions
- Low capacity of some MOH employees
- Inefficiency of MOH system

Tobacco control experts mentioned inappropriate usage of funds, lack of knowledge of Public Health or Tobacco Control bill and low prioritization of NCD and tobacco control as some challenges. The NGOs raised inadequate support from MOH for their activities, logistical constraints in addition to the issues raised by the tobacco control experts.

7.7. Constraints to Funding of NCDs and Tobacco Control from Development Partners

Government policy makers had the following constraints from the Development Partners in attracting funding for effective implementation of NCDs and tobacco control:

- Unwillingness of development partners to fund NCDs and tobacco control
- Late release of funds by development partners and government
- Inadequate resources from government
- Usage of funds for unbudgeted activities
- Inappropriate budgeting
- Difficulty in tracking and auditing funds because development partners directly fund regions and programmes
- Bureaucratic nature of fund disbursement
- No and limited amount of funds attached to NCD programmes
- Diversion of funds by MOH to implement unplanned activities
- Unscheduled transfer of staff

A few respondents such as Development Partners, NGOs and individual experts raised limited and/or no allocation of funds as the only challenge to funding NCDs and tobacco control programmes.

7.7.1. Lack of Coordination and Capacity to Mobilize Funding

Government as well as non-governmental agencies has undertaken fund-raising activities for NCDs and Tobacco control with varying degrees of success. However, lack of coordination and capacity of several organizations to mobilize funding remains a barrier to advancing tobacco control/ NCDs prevention and control in Ghana.

In general, the health sector in Ghana is financed by the traditional sources: Public funds (these are government funds which includes contributions to the National Health Insurance Fund (NHIF) but excludes premium paid by households, private funds (companies and households) and international funds (development partners) (311). The government is the

most important source of health funding. The sources of government funding include Public Grants, Internally Generated Funds (IGF). Public grant is a lump sum payment which is given directly to institutions to cover salaries of staff, non-salary expenditure items and capital expenditure. The IGF is mobilized by the institutions themselves through their services, the IGF also include private donations.

Another important source of NCDs and tobacco control financing is aid from donors. While government allocations for tobacco control related activities in the health sector, as well as in other relevant government sectors, are necessary for developing and implementing tobacco control programmes, for some time now the budget of the Health Ministry does not have a clearly earmarked allocation for tobacco control. The allocation for NCDs is also low or inadequate.

Much as it is recognized that tobacco control and NCDs prevention and control activities are multi-sectoral and require support from other sectors and ministries. For example, these may relate to support for alternative occupations (Ministries of Food and Agriculture) training of teachers school health coordinators for integrating tobacco control activities into the school system through the School Health Program (Ministry Of Education) and organizing mass media campaigns (Information Service Department) these sectors do not have specific allocations for tobacco control and NCD activities either from the Ministry of Health /Ghana Health Service budgets or the budgets of the various sectors.

It must be understood that even though the government by itself would be unable to provide all of the financial resources required for implementing NCDs and tobacco control programmes, an increase in contribution from the government is required on a regular basis to signal or show its unwavering commitment to achieving the goals of both the FCTC and NCDs, prevention and control. Such increased financial inflows will have to be clearly reflected in future budgetary allocations. It is interesting that the Minister of Health indicated at the UN High Level Summit on NCDs, 19-20 September 2011 that "the government is committed to the fight against NCDs and will provide the needed leadership and resources (314)."

Regulatory levies are another mechanism by which funds for tobacco control are generated through a fee/ levy collected by the Ghana Food and Drugs Authority for registering and

regulating tobacco products. This is done both prior to the introduction of a new tobacco brand into the market and also for annual renewal of the permission to market the brand. The money accrued from this regulatory levy is used for funding tobacco control programmes. [This model can also be used for other products such as alcohol which may have to be registered].

7.7.2. Fund Raising

Several governmental agencies and civil society groups have mobilized funds for NCDs and Tobacco Control activities from an array of sources such as pledges, donations. Special events are organized to raise funds such as raffle draws, dinner/dance and other programmes with participation charges. While some groups have done creditably, others have not been very successful. For example, a Board for Breast and Cervical Fund was established in 2008 by one of the Ministries to raise funds as at now this effort has not received the needed visibility and resources. It is therefore necessary to improve the capacity of organizations to engage in more sustainable fundraising campaigns since mobilizing resources locally is very important to fund health programmes including NCDs and tobacco control. People with expertise in resource mobilization must be engaged to help both governmental and civil society groups to raise funds.

7.7.3. Regulatory/ Penalty

The charging of this levy meets the provisions of the national law (Public Health Act 1 2012 ACT 581 Section 6 of which is a Tobacco Control). Besides, to regulatory levy, there are penalties to be collected for violations of the various provisions of the Ghanaian Law on tobacco control. Though according to Ghanaian Law on revenues or other moneys raised or received all monies collected through taxes and penalties are public funds and are paid in the contingency fund and such other public funds as may be established by or consolidated fund to be used across all sectors, under the authority of an Act of Parliament.

The Public Health Act makes provisions that the Minister of Finance can authorize the Health Minister to retain about 30 % of such money. Thus some money that would accrue to the

FDA and /or other authorities can be used for tobacco control activities at the national or local level (315).

7.7.4. Constraints to funding of NCDs and Tobacco Control

Constraints to funding of NCDs and Tobacco control is a limiting factor to an organization's performance, an obstacle to the MOH/GHS and Ghana as a whole in achieving its goal or objective. Some respondents identified delay in release of funds from government and some donors as well as inadequate amounts as constraints:

> *"from our end yes, it's unfortunate more of our resources go to item 1 (staff emoluments) and so what is left normally for the delivery of the service is small but with oil, we shall get more money" (inadequate funds)*

> *"WHO didn't release the money early and when they came they said it was too late"*

> *"Now, actually because the Ministry's basket is small, the cake is small so if you really don't fight, you won't get it that's how it's turned to be…."*

> *'WHO, yes I think WHO doesn't give much. WHO will like to give technical support but not financial support, they are not ready to give those monies"*

Government Policy makers consider the following as constraints:

> *"Lack of GOG funds to implement work plans"*

> *"Will power of the government to fight NCDs and control tobacco"*

> *"Priority and importance attached to control of NCDs and tobacco"*

> *"Weak collaboration between MOH unit and departments and other ministries"*

"Lack of team work"

"Inadequate number of trained personnel and staff"

"Non-involvement of media due to funding issues"
"office space"

"resource mobilisation"

"Lock-up of so many things in policy planning and talking too much about planning"
"Delay in passing the tobacco control bill since it started in 2001 till 2013"

"Ignorance of people about the bill"

"Muscle of tobacco producers since they are financially stronger than the government of the country"

For development partners the following were mentioned as constraints:

"slow coordination and implementation of activities"

"the headquarters monitoring control and authority over management of funds by regions because the funds are directly released to the regions"

"low capacity of some MOH employees"

"Inefficiency of MOH system"

In the case of the tobacco control expert inappropriate usage of funds, ignorance of people about the Public Health or Tobacco Control bill and low prioritization of NCD and tobacco control were the challenges pertaining to MOH.

For the NGOs, inadequate support from MOH in their activities, logistical constraints, stigma, ignorance of people about the Public Health or Tobacco Control Bill and also low prioritization of NCD and tobacco control are the challenges pertaining to MOH.

7.7.5. Constraints to Funding from Development Partners

Government policy makers had the following constraints from the Development Partners when it comes to attracting funding for effective implementation of NCDs and tobacco control:

> *"unwillingness of development partners to fund NCDs and tobacco control"*
>
> *"untimely release of funds by development partners and government"*
>
> *"inadequate resources from government"*
>
> *"usage of funds for unbudgeted activities"*
>
> *"inappropriate budgeting"*
>
> *"difficulty in fund tracking and auditing because development partners" directly fund regions and programmes"*
>
> *"bureaucratic nature of fund disbursement"*
>
> *"no and limited amount of funds attached to NCD programmes"*
>
> *"diversion of funds by MOH to implement unplanned activities"*
>
> *"unscheduled transfer of staff"*

For a few respondents, such as Development Partners, NGOs and the individual experts, limited funding and no allocation of funds to NCDs and tobacco control programmes were the only funding challenges.

7.7.6. Constraints to Funding for Meeting and Exchanges with MOH

When it comes down to constraints in funding in relating to MOH, there were general comments such as lack of support, limited staff, inadequate funding, bureaucratic nature of the MOH/GHS, conflicts arising from misunderstanding in the implementation of activities between MOH and GHS, inadequate involvement of civil society organisations in implementation of planned activities by the ministry and diversion of funds.

"Lack of support from the health sector"

"Limited staff"

"Inadequate funding"

"Bureaucratic nature of the ministry"

"Conflicts arising from misunderstanding in the implementation of activities between MOH and GHS"

"Inadequate involvement of civil society organisations in implementation of planned activities by the ministry"

"Diversion of funds"

Constraints to funding when it comes to respondents' personal opinions and perceptions

"NCDs are lifestyle diseases"

"It's not a concern for now (it's not much of an issues)"

"there's another school of thought that says that the NCDs, the people they attack are the wealthy now that we have an increase in life expectancy, most of the NCDs come with degeneration and most of them are pensioners who can afford or people who have actually seen money and have invested as suppose to the communicable diseases where these are vulnerable to address, so dependent on this and that but from where we are we think both are problems and they need to be tackled."

"most people think NCDs are diseases of the affluent and therefore those people can afford to visit the health facility but it's not every old person who is resourceful, those who are resourceful can afford but it's not all of them are."

"It's because previously it didn't exist since independence or we hadn't paid much attention and we as developing country are focusing much on infectious diseases and these things have crept on us and it has crept on us not because of anything but because people's lifestyle are changing. Previously, we lived very active lives by doing farming or fishing in this country but now we could hardly do those things so sedentary lifestyle diseases are creeping on us and people are dying of heart attacks and things like that"

"NCDs are not seen to be a priority"

"NCDs have not received the global push as compared to other diseases like HIV/AIDS and malaria."

7.8. Lack of Coordination and Capacity to mobilize funding

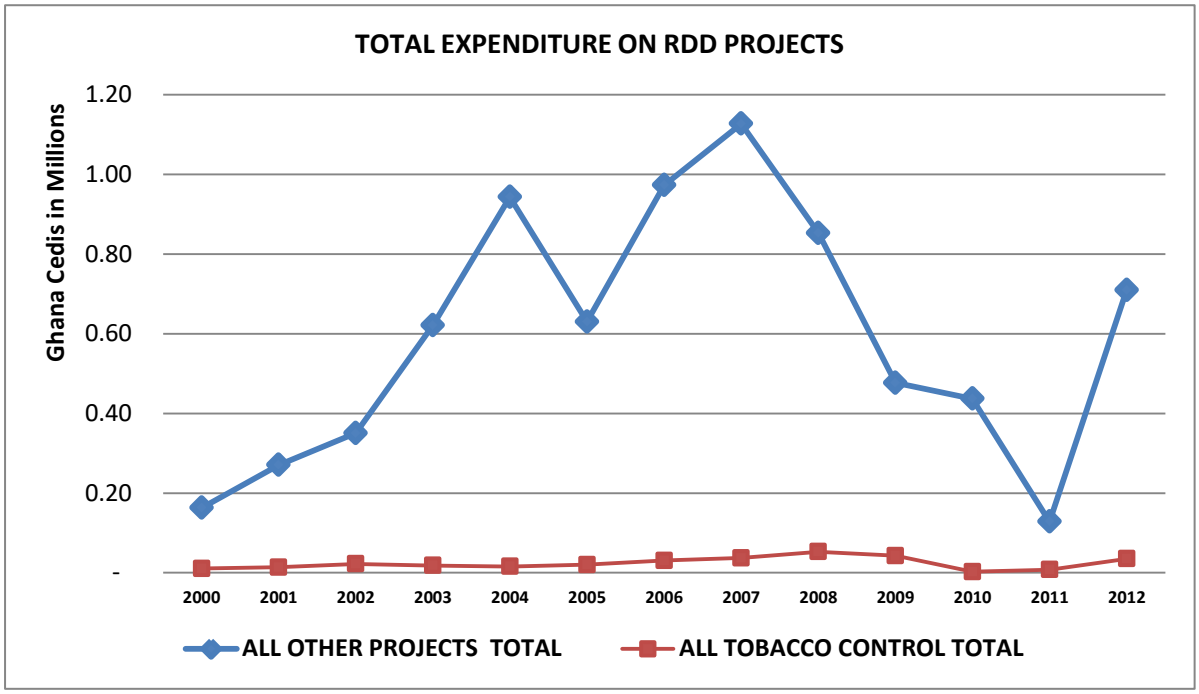
Some fund-raising activities/events have been undertaken by both governmental and non-governmental agencies with varying degrees of success. However, lack of coordination and capacity of several organisations to mobilize funding remains a barrier for them to make more impact in advancing tobacco control/ NCDs prevention and control in Ghana.

7.9. Total Expenditure on Research and Development (RDD-GHS) Projects

A significant difference between total expenditure on all other projects and that of tobacco control related projects was observed for the period of study. Across the twelve–year period and almost without an exception, expenditure on all other projects was greater than 200% of that tobacco control related projects. We observed a sharp rise in expenditure on all other projects from start of study (2000) and peaked during 2007. This sharp rise in expenditure on

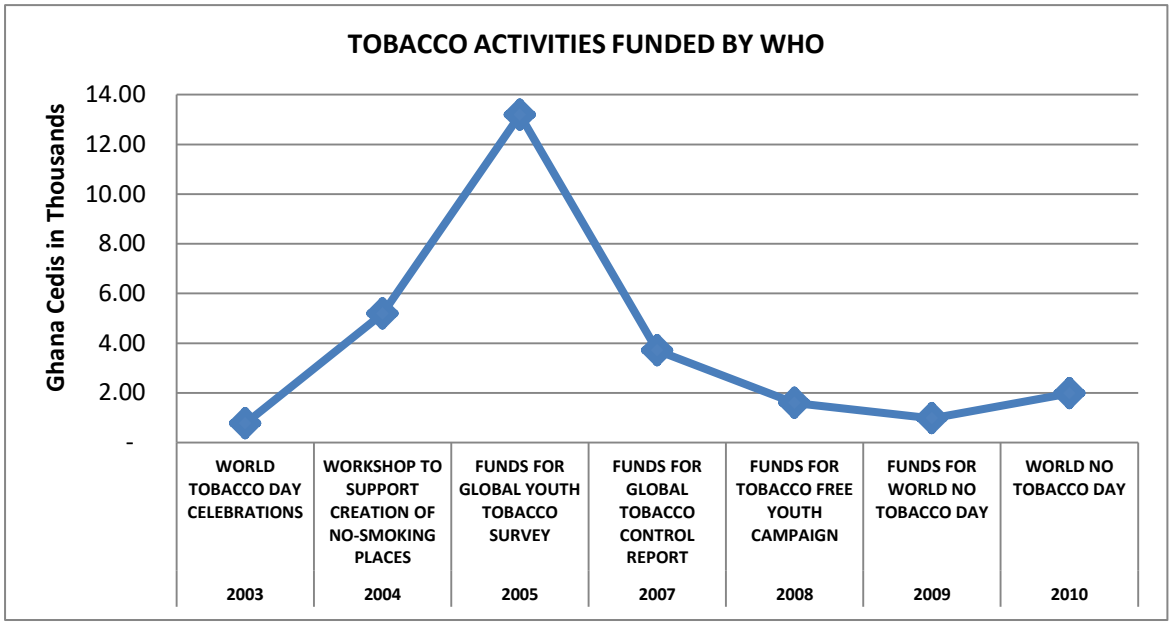
all other projects did not reflect any significant increase in expenditure on tobacco control projects. However, a gradual decline was noticed from 2007 to 2011 where total expenditure was close to the amount of monies spent on tobacco control. From the graph, it clear that all other projects receive or attract more funding compared to tobacco control activities.

Figure 15: Total Expenditure on RDD-GHS projects



A sharp rise in expenditure on tobacco control activities funded by WHO was observed between 2003 and 2005. However, a sudden decline in expenditure was seen to the end of our study in 2010. The peak expenditure observed in 2006 is attributed to funds received for the Global Youth Tobacco Survey. Generally, we observed low or inadequate funding of tobacco control activities during the period of the study.

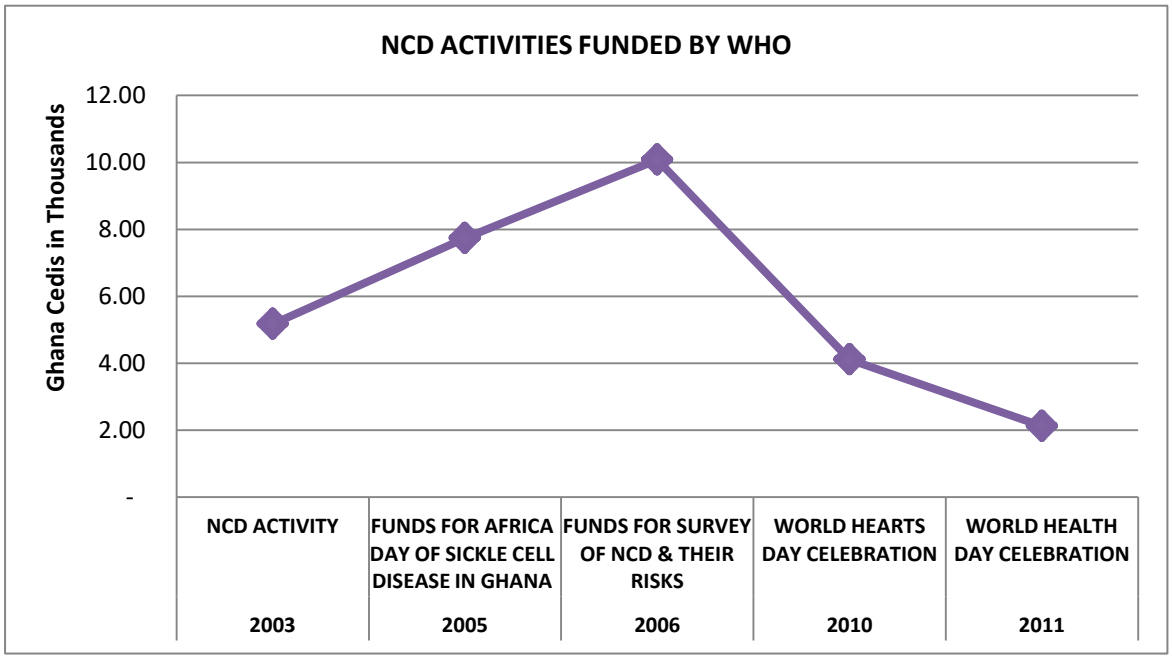
Figure 16: Tobacco Activities Funded by WHO



7.9.1. NCDs Activities Funded by WHO

Similar to the above figure, there was sharp rise in expenditure funded by WHO on NCD activities which peaked in 2006 and gradually declined until the end of the study in 2011. The STEPS study may have accounted for the peak of expenditure seen in 2006. Like that of tobacco control activities, funding for NCDs activities were low or inadequate during the period of study.

Figure 17: NCD Activities Funded by WHO



CHAPTER 8: INTERNAL CHALLENGES OF FCTC DEMAND REDUCTION PROVISIONS (ARTICLES 6)

This chapter examines perceptions on the imposition of higher taxes on tobacco and alcohol known as "Sin taxes". It further describes the trend and impact of taxes on importation of tobacco in Ghana. The classification of tobacco products, different taxes applied to tobacco imported and revenue accruing to government between 2004 and 2009 are described.

8.1. Perceptions on Imposition of Higher Taxes on Tobacco and Alcohol ("Sin taxes") in Ghana

Participants proposed the imposition of "Sin Tax" and recommended a swift Parliamentary approval. This approval would ensure that monies from such taxes would be exclusively used for NCDs prevention and control and tobacco control. However, a few disagreed with the imposition of "Sin Tax".

They recommended accountability on the part of the revenue authority, strong advocacy to develop coherent arguments in a simple language to lobby for cabinet's and parliament approval as well as need for developing annual work plans that addresses NCDs and tobacco control.

Some respondents were in favour of the imposition of the "Sin Tax" and recommended Parliamentary approval. In justification, this approval would ensure that monies from such taxes would be used exclusively for activities related to NCDs prevention and control and tobacco control.

> *"It's perfect because sin tax brings money and at the same time it prevents people from getting ill…it's a matter of writing to Cabinet for approval and then it goes to parliament and when parliament approves it and this one it's easy to sell"*

A few respondents mentioned imposing higher tax on tobacco products and alcohol was good but feared monies from such a tax could be used for other purposes.

> *"I think they should increases the taxes to raise funds for NCDs but whether*
> *when they increase taxes and get the money, whether they'll give us or not,*
> *that's another issue…"*

Participants who agreed to the imposition of higher taxes on tobacco and alcohol further opined to the setting up of a special fund such as the Ghana Education Trust Fund (GETFund) so monies that accrue from these taxes would not go into the consolidated fund in order to efficiently serve its purpose.

Some respondents also advocated for a proportion of the revenue that would be generated from these increased taxes to be allocated to the Ministry of Health to support the NCDs and tobacco control work plan.

> *"so long as it's used judiciously, it's fine and so long as the revenue authority will be able to give us the exact money they got from it and when it gets to the MOH, it'll be used for the purpose that is been..."*

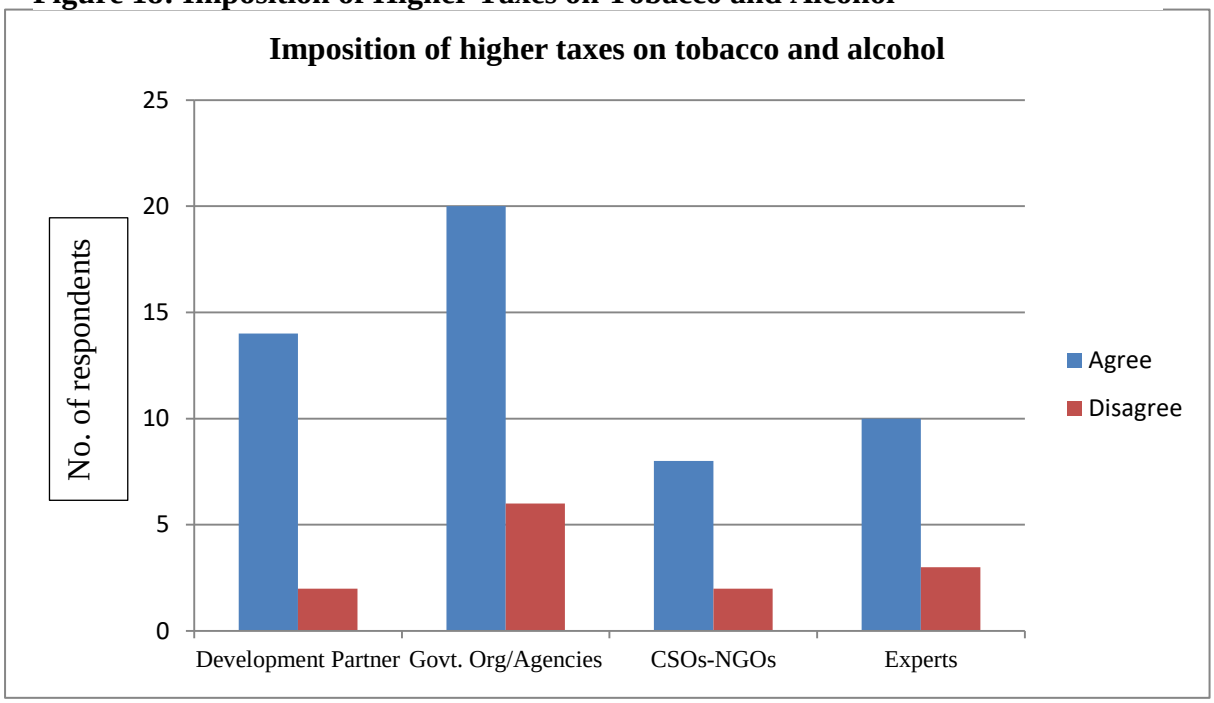
Others recommended that advocates should make strong coherent arguments in simple language to lobby for tobacco and alcohol control for cabinet's and parliament approval.

> *"that's why we the technocrats need to develop strong coherent arguments in a language that is simple for the politician to take in and go and argue."*

There is a need to develop an annual work plan for NCDs prevention and control and tobacco control.

"That is why we should be able to develop annual work plans that will speak to the issues and generate the money from there."

Figure 18: Imposition of Higher Taxes on Tobacco and Alcohol



8.1.1. Argument against Setting Aside a Special Fund for NCDs and Tobacco Control

A respondent who supported the imposition of higher taxes on tobacco and alcohol however disagreed with the setting up of a special fund for NCDs and tobacco control but proposed that advocates should rather lobby globally to have a certain %age of Gross Domestic Product (GPD) allocated to health and would be binding on the government of Ghana.

> *"I think you should fight globally to have a certain %age of GDP allocated to health and government should accept it. ... if you have a health fund then if somebody has... haemorrhage, you can fall on that, even if it's cancer, you can fall on that but taking each disease to create a fund, you can get very little for some of them and then you start crying.."*

Respondents who disagreed with the imposition of higher taxes on tobacco and alcohol expressed the need for an intensive education of the populace about the danger and effects of smoking and an assessment of how it would work in the African context.

> *"When you go in with the higher taxes you must also look at society, cutting the loss and educate the people on the issues and that's how I think you should do that rather than just higher tax".*

8.2. Demand Reduction Provisions (Articles 6 to 14)

8.2.1. Taxation and Prices of Tobacco Products in Ghana (Implementation of FCTC Article 6)

This section examines the trend and impact of taxes on the importation of tobacco in Ghana. It describes the classification of tobacco products, the different taxes applied to tobacco imported into the country and revenue accruing to government from tobacco between 2004 and 2009.

Following the WHO Framework Convention on Tobacco Control (FCTC) in 2003, many countries including Ghana are taking the initiative to pass legislation on tobacco use and also raise taxes in an effort to discourage tobacco consumption.

Tobacco tax increases are a simple and effective control tool. In addition to reducing cigarette consumption, tobacco taxes also typically generate high tax revenues for the countries and revenue from tobacco taxation can be used to promote health programmes and improve health.

Using routine data from the revenue generating institutions in Ghana, annual reports of research and academic institutions, internet sources of peer review journals and media reports, the study gathered information on different taxes levied on tobacco, revenue generated from tobacco, the different companies importing tobacco into the country, taxes companies pay and trends in tobacco importation and taxation between 2004 and 2009.

The results show that tobacco importation in Ghana has been on the increase between 2004 and 2009 after the manufacturing company, the British American Tobacco (BAT) company closed in 2006. Tobacco importation was as low as 176,845 kilograms in 2004 but as high as 2,073,007.59 by the close of business in 2009. This represented over a 1000% increase in tobacco importation within the period. The BAT Company remains the main importer of tobacco in Ghana with as much as 87% of yearly tobacco imports. Taxes including import duties and excise tax on tobacco were as low as 3.28% of total domestic excise and import sector revenue for 2004 and this declined further in tobacco revenue between 2007 and 2009. However, excise tax increased from 33% as a %age of Custom, insurance and freight value in 2004 to 226.9% in 2009 but import duty revenue dropped from 2.84% in 2007 to 1.38% in 2008 slightly rose to 1.54% in 2009. In general, there has been a decline in the proportion of tobacco revenue to total import sector and tobacco revenue.

Tobacco importation has an inelastic demand as huge excise taxes did not reduce importation significantly and this implies that tobacco importation appears insensitive to tax changes and tax increases.

According to the WHO FCTC Article 6.1, “Price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular younger persons.” Article 6.2(a), stipulates each Party should “take account of its national health objectives concerning tobacco control and implement tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption”(11,217).

The importance and effect of high tobacco taxation is known to have a significant effect on the reduction of tobacco use, particularly among the youth, in most low and middle-income countries (24)(316). In China for example, a 10% increase in taxes on tobacco was found to reduce tobacco consumption by 5% and this raised revenue to provide basic health care for 33 million rural residents (24). In South Africa between 1993 and 2009, total taxes (including excise and sale) on cigarettes increased from 32% to 52%. In that same period cigarette sales declined by 30%, whilst government revenue increased by 800%, with the smoking prevalence in adults decreased to 25% (317). Studies from Philippines which had adopted a radical “Sin Tax” in 2013 had an increase of tobacco excise duties by as much as 340% raising the equivalent of US USD1.6 billion in its first year. Some of this money was used to subsidise health insurance for 14.7 million poorer people (316). These funds generated from increased taxes could be used to implement and enforce tobacco control policies and pay for related public health and social programs (153,318,319).

The World Bank recommends that tobacco taxes should be two-thirds to four-fifths of the retail price of tobacco to reduce its consumption (24). Despite the effectiveness of tobacco taxes on consumption and revenue generation, there is evidence that since 2002 prices of locally branded tobacco are on the decrease in some countries including Ghana. According to the WHO, cigarette prices in Ghana are still low compared to many other African countries (64).

We reviewed tobacco revenue documents from Customs, Excise and Preventive Service (CEPS) of the Ghana Revenue Authority (GRA), Ministry of Finance and Economic Planning, local newspapers and magazines, internet sources and informal interviews with key individuals in Ghana. We further reviewed periodic and annual reports from the Ghana Statistical Services and Institute of Social and Economic Research (ISSER) of the University

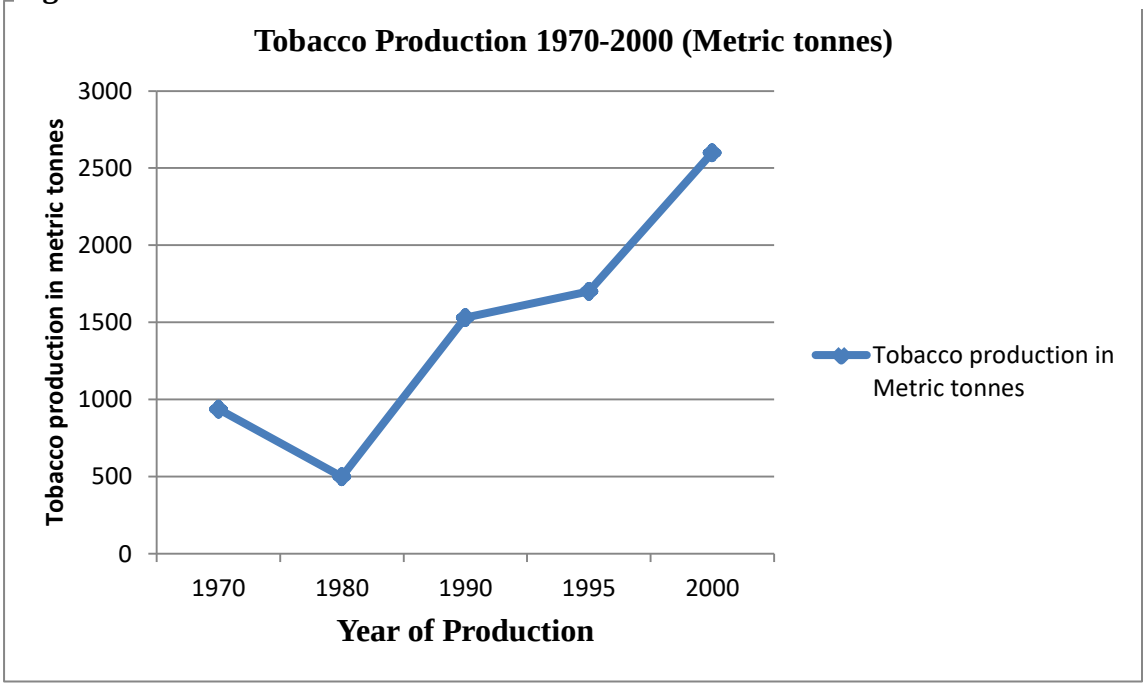
of Ghana between 1998 and 2009. Relevant tobacco taxation and policy documents as early as 1970s were also reviewed.

8.2.2. Trend in Tobacco Production and Importation in Ghana

Cigarette manufacturing in Ghana began in 1954 (64). The main tobacco industries were the British America Tobacco (BAT)–owners of Pioneer Tobacco Company and its successor International Tobacco Company–and Meridian Tobacco Company. The BAT folded up manufacturing in Ghana in 2006 and relocated to Nigeria in a bid to minimize the cost of production (64,320). Prior to its closure of business in Ghana, BAT incurred a manufacturing loss of over USD11 million and media reports attributed the closure to hard government policies on tobacco and allied products. The low tobacco prevalence attributable to early policy directive on tobacco advertising and unfavourable economic conditions for the tobacco industry (64) may have resulted to losses and subsequent closure of BAT.

Available data indicate that as of 1966, over 200 million cigarettes were sold per month and production increased by 76% between 1968 and 1976 with about an average consumption of 600 cigarettes per person in 1977 (64,321,322). Domestic production also grew at formidable pace in the 1980s and Ghana was able to export tobacco leaf in 1986 (Figure 18).

Figure 19: Tobacco Production 1970 - 2000



Source: ERC Statistics International, www.who.int/tobacco/media/en/Ghana

Consumption of cigarette however has been on the decline since 1984 (64,323–325). Tobacco importation in Ghana was quite negligible during the period when tobacco was produced and manufactured locally (Figure 18). The fold up of BAT manufacturing in 2006 resulted in high importation of tobacco products into the country. There was about 400% increase in the importation of tobacco products between 2007 and 2009 following the closure of BAT manufacturing in Ghana (Figure 19). The increase in tobacco importation however was over 1000% in 2009 from the 2004 importation level.

8.2.3. Companies importing Tobacco in Ghana

Since 2004, two main companies (BAT and TargetLink Ltd) have had the largest share of tobacco imported to Ghana. Some formal institutions, pharmaceutical companies and smaller businesses import tobacco products in smaller quantities. Tobacco importation by these

companies started rising in 2006 and peaked in 2008 and slightly dropped for TargetLink Ltd and other category of companies in 2009 (Table 3).

Figure 20: Tobacco Imports

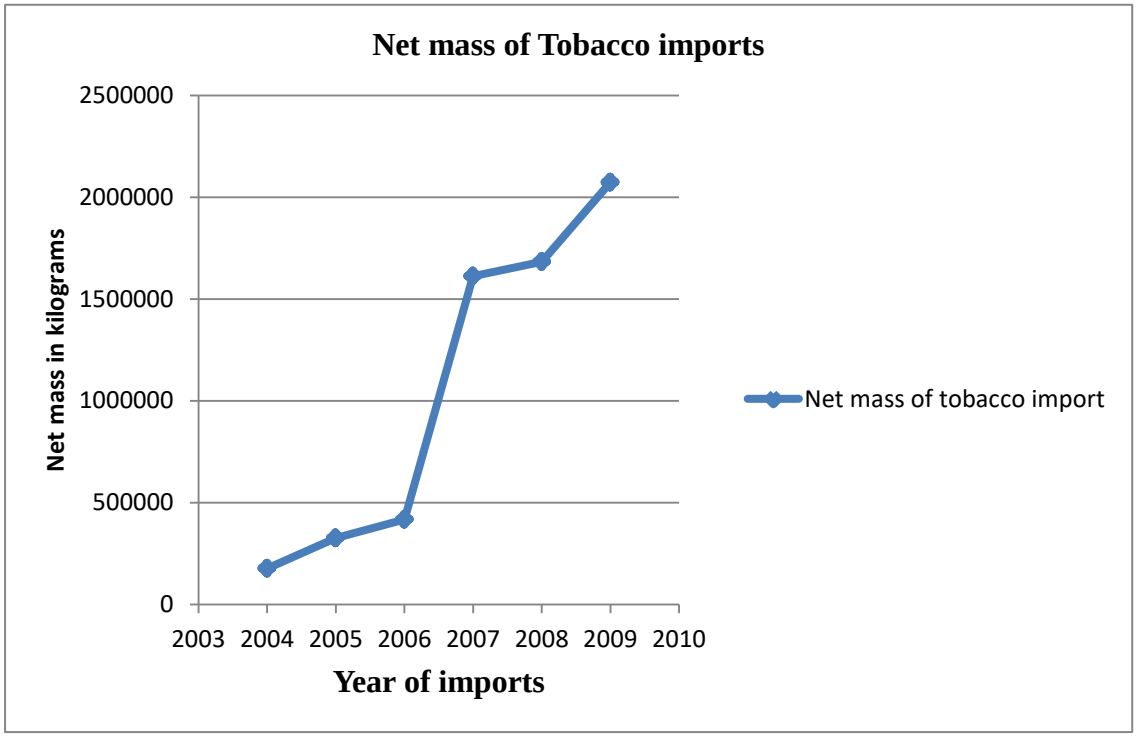


Table 5: Tobacco Importation by Major Companies in Ghana 2004 - 2009

Year	Company	Net Mass	Net Mass % imported by Company
2004	British American Tobacco	149, 339	84.5
	TargetLink Ltd	26549	15.0
	Other companies/groups	925	0.5
	Total	**176813**	100
2005	British American Tobacco	311998	95.5
	TargetLink Ltd	11260	3.5
	Other companies/groups	3357	1.0

Year	Company	Net Mass	Net Mass % imported by Company
	Total	**326615**	**100**
2006	British American Tobacco	324257	77.6
	TargetLink Ltd	90034	21.6
	Other companies/groups	3416	0.8
	Total	**417707**	**100**
2007	British American Tobacco	1468271	91.1
	TargetLink Ltd	137185	8.5
	Other companies/groups	6742	0.4
	Total	**1612198**	**100**
2008	British American Tobacco	1,425,832	84,8
	TargetLink Ltd	234000	13.9
	Other companies/groups	22269	1.3
	Total	**1,682,101**	**100**
2009	British American Tobacco	1,808,949	87.3
	TargetLink Ltd	255,089	12,3
	Other companies/groups	8970	0.4
	Total	**2,073,008**	**100**

8.3. Tobacco Production in Ghana

The Pioneer Tobacco Company began cultivation and manufacturing of cigarettes in Ghana in 1954 and had political support for its manufacturing initiative. However, in 1962, government of Ghana brought the marketing of cigarettes under state control by purchasing the tobacco leaf department of PTC through legislation and renaming it the Ghana Tobacco Leaf Company with PTC retaining shares and managerial roles in the company. In 1967 however, government issued a policy on Ghanaian ownership of foreign companies and this led to government buying 40% of the PTC shares and 15% shares were sold to the public with PTC retaining 45% of the shares. Thus PTC remained the only tobacco producing and manufacturing company until 1976 when the monopoly was broken by International Tobacco Ghana (ITG). In 1989, CEPS charged ITG with a levy of US USD3.3 million in unpaid duty and sales tax, causing ITG to cease trading in 1989 (324,326).

8.4. Classification of Tobacco Products Imported

Tobacco products are classified into several types by the CEPS and taxes vary by whether products contain tobacco or not. The classification of tobacco products between 2004 and

2005 were broadly defined to contain either tobacco or no tobacco until 2006 when it was modified to include a finer description indicating quality and brand of tobacco. The trend shows differences in year by year classification of tobacco products (Table 4).

Table 6: Classification of Tobacco Products Imported

Tobacco Products 2004-2005	**Tobacco Product Classification 2006**	**Tobacco Product Classification 2007**	**Tobacco Product Classification 2008**	**Tobacco Product Classification 2009**
-****	Tobacco not stemmed/stripped	Tobacco not stemmed/stripped	Tobacco not stemmed/stripped	-
Tobacco wholly or partly stemmed/ stripped	Tobacco wholly or partly stemmed/ stripped	Tobacco wholly or partly stemmed/stripped	-	Tobacco wholly or partly stemmed/stripped
Cigars, cheroots and cigarillos containing tobacco	Cigars, cheroots and cigarillos containing tobacco	Cigars, cheroots and cigarillos containing tobacco	Cigars, cheroots and cigarillos containing tobacco	Cigars, cheroots and cigarillos containing tobacco
Cigarettes containing tobacco	Cigarettes containing tobacco	Cigarettes containing tobacco	Cigarettes containing tobacco	-
Cigars, cheroots, cigarillos, cigarettes, etc not containing tobacco	Cigars, cheroots, cigarillos, cigarettes, etc not containing tobacco	Cigars, cheroots, cigarillos, cigarettes, etc not containing tobacco	Cigars, cheroots, cigarillos, cigarettes, etc not containing tobacco	-
Smoking tobacco with or without tobacco substitutes	Smoking tobacco with or without tobacco substitutes	Smoking tobacco with or without tobacco substitutes	Smoking tobacco with or without tobacco substitutes	-
-	-	Homogenized or reconstituted tobacco	-	-
-	-	-	Premium cigarettes (State express, Rothmans, King Size)	Premium cigarettes (State express, Rothmans, King Size)
-	-	-	High quality cigarettes (e.g. Embassy, Diplomat)	High quality cigarettes (e.g. Embassy, Diplomat)
-	-	-	Medium Quality Cigarettes (London, King	Medium Quality Cigarettes (London,

Tobacco Products 2004-2005	Tobacco Product Classification 2006	Tobacco Product Classification 2007	Tobacco Product Classification 2008	Tobacco Product Classification 2009
			Size, London Menthol)	King Size, London Menthol)
-	-	-	Low quality cigarettes (Pall Mall, Kind size/Menthol, Tusker King Size/regular	Low quality cigarettes (Pall Mall, King Size/Menthol, Tusker King Size/regular
-	-	-	-	Tobacco Refuse
Other manufactured tobacco,	Other manufactured tobacco,	Other manufactured tobacco,	Other manufactured tobacco,	

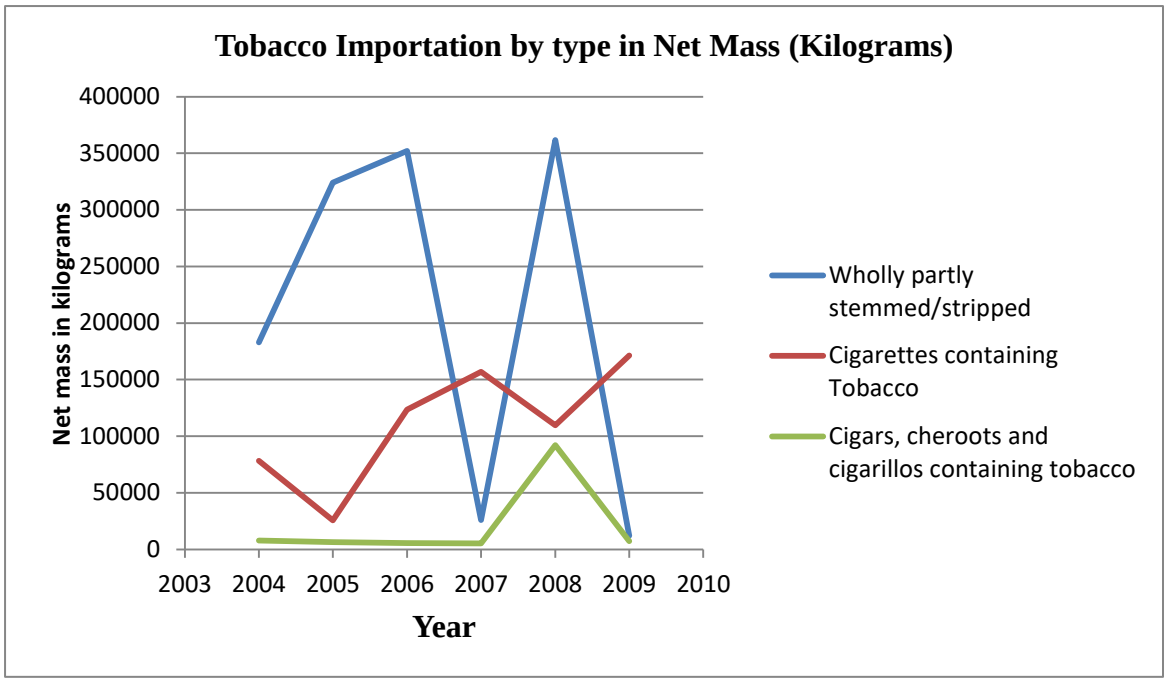
-******** not a classification in year of reference

Between 2008 and 2009, classification varied considerably based on whether tobacco products contain low or high tar. High quality cigarettes are believed to have low tar compared to low and medium quality cigarettes (327) and may pose difficulty in attracting the right tax per type of tobacco product. The international classification of raw and unprocessed tobacco is known as all forms of unmanufactured and refuse tobacco. This includes tobacco supplied as whole plants or leaves in the natural state, or as cured or fermented leaves. It also includes tobacco that has been stemmed/ stripped, trimmed or untrimmed, broken or cut, with pieces cut to shape. The waste resulting from the process of the leaves or manufacturing of the tobacco which includes the stalks, stems, midribs, trimmings and dust is known as the tobacco refuse (328).

8.4.1. Tobacco Importation by Classification

The commonest tobacco product imported between 2004 and 2006 was tobacco wholly/ partly stemmed/ stripped (unmanufactured tobacco) followed by cigarettes containing tobacco. However, after the closure of BAT, importation of cigarettes containing tobacco increased markedly to over 1.5 million net mass between 2007 and 2008 out-tripping the importation of tobaccoco wholly/ partly stemmed/ stripped (see Figure 20).

Figure 21: Tobacco Importation by Type



A drastic increase in importation of cigarettes containing tobacco from about 91,000 to over 2,000,000 kg was observed between 2006 to 2009. A further observation showed that there was more importation of medium and low quality branded cigarettes. The sharp increase in medium to low quality branded cigarettes could be due to the high excise taxes on tobacco thus driving the increase in demand for low quality products that may contain high tar exposure.

8.5. Taxation and Revenue Generation

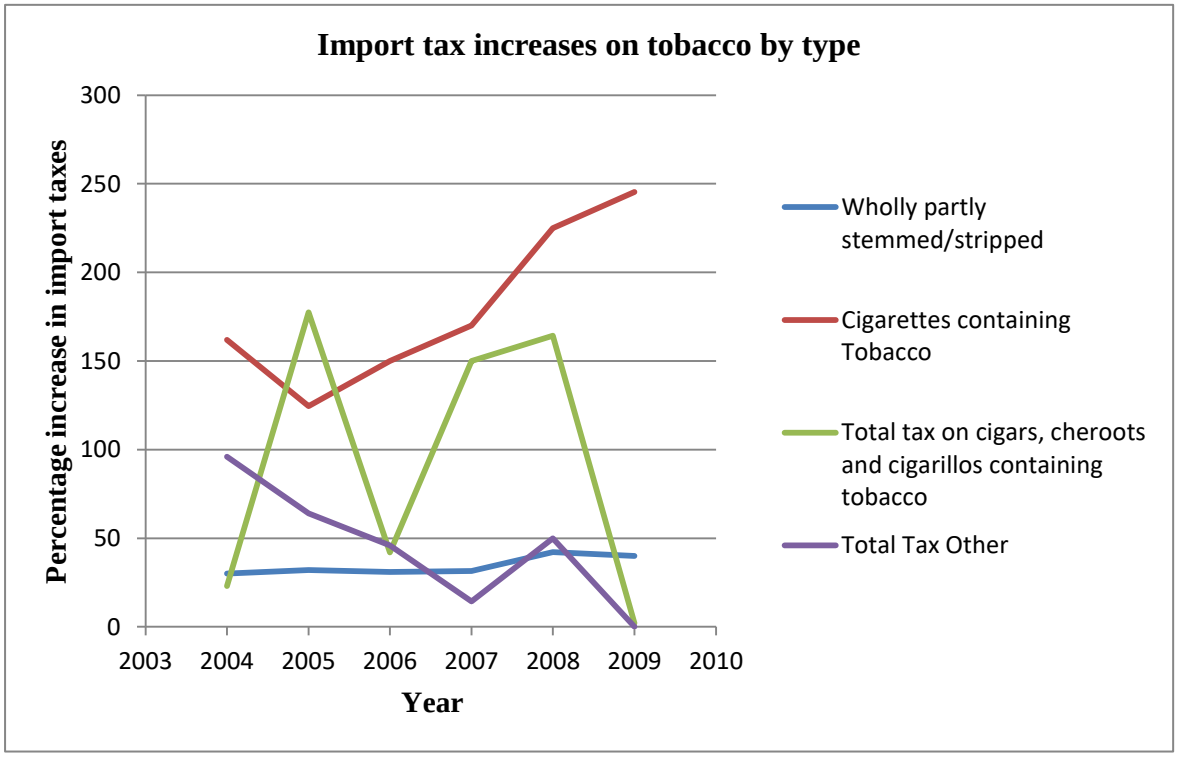
Many countries derive revenue from taxes on various goods they import and export. In most developing countries taxation is the main source of revenue for many governments. Excise taxes, notably on tobacco and petroleum products and on alcoholic beverages, raise revenue equivalent to 1.9% of GDP in Sub-Saharan Africa (64).

Ghana however unlike Malawi and Zimbabwe that depend mostly on revenue from tobacco, derives little revenue from tobacco compared to other products that yield a greater %age of revenue. Though governments' interest is to generate revenue from taxes, revenue is often not the only reason for which government imposes taxes. While excise rates on tobacco products may be increased primarily to raise revenue, there are also health benefits from reduced tobacco consumption. In Ghana, the excise duty is ad valorem tax calculated on the basis of custom, insurance, and freight plus import duty or as a specific tax on the number of cigarettes sticks imported.

Excise tax in Ghana is collected on only petroleum, tobacco (i.e. cigarettes), beer, spirits and some soft drinks which are goods that are often discouraged by society and therefore the rate of excise duties tend to be high. Tobacco products considered harmful to the consumer such as high quality cigarettes cigars, cheroots and cigarillos containing tobacco and cigars, cheroots, cigarillos, cigarettes not containing tobacco, all attracted higher taxes per kilogram (GH¢ 13,462 per kilo in 2009) whereas medium to low quality branded products attracted lower taxes per kilogram (GH¢ 11.80 per kilo). These high-quality cigarettes however attracted higher taxes per kilogram than medium to low quality products. Thus, what guides the rate on taxes on the different brands of cigarettes and tobacco in general is unclear.

Tobacco attracts about six kinds of duties and levies once imported. These include import duty (20%), value-added tax (12.5%), excise duty (140%), national health insurance levy (2.5%), ECOWAS levy (0.5%) and EDIF tax (0.5%).

Figure 22: Taxes on Tobacco by Type



Cigarettes and cigars containing tobacco attracted the highest taxes and there has been heavy taxation on these types of products over the years (Figure 21). Cigarettes containing tobacco attracted the highest excise taxes of 225% and 245.45% of the total importation cost in 2008 and 2009 respectively. It is believe these high excise taxes may discourage smoking. Whereas there have been consistent increases in taxes on cigarettes containing tobacco, taxes on cigars, cheroots, cigarillos containing tobacco has been inconsistent. This is mainly due to yearly classification and reclassification of taxes of this category of tobacco product. Excise taxes on cigarettes containing tobacco constituted an average of 82% of total tax on products containing tobacco. Excise duties were not levied on tobacco wholly or partly stemmed/stripped and tobacco not stemmed/stripped thus total taxes on this type of product has been low and inconsistent over the years.

Taxes paid by companies that import tobacco also showed substantial increases in total tax paid since 2004. Whereas taxes on tobacco products have been heavy on the big companies (BAT and TargetLink Ltd), the other category of companies and institutions importing tobacco which include particular embassies in Ghana, tourists development corporation and other smaller companies have been enjoying higher tax exemptions (Tables 5,6 and 7).

Table 7: Trends of Import Taxes paid by British American Tobacco Company, Ghana

Year	Net Mass	Total Value of tobacco (GH¢)	Total tax paid (GH¢)	Total Tax exemption (GH¢)	Tax as Percentage of Total Value (%)
2004	149,339	363,792.70	103,132.78	0	28.35
2005	274,000	646,235.21	182,070.58	0	28.17
2006	324,257	830,505.85	227,489.35	8,045.80	27.39
2007	1,468,271	11,023,107.92	18,715,513.99	1,030,894.70	169.78
2008	1300732	2,787,908.99	6,840,326.48	677,206.80	245.36
2009	1,497,407	6,614,083.62	15,877,976.69	1,602,553.50	240.06

Table 8: Trend of Import Taxes paid by TargetLINK Ltd, Ghana

Year	Net Mass	Total Value of Tobacco GHC	Total Tax Paid GHC	Total Tax Exemption	Tax as Percentage of Total Value
2004	26,569	117,444.69	209,103.36	0	178.04
2005	11,260	122,444.69	219,669.43	0	179.40
2006	90,034	217,260.65	389,818.73	0	179.40
2007	137,185	321,949.01	577,607.47	0	179.41
2008	213494	479,201.42	1,136,361.25	0	237.14
2009	211195	215,887.53	462,664.11	0	214.31

Table 9: Trend of Import Taxes Paid by Other Companies, Ghana

Year	Net Mass	Total Value of Tobacco GHC	Total Tax Paid GHC	Total Tax Exemption	Tax as Percentage of Total Value
2004	925	23,782.64	2,621.11	38,528.57	11.02
2005	3,357	60,884.44	1,323.28	105,989.55	2.17
2006	3,416	59,704.87	4,393.32	72,546.33	7.36
2007	6,742	45,748.01	3,075.79	69,635.56	6.72
2008	20351	110,478.78	112,783.86	22,083.95	102.09
2009	7542	68,61.3	1,453.83	5,628.64	21.19

The heavy taxes (over 200%) paid by tobacco companies like BAT and TargetLink have led to drop in tobacco importation by TargetLink. The BAT recorded a drop in importation by 12% in 2008 but rose again by 13% in 2009 exceeding the 2007 level by only 1% (Table 6). Although the institutions and the other smaller companies have been enjoying exemption from paying taxes, there have been huge cuts in the exemptions they enjoy and hence there is a drastic drop in the importation of cigarettes by institutions and embassies in the other category.

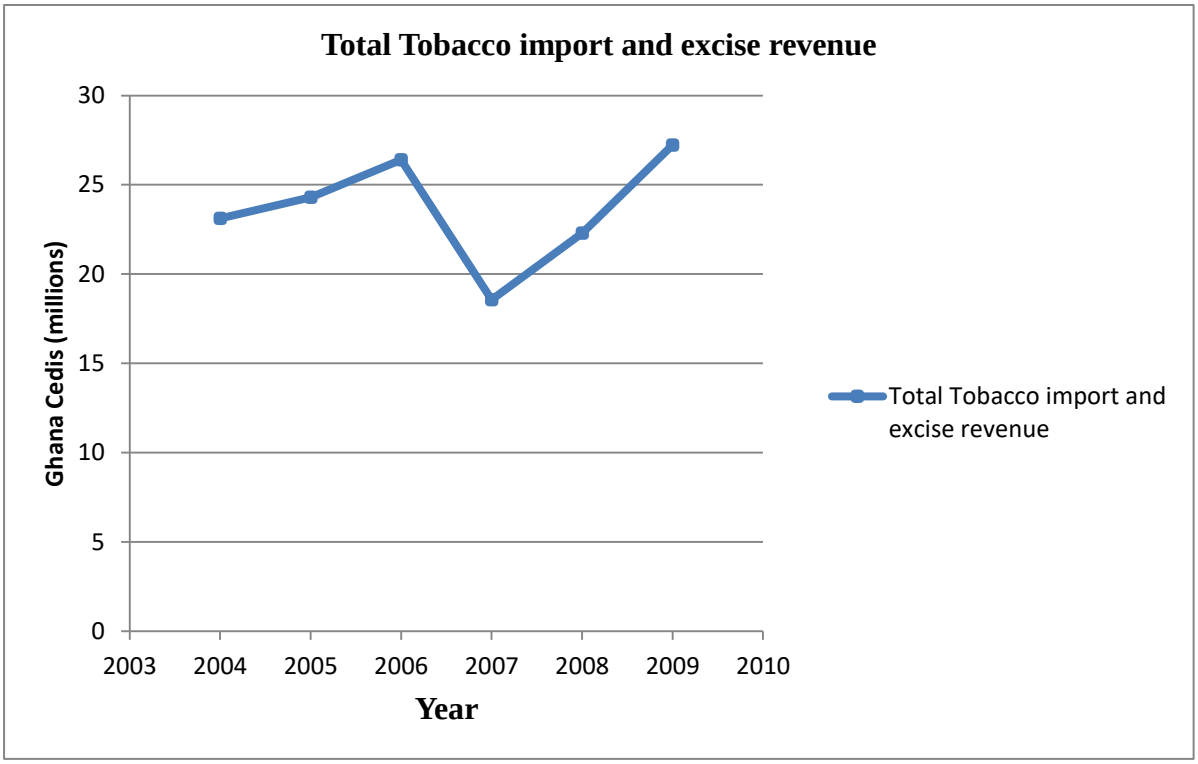
Overall, there have been substantial increases in excise and total taxes from the period 2004-2009 and yet this did not yield significant reduction in tobacco products importation as observed in Table 8.

Table 10: Excise and Import Taxes on All Tobacco Products, 2004 – 2009

Year	Net Mass	Total CIF (GH¢)	Import Duty (GH¢)	Excise Tax (GH¢)
2004	176,845	505,039.72	65,254.61	166,952.88
2005	326,615	964,393.7	102,851.91	173,804.77
2006	417,707	1,107,491.00	128,015.09	305,653.74
2007	1,612,198	11,390,804.94	1,387,522.14	15,812,725.62
2008	1,534,577	9,78,4703.3	145,309.16	20,253,061.55
2009	1.716,144	10,826,163.94	43,911.00	24,564,565.98

The consistent rise in excise tax corresponds with a much lower import duty on tobacco products despite the fact that there is a standard 20% flat import tax on goods imported. The import duty as a percentage of the CIF reflects a lower than 20% rate (Figure 22).

Figure 23: Excise and Import Duties on All Tobacco Products



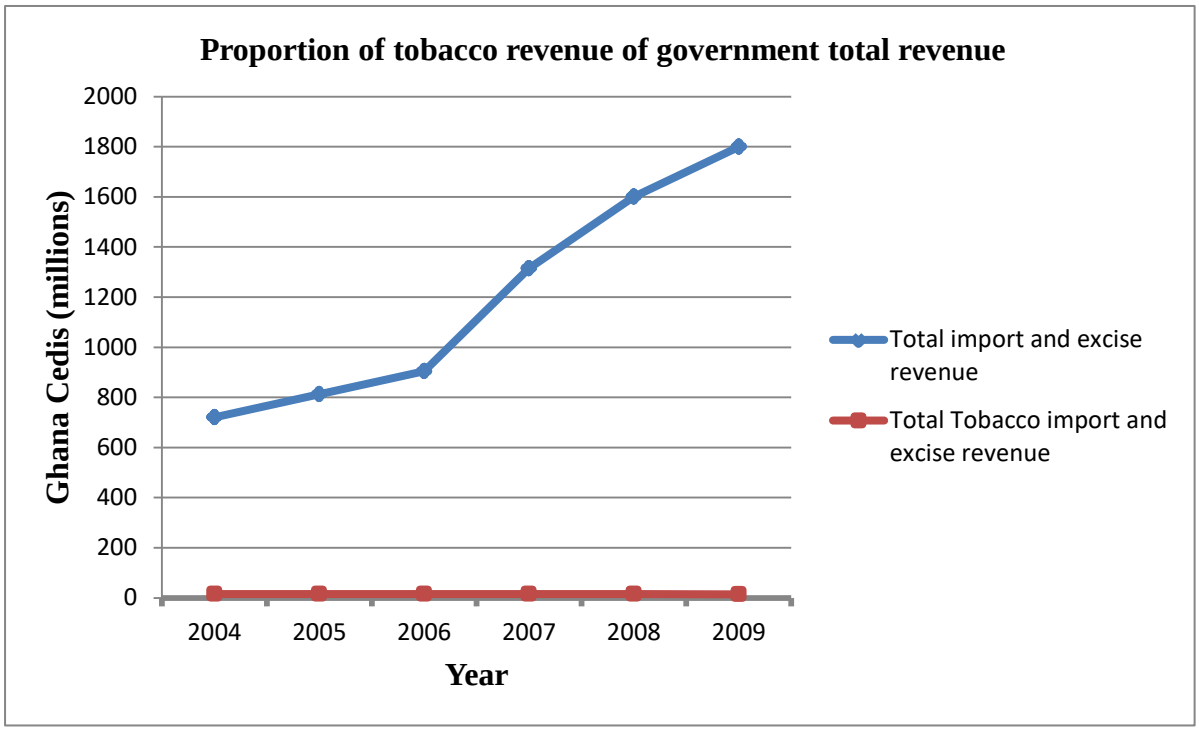
The importation of cigarettes and cigars, cheroots and cigarillos containing tobacco which constitute the major tobacco commodity imported was low when the BAT was operating in Ghana, hence tax revenue from tobacco products imported was substantially low from 2004 to 2006. With the closure of local manufacturing of cigarettes, the importation of cigarettes containing tobacco rose in 2007 reaching a peak of 2,073,007.59 kilograms in 2009 and contributing to total revenue of GHC 24,608,476.98 in 2009 (Figure 22).

The huge excise tax of 226.7% levied on tobacco products in 2009 reduced total revenue from all tobacco products significantly as tobacco product importation increased slightly (Figure 23).

Tobacco revenue contributes about 2% on average to total Government import sector and domestic excise revenue and has remained negligible compared to overall total Government import sector and domestic excise revenue over the years (Figure 23). Government total

import sector and domestic excise revenue rose substantially between 2007 and 2009 with a corresponding fall in the %age of total tobacco tax revenue of 2.84% in 2006 to 1.53%, 1.38% and 1.54% in 2007, 2008 and 2009 respectively.

Figure 24: Proportion of Tobacco Revenue of Government Total Revenue



8.5.1. The Demand for Tobacco: How High Can Tobacco Taxes be increased?

The extent to which taxes are placed on a particular commodity depends on the elasticity of demand for that product. A commodity that has inelastic demand means that higher prices do not reduce demand significantly and hence such a product can attract higher and higher taxes. For products that are sensitive to price change or are elastic, a small increase or decrease in price will increase or decrease demand for that product significantly. For a tax system to continue to raise adequate revenue, it helps if taxes are income inelastic. This occurs when revenue rises in line with national income even when no adjustments are made to the tax rates or bases. Where the tax system lacks elasticity, taxes will have to be modified frequently to maintain revenues. Thus elasticity aims to measure the revenue that would be generated automatically if the tax system were to remain unchanged over time. Cigarettes containing

tobacco appear to have an inelastic demand and it is insensitive to higher taxes as more revenue is generated with little change in the tax base. Figure 5 and Figure 6 show that it was only at a very high tax of over 245% (all taxes on cigarettes containing tobacco) that led to a slight drop in approximately 21,000 kilograms of imported cigarette containing tobacco in 2009 for only the other category of importers and TargetLink Ltd.

Higher taxes are levied on higher quality cigarettes because it is believed to contain less harmful effects than medium to low quality ones which are more harmful. And there was a high importation of low quality tobacco products because they are cheaper to import and still cheaper after huge taxes. Though low tar does not prevent the risk of lung cancer it is quite worrying that medium to low quality tobacco products attracted lower taxes per kilogram imported. Also embassies and diplomatic organizations enjoy exemptions when they import small quantities and this encourages smoking and risk of secondary smoking. In order to have the desired impact all cigarettes irrespective of the level of tar should attract high excise duties to have the desire effect. Current tax exemptions should not apply to tobacco products if a significant reduction in tobacco product importation and use are to be discouraged. There will also be the need to review the import duty tax which is currently negligible since even high excise taxes are not significant enough to reduce importation and demand for a highly inelastic product such as tobacco.

Tobacco taxes in Ghana are much higher than often reported with excise taxes as high as 206% and 226.9% in 2008 and 2009 respectively. These are aimed at deterring the population from smoking although they are substantially lower than other developing countries such as Philippines. The poor effect of taxes in reducing tobacco importation and use is due to the inelastic demand of tobacco. The import duty of 20% on tobacco taxes has failed to significantly reduce tobacco importation even though excise duties continue to soar. Thus, for taxes to have any effect on tobacco importation and subsequent demand, both import and excise duty need to rise consistently.

With the renewed anti-smoking campaigns around the world and the coming into force of the WHO FCTC, there are greater prospects in reducing the harm from tobacco than has been the case several decades back. But is every country putting in enough efforts in raising taxes on tobacco importation and sales? As part of the implementation of the WHO FCTC, in a news

article of March 2009, President Obama signed a law early in his administration to raise taxes from 39 cents to USD1.01 per pack of cigarettes and from 19.5 cents to 50 cents per pound for chewing tobacco. This increase in taxation on tobacco was among others, to raise money to finance expansion of Health Insurance for Children (201,329).

Some cost-effective tobacco control approaches aimed at reducing smoking among adults and youth are high tobacco tax, ban on direct and indirect tobacco advertising, smoke-free environment in all public and work places as well as large clear graphic health messages on tobacco packaging.

8.5.2. Tobacco Tax Benefits the Economy

Studies have shown that raising tobacco taxes is one of the cost effective ways to reduce tobacco use and increase revenue for governments (319,330). These revenues can pay for tobacco control interventions, combating infectious diseases or other national priority programmes. Countries with efficient tax systems have benefitted from substantial tax increase (319,330). It is also well-established that significant increase in price induce most current smokers to quit and deter many youth from taking up tobacco use which leads to large reduction in death and disease caused by the usage of tobacco (153,319,330,331).

Excise taxes are an important source of revenue in most African countries. Evidence from IMF data from 17 African countries show that excise taxes have yielded approximately 2% of GDP since 1973. Thus, controlling tobacco using excise taxes together with anti-tobacco measures such as ban on smoking in public places might lead to the desire results of getting smokers to quit smoking.

In 2007, Ghana shifted from ad-valorem to a specific tax regime for simplicity in administration and enforcement while ensuring a steady stream of revenue and discouraging tax evasion and smuggling. This shift in policy regime is consistent with current international trends and best practices. Ghana applied this specific tax regime on petroleum products earlier and extended to beer, wine, spirits and tobacco (217,283,289).

In Article 6.1, of the WHO FCTC Parties recognize that "price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons", but in 2010 It was not clear if the Government of Ghana recognizes from a policy perspective that tobacco taxes are an effective means to reduce tobacco use. It was clear, however, that an excise tax was imposed on tobacco products (as well as alcohol) partly because those products were considered harmful to health (217,283,289).

Similarly, in Article 6.2(a) of the same WHO FCTC, it stipulates that each party should “take account of its national health objectives concerning tobacco control and implement tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption.” Before 2007, Ghana imposed a flat ad valorem rate of 140% (of the Cost, Insurance and Freight - CIF - value) on all tobacco products. In same year 2007, the taxation structure was changed for cigarettes to a specific excise tax. The rate varied depending on the type of cigarette imported (217,283,289).

The following rates were imposed during 2008 and 2009: Premium cigarettes were 0.0275 cedis per stick; High quality cigarettes were 0.0235 cedis per stick; Medium quality cigarettes was 0.0175 cedis per stick and Low quality cigarettes was 0.01 cedis per stick. The other types of taxes imposed on tobacco products was import duty was 20% of CIF value (cigarettes produced within Economic Community of West Africa States (ECOWAS) and imported to Ghana are exempt from the import duty). The National Health Insurance Levy was 2.5% of CIF + Import duty value (this levy is imposed on all products in the market which are subject to VAT, it is collected at the same time as VAT); ECOWAS levy was 0.5% of CIF value (imposed on most imported products); Economic development and investment fund was 0.5% of CIF value (imposed on most imported products); Processing fee was 1% of CIF value (only imposed on products benefiting from the import duty waiver above); Value-added tax (VAT) was 12.5% of CIF + Import duty value +excise tax (initially, the enforcement agency - Customs - used only CIF + Import duty as the base. The Ministry of Finance recommended to Customs to make sure that the excise value was also taken into account in the base for the VAT tax (217,283,289).

The main reason why the tax structure was changed in 2007 was for revenue generation purposes and affected all non-petroleum excisable products (tobacco, alcoholic and non-alcoholic drinks). The Government assumed tax neutrality, i.e. follow one tax policy approach for all non-petroleum excisable products. This meant that the government looked at the effect of tax change as a whole and not by product and the purpose was to increase revenue from those products taken altogether (217,283,289).

After two years of imposition of the new tax structure introduced in 2007, the government noted a decrease in their total tax revenues from non-petroleum excisable products. The reduction in revenue was mainly driven by the decrease in revenues from alcoholic beverages. However, revenues from tobacco taxes actually increased. Unfortunately, because of the tax neutrality approach and the fact that total revenues went down, the government decided to go back to the old regime with the rates applied on the excisable products before 2008. For tobacco products, in particular cigarettes, this meant basically a reduction of the tax rate (217,283,289).

In 2010 the Ministry of Finance decided to impose the flat ad valorem rate of 140% of CIF value. Even though the rate seems like a high rate, when converted as a %age of the retail price, excise tax only represents 22% of the price and the total tax (excise + import duty + VAT + other levies) share is 31% of the retail price. The retail price used here is the price of the brand London King Size reported by MoF as the most popular brand. The price of the pack amounted to 2.00GHC (approximately USD 0.66) in 2010. It was recommended to the government by the 2010 Needs Assessment in Ghana to consider increasing excise taxes on tobacco products. However, the increase should not only cover cigarettes but all tobacco products in order to avoid substitution of consumption to other tobacco products (217,283,289).

Furthermore, Article 6.2(b) requires Parties to prohibit or restrict, as appropriate, sales to and/or importations by international travellers of tax- and duty free tobacco products. The quantity limit for importation of tobacco products by international travellers was not clearly stated in the Customs law and is left at the discretion of each customs officer. Therefore the needs assessment realised the gap as lack of an objective guidance for the quantity limit which makes it difficult to enforce the duty free law for tobacco products and therefore hard

to control the amount brought into the country through duty free channel. It was recommended that the Customs law clearly sets the limit for the sale and/or importation of tobacco products by international travellers entering the country (217,283,289).

In setting tobacco tax rates however, governments need to take into account several factors, including the impact of smuggling, cross-border shopping, and duty free purchases on ferries and planes. With respect to the structure of tobacco excises, countries are to tax all types of tobacco - cigarettes, cigars, pipe tobacco, snuff or chewing tobacco, and hand-rolling tobacco. Unfortunately, in Ghana, as demonstrated high excise taxes are levied on high premium and quality products containing tobacco such as cigarettes containing tobacco category and the cigars, cheroots and cigarillos containing tobacco category whereas low to medium quality tobacco attract lower taxes though they contain higher tar than the premium or high quality tobacco products. All other forms of tobacco products attract normal taxes which are not simple and easy to administer as excise taxes. Thus all tobacco products should attract excise taxes as well as the import duties.

It is clear that lobbying for a very high excise taxes as well as review of import duty on tobacco will discourage its importation and consumption in Ghana. This is evident in the slight reduction in tobacco importation seen in 2009 for the other companies/groups though this may lead to evasion of tax and smuggling. Also, ensuring all required taxes are levied on tobacco will discourage importation and use in Ghana. However, this can be effective if policies and legislation on banning smoking in public places are implemented.

CHAPTER 9: SUPPLY REDUCTION PROVISIONS (ARTICLES 17 TO 18)

9.1. Implementing the Framework Convention on Tobacco Control (FCTC) Article 17 & 18 – the Case of Ghana

This section explores the experiences of tobacco farmers whether they still grow tobacco, alternative crops under cultivation and challenges faced.

The results show that tobacco farming is no longer active in the study area since the BAT closed the manufacturing operations. This has rendered the farmers poorer. Former tobacco farmers were supported and received technical assistance from BAT for their tobacco farming activities. The support received from BAT improved tobacco yields and the socio-economic livelihoods of farmers. Most farmers now earn their major income from now identified alternative crops. Unlike other situations, farmers in this study have already identified alternatives but lack the support they received from their previous partners – BAT.

The study revealed no evidence of governmental support to former tobacco farmers to turn to alternative livelihoods. There is lack of special programs or efforts to reintegrate these tobacco farmers into the mainstream activities of the MOFA. Additionally, data shows no communication or relationship between the formers farmers and the MOFA. Currently former tobacco farmers are confronted with many challenges encompassing limited access to financial credit facilities, price fluctuations of most of their crops and the lack of ready market for their produce. Farmers also lack agricultural extension services and farm implements to help improve yield of identified alternative crops.

Tobacco is widely grown as a cash crop in many developing countries (38). In the past decades there has been introduction of alternative livelihoods to tobacco farming around the world (13,332–336).

In Ghana, tobacco cultivation began in the 15th century (225). The Tobacco Atlas (2012) indicates Ghana has between 5,00 0 to 9,999 hectares devoted to tobacco growing (24).

British American Tobacco Ghana (BAT) formerly PTC introduced the commercial cultivation of tobacco in 1954 (64). BAT acquired about 80% of its raw materials locally, until the closure of its manufacturing operations in 2006. This meant tobacco farmers lost a major market for their crop (54).

Tobacco farming in Ghana is mainly in the Brong Ahafo region and on a small scale in the Volta region (283,337–340). Most farmers cultivated an average of 1-5 acres of land for tobacco farming whereas farmers in some communities practice block farming. Now, there is considerable decrease in tobacco farming due to the closure of BAT manufacturing operations. Nonetheless few farmers cultivate at their backyards for the local market. The famers sell mainly to people from Northern Ghana and sometimes Burkina Faso on credit or at very low price.

The farmers have been left without any support from government. However the WHO FCTC calls for support for economically viable alternative activities for tobacco growers through Article 17 and 18 (11,36,38,283,333,341–344). In accordance with the Article 17 and 18 of the FCTC farmers are being supported to replace tobacco with alternative livelihoods in some developing countries (36,345). However, Ghana has neither paid attention to the conventions of Article 17 and 18 in any of its policies nor Public Health Law (12,217). Till date, there are no policies and mechanisms to support small scale tobacco farmers to adjust to the withdrawal from the tobacco industry and shift to alternative livelihood (217,218).

There is little knowledge about alternative livelihoods as steps towards reducing dependence on tobacco cultivation in Ghana. This section examines whether farmers still grow tobacco or have identified alternatives. Also, the study finds out the challenges and policy implications for tobacco farming.

9.2. Current Situation on Tobacco Farming

The data shows that farmers in the study area are no longer cultivating tobacco because of lack of ready market. However, very few farmers still cultivate tobacco which is sold on the local market and sometimes to buyers from neighbouring countries.

"About 7 years ago… we stopped the cultivation of tobacco."

"not aware of any farmer in the area who still cultivates tobacco."
(Government official)

"We stopped cultivating it here completely…. The company hired the land for the farmers. All the farmers did our farms there so that they can easily supervise us…. I cultivated it for about 8 years. I was born in 1966 when people were already cultivating."

"I have a shop… I don't farm anymore…I used the money from tobacco farming to buy things for the shop… "

Discussants indicated that while engaged in tobacco farming, some earnings were used to cultivate other crops to earn extra income as well as pay fees of wards. During the BAT era educational scholarships were offered to children of registered farmers. Respondents complained of untold hardship since these benefits are unavailable due to BAT manufacturing operations' closure.

"Times are hard now. I invested all the money I got from the sale of tobacco into my shop when the tobacco business collapsed… I am not able to make enough profit because I can't fill my shop as much as I used to… All the farmers did our farms there so that they can easily supervise us…Most of us got nothing from them…"

"ever since we stopped the tobacco, life has been difficult because that was helping us send our children to school and also build houses and with some of the buildings where we got to, we haven't been able to continue since we stopped because what we'll eat is difficult to get so life has been difficult for us…"

"I was part of the first people who started growing mangoes in Kintampo but either the mangoes get destroyed by fire or the money to buy chemicals to spray was a problem… "

Most farmers have identified alternatives crops without the support from Government. The farmers recalled with "pain" how BAT provided them with excellent agricultural extension

services–tractor services, loans, provision of fertilizers and well-coordinated supervision–which facilitated their farming practices and earn more money. The lack of these services has negatively affected the yield of their current alternative crops and thus their living conditions. Whereas others have identified and engaged in alternative cropping, some farmers have no plots of land to continue farming because during tobacco production they were engaged in block farming. This has rendered them unemployed and poorer.

> *"when the government asked us to stop the cultivation, we obeyed and stopped…So the prices were not good but our executives were always fighting for BAT and we also couldn't do anything because we were just farmers. We were helpless but we got some money at the end… But the government explained to us that it was harmful to our health. We took the advice and stopped."*

> *"We don't get loans when we go to the banks. They ask for collateral security and I also don't have so they tell you to go away… The chiefs hired the land for them. He bought the land from the chiefs here unlike Nkoransa where the chiefs gave the land free of charge to them. So there BAT gave the land back to the chiefs/owners but here because the chiefs sold the land to them, they couldn't take it back. That's the problem…they gave everything back to the chiefs as a gift."*

9.3. Alternative Livelihoods for Tobacco Farmers

The evidence from the group discussions shows that the majority of people who previously cultivated tobacco has found alternative crops to grow. Most of the respondents have shifted from cultivation of tobacco to other crops and fruits whereas a few are trading. Only two farmers are into livestock rearing.

> *"… most of those farmers are into alternative crops now…"*
> *Government official*

"when the work collapsed, I started growing cashew and mangoes and then grow some other crops for consumption… like maize, cassava, plantain and yam… cashew"

Farmers reported alternatives such as mangoes, cashew and maize as their main source of income. However, respondents also grow seasonal crops for extra income. Farmers indicated that their farming activities are limited to crop farming during the rainy season and vegetable farming during the dry/lean season which comes immediately after harvesting the crops.

According to the discussants, vegetables such as pepper, cabbage and tomatoes are grown during the rainy season whereas crops like maize, cassava, groundnuts, yam and beans are cultivated during the lean season. They however maintained maize, mangoes and cashew as their main identified alternative crops to tobacco.

"the tobacco farmers, they were not cultivating tobacco alone, tobacco and what they'll eat. Like if you go to Wenchi, that's a very big maize growing area so when they come to their maize farm, they are under MOFA but once you go to your tobacco farm, MOFA hasn't got the mandate to come there. Maybe the officer who is working there might have knowledge in tobacco and he might do that on private line but MOFA in actual fact didn't have the mandate to cover extension on tobacco." Government official

"when I stopped the tobacco, I've been farming… plant yam, maize and cassava…"

I grow yam, cassava maize and beans and the one which gives me more money is beans… I'm not able farm nowadays. I can't go unless they carry me but I used to grow yam and cassava…

I'll say it's the mangoes but the first time we were planting the cost involved in buying the chemicals and I was not getting enough money from the beans to spray so the first year they all got destroyed and so I'll say it's the beans that I get some money from…"

"I grow maize, beans and yam…I'm able to grow the maize on a large scale; from there, it's the beans but the yam is for consumption at home…"

Discussants mentioned different acres for the cultivation of the various crops. The acreage for maize ranged from two to thirty, whereas that for cassava, yam and mangoes was in the range of half to eight acres. Cashew had two to ten acres of land cultivated.

"I grow four acres for the cashew and for the mangoes the land is small so about half acre and I rent somebody's land to grow the yam…"

"about three acres...I also grow maize and I grow about four acres… the one that brings in more money is the cashew…"

"I grow five acres (Mangoes)… the tomatoes; all the time I grow one acre…I grow about two acres of cashew"

"two and half acres of yam… I grow maize and yam … it's the maize that I get something from it and I have about two acres."

"I cultivate one acre for the maize and one acre for the groundnuts… I cultivate eight acres for the beans and the maize too eight acres and two and half acres for the yam… I cultivate three acres for the yam and three acres for the maize and ever since the tobacco business collapsed so money is difficult to come by and you can't do what you want to do…"

"I also have yam about two acres… I also grow cashew, maize and yam …I grow two acres for the maize and one a half acre for the yam…"

eight acres and the mangoes, I have four acres of the genuine ones and three acres of the small ones… maize; fifteen acres; the yam and the cassava; it's just about one acre…and the beans; six acres. ..

9.4.1. Ministry of Food and Agriculture (MOFA) Association with Former Tobacco Farmers

The data showed that most former tobacco farmers had limited interactions with MOFA during the era when BAT was manufacturing in Ghana. From the discussions, MOFA did not have any working relations with tobacco farmers or any policy agreements with the BAT during the manufacturing period.

> *"the agric people don't have any help to offer us… they told us they'll give us loans and they kept postponing…*
>
> *"we didn't have any relationship with them... If you go to the agric people right now for a loan they'll tell you to form a group and you'll follow up till you give up…sometimes they play politics…"*
>
> *"MOFA doesn't have alternative livelihood for former tobacco farmers. We don't have special programs for such farmers."*
>
> *"the ministry of agric does not help us and even by the time it'll come, the farming season will be over…."*
>
> *"they'll bring somebody to show you how to do it but when it comes to selling…"*

A few respondents indicated that MOFA had offered assistance to them in their current farming activities. According to the farmers MOFA provided assistance in the form of livestock, ploughing of farm lands, providing fertilizer, seedling and some technical assistance. These services are provided to farmers as soft loans to be repaid over an agreed period.

Most discussants accused MOFA of favouritism and discrimination in offering assistance to farmers but respondents from MOFA denied this assertion. MOFA further explained that there were little or no interactions with the tobacco farmers during the time they worked with BAT in cultivating tobacco.

"most farmers shy away from MOFA because they are not credible. The farmers are usually advised to form Farmer Based Organizations (FBO). These farmers should have a common need and when they started to function effectively we linked them up with loans etc.,

"…MOFA doesn't have alternative livelihood for former tobacco farmers. We don't have special programs for such farmers. We leave them to decide on their own then we give them some assistance and education… the director admitted that farmers in his district did not have other alternatives so they were managing despite the economic challenges."

"it's not discriminatory, it's a matter of choice, if you feel you can bear with the cultivation of maize which at times the market is like this and that sort of thing then its."

Farmers' inability to repay loans and organize themselves into functional groups or associations was mentioned as reasons for the limited support from MOFA. Respondents from the district MOFA emphasized that, there are no special programs targeted at supporting the migration of former tobacco farmers to alternative livelihoods.

"We have a rural bank here and we've formed a group and went to MOFA and did everything but they didn't give us. They said some people have taken loans and didn't pay back…so they won't give us…two of us went to the agric people to see if they can give us some goats to rear so that it can help us but nothing"

" …so this year they only gave us fertilizer… I don't have a working relationship with them but they have a program where you can consult their teams.... apart from the cocoa farmers, they don't give the other farmers loans… with the exception of these groups loan that they

give…even that if you tell them you are going to farm with it, they won't give you."

"after we had done the first process and didn't get any help from them, we didn't go further…so if we should get work from the agric people, we'll like it because they give you money to do everything so the agric people will be better than the NGOs."

9.4.2. Issues with the BAT Discontinuing Tobacco Production in Ghana

Tobacco farmers were very dissatisfied with the BAT and how the company left Ghana. They were not happy about the communication process of when they will cease production and the compensation of orange seedlings given to them.

"when the company was leaving they gave us mangoes to plant and even that each farmer was just given one acre. Some of the farmers didn't have lands and were renting so you cannot go and plant the mangoes on it because the land has not been sold to you so with the mangoes some didn't have lands to plant them. And also the time they gave us the mangoes, it was getting to the dry season so most of them died so the company didn't really have time to sit with us and discuss issues and they did what they wanted."

"… they didn't do anything for us and all we know was that we've stopped growing the tobacco…"

The officials asked us what we wanted from them. We went for a meeting and I told them they had to give us money…the... They (elderly tobacco farmers) even sent me out of the meeting and told me what I was saying was wrong…Within six months the work collapsed and they brought ninety mango seedlings and said that only those who had lands could have the mangoes. Those who didn't have lands were out. I for instance didn't get some because I didn't have a land

"… There were no arrangements. It was after the closure that they said they were going to plant mangoes for us… I have never seen anybody's mangoes."

"They didn't give us any information until the last two years of their existence here. They told us the government had given them two years to close down the factory so they were moving to Nigeria after that…. "

"… They didn't ask us anything. Some elderly ones amongst us told them they didn't want the mango seedlings because they didn't have money to cultivate."
"… when they stopped some of the farmers kept thinking and died through that…"

9.4.3. Awareness on International Tobacco Regulations

Almost all the discussants had heard about Framework Convention on tobacco control (FCTC). Most of who could link the FCTC to WHO as the organization responsible for the discontinuation of tobacco farming. Some respondents could not mention the source of the information while a few mentioned hearing from radio, television and BAT officials.

"I understand Ghana has subscribed to some conventions and it has banned the production of tobacco in the country so as at now we don't have anything to do with it."

"they said WHO was going to stop the work …that's was all. they said WHO said we should stop…we heard it on the radio… even the cigarette pack, they've written on it that it's poisonous.. they said if you smoke, you can get cancer and it can kill you… if somebody is smoking and you are by the person, it can also affect you…they told us that if we stop growing the tobacco, the smoking will reduce…so that was why the government said it's banning the growing of tobacco."

"it reduces your lifespan and it also gives cancer and the diseases that affect the liver... we heard the cigarette doesn't help and also it destroys the land that the tobacco is grown on and those who smoke have problems but I haven't smoked before…"

"that the tobacco causes diseases and WHO has said smoking gives cancer and other diseases and this was the reason why the tobacco company collapsed…

"it's harmful and it causes a lot of diseases and you don't have to smoke in public because it causes a lot of diseases so this was what caused the tobacco business to collapse."

"They say it reduces a person's life span. It gives cancer and this one that attacks the liver. We heard that cigarettes are not good for our health and two we heard that the cultivation of tobacco destroys our lands."

9.4.4. Challenges in Alternative Livelihoods

Discussants gave account of the numerous challenges that they face in their current livelihoods. The most reported challenge was their limited access to financial credit facilities. This is because from the discussion, the farmers were unable to meet loan or credit requirements. They claimed that their inability to access credit facilities makes it difficult to sustain and expand their farming business.

"The challenge is that when I go to a bank for a loan now they would ask for a collateral or security and if I don't have they wouldn't give me that loan. I don't have any… I don't have a car. I go with a Neoplan bus. I buy the things and put them in the bus to bring them here for me… I normally leave here on Fridays, get there on Saturday morning, buy the goods and put them in the bus on the same day and by Sunday morning we are back here. I sleep in the bus… We don't get loans when we go to

the banks. They ask for collateral security and I also don't have so they tell you to go away…."

Farmers reported lack of price regulations and viable marketing schemes for their farm produce as another daunting challenge. They argued that price fluctuations coupled with middle men involved in marketing of their produce prevents them from making sufficient profits to expand their cultivation.

The farmers lack agricultural extension services and farm implements which hitherto were provided by BAT. This they believe has affected their produce and livelihood.
The farmers further expressed a concern for storage facilities to store excess farm produce. These challenges were confirmed by the MOFA respondents.

"I also grow cashew, maize and yam and in all these we use our strength, there's no help from anywhere so we are not able to do it on a large scale in order to get money to look after your children… I'm not able to do the maize well because I don't have the money to buy fertilizer…the selling is not good…both the selling of the cashew and the maize are not good."

"About challenges the farmers in the Kintampo faced. He said the frequent bush fires in the dry season were the major problem. Input cost for land preparation, fertilizers and hiring of labourers he noted was another challenge. …"
"MOFA could not do anything about fix pricing of other crops just like the cocoa crop. It's a policy issue and even that, we can't compare other crops to cocoa at all. Farmers had their own approaches to things but as a ministry, we also had their activities."

Discussants indicated that they are not able to neither expand their cultivation nor predict the sustainability of their current occupation because of the inadequate pricing offered for their

produce, inability to secure funding from banks and the scare numbers of companies offering support and assistance to them.

Respondents from the MOFA at the district level indicated that they were not aware of any collaboration with the World Food Programme (WFP) in the study area at present. Respondents from the main ministry reported that in the past, the WFP did not collaborate with them nor assist the farmers to cultivate the crops but rather bought from farmers in times of emergencies. Currently, the WFP not alone collaborates with the MOFA to assist farmers to cultivate food crops particularly maize and rice mainly in the northern areas but also serves as the market for these farmers by buying the harvests for their activities in other countries which experience emergencies. WFP provides the farmers with the agricultural inputs and standards and MOFA provides the technical advice and monitoring of the farmers to ensure that the produce meets the standards set by the WFP and are safe from all chemicals for use. They reported that to assist the MOFA to fulfil its role in the collaboration, the WFP provides the MOFA with some vehicles to ensure effective monitoring of the farmers.

> *"World food program, they buy maize and rice for emergency cases for other countries. They offer a big market for our farmers…even gone down to extend some of their facilities to farmers especially in the northern areas for them to cultivate maize and other crops so that they will buy. At times, the farmers cultivate and because of the cultural practices, they don't do very well and it becomes a problem for world food program because world food program has set its standards so now they are collaborating with MOFA…"*

> *"it's extension and trade, they are collaborating with group of farmers, they give the inputs and they cultivate under certain standards so that it becomes marketable free of aflatoxins and those chemicals that will make them cancerous… "*

> *"The ministry (MOFA) has not got any collaboration with WHO at the moment."*

9.4.5. Policy implications of Alternative Crops to Tobacco

Respondents from the MOFA indicated the willingness to collaborate with any agency or country to assist the farmers in the country. They indicated that lands that were used for cultivating tobacco were good for the cultivation of maize and rice. They added that although they were giving some support to some farmers, this has been minimal and they have not had any special programs for integrating former tobacco farmers into mainstream MOFA activities. They therefore welcomed any organization or agency that is willing to work with them to assist the farmers in the country.

> *" the lands that they were using for tobacco cultivation are very good lands for maize cultivation and rice… we have programs at the district level, for instance, the government is doing block farming and the block farming has got support that will be attractive in a way to you. We give fertilizer, the seeds and there's also mechanization, the land is ploughed for you so if they make themselves available at the district level, they can be put in…"*

> *"they need to be sensitized as to how the income will vary and they need to exercise patience…there should be a collaborative work…. Now, there's this Ghana nut factory at Techiman and they can go into soya bean cultivation which is very good in certain parts of the country but we have to move systematically and put things in place."*

Some farmers however were of the view that as long as they made good monies from tobacco cropping they will continue to grow if BAT came back as this quote depicts:

> *"I wouldn't have stopped growing tobacco, I don't care if someone decides to smoke I will continue growing, I still want to grow tobacco because it gives me more money"*

During the discussions it was evident that most of the participants had come to terms with the fact that BAT was gone for good and there was the need to look for an alternative source of

income. Majority of them were of the view that maize could be a good alternative provided the government provides farmers with the requisite structures and implements. A ready market for the produce as well as guaranteed market price was also vital in ensuring that farmers earn equivalent amount of revenue as they did during tobacco farming to enhance their livelihoods.

> *"Governments come and go, so if there is going to be any arrangement it should be a permanent one so we can always have work to do, this will prevent the young ones from migrating to the big cities"*

Growing long term crops such as cashew, mangoes and citrus came up but they were however quick to say that it may be problematic for farmers who did not own lands. The farmers from one district (Banda Ahenkoro) came out vehemently to say that land acquisition had been a problem for them and even with the commencement of the Bui dam project they doubt if there may have enough land to go into permanent cropping.

> *"Bui dam project has taken a larger portion of our land so long term crops will be difficult it won't help us. We have no land" Banda Ahenkoro*

The results show that tobacco farming is no longer active in the study area since the BAT closed the manufacturing operations. This has rendered the farmers poorer than they were at the time they worked with BAT. Our data show that tobacco farmers were supported and received technical assistance from BAT for their tobacco farming activities. The support received from BAT improved tobacco yields and the socio-economic livelihoods of farmers. Thus farmers were attracted and trapped into tobacco production. This affirms the findings of recent studies which identified reasons for farmers continual attraction into tobacco production as the ready market and quicker returns on produce as well as enormous support received from tobacco industries (342,344)(346).

The current study found that most farmers earn their major income from now identified alternative crops. Hitherto, smallholders cultivated tobacco on full time basis. The WHO

FCTC calls for support for economically viable alternative activities for tobacco growers through Article 17 and 18 (218,283,341)(11)(36,38,333,342,343).

Unlike other situations, farmers in this study have already identified alternatives but lack the support they received from their previous partners–BAT. Consistent with the conventions of FCTC, several approaches are adopted by countries with regards to support to shifting farmers from tobacco to alternatives. Development partners and civil society organizations led support to identify alternative livelihoods such as giant bamboo for farmers have been seen in some countries (Ref). In Brazil, Mexico and Taiwan, governments are supporting farmers in alternatives such as poultry, aquaculture, beekeeping, dairy, vegetables (beans, tomatoes and chili), fruits (papaya and banana), maize, sorghum and rice.

However, these economically viable alternatives crops vary from country to country depending on the climatic conditions and the ready market. In some countries, there are financial commitments in allocation of funds to help farmers shift to alternatives whereas policies and legislations for alternative livelihoods have been adopted in others (344). In addition, pilot research projects are ongoing in countries–Kenya, Uganda, Tanzania and South Africa–for alternatives like bamboo, food crops, trees for wood, pineapple, soya, pepper, watermelons, and animal husbandry (13). In Ghana, none of these approaches are adopted to migrate tobacco farmers to alternatives livelihoods. Also, there are neither policies nor pilot research projects initiated to identify alternatives for farmers. Further, there is lack of support to farmers who have identified alternative livelihoods to tobacco cultivation. To this end, we believe, this is a complete noncompliance to the agreements of the article 17 and 18 of the FCTC (217,218).

Our study revealed no evidence of governmental support to former tobacco farmers to turn to alternative livelihoods. There is lack of special programs or efforts to reintegrate these tobacco farmers into the mainstream activities of the MOFA. Before now, plans and programs should have been put in place to support this group of farmers to transfer their tobacco farming experience to alternative cropping. We found that a few farmers have benefited from some marginal support from MOFA, due to their personal associations with representatives of the Ministry. However, this may not be enough as these affected farmers are many and need to be integrated and bloc into the MOFA activities. In the meantime, if

well-designed migration approaches are not initiated and the tobacco industry resurfaces, farmers will plausibly not hesitate to go back to farming tobacco due to benefits–reliable markets, credits facilities, farming inputs and technical support–they received during the BAT manufacturing era (335). Additionally, our data shows that there was no communication or relationship between the formers farmers and the MOFA. Indeed BAT like many tobacco industries, shield farmers from relating with governments in order to reduce cost of production (333). Direct relation of farmers with the tobacco industry without MOFA serving as intermediaries is an important policy issue which needs to be addressed by tobacco farming or growing countries. This confirms the need for development and subsequent implementation of policies to address article 17 and 18 of the FCTC in Ghana (333).

Former tobacco farmers are confronted with many challenges encompassing limited access to financial credit facilities, price fluctuations of most of their crops and the lack of ready market for their produce. In addition, farmers lack agricultural extension services and farm implements to help improve yield of identified alternative crops. These challenges were non-existent when BAT were manufacturing and therefore has affected their current produce and livelihoods. The challenges experienced by the farmers were similar to the findings of earlier study conducted in the Volta Region (347).

CHAPTER 10: GOVERNMENT STRATEGIES TO PRIORITISE TOBACCO AND NCDS

This chapter explores whether NCDs and tobacco control is on the government's agenda and how to make a priority. It further examines how to mobilize resources for NCDS and tobacco control and whether there is a specific funding stream to address FCTC commitments. The chapter has three sections:

10.1: Getting NCDs and Tobacco Control on the agenda/ as a priority
10.2: Resource mobilisation for NCDs and Tobacco control
10.3: Whether there is a specific funding stream to address FCTC commitments

10.1. Getting NCDs and Tobacco Control on the Agenda as a Priority

Stakeholders interviewed were of the view that, stronger collaboration, strong advocacy and lobbying featured most in making NCDs and tobacco control a priority and high on the agenda. Others include having a policy, increasing commitment to work, effective leadership and strengthening capacity. Some views of the respondents are:

> *"NCDs and tobacco control are a responsibility of government, if any government will sit down and allow donors to fund NCDs then what are they going to do because NCDs are the diseases either communicable or non-communicable, every society has ill-health and that is the ill-health of society so if a government says that I want to control your health conditions then they must be prepared to take up NCDs and CDs but you see issues like maternal health and others, have some other areas that will warrant a donor come in and help"*

Table 9 shows breakdown of responses to what needs to be considered in getting NCDs and Tobacco control on the agenda.

Table 11: Getting NCDs and Tobacco Control onto the Agenda

Respondents	Advocacy	Policy	Priority & Resource allocation	Work Commitment	Effective Leadership	Strengthening Capacity
Development Partner	3	2	9	0	2	1
Governmental Organization	10	4	11	4	2	4
CSO – NGOs	3	2	3	0	1	1
Individuals	5	2	4	0	1	0
TOTAL	**21**	**10**	**27**	**4**	**6**	**6**

10.1.1. NCDs and Tobacco Control as Priority

Many respondents considered NCDS and Tobacco control as a priority health issue in Ghana. These issues have been captured in various official documents of the Ministry of Health and the Ghana Health Service.

> *"NCDs generally are a priority area, it's one of the ten top priorities of the MOH and GHS, NCDs generally. Tobacco necessarily may not have been mentioned specifically but as a feature of NCDs, yes it's captured as one of the ten priorities"*

There were a few respondents who mentioned that although NCDs and tobacco control are identified as a priority in official documents, the fact that funding is limited or non-existent suggests that NCDs and tobacco control are not given the deserved attention hence not priority as claimed:

> *'I think it didn't use to be but now it's on the agenda because once the steering committee has been formed, it's on the agenda but it's not just about steering committee, it's about the implementation strategies and the commitment to commit funding into it. You can say something is your priority but if you don't put money into it, for me it's not your priority'*

10.2. Resource Mobilization for NCDs and Tobacco Control

10.2.1. Potential Funding Sources

Many of our study respondents supported imposition of the 'Sin Tax'. They expressed the view that such a tax will need Parliamentary approval as required by law. They also proposed that such an approval should ensure that monies from such tax would be used exclusively for activities related to NCDs prevention and control and tobacco control. According to a respondent, 'it's perfect because sin tax brings money and at the same time it prevents people from getting ill…it's a matter of writing to Cabinet for approval and then it goes to Parliament and when Parliament approves it and this one it's easy to sell".

Other respondents while supporting the imposition of "sin tax" as a way of raising funds, expressed fear that monies from such a tax would be used for other purposes.-"so long as it's used judiciously it's fine and so long as the revenue authority will be able to give the exact money they got from it and when it gets to the MOH, it will be used for the purposes that it has been set for"

> *"Getting a council and a focal person in place who will look at convincing Development Partners to fund NCDs*

There were other suggestions that efforts should be made to engage more local corporate bodies on resource mobilization for NCDs and Tobacco control.

> *"Since the law is in place clear budget should be set and funding sort from government."*

A number of constraints were identified. Some respondents identified delay in release of funds from government and some donors as well as inadequate amounts as constraints:

> *"from our end yes, it's unfortunate more of our resources go to item 1*

(staff emoluments) and so what is left normally for the delivery of the service is small"

10.3. Funding Stream to Address FCTC Commitments

In view of the magnitude of FCTC commitments, the current level of funding cannot be said to be adequate to carry on the resource-demanding activities in meeting the obligations of the Convention.

Respondents mentioned the existing sources of funds for NCDs and Tobacco control as the government of Ghana, development partners, UN agencies and International NGOs.

"we get GoG (government of Ghana) funds, we get from donors, sector budget support and earmarked funding".

10.4. Summary Discussions

This study provides a snapshot of the different barriers affecting the ongoing process of FCTC implementation. The findings illustrate the challenges ahead and the actions or interventions needed to support the implementation process of the FCTC.

10.4.1. Lack of adequate financial resources

As highlighted by many informants in our study, one of the most important barriers to FCTC implementation was the lack of a stable source of funding. The lack of a stable source of funding was identified as an important challenge in our study. The lack of funds is one of the major problems facing FCTC implementation in many developing countries. As a result of the lack of funds to control their own projects, many developing countries largely depend on foreign aid/donor partner support.

In addition to lack of adequate financial resources, it must be emphasized that the implementation of the FCTC is also constrained by delays in disbursement of funds from the central government. Sometimes funds are received late. This affects very much the

implementation of some programmes as some of the planned activities are delayed to start or postponed to other times.

The importance of ensuring adequate resources to meet desired FCTC goals has been noted in various studies (187,194,197,201,206,208) as requiring special attention if the implementation and sustainability of FCTC provisions are to succeed.

The issue of inadequate funds must be seen against the background that the central government has limited resources since there are various health needs to budget for hence the need for tobacco control advocates to lobby for the imposition of sin tax to generate more funds for health-related programmes as done in countries like Thailand, Philippines, Vietnam and Mexico.

10.4.2. Lack of Adequate Human Resources

In addition to the funding problem, there is a lack of manpower. Our findings indicate that Ghana does not have enough human resources who are also technically competent to execute and supervise the implementation of planned activities. This finding is consistent with other studies and reports from around the world (184,187,194,196,205,208). For example, in Ghana, we do not have the adequate staff and capacity to carry out cessation support services at the health facilities and community levels. Inadequate training of healthcare providers to deliver cessation interventions is a barrier. Healthcare professionals usually do not enquire about history of smoking in the patient as they are not sensitized regarding the impact of smoking habit on health and disease and the benefits of smoking cessation.

Meanwhile, behavioural therapies ranging from simple advice offered by a physician or a healthcare provider to a much elaborate therapy by a counsellor have been shown to be efficacious (348). Simple advice from a healthcare provider has been shown to increase abstinence rates significantly (by 30%) compared to no advice (349).
The lack of adequate personnel also affects issues such as enforcement of regulations.

10.4.3. Lack of Political Will or Commitment

Insufficient political support has been recognized as a challenge to full WHO FCTC implementation (123,193,194,207). Political commitment is the 'decision of leaders to use their power, influence and personal involvement to ensure that…programs, receive the visibility, leadership, resources and on-going political support effective action to limit the spread of… and mitigate the impacts of an epidemic…. Political commitment in the broadest sense means leadership commitment. Country leadership includes political and government leaders and many others (350).

Heaver (2005) also argues that an issue can receive impressive political attention when high-level officials address it through speeches, executive directives, setting of targets and establishment of coordinating structures, but this appears to be insufficient. Evidence of deeper political commitment would include allocation of the necessary authority, accountability and resources to relevant ministries; and the exercise of oversight to ensure progress in developing strategies and operational plans (351).

In addition, high-level political champions may be the only actors capable of generating system-wide commitment on the part of mid-level ministry officials and staff, and the managers and implementers at regional, municipal and local levels. The commitment of the managers and implementers is crucial for effective implementation, but they will need to receive sustained and meaningful signals and incentives from higher levels in their organizations (351).

Considering the implementation of FCTC in Ghana, one can argue that to some extent the existence of a law the Public Health Act (Act 581, 2012 - Part 6 on tobacco control measures) that has been set out to regulate tobacco control and the occasional comments made by political leaders on issues of tobacco control are an important part of political commitment. However, since the Legislative Instrument which provides regulations or administrative instructions to enable effective implementation of existing tobacco control measures has yet to be passed by Ghana's Parliament and the fact that the current inadequate financial resources allocated for tobacco control activities call into question the political commitment to the implementation of the FCTC. Meanwhile, political commitment and support to tobacco

control are important in order to keep FCTC high on the agenda and ensure that commitments are translated into action.

CHAPTER 11: DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

11.1. Discussion

This chapter discusses the mechanisms and challenges of the policy process of existing and potential funding sources for the implementation of WHO FCTC in Ghana. In this section, key stakeholders' role in agenda setting, policy process and formulation will be discussed using the conceptual framework of the study. Further, I discuss the different challenges in the stages of the policy processes identified by the study and their effects on the outcomes of the WHO FCTC implementation in Ghana. Policy analysis studies examine the evolution of policies, institutions and programmes over time at national and global levels (352). Health policy analysis is a multi-disciplinary approach that focuses on understanding the factors and forces that influence why and how policies are initiated, formulated, negotiated, communicated, implemented and evaluated (17,18,353,354). Policy analysis is premised on the understanding that legislation and policy guidelines, although seen as the endpoint of 'policy development', are only the starting point and that health policy is brought alive by the ways in which actors or stakeholders, translate their understanding of legislation / policies into their behaviours and practices (17,354).

The major thematic areas arising from findings of this study include: (i) overall progress in the implementation of the WHO FCTC; (ii) governance; internal challenges of FCTC – demand reduction provisions (Articles 6 to 14); (iii) supply reduction provisions (Articles 15 to 18); (iv) the way forward - getting tobacco control and NCDs on the agenda as a priority; and (v) resource mobilization for the implementation of the WHO FCTC.

The conceptual framework and the four elements that are essential to analyse factors influencing the policy process and the implementation of health policies: actors (individual, groups or organizations), content, context (situational, structural, cultural and international factors) and processes (problem identification, policy formulation, policy implementation and evaluation) will be applied to discuss the major thematic areas of the findings of this study These helps understand how the various factors, which are all connected alongside shaping the political priority (4,18).

The conceptual framework of analysis that attempts to understand why some global health initiatives are more successful in generating funding and political priority than others. The framework has been applied most prominently to maternal mortality, new born survival and mental health, but scarcely applied to tobacco control or the implementation of the WHO FCTC (4,17–19,229). The use of the conceptual framework including components from the Shiffman and Smith framework demonstrates that despite recent significant strides made, the implementation of the FCTC still faces major challenges in establishing itself as a national and global initiative with meaningful political priority (4,17–19,229).

The conceptual framework have argued that a health issue gains political priority when three conditions are met such as; country political leaders & international leaders publicly and privately express support for issue; and do so in a sustained fashion; policies are enacted to address problem; and resources (appropriate to disease burden) are allocated to the issue. In the case of the WHO FCTC, none of these conditions is currently being met in a substantial way. There is little public (or private) support for tobacco control in Ghana as a priority (4,17–19,229).

11.2. Funding stream to address FCTC commitments

The Walt & Gilson and Shiffman & Smith emphasises the strength of the individuals, research institutions, NGOs and organisations concerned with the issue (4,17,18). These frameworks may have a strong influence on the policy process, according to their level of power, for example, resources (17,230). In this influence on the policy process, there are factors including policy community cohesion which shapes the political priority (4,17). It is the degree of coalescence among the network of individuals and organisations that are centrally involved ,such as the parties/ countries to the WHO FCTC at the global level (4,17) and all the other development and key stakeholders at the National levels of the specific countries.

There is an enabling legal, policy and fiscal environment and an enabling context that together facilitate the achievement of the MDGs in South Africa likewise of tobacco control in Ghana. At the same time, the content analysis reveals potential overlap, fragmentation and lack of co-ordination of the various laws and policy initiatives. This study confirms similar findings. The South Africa National Health Act (Act 61 of 2003) has been on the statute

books for five years but progress in implementation remains slow and both the National Health Amendment and Medical Schemes Amendment Bills have lapsed (354). Similarly, in Ghana the drafting and processes involved in passing the Tobacco Control Law (Part VI) of the Public Health Act 851 (2012) took almost 10 years and has been three years since it was passed as the Public Health Act.

The Public Health Act 851 (2012) articulates the intention to take many recommendations arising from the WHO FCTC and guidelines initiatives forward. However, there does not appear to be any prioritisation of the implementation of legislation or recommendations, thus raising doubt as to the ability and capacity of the health sector (MOH and GHS) to make measurable progress.

The process and timing of many policy initiatives appear to be flawed, often resulting in alienation of many stakeholders, particularly those responsible for implementation (354). The implementation of the WHO FCTC is a typical example. This study revealed that although the WHO FCTC and the Public Health Act is welcomed and supported by many, to date, a transparent process and meaningful public participation have been largely absent.

Having ratified the WHO Framework Convention on Tobacco Control (FCTC) treaty, Ghana is obliged to implement its provisions through national law, regulation, or other measures. The WHO FCTC also calls on Parties to provide in their budgets, financial resources for implementation of the Convention (11,217). These resources should be availed through the relevant ministries and government agencies. Since the FCTC entered into force for Ghana on 27 February 2005 (217,341), the various sectors such as the Ministry of Health and Ghana Health Service has shown substantial leadership as their presence of individuals or positions capable of uniting the policy community and acknowledged their strong support (4,17,230) for the cause, together with their partners, relevant Ministries, Departments and Agencies (MDAs) and all stakeholders including Non-governmental organizations to implement the Convention and develop sustainable tobacco control programmes (217,218).

A Tobacco Control Inter-Agency Coordinating Committee with a mandate from the government to coordinate implementation of the Convention and also offer a platform for increased understanding of treaty obligations within the whole of government and beyond has

been established. This study strengthens the guiding institutions such as the Ministry of Health and the Ghana Health Service in their effectiveness of coordinating mechanisms with the mandate to lead the initiative such as the implementation of the WHO FCTC (4,17). Furthermore Ghana now has an Act of Parliament, Public Health Act 851 (2012), part six of which deals with Tobacco Control Measures in line with the Convention and its guidelines (12,300). Activities aimed at raising public awareness about the existence and the rationales for these laws, in collaboration with civil society are being undertaken with a view to support the enforcement of the laws. The Ministry of Health and Ghana Health Service now have a specific budget line for tobacco control activities as captured in their programme of work. For example, the Ministry of Health 2013 Programme of Work indicated an amount of two hundred and eighteen and fifty-five thousand Ghana cedis (₵218.550) for strengthening of Tobacco Control Programme-FCTC. The amount is part of Donor Sector Budget support (355).

On the contrary, other relevant ministries and agencies are yet to provide for tobacco control in their budgets, or to raise funds to support the implementation of the relevant provisions of the Convention as their responsibility towards meeting the obligations of the treaty.

The Food and Drugs Authority Ghana (FDA) which is an agency of the Ministry of Health, has the Tobacco and Substance of Abuse Department which is responsible for the regulation of tobacco and tobacco products as well as the regulation of illicit narcotics, psychotropic substances and precursor chemicals. Under its mandate, the Department regulates the importation and use of these substances by means of a permit system and other regulatory functions. The importing companies have to furnish the FDA with advice of receipt, annual returns, and the requisitions for the ensuing year (285,294,356).

In accordance with Legislative Instrument (LI 2206 A.I.2013) - which is (Fees and Charges Amendment) Instrument, 2013, LI 2206, Food and Drugs Authority (FDA) is required to charge various fees for registration of products including tobacco and tobacco products registration. The current approved fee is USD 25,000 per brand/variant for one year duration. The fee is an increase from USD 10,000 per brand for one year duration when registration of tobacco and tobacco products began in 2008. The FDA also charges Administrative Charges on inspection of tobacco and tobacco products. The current rate is 2,000 Ghana cedis.

Furthermore, FDA is authorized to charge "Non-compliant facilities on prohibitions on smoking at public places (285,294,356).

Since 2007 when a Ministry of Health directive authorized the FDA to regulate tobacco and tobacco products, the FDA has used its internally generated funds to organize various activities in relation to tobacco control (285).

Some of the activities include the development of operational forms for tobacco and tobacco products, stakeholders meeting for importers of tobacco and tobacco products on advertisement of tobacco and tobacco control products and labelling requirements, meeting for stakeholders in tobacco control to deliberate on tobacco regulation, dossier evaluation of tobacco and tobacco products and training of a staff member on tobacco regulation in Brazil. Other activities are related to public education in various schools on the harmful effects of tobacco use, vetting of tobacco and tobacco product packages with health warnings and monitoring of points of sale (285).

Under the Public Health Act 2012 (Act 581) the Minister of Health, may in consultation with the Food and Drugs Authority by legislative instrument, make Regulations to provide for imposition of fines against a list of offences under clause 77 of the Public Health Act 581. Furthermore, Act 581 provides that the Health Minister may in consultation with the Minister for Finance retain thirty per cent of the fines imposed and other proceeds for the performance of functions of the Food and Drugs Authority under this Part (i.e. Tobacco Control Measures) (12,300).

A review of three policy initiatives in South Africa aimed at improving the functioning of the health system found that there is an enabling legal, policy and fiscal environment and context that facilitates the achievement of the MDGs in South Africa. However, there is potential overlap, fragmentation and lack of co-ordination of the various laws and policy initiatives. Progress with the implementation of the National Health Act remains slow and both the National Health Amendment and Medical Schemes Amendment Bills have lapsed (354). It also illustrates that the process and timing of many policy initiatives appear to be flawed, often resulting in alienation of many stakeholders, particularly those responsible for implementation. Although the Ghana Public Health Act which includes the tobacco control

section as such as or in the same vein as the proposed National Health Insurance system in South Africa is welcomed and supported by many, to date a transparent process and meaningful public participation of implementation have been absent (354).

11.3. Current Sources of Funding

In every public policy, actors have different roles to performance in all the stages of the process (4,17) especially when it comes to funding support. In the health sector these will include all stakeholders which involve the Government, Development Partners or International Agencies, Civil Society - NGOs, which could be categorize as public and private sector.

The health sector in Ghana is financed by the traditional sources: Public funds (these are government funds which includes contributions to the National Health Insurance Fund (NHIF) but excludes premium paid by households, private funds (companies and households) and international funds (development partners) (311). The government is the most important source of health funding. The sources of government funding include Public Grants, Internally Generated Funds (IGF). Public grant is a lump sum payment which is given directly to institutions to cover salaries of staff, non-salary expenditure items and capital expenditure. The IGF is mobilized by the institutions themselves through their services, the IGF also include private donations.

Another important source of tobacco control financing is aid from donors. While government allocations for tobacco control related activities in the health sector, as well as in other relevant government sectors, are necessary for developing and implementing tobacco control programmes, for some time now the budget of the Health Ministry does not have a clearly earmarked allocation for tobacco control. The allocation for tobacco control is also very low or inadequate. Much as it is recognized that tobacco control activities are multi-sectoral and require support from other sectors and ministries. For example, these may relate to support for alternative occupations (Ministries of Food and Agriculture) training of teachers school health coordinators for integrating tobacco control activities into the school system through the School Health Programme (Ministry of Education) and organizing mass media. Campaigns (Information Service Department) these sectors do not have specific allocations

for tobacco control activities either from the Ministry of Health /Ghana Health Service budgets or the budgets of the various sectors.

So the concept of Good Governance comes into play and is increasingly being discussed in the context of Public Health (306,307). Most definitions on governance rest on three dimensions: authority, decision-making and accountability. Governance determines who has power, who makes decisions, how other players make their voice heard and how account is rendered. Governance is about the more strategic aspects of steering, making the larger decisions about both direction and roles as evident in the implementation of the WHO FCTC (357).

Governance is complicated by the fact that it involves multiple actors especially in tobacco control. These multiple actors are the organization's stakeholders. They articulate their interests; influence how decisions are made, who the decision-makers are and what decisions are taken. Decision-makers must absorb this input into the decision-making process. Decision-makers are then accountable to those same stakeholders for the organization's output and the process of producing it. Governance is also a highly contextual concept. The process and practices that will apply will vary significantly given the environment in which they are applied. Governance in the public sector needs to take into account legal and constitutional accountability and responsibilities (357,358).

Additionally, evidence also explains further as the process of decision-making and its implementation, an analysis of governance focuses on formal and informal actors involved in decision-making and implementing decisions made and the formal and informal structures that have been set in place to arrive at and implement the decision. These decisions can be made within different levels and institutions and arrangements. Some of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) criteria of good Governance include participation, consensus orientation, accountability, transparency, responsiveness and effectiveness. Government is one of the actors and others involved in governance vary depending on the issues at stake. The key and relevant stakeholders need to be involved for the implementation of the WHO FCTC to progress to the next level (306,307).

Tobacco control, in individual countries and worldwide, benefits from a uniquely powerful legal instrument for global health governance. That is the WHO Framework Convention on Tobacco Control. This was the first treaty negotiated under the auspices of WHO. It is one of the most rapidly and widely embraced treaties in the history of the United Nations. The treaty was developed in response to the globalization of tobacco use, which is facilitated through a variety of complex factors with cross-border effects. The treaty recognizes that tobacco use is a transnational threat to health and that control requires a coordinated response among nations. It recognizes that the most effective way to control tobacco is through the rule of law. This means a comprehensive range of laws tackling both supply and demand, and this means strong laws. The treaty operationalizes the principles of equity and fairness (358).

In the political context according to the conceptual framework where the environment in which actors or stakeholders operate could have a global governance structure (4) such as the Ghana Ministry of Health likewise other parties to the WHO Convention institutionalising the Coordinating Health Committee for tobacco control (11) which is the degree to which norms and institutions operate. This gives them a platform for effective collective action (4).

At the same time since the WHO FCTC is an international treaty (11) there is the policy window (4) such as Agenda 2030 - Time for Action on NCDs highlighted “strengthen implementation of the WHO FCTC as target 3.a under the four means of implementation targets are included to support the attainment of the health targets which are important building blocks of the NCD response (359,360). Furthermore in discussing the 2015 Global framework for financing development and NCDs in Addis Abba Action Agenda framework, tobacco taxation was key in the four areas identified (359,360). These are political moments when global conditions align favourably for an issue (4) such as the Sustainable Development Goals (SDGs) presenting opportunities for advocates to influence decision makers. Here the Civil society mobilization presses international and national authorities to address the issue at the global level (4).

It must be understood that even though the government by itself would be unable to provide all of the financial resources required for implementing tobacco control programmes, an increase in contribution from the government is required on a regular basis to signal or show its unwavering commitment to achieving the goals of the WHO FCTC. Such increased

financial inflows will have to be clearly reflected in future budgetary allocations. It is interesting that the Minister of Health indicated at the UN High Level Summit on NCDs, 19-20 September 2011 that "the government is committed to the fight against NCDs which includes tobacco control and will provide the needed leadership and resources (314)."

Regulatory levies are another mechanism by which funds for tobacco control are generated through a fee/ levy collected by the Ghana Food and Drugs Authority for registering and regulating tobacco products. This is done both prior to the introduction of a new tobacco brand into the market and also for annual renewal of the permission to market the brand. The money accrued from this regulatory levy is used for funding tobacco control programmes. This model can also be used for other products such as alcohol which may have to be registered. The charging of this levy meets the provisions of the national law (Public Health Act 1 2012 ACT 581 Section 6 of which is a Tobacco Control) (12,300).

Besides, to regulatory levy, there are penalties to be collected for violations of the various provisions of the Ghanaian Law on tobacco control. Though according to Ghanaian Law on revenues or other moneys raised or received all monies collected through taxes and penalties are public funds and are paid in the contingency fund and such other public funds as may be established by or consolidated fund to be used across all sectors, under the authority of an Act of Parliament. The Public Health Act makes provisions that the Minister of Finance can authorize the Health Minister to retain about 30 per cent of such money. Thus some money that would accrue to the FDA and /or other authorities can be used for tobacco control activities at the national or local level (315).

Some international/ external financial assistance has been received from a multiplicity of sources-bilateral channels of multilateral channels to support tobacco control activities. The FCTC endorses such assistance of greater financial support to developing countries including Ghana. For example, for tobacco control IDRC /CDC Bloomberg philanthropists have provided both financial and technical assistance for various activities including other sources such as research and commendations. The US government, through the Global Tobacco Surveillance System GSTSS) has supported Ghana to collect data through three surveys: the Global Youth Tobacco Survey (GYTS) GTSS entrance. All the research projects have one way or another enhanced the country's capacity to design, implement and evaluate tobacco

control interventions, while monitoring key articles of the WHO Framework Convention on Tobacco Control and MPOWER strategies (308).

Although Ghana's current investments in health are notable more can be done to ensure that investments meet the public need for expanded access to quality health services to promote prevention and effectively respond to critical needs. However, Ghana's new stations as a lower middle income country has implications for foreign assistance in the medium to long term, given that roughly 40% of Ghana's budget comes from development partners, and in the health sector, donors currently account for some 22 % of the sector budget. Ghana rebased its GDP figures in 2010, which elevated the country into lower middle income status, according to widely- used UN status. It is worthy of note, that Development Partners and the GOG have begun discussions about Ghana's lower middle-income stations, new oil revenues and the potential implications regarding development assistance in the medium to long term (308–311).

However, Ghana's new National Policy on Private Public Partnership could leverage private sector resources to fund important public health infrastructure projects in the medium to long term. Private sector institutions in partnership with the Ministry of Health and Ghana Health Service have mobilized resources to sponsor multifaceted promotional campaigns to reinforce healthy behaviours, including mass media, community interventions and other means to raise interest, understanding and use priority interventions. These private sector organisations have funded tobacco control related activities as part of their corporate social responsibility programmes. Some of these activities have coincided with international days such as World Cancer Day (February 4) World No Tobacco Day (May 31) World Heart Day (September).

There is increasing awareness and concern in the business sector about the impact of tobacco control and NCDs on both worker health and on the less developed community. A number of companies have implemented workplace health programmes and engage in keep fit exercises at weekends and on some public holidays. Sometimes, they support health screening exercises for their employees. Through these programmes, they play a role in influencing individual behaviour and social norms.

Encouraging companies to invest in their employees' health care is a possible area of resource mobilization. It must be noted that through these preventive activities and donations both in cash and in kind, the private sector has made contributions. However, these contributions are difficult to track and bypass the Ministry of Health and Ghana Health Service. This is because the organisations have independent budgets and are not captured by national statistics. It will be prudent to strengthen links with the private sector so as to improve resource tracking mechanisms of their contributions to tobacco control in order to have much more comprehensive data on corporate funding.

11.5. Potential Funding Sources and "Sin Taxes"

The recommendation by the WHO FCTC which provided countries with evidence-based guidelines, international accountability and implementation to impose a higher tax on tobacco products (11) was backed by a growing body of evidence demonstrating the effectiveness of higher tobacco taxes and prices in reducing consumption of cigarettes and other tobacco products (361–364). Taxes on tobacco and alcohol products are commonly referred to as "sin taxes".

Studies consistently show that raising taxes on tobacco is the most cost-effective measure for reducing tobacco use. (361,364). However, countries, particularly low- and middle-income nations, are struggling with implementation of sin taxes because of limited capacity and persistent fears that tax increases are difficult to implement and will lead to all kinds of disastrous consequences like an uncontrolled illicit market, increased unemployment, reduced revenue or an unfair burden on the poor (364).

The main goal of tobacco taxation is to reduce consumption by making tobacco products progressively less affordable. At the same time, increases in tobacco taxes generate significant increases in the revenues which can then be used to fund programmes (8). Article 6 of the WHO FCTC recognizes that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, and requires countries to implementing tax and price policies on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption (8).

Raising tobacco taxes so that they account for at least 70% of retail prices would lead to significant price increases, induce many current users to quit, and deter numerous youth from taking up tobacco use, leading to large reductions in the death and disease caused by tobacco use. Only few countries in the Region comply with this requirement in the AFRO (8).

Evidence shows that a well-administered tobacco tax leads to the desired result of reducing consumption and its crippling health consequences, and not producing the terrible economic outcomes often portrayed by the tobacco industry (364).

In fact, increased tax and prices for tobacco actually benefit governments by increasing revenues, which can then be used for state services, such as healthcare (364). This win-win result of reducing consumption and increasing revenues should be embraced during this period of economic hardship, when governments face increasing needs to find new ways to fund spending, particularly for health care. Tobacco taxation is a simple and effective means of increasing revenues without adverse effects on the economy (364).

Earmarked or dedicated tax on tobacco products, alcohol, and on various food and beverages for example on refined, processed foods and sugar sweet beverages that have harmful health effects would generate much more financial resources, from which several components of the tobacco control programme can be funded. Examples of such taxes have been levies in other countries such as Thailand and Nepal (365). In these countries, revenues earned from such a tax have been used for funding not only tobacco control but also a variety of other health promotion activities.

Philippines has raised taxes after decades of opposition from the tobacco industry and allied politicians which the new legislation has earmarked majority of its revenue for health insurance plan to all poor and near-poor and also invest in upgrading of health facilities since 2012 (363). In the African region, Gambia changed the base for its excise on cigarettes from weight to volume in 2012. Evidence shows that basing taxes on weight of tobacco encourages the industry to produce lighter – but not less harmful – cigarettes to pay less taxes. In 2013, Gambia also raised the excise on all tobacco products to the same rate. This has the benefit of discouraging consumers from switching to a cheaper product when taxes are increased (366).

As part of efforts to reduce the consumption of tobacco products and its related health hazards, Parliament of Ghana recently approved an increase in tobacco taxes through the passage of the Excise Duty (Amendment) Bill, 2015 into Law. The Bill seeks to amend the first schedule of the Excise Duty Act, 2014 (Act 878) and proposes an increase the excise duty on cigarettes and cigars from 150 per cent of the ex-factory price to 170 per cent (289).

"The primary objective of the bill was to increase prices of tobacco products to serve as a disincentive to reduce the consumption of tobacco products in the country." Ghana's Excise tax as a %age of cigarettes price was one of the lowest in the region and in an effort to reduce the consumption of tobacco and its related health hazards, there was the need to increase the excise duty on tobacco products to bring in tandem with the average for Africa (289).

This measure is in line with Ghana's obligations under Article 6 of the WHO Framework Convention on Tobacco Control (11,283), to which Ghana is a Party since February 2005 (367). A Needs Assessment concerning Ghana's obligations under the WHO FCTC was conducted jointly by the Convention Secretariat (WHO FCTC) and the Government of Ghana in April 2010 (217).

Advocates of tobacco control would need to lobby the Health Minister and help to draft such a proposal for instituting a sin tax in Ghana. Such a proposal would need to be considered and approved by the cabinet before it goes to Parliament for discussions and passage before sin tax becomes operational. There is no doubt that calling for sin tax would face stiff opposition from various sections of society since its institution has the potential of making government "unpopular" and increasing the tax burden on some sections of the society.

Advocates need to argue that increasing taxes especially on tobacco, alcohol and other products leads to decline in tobacco consumption, especially among the young and the poor, where price elasticity is greater. A special levy/ tax on tobacco would therefore, provide the dual benefits of generating financial resources for tobacco control and contributing directly to tobacco control through its effect as a disincentive to tobacco consumption (364,368).

This is confirmed in a recent study looking at financing health promotion in South East Asia which in line with the WHO FCTC there is a call to increase investment in and explore

potential role of innovative financing mechanism. The multi-country study in South-East Asia Region reviews trend of expenditure on health promotion, innovative financing experiences, and views of policy stakeholders on innovative financing (365).

As in the African region and particularly in Ghana this confirms limited data show very small amount spent on preventive and health promotion services, rather than social mobilization and reduction of primary risk factors, notably tobacco and alcohol consumption etc. Only two countries have innovative financing from sin tax and from tobacco and alcohol earmarked tax to health. Nepal Health Tax Fund is orientated toward treatment of cancers, while Thai Health Promotion Foundation focuses more on social mobilization and strong campaign against tobacco and alcohol consumption, and healthy lifestyles (365).

Results showed policy makers and key stakeholders indicate serious under-funding for health promotion. Government should spend more than double or triple of the current spending level on health promotion. A consensus view emerged in favour of potential role of earmarked tax from alcohol and tobacco, as most desirable and most feasible sources. Innovative financing for health promotion is one of several policy choices to mobilize additional resources. Policy maker's views consistently confirm the underfunding of health promotion which requires a significant increase in current level of spending (365). Our study confirms that, in view of resource constraints, intense mobilization of more resources from hazardous products such as tobacco and alcohol is recommended. And this requires strong political leadership and commitments in every region.

Furthermore, advocates also have to argue that having such a tax would not be an alien principle, as the concept of an earmarked tax has already been applied to other sectors of the economy. For example, Ghana Road Fund which is regulated by the Road Fund Act 1997, Act 536; draws funding from levies on petroleum products, road, bridge tolls and vehicle registration fees (369). The Fund's goal is to ensure the regular maintenance of Ghana's road network by the provision of adequate and sustainable resources for financing road projects through efficient and effective management of the fund (369). In addition, the Tourism Act, 2011 (Act 817) has established the Tourism Development Fund (TDF) from which there is legislative instrument, L1. 2185 (Tourism Levy A Regulation) (370). The TDF drawings funding from seed capital from government donations and grants, moneys earned by the

operation of any project enterprise financed by the operation of any project enterprise financed from the fund or investments and other moneys that the Minister of Finance in consultation with the Minister of Tourism may determine with the approval of Parliament (370).

The main source of funding for the Tourist Development Fund (TDF) the levy is one per cent of a visitor's total expenditures at tourist site. It is collected by the tourism facility, which pays it into an account at designated banks countrywide. The fund is managed by a board and a fund administrator, appointed from the private sector according to the law. Contributions into the Tourism Fund started in October 2012 (370). The law mandates the board to apply proceeds of the fund into "relevant tourism activities as the board may determine".

11.5. Tobacco Industry Participation in Policy Development

The strategies of the tobacco industry and the challenges for developing countries in the 21st century has increase at a disturbing rate and Africa and Asia are current targets (371–373). The tobacco industry is aggressively opposing legislations and the implementation of the WHO FCTC, especially in developing countries an alternative to the losing markets in the developed world (372). In pursuit of their agenda, the industry has employed various strategies and tactics including cigarettes smuggling, recruiting of new and young smokers, denying the health consequences of smoking, manipulating governments to delay tobacco control legislations and the sponsoring of health professionals and academic institutions to act in their favour (372). Study within the Asian Region highlighted the lack of finance for public health made both governments and academic institutions alike welcome industry funding (374).

Indeed, many countries (most low and middle income countries) have embraced the Framework Convention on Tobacco Control (FCTC), but there are more challenges in implementing the policies that will counteract the activities of the tobacco industry (371–373). Ghana like many other countries faces many challenges in implementing Article 5.3 Guidelines of the WHO Framework Convention on Tobacco Control (FCTC). There are currently no clear policies on how to engage with the tobacco industry in protecting public health policy from influence by vested interests. Although manufacture of tobacco products

have stopped in Ghana, tobacco products importers are regularly engaged in lobbying government to halt increases in tobacco taxation (54,217).

There is very little awareness about the Article 5.3 and its guidelines among government officials and key stakeholders. There is also no clear guidance on implementing Article 5.3 and its guidelines in the government (54,217). For instance, Benin was one of the many 180 states that signed the FCTC but admitted lack of governments power to interfere in the activities of the tobacco industry because of the jobs and revenue of the industry (372).

The Article 5.3 guidelines are a powerful tool to be used by governments and advocates against tobacco industry efforts to influence government policy. The guidelines characterises a powerful statement by the COP on the dealings of the tobacco industry, affirming that it should not be regarded as an ordinary 'stakeholder' in government policy development and implementation (375).

Despite significant global progress in implementation of the WHO Framework Convention on Tobacco Control (FCTC) (120,193) almost 10 years after it came into force, the degree of progress varies greatly across the treaty articles and across countries. A significant driver of this variance in implementation is the tobacco industry, which continues to actively interfere with FCTC implementation by seeking, directly or indirectly, to defeat, dilute and delay effective tobacco control measures (373,376).

Useful or informative information about successes and challenges about the FCTC implementation are reported to the COP but there is limited information about Article 5.3 and so far no attempt has be made to measure it systematically at country levels (373,375).

Ghana, likewise Brunei and many other governments neither supports non-participation or allowing representation from the tobacco industry in their delegations to the COP sessions or other FCTC-related meetings nor accept any industry sponsorship to attend these meetings. Ministry of Health and the Ghana Health Service as main implementers likewise the country Brunei does not allow the tobacco industry to participate in health policy development, accepts no contributions from the tobacco industry or corporate social responsibility (CSR) activities, gives no benefits to the industry, has no unnecessary interaction with the industry

and requires the industry's representatives to provide information periodically. It must be noted that Ghana (since 2006) same as Brunei does not grow tobacco, has no cigarette manufacturing facilities and has a small tobacco market (183,373,377).

Ghana, Lao PDR, Malaysia and Thailand do not allow membership of the tobacco industry in the multi-sectoral committee/ advisory group that set public health policy (54,373). Most governments including Ghana do not allow any tobacco industry representatives on their delegation to sessions of the Conference of the Parties or its subsidiary bodies nor accept their sponsorship for delegates (54,217,377), but some governments still accept or endorse offers of assistance from the tobacco industry in implementing tobacco control policies (373). Furthermore governments receive tobacco industry contributions (monetary or in kind) or endorse industry corporate social responsibility activities (54,217,373). Ghana Customs and Excise Duty (known as part of the revenue agencies) receive tobacco industry assistance in the form of technical support such as training of officers and donate motto bikes for their operations in handling smuggling (54,217,377). Unlike Lao PDR, Philippines and Thailand who have instituted measures to prevent or reduce industry interference (373), most Governments such as Ghana and the Africa region do not have a procedure for disclosing interactions with the tobacco industry (8,217).

Ghana likewise all governments (in SEATCA), except Brunei, receive some form of contributions (monetary or otherwise) from the tobacco industry, and with the exception of Brunei and Lao PDR, government agencies or officials endorse tobacco industry CSR activities or from partnerships with the industry in receiving contributions. The Ghana Revenue Agencies (specifically Customs) is the only agency that receives taxes on behalf of Government and receives some support in the form of training and motto bikes for monitoring of anti-smuggling activities in and tackling the illicit cigarette in the country (54,373).

In the Ghana Public Health Act 851 (2012) public places which is indoor and outdoor such as restaurants etc. are supposed to be 100% smoke-free but likewise Malaysia, restaurants and eating places are not 100% smoke-free which is a benefit to the tobacco industry (285,300,373).

From the SEATCA (seven Southeast Asian countries) assessment of the tobacco industry interference (TII) index measuring the implementation of WHO Framework Convention on Tobacco Control (FCTC) Article 5.3 at country level and this study, one can confidently say that countries still have a long way to go in implementing Article 5.3. While governments have made efforts to raise awareness on TII and policies relating to Article 5.3, these are not carried out in a systematic and consistent manner. This is why no country has a perfect score and why efforts to prevent and reduce TII are in a constant state of flux (373). There is also scarcity of literature in the AFRO and Ghana specifically to show the areas been influenced by the industry (54,217).

Since FCTC implementation requires a 'whole of government' approach and not just actions by the Ministries of Health and the Ghana Health Service, it is important that all relevant stakeholders be sensitise of TII within their sectors, as well as their roles in implementing the Article 5.3 Guidelines and all the other articles. Ghana has established a multi-sectorial government body that will take charge of coordinating and implementing the WHO FCTC but its yet to start active work including the industry monitoring and the TII (217).

Banning so-called CSR activities by the tobacco industry and requiring the tobacco industry to disclose periodically information (on tobacco production, manufacture, market share, revenues, expenditure on marketing, lobbying, philanthropy and political contributions) can be included in the code of conduct or carried out through legislation. If such efforts are systematically stepped up in all countries, these will assist governments towards better compliance with the FCTC in general and the Article 5.3 Guidelines in particular (285,294).
In order to accelerate FCTC implementation, governments and civil society need to be more proactive in de-normalising the tobacco industry (378). Examining the index results, learning from the successes and mistakes of other countries and anticipating the challenges ahead can facilitate this seemingly daunting task (373).

11.6. WHO FCTC Article 17 & 18 - Alternative Livelihoods to Tobacco Farming

In Ghana as well as in many countries, revenue generated from tobacco taxes apart from using it to improve the health sector could also be allocated for economic development and alternative livelihood programmes in the tobacco growing areas to mitigate any potential

negative impact of tobacco taxation (363). The economy of many low and middle income countries such as Malawi and Brazil depend substantially on the cultivation and export of tobacco. In this era of global economic crisis such challenges for developing countries are paramount (372).

The WHO FCTC calls for support for economically viable alternative activities for tobacco growers through Article 17 and 18 (11,332). The fourth conference of parties (COP 4) work on Article 17 provides guidance on viable alternatives, but the International Tobacco Growers Association (ITGA) is opposed to this and continues to fight substitution (379).

The results show that tobacco farming is no longer active in the study area since the BAT closed the manufacturing operations. This has rendered the farmers poorer than they were at the time they worked with BAT. Our data show that tobacco farmers were supported and received technical assistance from BAT for their tobacco farming activities. The support received from BAT improved tobacco yields and the socio-economic livelihoods of farmers. Thus, farmers were attracted and trapped into tobacco production. This affirms the findings of recent studies which identified reasons for farmers continual attraction into tobacco production as the ready market and quicker returns on produce as well as enormous support received from tobacco industries (342,344)(346).

The current study found that most farmers earn their major income from now identified alternative crops. Hitherto, smallholders cultivated tobacco on full time basis. The WHO FCTC calls for support for economically viable alternative activities for tobacco growers through Article 17 and 18 (218,283,341)(11)(36,38,333,342,343).

Unlike other situations, farmers in this study have already identified alternatives but lack the support they received from their previous partners–BAT. Consistent with the conventions of FCTC, several approaches are adopted by countries with regards to support to shifting farmers from tobacco to alternatives. Development partners and civil society organizations led support to identify alternative livelihoods such as giant bamboo for farmers have been seen in some countries (13). In Brazil, Mexico and Taiwan, governments are supporting farmers in alternatives such as poultry, aquaculture, beekeeping, dairy, vegetables (beans, tomatoes and chili), fruits (papaya and banana), maize, sorghum and rice.

However, these economically viable alternatives crops vary from country to country depending on the climatic conditions and the ready market. In some countries, there are financial commitments in allocation of funds to help farmers shift to alternatives whereas policies and legislations for alternative livelihoods have been adopted in others (344). In addition, pilot research projects are on-going in countries–Kenya, Uganda, Tanzania and South Africa–for alternatives like bamboo, food crops, trees for wood, pineapple, soya, pepper, watermelons, and animal husbandry (13). In Ghana, none of these approaches are adopted to migrate tobacco farmers to alternatives livelihoods. Also, there are neither policies nor pilot research projects initiated to identify alternatives for farmers. Further, there is lack of support to farmers who have identified alternative livelihoods to tobacco cultivation. To this end, we believe, this is a complete noncompliance to the agreements of the article 17 and 18 of the FCTC (217,218).

Our study revealed no evidence of governmental support to former tobacco farmers to turn to alternative livelihoods. There is lack of special programs or efforts to reintegrate these tobacco farmers into the mainstream activities of the MOFA. Before now, plans and programs should have been put in place to support this group of farmers to transfer their tobacco farming experience to alternative cropping. We found that a few farmers have benefited from some marginal support from MOFA, due to their personal associations with representatives of the Ministry. However, this may not be enough as these affected farmers are many and need to be integrated en bloc into the MOFA activities. In the meantime, if well-designed migration approaches are not initiated and the tobacco industry resurfaces, farmers will plausibly not hesitate to go back to farming tobacco due to benefits–reliable markets, credits facilities, farming inputs and technical support–they received during the BAT manufacturing era (335). Additionally, our data shows that there was no communication or relationship between the formers farmers and the MOFA. Indeed BAT like many tobacco industries, shield farmers from relating with governments in order to reduce cost of production (333). Direct relation of farmers with the tobacco industry without MOFA serving as intermediaries is an important policy issue which needs to be addressed by tobacco farming or growing countries. This confirms the need for development and subsequent implementation of policies to address article 17 and 18 of the FCTC in Ghana (333).

The former tobacco farmers are confronted with many challenges encompassing limited access to financial credit facilities, price fluctuations of most of their crops and the lack of ready market for their produce. In addition, farmers lack agricultural extension services and farm implements to help improve yield of identified alternative crops. These challenges were non-existent when BAT were manufacturing and therefore has affected their current produce and livelihoods. The challenges experienced by the farmers were similar to the findings of earlier study conducted in the Volta Region (347).

Applying the WHO FCTC to LMICs: Lessons from Ghana

With more than 80% of deaths from the tobacco epidemic projected to occur in LMICs (39) and tobacco control as a development issue (153), coordinated efforts needs to be made in the implementation of the FCTC. One major challenge in LMICs is lack of research information. These could only be achieved when lessons are learnt from similar context.

The WHO FCTC has come a long way and for countries to have an effective implementation the following needs to be considered:

- Getting a "whole-of-government" approach to implementation of the Convention;
- Effective use of existing evidence-based implementation tools eg. WHO FCTC Guidelines and WHO technical package "MPOWER";
- Sustainable funding of comprehensive programs – government regular budget; Disbursement of funds done timeously.
- Using excise tax increases – for price increase revenue collection;
- Government - explore potential feasibility to establish innovative financing introducing "sin tax"
- Increase funding - supply of equipment, institutional strengthening and staff capacity building programmes
- Incorporate tobacco control in all bilateral and multilateral assistance programs
- FCTC needs to achieved a commensurate visibility, policy attention and funding particularly in LMIC
- Increase technical assistance, surveillance and support

11.2. CONCLUSIONS

This study documents the mechanisms and challenges associated with funding of tobacco control in Ghana. Tobacco control professionals and advocates need to undertake effective lobbying for improved prioritization for the health sector. In addition, there is the need for civil society organizations and individuals interested in tobacco control to collaborate and ensure key decision-makers are influenced to adequately finance tobacco control.

The current funding of tobacco control is inadequate to meet the goals of the FCTC and NCD prevention and control. Therefore, there is a very strong case for increased public and private funding for tobacco control, in view of their multiple health and social benefits.

Furthermore, to meet the increasing burden and rising costs for tobacco control significant efficiency improvements would be required and the need for a comprehensive strategy to finance tobacco control on a sustainable basis need to be emphasized.

There is the urgent need to integrate NCDs prevention and control into the relevant components of the health delivery system, so that we can collectively pull together and share resources to get laudable and viable results.

Finally promoting tobacco control is indeed a shared responsibility that requires the concerted efforts of all stakeholders.

Former tobacco farmers have already identified alternatives but they lack the support from government. The former tobacco farmers are confronted with various challenges including limited access to financial credit facilities, price fluctuations of most of their crops, lack of ready market for their produce and lack agricultural extension services and farm implements help improve yield of identified alternative crops. There is noncompliance to the agreements of the article 17 and 18 of the WHO FCTC in Ghana.

11.3. RECOMMENDATIONS

- Government should continue to play a lead role in funding NCDs and tobacco control through increased budgetary allocations and other sources of funding. Government disbursement of funds should be done timeously.

- Government should give tax incentives to encourage industry to donate more resources to provide infrastructure, equipment and funds for NCDs and tobacco control prevention and control.

- Government should explore potential feasibility to establish innovative financing for NCDs and tobacco control through introducing sin tax for tobacco, alcohol, and on refined, processed foods and sugar-sweetened beverages.

- Development partners' support from WHO in particular has so far been commendable. However, there should be increase funding for supply of equipment, support for institutional strengthening and staff capacity building programmes. Other development partners identified in this review should endeavour to emulate the giant feat attained by the WHO.

- MOH (Government of Ghana) should carefully manage donor and locally generated funds to ensure continued support and commitment of the donor community and private sector in funding NCDs and tobacco control.

- There should be appropriate, funding mechanisms which should include institutional arrangements for promoting alternative crops, education, communication and training. Efforts also should be made to integrate such policies into existing government schemes or programmes to promote sustainable development.

- MOFA should lead in promoting economically viable alternatives to former tobacco farmers and integrating its support into the government's overall food and agriculture programme.

- Government should seek for possible collaboration in helping to meet the obligations under Article 17 and 18 of the FCTC.

- This study recommends that there is the need for more/further research on the viability of alternative livelihoods to tobacco farming and also policies and

programmes are urgently needed to improve farmers access to markets for alternative crops.

- The study further recommends that Policy makers and Governments in Africa should use existing evidence to inform the creation and implementation of projects that provide economically viable alternatives for tobacco farmers to be integrated with existing programs where possible and exit tobacco farming.

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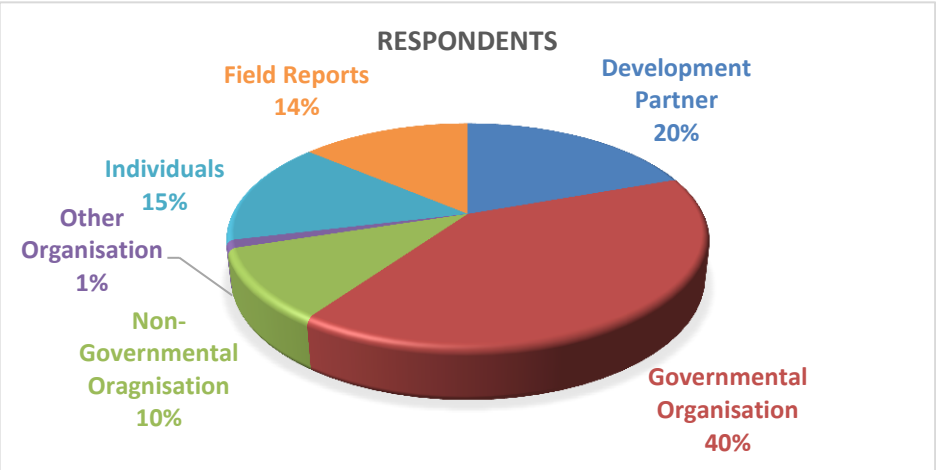
APPENDIX 1: DEFINITION OF TERMS

Actors	Could be individuals, research institutions, NGOs and organizations. They may have a strong influence on the policy process, according to their level of power (e.g. resources) (2,17,18,230).
Civil Society Organisations (CSOs) and Non-Governmental Organization (NGO)	The term Civil Society Organisations (CSOs) is used in this thesis to indicate a wide range of civil society actors including NGOs. The accepted understanding of the term CSOs is that of non-state, not-for-profit, voluntary organizations formed by people within the social sphere of civil society. These organizations draw from community, neighbourhood, work, social and other connections. They cover a variety of organizational interests and forms, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause. The term NGO is also commonly used to describe non-state, not-for-profit, voluntary organizations. However, NGOs usually have a formal structure and are, in most cases, registered with national authorities (23,296,380–384).
Content	Refers to the substance of a policy (2,17,18,230).
Context	Consists of: 1) Situational factors: transient and not permanent and linked to the immediate context. 2) Structural factors: more permanent elements, including the political system, the economic context and the demographic characteristics of a setting. 3) Cultural and religious factors. 4) International factors: global dimensions influencing

	international cooperation on health among states (2,17,18,230).
DALYs / YLDs definition	YLDs = Years Lived with Disability; DALYs = Disability Adjusted Life Years The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability. (**Definition of DALY:** The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health...) Disability-Adjusted Life Year (DALY) Quantifying the Burden of Disease from mortality and morbidity (385). o One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. o DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for incident cases of the health condition (385).
Process	Is the way in which policies are initiated, elaborated, negotiated, implemented and evaluated (2,17,18,230).
Sin Taxes	Imposition of higher taxes on tobacco and alcohol
Stakeholders	Stakeholders will be defined as any individual, group, or institution/agency/organization that has a vested interest in tobacco control and NCDs in general (250,258–265)
WHO Framework Convention on Tobacco Control (FCTC)	The WHO FCTC is a treaty adopted by the 56th World Health Assembly on May 21, 2003. It became the first WHO treaty adopted under article 19 of the WHO constitution. The treaty came into force on February 27, 2005. It had been signed by 168 countries and is legally binding in 180 ratifying/accessioned countries. There are currently 23 non-parties to the treaty (12 which have not signed and 11 which have signed but not ratified). The FCTC, one of the most quickly ratified treaties in United Nations history, is a supranational agreement that seeks "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke" by enacting a set of universal standards stating the dangers of tobacco and limiting its use in all forms worldwide. To this end, the treaty's provisions include rules that govern the production, sale, distribution, advertisement, and taxation of tobacco (Status as at 03-11-2015) (367,386).

APPENDIX 2: AGENCIES AND ORGANIZATIONS SUPPORTING TOBACCO CONTROL AND NCDS

Figure 25: Respondents' Segregated According to Organisation



List of Government Agencies/ Institutions

1. Ministry of Health
2. Ghana Health Service
3. Food and Drugs Authority
4. Environmental Protection Agency
5. Ghana Statistical Service
6. Ghana Revenue Authority - Customs, Excise and Preventive Service
7. Ghana Standards Board
8. Ministry of Food and Agriculture
9. Ministry of Foreign Affairs and Regional Integration
10. Ministry of Youth and Sports
11. Ministry of Information
12. National Media Commission
13. Ministry of Employment and Social Welfare
14. Ministry of Environment, Science and Technology
15. Ministry of Trade and Industry
16. Ghana Tourist Board
17. Ministry of Education
18. Ministry of Justice & Attorney General
19. Ministry of Gender, Children and Social Protection
20. Parliamentarians – Parliament of Ghana

Development Partners of the Heath Sector

Multilateral Agencies

1. World Health Organisation (WHO)
2. United Nations Children's Fund (UNICEF)
3. United Nations Population Fund (UNFPA)
4. United Nations Development Program (UNDP)
5. Department for International Development (DFID)
6. World Bank
7. Embassy of the Kingdom of the Netherlands
8. Royal Danish Embassy (DANIDA)

Bilateral partners

1. Japan International Cooperation Agency (JICA)
2. Canada International Development Agency (CIDA)
3. European Union (EU)

Civil Society Organizations & NGOs

1. Integrated Social Development Centre (ISODEC)
2. Coalition of NGOs in Tobacco Control (CNTC)
3. Ghana Coalition of NGOs in Health and Consumer Associations
4. Vision for Alternative Development (VALD)
5. Future Rescue
6. Healthy Ghana
7. Network for Community Planning and Development (NECPAD)

Table 12: List of Government Agencies/ Institutions Vision and Mission

Respondent	Type of Organisation	Who	Mission and Vision	Priority
JICA Ghana	*Development Partner (DevP)*	*Health Section Head*	• *Support bottom up Ghanaian health system*	• *Health, education, agriculture, infrastructure etc.*
CHAG	*Government Policy Maker (GovtPM)*		• *To promote the healing ministry of Christ and be a reliable partner in the Health Sector in providing the health needs of the people in Ghana in fulfilment of Christ's mandate to go and heal the sick*	• *Training of members* • *Disseminate policies and guidelines from the ministry* • *Promoting health and* • *Coordinating activities of the churches*
Chest Clinic	*Health Delivery*	• *Head of Chest clinic Physician immunologist*	• *Diagnosis and management of HIV and TB cases* • *Screening for other chronic lung diseases* • *Treatment of respiratory and asthma related illnesses* • *Carry out public health activities*	•
Canadian High Commission for the CIDA Ghana	*Development Partner (DevP)*	*Program analyst*	• *Support to the Ministry of Food and Agriculture* • *Sustainable livelihoods, nutrition, basic agriculture, working with small holders* • *Alternative cropping, alternative livelihoods* • *Looking at value chains through a Canadian organisation called MIDA*	• *food security specifically, agricultural productivity and nutrition* • *children and youth* • *water and sanitation*
World Bank	*Development Partner (DevP)*	*Senior operational officer*	• *Addressing infant mortality*	• *Funding project on health insurance to support the health Insurance program*
World Health Organisation, Geneva	*International Development Partner (DevPInter)*	*Technical officer in the convention secretary in the unit of implementation assistance and partnership*	• *To support countries to conduct needs assessment* • *To build partnership and provide any kind of assistance to the implementation of the inferential and particularly to develop database on available* • *To provide technical assistance including legal assistance in countries or if developing their national action plan or policies strategy or drafting their legislation or regulations,* • *Focal person for the implementation of the Article 11 and 12.* • *In eleven, we are facilitating, granting lessons to parties.* • *In twelve, we develop some technical resources like the website of advocacy, education, training materials.* • *focal person from the convention secretary to the Aids coordinator, deputy of TFI and the regional office*	•
Ghana Education Service – School Health Education Program Unit	*Government Policy Maker (GovtPM)*	*Programme Officer*	•	•
Ghana Tourist Authority	*Government Policy Maker (GovtPM)*	*Quality Assurance Manager*	•	•
Attorney General (AG)	*Government Policy Maker (GovtPM)*	*Principal State Attorney*	• *Conduct civil cases for the government* • *Give legal opinions* • *Negotiate agreements* • *Review agreements* • *State's attorney* • *Vet agreements*	• *Passing of laws, the LIs the regulations and making sure they are effective and implementable regulations, LIs, guidelines.* • *Occasionally enforcement to make sure that whichever law is passed is enforced to the core*
Ghana Health Service (GHS)	*Government Policy Maker (GovtPM)*	*Chief Psychiatrist (Medical director of Accra psychiatric hospital)*	•	•
Ghana Health Service (GHS)	*Government Policy Maker (GovtPM)*	*Deputy Director Health Promotion*	• *Manage the communication and advocacy aspect and health intervention*	
Ghana Health Service (GHS)	*Government Policy Maker (GovtPM)*	*Director Of Finance*	• *Managing finance issues of GHS*	
Food and Drugs Authority (FDA)	*Government Policy Maker (GovtPM)*	*Head of Tobacco and substances abuse*	•	•
Ghana Statistical Service (GSS)	*Government Policy Maker*	*Deputy Director in charge of operations*	• *GSS is a public service institution established by law that's PNDC law 135 of 1985 with the mandate to collect, compile and publish socio*	• *GSS coordinates the national statistical system and the national statistical system*

Respondent	Type of Organisation	Who	Mission and Vision	Priority
	(GovtPM)	*Head of survey organisation team (Senior Statistician)*	*demographic and economic data* • *Sole purpose of conducting the three national censuses i.e. population and housing census, agricultural census and industrial census as well as conducting household based surveys, they are the Ghana living standard surveys, Ghana demographic and health surveys, the other surveys like labour force surveys, multiple indicator cluster surveys and others*	*is actually made up of the producers, users, suppliers and the teaching and research institutions which are involved in the use and production of social statistics.* • *To set the standards for the collection of social statistics and ensure that all data is collected by the other MDAs* • *To ensure that the concepts and divisions are harmonised and all use the same concept.*
Ministry of Environment, Science and Technology	*Government Policy Maker (GovtPM)*	*Director of science, technology and innovation.*	•	•
Ministry of Food and Agriculture (MoFA)	*Government Policy Maker (GovtPM)*	*Deputy Director*	•	•
Ministry of Trade and Industry	*Government Policy Maker (GovtPM)*	*Director for Industry (SME division)*	•	•
Ministry of Health (MOH)	*Government Policy Maker (GovtPM)*	*Chief health educator, (Head of program unit for regenerative health)*	• *Primary prevention of NCDs*	• *Healthy education* • *Educate the people of Ghana on how to live a healthy style*
National Development Planning Commission (NDPC)	*Government Policy Maker (GovtPM)*	*Vice Chair*	•	•
National Media Commission (NMC)	*Government Policy Maker (GovtPM)*	*Deputy Executive Secretary*	•	•
	Government Policy Maker (GovtPM)	*Deputy Director Commissioner Services*	•	•
Ministry of Information (MOI)	*Government Policy Maker (GovtPM)*	*Deputy Director of Information*	•	•
Ghana Coalition of NGOs in Health	*Non-Governmental Organisation (NGO)*	*National Coordinator*	•	•
ISODEC		*Policy Analyst*	• *Engage government to bring about reforms and changes that will better the lives of the citizenry*	• *Engage governments on health issues to ensure access to health for all*
Ministry of Youth and Sports	*Government Policy Maker (GovtPM)*	*Human Resource Research, Statistics and Information Management*	•	•
Member of the Parliament of Ghana		*Member of the Health Committee*	•	•
Future Rescue Foundation	*Non-Governmental Organisation (NGO)*		•	•
Movement for Tobacco and Substance Abuse (MATOSA)	*Non-Governmental Organisation (NGO)*	*President of the Movement for Tobacco and Substance Abuse*	• *Advocacy for tobacco free country*	•
Member of the Parliament of Ghana		*Chair For Select Committee On Health*	•	•
TC Expert	*Non-Governmental Organisation (NGO)*	*Public health physician*	•	•
Ministry of Women		*Chief Development*	•	•

Respondent	Type of Organisation	Who	Mission and Vision	Priority
and Children's Affairs		*Planner (Research)*		
Ghana Health Service (GHS)	*Government Policy Maker (GovtPM)*	*Programme Manager NCDs*	• *Cardiovascular diseases,* • *Diabetes,* • *Cancers and* • *Chronic respiratory disease.* • *Sickle cell as one of our major NCDs* • *Mental health* • *The major risk factors, tobacco, alcohol, exercise, healthy lifestyle we have various agencies looking at it.* • *The regenerative program which is mainly looking at exercises and fruits and vegetables intake.* • *The alcohol, we have a focal point for alcohol currently and we have another focal point for tobacco,* • *The NCD program is coordinating all that so that's our priority in terms of the disease and the risk factors.*	•
Sickle Cell NGO	*Non-Governmental Organisation (NGO)*		• *Sickle cell advocacy*	•
Cancer Society	*Non-Governmental Organisation (NGO)*	*Trustee and also the acting executive secretary and a Strong Advocate*	• *Increase the awareness about cancer (prostate, breast, cancer of the cervix, cancer of the stomach, liver and childhood cancers)* • *Facilitating treatment for people with cancers*	•
United Nations Women	*Development Partner (DevP)*	*National program coordinator*	• *Women's political participation* • *Women in leadership* • *Women's economic empowerment* • *Violence against women and* • *Women peace and security issues* • *Gender mainstreaming and budgets, policies, plans, research, monitoring and evaluation*	•
Former Director of Medical Services	*Government Policy Maker (GovtPM)*	*Director of Medical Services*	• *Communicable diseases*	•
Ministry of Foreign Affairs	*Government Policy Maker (GovtPM)*		• *Multilateral issues* • *Occasional handle bilateral issues*	•
Former Deputy Director General(GHS)	*Government Policy Maker (GovtPM)*	*Former deputy director general for GHS and currently the chief executive and the president for the centre for health and social services*	• *Research in health systems and universal coverage* • *Training and capacity development and coordination of technical support* • *Hosting donor arrangements in the country*	•
World Health Orgainsation (WHO)	*Development Partner (DevP)*	*National Professional Officer for Family Health and Population*	•	• *NCD is part of the Disease Control Officer's itinerary* •
CHAG			•	•
			•	•
United Nation's Population Fund (UNFPA)	*Development Partner (DevP)*		• *Focusing on two main areas which are MDG 5 and adolescent health, anything adolescent or youth especially adolescent reproductive health* • *Anything in relation to that such as obstetric emergency care, family planning, skilled attendance and birth,* • *Aspects of population issues that are very relevant* • *HIV and AIDS*	•
United Nations Children's Fund (UNICEF)	*Development Partner (DevP)*		• *Working for the women and children* • *Working on MDG 1, 4, 5 and 6 for our health and nutrition sector response.* • *MDG 1, very much focused on reducing malnutrition amongst women and children that nutrition and food micronutrients deficiencies like vitamin A and iodine.* • *MDG 4 is on child survival, children under the age of five primarily,*	•

Respondent	Type of Organisation	Who	Mission and Vision	Priority
			that's where the largest number of deaths are and our focus is very much on reducing newborn deaths • *Also work for the treatment and also the prevention of these diseases so we support the immunisation program, that's another key area focus for us.* • *MDG 5 which is the maternal health, recognising the key links between mother's health and child survival and sort of reducing maternal deaths during or after pregnancy that continues to be an important focus area and* • *MDG 6, focusing on tropical illness, malaria and also related to MDG 4 and HIV. Focus on HIV is prevention of mother to child transmission of HIV and diagnosis and treatment of HIV*	
Ghana Health Service – Policy, Planning, Monitoring and Evaluation (PPME)	*Government Policy Maker (GovtPM)*		• *MDG 1 so on our part we are looking at nutrition, promoting healthy nutrition* • *Healthy lifestyles* • *MDG 4, child mortality about child health, reducing child mortality by two thirds.* • *Maternal mortality or maternal health in general, this reduction by three quarters* • *MDG6, we are looking at both communicable and non-communicable diseases*	•
European Union (EU)	*Development Partner (DevP)*			•
Deaprtment For International Development (DFID)	*Development Partner (DevP)*		• *Health system strengthening and our main support there is sector budget support and technical assistance to the main sector* • *National malaria control program on the bed net campaigns and* • *Reproductive health.*	•
United Nation's Development Programme (UNDP)	*Development Partner (DevP)*		•	•

APPENDIX 3: DATA COLLECTION TOOLS

Possible Questions – FGD Guide/ In-depth interview guide/ Semi-structured questionnaire

Existence of funding stream to address the WHO FCTC and appropriateness:

- What are the existing funding sources for tobacco control in Ghana?
- What about NCDs? Probe for: Local and International
- What are the activities that are funded for tobacco control and NCDs? **OR**
- Which activities are funded for tobacco control and NCDs?
- Where the money does comes from?
- What about the FCTC implementation?
- What are the specific funding mechanism to address FCTC commitments in Ghana?
- How is the level of funding? Is the level of funding adequate? Why/ Why not?
- What would you recommend as adequate or appropriate?
- Are there any potential funding sources (both local and international) for tobacco control in Ghana?
- What about NCDs?
- What are the current plans for tobacco control? Are there any specific plans for tobacco control? (Probe for NCDs in general).

Potential funding sources:

- Where does funding for tobacco control and NCDs come from? (probe for Govt. dev. Partners etc.) Who provides funding? Why / Why not?
- Where do you think funding should come from?
- What would be the appropriate thing to do? How can it be sustainable? Why?
- How recently have you received funding for tobacco control and NCDs?
- How are targeted programmes on (NCDs & TC) being funded and used?

Attitudes and perceptions of key government policy makers:

- What are the attitudes and perceptions of key government ministries NGOs and key corporate organizations towards funding for NCDs and tobacco control? Probe for:
    - Health
    - Finance
    - Trade
    - Agriculture
    - Etc.
- Are attitudes Positive or Negative? Why? Explain further.

Constrains to Funding:

- What are the constraints to funding for tobacco control in Ghana?
- What about the constraints to funding for NCDs?
- Why do you say these are constrains? Give specific examples of some of these constrains.
- How have you been able to address these constrains? Why?

Factors to facilitate access to ODA:

- What are the factors that would facilitate/ enable greater access to Official Development Assistance for NCDs and tobacco control in Ghana? Why? Please explain your reason.
- What role does availability of funding have in the policy direction for tobacco control?
- What lessons can be learnt from this research to contribute to a better understanding of how funding mechanisms could more effectively be delivered and managed for NCDs and tobacco control?
- What suggestions whom you recommend to facilitate greater access to ODA for NCDs and tobacco control? Why?

Prospects for long term effectiveness of funding mechanisms:

- What are the prospects for the long term effectiveness of the funding mechanisms for NCDs and tobacco control? How? Why?
- How will this be successful? Why?
- What can your organisation or institution contribute to achieve this? How are you going to implement this?

Funding Agencies / Development partners influence on policy formulation:

- How have you and your organisation / institution contributed to the policies on Health in general?
- How easy or difficult is it for policies to be formulated on health issues?
- Have you in the past discussed anything on NCDs and tobacco control?
- How would you influence the policy formulation on NCDs and tobacco control?
- What about the implementation?
- What role can you play?

Recommendations to ensure effective delivery and management of funding mechanisms:

- What lessons can be learnt from this research to contribute to a better understanding of how funding mechanisms could more effectively be delivered and managed for NCDs and tobacco control?

What suggestions would you make for the effective provision or funding for NCDs and tobacco control in Ghana

APPENDIX 4: EXPLANATORY STATEMENT FOR IN-DEPTH INTERVIEW

MONASH University

Title: Tobacco Control through the FCTC - A Case Study of Funding Mechanisms in Ghana
This information sheet is for you to keep.

My name is Edith K. Wellington and I am conducting a research project with Pascale A. Allotey a Professor of Public Health, Daniel D. Reidpath, Professor in Population Health Global Public Health, School of Medicine and Health Sciences and Prof Dr Irene Akua Agyepong, Regional Director of Health Services, Greater Accra towards a PhD-Med at Monash University. This means that I will be writing a thesis which is the equivalent of a short book. We have funding from NCDP/ IDRC. You are invited to take part in this study.

Please read this Explanatory Statement in full before making a decision.
You have been chosen to participate in this interview by the head/director because you are a staff of an institution/agency that works on health issues in Ghana and/or international.

The aim/purpose of the research:
The aim of this study is to explore the policies and sources of funding mechanisms for tobacco control and non-communicable diseases prevention and control in Ghana taking account of other national health priorities.
I am conducting this research specifically to: 1) explore whether there is a specific funding stream to address the WHO Framework Convention for Tobacco Control (FCTC) commitments and to determine how adequate such funding is; 2) determine the current and potential funding sources for Non-communicable diseases (NCDs) and tobacco control; and 3) identify constraints to funding for Non-communicable diseases and tobacco control in Ghana.

Possible benefits:
The results of this study will build the evidence base on the management of NCDs and tobacco control funds and its adequacy in Ghana. It also seeks to extend our understanding of how to raise and manage funds to fulfil the goals of WHO FCTC which Ghana is a

signatory to and the overall NCDs prevention and control efforts not only in Ghana, but also in other developing countries.

What does the research involve?

The study involves in-depth interviews with individuals of institutions/ agencies. Questions on tobacco control and non-communicable diseases will be asked and the discussion will be audio taped and later transcribed.

How much time will the research take?

The in-depth interviews will take approximately one hour.

Inconvenience/discomfort:

There should not be any discomfort or harmful effect from this interview. All information obtained from the interview will be kept anonymous and confidential.

Payment:

There will be refreshment and cost of transportation (GH¢5.00 - GH¢10.00) will be reimbursed for those who will need to travel.

You can withdraw from the research:

Being in this study is voluntary and you are under no obligation to consent to participation. However, if you do consent to participate, you may withdraw from prior to the beginning of the in-depth interview.

Confidentiality:

Everything will be done to protect your right to privacy. There will be no mention of names or the identity of participants will not be made available during the analysis of the results as well as in the thesis writing and published articles.

Storage of data:

Storage of the data collected will adhere to the University regulations and kept on University premises in a locked filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Results:

If you would like to be informed of the aggregate research finding, please contact Mrs Edith K. Wellington on her mobile: [redacted] The findings are accessible from July 2013 until May 2014.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	**If you have a complaint concerning the manner in which this research CF12/0437-2012000191 (MUHREC) is being conducted, please contact:**
Edith Koryo Wellington, Research and Development Division, Ghana Health Service, P. O. Box MB-190, Accra–Ghana, Email: [redacted] (Global Public Health, School of Medicine and Health Sciences, MONASH University Sunway), Phone Cell: [redacted] Prof Dr Irene Akua Agyepong, Regional Director Health Services, Ghana Health Service /Prof. Prince Claus Chair 2008-10, Univ. Utrecht, Greater Accra Regional Health Directorate, P.O. Box 184, Accra-Ghana; [redacted] Prof Pascale A. Allotey, Global Public Health, School of Medicine and Health Sciences, MONASH University, Jalan Lagoon Selatan, Bandar Sunway, 46150 Selangor Darul Ehsan, Malaysia; Email: [redacted] Prof. Daniel D. Reidpath, Global Public Health, School of Medicine and Health Sciences, MONASH University , Jalan Lagoon Selatan, Bandar Sunway, 46150 Selangor Darul Ehsan, Malaysia; Email: [redacted]	Administrator, GHS Ethical Review Committee, Research and Development Division, Ghana Health Service, P. O. Box MB-190, Accra–Ghana, Email: [redacted] The IRB/IACUC Office hours of 8am-5pm, Tel: [redacted] or email addresses: [redacted] You may also contact the chairman, Mr. Okyere Boateng, Cell: [redacted] when necessary. Executive Officer, Monash University Human Research Ethics Committee (MUHREC), Building 3e Room 111, Research Office, Monash University VIC 3800, [redacted]

Thank you. Edith K. Wellington

APPENDIX 5: CONSENT FORM FOR IN-DEPTH INTERVIEW

MONASH University

Title: Tobacco Control through the FCTC - A Case Study of Funding Mechanisms in Ghana
NOTE: This consent form will remain with the MONASH University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

I agree to be interviewed by the researcher	☐ Yes	☐ No
I agree to allow the interview to be audio-taped	☐ Yes	☐ No
I agree to make myself available for a further interview if required	☐ Yes	☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw prior to the beginning of the in-depth interview without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the in-depth interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that data from the in-depth interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period.

Participant's name :

Signature :

Date :

Witness's name :

Signature :

Date :

APPENDIX 6: EXPLANATORY STATEMENT FOR FOCUS GROUP DISCUSSION

MONASH University

Title: Tobacco Control through the FCTC - A Case Study of Funding Mechanisms in Ghana
This information sheet is for you to keep.

My name is Edith K. Wellington and I am conducting a research project with Pascale A. Allotey a Professor of Public Health and Daniel D. Reidpath, Professor in Population Health Global Public Health, School of Medicine and Health Sciences and Prof Dr Irene Akua Agyepong, Regional Director of Health Services, Greater Accra towards a PhD-Med at Monash University. This means that I will be writing a thesis which is the equivalent of a short book. We have funding from NCDP/ IDRC. You are invited to take part in this study.

Please read this Explanatory Statement in full before making a decision.
You have been chosen to participate in this discussion by the head/director because you are a staff of an institution/agency that works on health issues in Ghana and/or international.

The aim/purpose of the research:
The aim of this study is to explore the policies and sources of funding mechanisms for tobacco control and non-communicable diseases prevention and control in Ghana taking account of other national health priorities.

I am conducting this research specifically to: 1) explore whether there is a specific funding stream to address the WHO Framework Convention for Tobacco Control (FCTC) commitments and to determine how adequate such funding is; 2) determine the current and potential funding sources for Non-communicable diseases (NCDs) and tobacco control; and 3) identify constraints to funding for Non-communicable diseases and tobacco control in Ghana.

Possible benefits:

The results of this study will build the evidence base on the management of NCDs and tobacco control funds and its adequacy in Ghana. It also seeks to extend our understanding of how to raise and manage funds to fulfil the goals of WHO FCTC which Ghana is a signatory to and the overall NCDs prevention and control efforts not only in Ghana, but also in other developing countries.

What does the research involve?

The study involves focus groups discussions in groups of 6 people of institutions/ agencies. Questions on tobacco control and non-communicable diseases will be asked and the discussion will be audio taped and later transcribed.

How much time will the research take?

The focus group discussions will take approximately one hour.

Inconvenience/discomfort:

There should not be any discomfort or harmful effect from this discussion. All information obtained from the discussion will be kept anonymous and confidential.

Payment:

There will be refreshment and cost of transportation (GH¢5.00 - GH¢10.00) will be reimbursed for those who will need to travel.

You can withdraw from the research:

Being in this study is voluntary and you are under no obligation to consent to participation. However, if you do consent to participate, you may withdraw from prior to the beginning of the focus group or in-depth interview.

Confidentiality:

Everything will be done to protect your right to privacy. There will be no mention of names or the identity of participants will not be made available during the analysis of the results as well as in the thesis writing and published articles.

Storage of data:

Storage of the data collected will adhere to the University regulations and kept on University premises in a locked filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Results:

If you would like to be informed of the aggregate research finding, please contact Mrs Edith K. Wellington on her mobile: [redacted] or email at: [redacted]The findings are accessible from May 2013 until May 2014.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	**If you have a complaint concerning the manner in which this research CF12/0437-2012000191 (MUHREC) is being conducted, please contact:**
Edith Koryo Wellington, Research and Development Division, Ghana Health Service, P. O. Box MB-190, Accra–Ghana, Email: [redacted] (Global Public Health, School of Medicine and Health Sciences, MONASH University Sunway), Phone Cell: [redacted] **Prof Dr Irene Akua Agyepong**, Regional Director Health Services, Ghana Health Service /Prof. Prince Claus Chair 2008-10, Univ. Utrecht, Greater Accra Regional Health Directorate, P.O. Box 184, Accra-Ghana; [redacted] **Prof Pascale A. Allotey**, Global Public Health, School of Medicine and Health Sciences, MONASH University, Jalan Lagoon Selatan, Bandar Sunway, 46150 Selangor Darul Ehsan, Malaysia; Email: [redacted] **Prof. Daniel D. Reidpath**, Global Public Health, School of Medicine and Health Sciences, MONASH University , Jalan Lagoon Selatan, Bandar Sunway, 46150 Selangor Darul Ehsan, Malaysia; Email: [redacted]	Administrator, GHS Ethical Review Committee, Research and Development Division, Ghana Health Service, P. O. Box MB-190, Accra–Ghana, Email: [redacted] The IRB/IACUC Office hours of 8am-5pm, Tel: [redacted] You may also contact the chairman, Mr. Okyere Boateng, Cell: [redacted] when necessary. Executive Officer, Monash University Human Research Ethics Committee (MUHREC), Building 3e Room 111, Research Office, Monash University VIC 3800, [redacted]

Thank you - Edith K. Wellington

APPENDIX 7: CONSENT FORM FOR FOCUS GROUP DISCUSSION

MONASH University

Title: Tobacco Control through the FCTC- A Case Study of Funding Mechanisms in Ghana
NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that:

I agree to be involved in the focus group discussion	☐ Yes	☐ No
I agree to allow the focus group to be audio-taped	☐ Yes	☐ No
I agree to make myself available for a further interview if required	☐ Yes	☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw prior to the beginning of the focus group discussion without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the focus group discussion for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that data from the focus group discussion will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period.

Participant's name :

Signature :

Date :

Witness's name :

Signature :

Date :

Monash University Human Research Ethics Committee (MUHREC)
Research Office

APPENDIX 8: HUMAN ETHICS CERTIFICATE OF APPROVAL

MONASH University

Human Ethics Certificate of Approval

Date: **17 February 2012**

Project Number: **CF12/0437 – 2012000191**

Project Title: **Tobacco Control through the WHO FCTC: A Case Study of Funding Mechanisms in Ghana**

Chief Investigator: **Prof Pascale A Allotey**

Approved: **From: 17 February 2012** **To: 17 February 2017**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research**.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, MUHREC

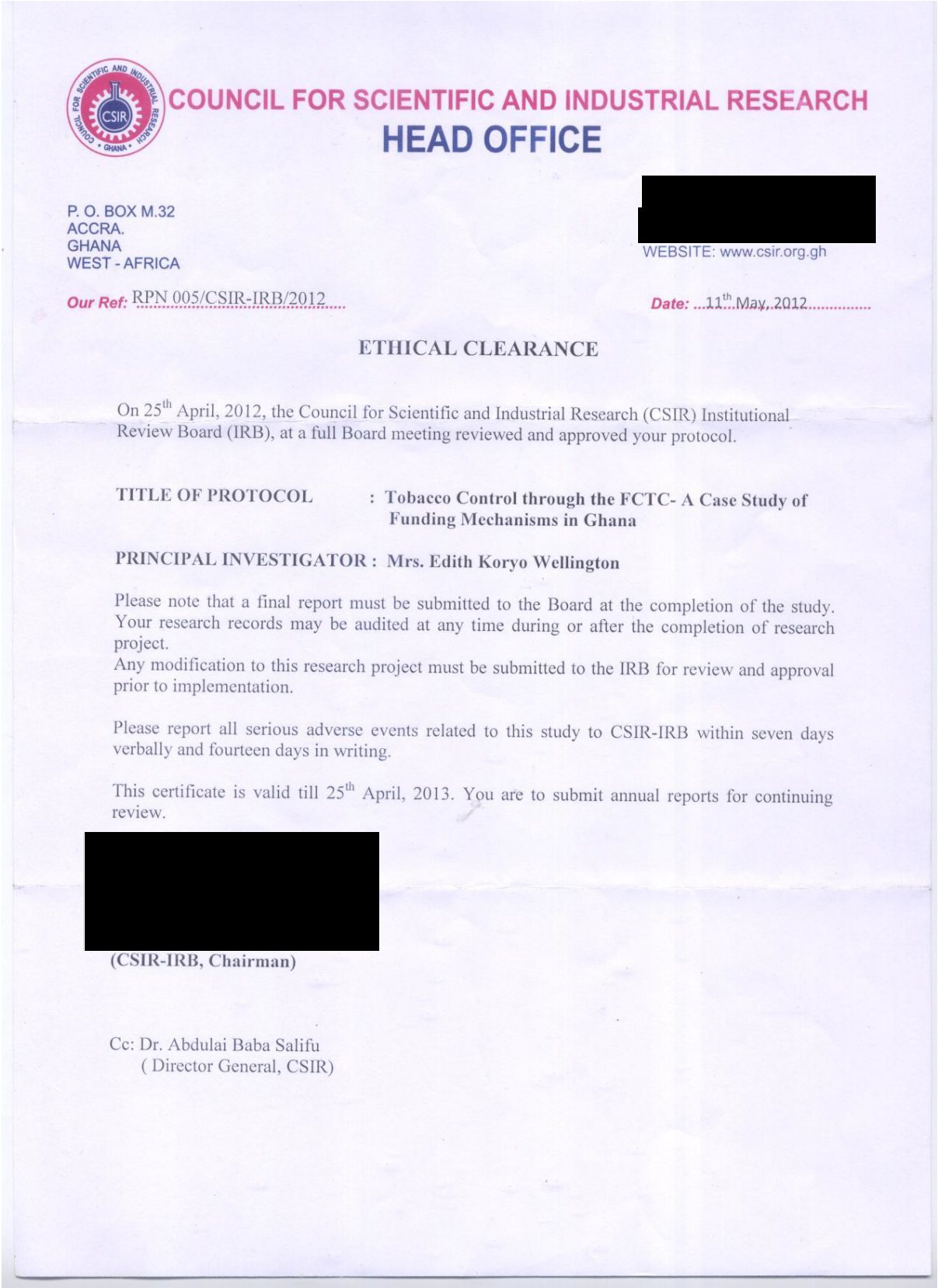
cc: Prof Daniel Reidpath, Ms Edith Koryo Wellington

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton

[redacted]

Email [redacted] www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C

APPENDIX 9: ETHICAL CLEARANCE- COUNCIL FOR SCIENTIFIC AND INDUSTRIAL RESEARCH



COUNCIL FOR SCIENTIFIC AND INDUSTRIAL RESEARCH
HEAD OFFICE

P. O. BOX M.32
ACCRA.
GHANA
WEST - AFRICA

[redacted]
WEBSITE: www.csir.org.gh

Our Ref: RPN 005/CSIR-IRB/2012

Date: 11th May, 2012

ETHICAL CLEARANCE

On 25th April, 2012, the Council for Scientific and Industrial Research (CSIR) Institutional Review Board (IRB), at a full Board meeting reviewed and approved your protocol.

TITLE OF PROTOCOL : **Tobacco Control through the FCTC- A Case Study of Funding Mechanisms in Ghana**

PRINCIPAL INVESTIGATOR : **Mrs. Edith Koryo Wellington**

Please note that a final report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the completion of research project.
Any modification to this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to CSIR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 25th April, 2013. You are to submit annual reports for continuing review.

[redacted]
(CSIR-IRB, Chairman)

Cc: Dr. Abdulai Baba Salifu
(Director General, CSIR)

APPENDIX 10: ETHICAL CLEARANCE - GHS ETHICS REVIEW COMMITTEE

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
[redacted]

April 5 , **2012**

EDITH KORYO WELLINGTON (Mrs.)
MONASH UNIVERSITY
Global Public Health
Jeffrey Cheah School of Medicine and Health Sciences
MONASH University Sunway Campus
Jalan Lagoon Selatan, Bandar Sunway, 46150
Selangor Darul Eshan, Malaysia

ETHICAL CLEARANCE - ID NO: GHS-ERC: 04/03/12

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Tobacco Control through the WHO Framework Convention on Tobacco Control (FCTC): A Case Study of Funding Mechanisms in Ghana"

This approval requires that you submit periodic review of the protocol to the Committee and a final full review to the Ethical Review Committee (ERC) on completion of the study. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification of the project must be submitted to the ERC for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your mother organization before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this protocol

SIGNED.....[redacted]
PROFESSOR FRED BINKA
(GHS-ERC CHAIRMAN)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX 11: EXECUTIVE SUMMARY OF GHANA'S NEEDS ASSESSMENT - 2010

NEEDS ASSESSMENT FOR IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL IN GHANA

EXECUTIVE SUMMARY

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first and only public health treaty negotiated under the auspices of the World Health Organization (WHO) and was adopted in 2003. It has since become one of the most widely and rapidly embraced treaties in the history of the UN and it currently has 169[1] Parties. Ghana ratified the WHO FCTC on 29th November 2004 and was among the first 40 countries to do so. The Convention entered into force for Ghana on 27 February 2005.

*A needs assessment exercise for implementation of the WHO FCTC was conducted jointly by the Government of Ghana and the Convention Secretariat in April to May 2010, including the mission of an international team to Ghana from 15 to 19 April 2010. The detailed assessment involved relevant ministries and agencies of the government of Ghana with support from the WHO's Tobacco-Free Initiative (WHO-TFI) and the WHO Country Office in Ghana (**Annex I**). This needs assessment report therefore presents an article by article analysis of the obligations that Ghana has to the Convention; the progress the country has made in implementation; the gaps that may exist and the subsequent possible actions that can be taken to fill those gaps.*

The key elements which need to be put in place to enable the government of Ghana to meet its obligations to the Convention are summarized below and further details are found herein in the needs assessment report.

First, the WHO FCTC is an international treaty and therefore international law. Having ratified this treaty, Ghana is obliged to implement its provisions through national law, regulation or other measures. There is therefore need to analyse this report, identify all obligations in the substantive articles of the Convention, link them with the relevant agencies, avail the required resources and seek support internationally where appropriate.

Second, a National Tobacco Control Steering Committee (NTCSC) was established by the Minister of Health in January 2002. Members of the committee were tasked to support the Ministry in policy development, advocacy, and advice on effective intervention strategies. Though NTSCS has continued to play some coordination role, a national coordination committee on implementation of the Convention has not yet been formally set up since Ghana ratified the Convention in 2004. Therefore establishment of a multi sectoral national coordinating mechanism with a formal mandate from the government to coordinate implementation of the Convention is urgently needed. This mechanism will also offer a platform for increased understanding of treaty obligations within the whole of government and beyond.

*Third, the WHO FCTC is a comprehensive treaty whose implementation requires the involvement of many sectors for formulation of comprehensive national legislation, regulation and other measures including setting up an infrastructure for enforcement and identifying regulatory authorities with clear mandates. Ghana has existing laws, regulations and administrative directives that address some obligations to the Convention (**Annex II**). A comprehensive legislation would however strengthen the framework for implementation of the Convention in Ghana. A Tobacco Control Bill has been drafted and requires approval of the Executive arm of government before it can be presented to the Parliament for debate. It is very urgent for Ghana to have a comprehensive Tobacco Control law in line with the Convention and its guidelines.*

Fourth, while it is crucial to speed up the legislation agenda, opportunities exist for the different Ministries and agencies to review and utilize the existing laws and regulations to meet some of the treaty obligations. Clearer

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provisions on who the executing authorities are and their mandate to enforce and apply appropriate sanctions for non-compliance are recommended. Raising public awareness about both the existence and the rationale for these laws, in collaboration with civil society, will support the enforcement.

Fifth, the Convention also calls on Parties to provide in their budgets, financial resources for implementation of the Convention. These resources should be availed through the relevant ministries and government agencies. The information on allocation of budgets of the concerned government ministries and agencies that contribute to the implementation of the Convention should be identified and activities coordinated so as to ensure optimal use of these funds. Setting up a funding mechanism for implementing the Convention will ensure sustainability in efforts to meet treaty obligations.

Sixth, there is potential for international cooperation with development partners including UN agencies regarding implementation of the Convention. The Ghana Joint Assistance Strategy is developed every five years and the current one ends in 2010. Some areas in health such as HIV/AIDS, maternal and child health and malaria have been identified as key areas of assistance from the development partners. The United Nation Country Team is in the process of developing the next five year United National Development Assistance Framework (UNDAF) for 2012-2016. There is an urgent need to advocate for the inclusion of implementation of the WHO FCTC - the first international health treaty - into the future Ghana Joint Assistance Strategies and UNDAF.

Seventh, The Comprehensive Africa Agriculture Development Programme (CAADP) can be an entry point for the Ministry of Food and Agriculture to work with the World Food Programme and other development partners in providing support to Ghana's small scale tobacco farmers to transition to economically viable alternative livelihoods. In the context of South-South cooperation, technical support can be accessed from other developing countries and countries with economies in transition that have had positive outcomes with alternative livelihoods for tobacco farmers.

Eighth, particular attention needs to be given to the obligations with a clear deadline after the entry into force of the Convention for Ghana and these are Article 11 (Packaging and labelling of tobacco products) within 3 years (February 2008) and Article 13 (Tobacco advertising, promotion and sponsorship) within 5 years (February 2010). The guidelines of Article 8 (Protection from exposure to tobacco smoke) recommend that Parties should ban smoking in public places and indoor workplaces by providing universal protection within a 5 year timeline (February 2010).

Addressing the issues raised in this report will make a substantial contribution to meeting obligations to the WHO FCTC and improvement of the health status in Ghana. The final report of this joint needs assessment, which follows this summary, can also be the basis for any proposal(s) that may be presented to relevant partners to support Ghana to meet its obligations to the Convention.