A case study on analyzing a tobacco control initiative with a health in all policies lens

Introduction

At the time of writing Bhutan 2013, Bhutan does not have a specific HiAP approach. It does, however, have a development philosophy called “Gross National Happiness” (GNH) which is intrinsically inter-sectoral in intent and action, just like HiAP. The GNH philosophy, which is rooted in the state religion- Buddhism, believes that “sustainable development should take a holistic approach towards notions of progress and give equal importance to non-economic aspects of wellbeing [1]. GNH, which acknowledges health as a determinant of happiness and wellbeing, informs all executive decisions and guides all policy development. This paper applies a HiAP lens to the tobacco control efforts that have been governed by a GNH philosophy in Bhutan.

Today’s tobacco control efforts are steeped in strong religious and cultural values that have always heavily influenced anti-tobacco sentiments in Bhutan. As early

The WHO HiAP

An approach to public policy across sectors which encourages taking into account the health implications of decisions and working collaboratively to improve the population health and health equity outcomes.

The 6 components for HiAP in action are:

1. Establish the need and priorities for HiAP
2. Frame planned action
3. Identify supportive structures and processes
4. Facilitate assessment and engagement
5. Ensure monitoring, evaluation, and reporting
design and execution, are inter-sectoral with participation from different ministries, religious groups and civil society. The health sector plays a leading and coordinating role.

Understanding Gross National Happiness
Coined by the King of Bhutan in 1972, GNH implies that sustainable development should take a holistic approach to progress and give equal importance to the non-economic aspects of well-being. There are 9 domains and indicators of well-being: psychological, health, education, time use, cultural diversity and resilience, good governance, community vitality, ecological diversity and resilience, and living standards. Chaired by the PM, the GNH Commission is responsible for integrating GNH into Government planning and policy making. It uses the ‘GNH Screening Tool’ to assess the suitability of proposed policy including the impact of one sector’s policy over another. It examines opportunities for inter-sectoral coordination and promotes a policy environment geared towards collaboration leading to better outcomes.

Using an HiAP lens, this case study offers a history of tobacco control efforts over the last two decades; analysis of the factors which appear to have strengthened Bhutan’s recent tobacco control efforts; and offers some lessons that could help in its future implementation.

Background - the emergence of inter-sectoral tobacco control efforts

Tobacco control in the 1990s
During the 1980s and 1990s, a porous Bhutan-India border, low taxation and the lack of regulatory licensing made tobacco cheap and easily available throughout the country. The Ministry of Health in cooperation with religious leaders led some anti-tobacco efforts including media awareness campaigns and religious statements. Advocacy messages were coordinated with schools, health institutes, religious bodies and with the support of the WHO with various ‘World No Tobacco Days’. The activities resulted in the creation of a formal tobacco control program in 1998.

In the 1990s, inter-sectoral initiatives were spearheaded at a district level. The new DYT development committees, formed as a result of the implementation of decentralization in Bhutan, developed initiatives to control tobacco use mainly by banning tobacco sale and declaring smoke-free zones [5]. The DYT committees included representatives from health, education, finance, agriculture etc, and were responsible for all policy decisions at a local level. Their efforts set a platform for inter-sectoral action. However, with no legally binding mandate for their tobacco control efforts, enforcement was weak. At this time, Parliament was against passing a tobacco control law and recommended a continuation of education and awareness campaigns through the influence of religious and public health leaders.

Tobacco control 1999-2010
By 2000, 18 out of 20 districts declared smoke-free zones. However, enforcement was weak and sales of tobacco was rampant. In response, Bhutan announced its support for the WHO Framework Convention on Tobacco Control (FCTC) which it signed in 2003 and ratified in 2004. This led to the development of a national tobacco control strategy led by the National Multi Sectoral Task Force (NMSTF), a working group of fifteen agencies formed by the Ministry of Health in 2001.

The NMSTF focused on coordinating multiple central and local government bodies to provide guidance on administering the national tobacco control program. Among its achievements was the institutionalization of both individual and collaborative roles.
for each of the fifteen participating national and subnational agencies [6]. However, the NMSTF was discontinued as it did not have a legal mandate to enforce the tobacco control strategy. Nevertheless, the roles which were developed by the group still exist today in a different grouping under the current Tobacco Control Boards’ Task Force for demand and supply reduction.

The nation-wide ban on tobacco sales and the designation of no smoking areas to be enforced by multiple agencies was passed 2004-5, finally giving traction to the proposed local actions started by districts in the 1990s.

**The Tobacco Control act 2010**

In compliance with the general obligations of Article 5 of the WHO FCTC, the Royal Government initiated the drafting of the Tobacco Control Bill in 2007. The passing of the Tobacco Control Act in 2010 came as a result of a five year study and deliberation period including stakeholder interviews, clarifying the roles and responsibilities of participating sectors, penalties for lack of compliance and the drafting of legislation. Further actions included multiple rounds of discussions in the National Assembly and Council, until a final version was approved by the King.

The government created the Tobacco Control Board and the Bhutan Narcotic Control Agency (BNCA), which had inter-sectoral representation from eleven and nineteen agencies respectively. In 2013, the Act was amended to include a legal framework for enforcement which included a detailed list of roles and responsibilities, and policies and procedures.

**Analysis of the factors which have strengthened Bhutan’s Tobacco Control Act**

There are four factors which appear to strengthen Bhutan’s Tobacco Control Act (Figure 2). These are analyzed in the following section. In addition, some examples of the HiAP approach to health are identified and demonstrate how HiAP could be implemented in Bhutan within their existing mechanisms.

**Political commitment**

Within the last 15 years, there has been a ‘policy change window’ where political will to prioritize tobacco control has been
obtained at the international and national level. In contrast to the 1990s when local districts spearheaded inter-sectoral tobacco control efforts, the Government declared its commitment at the WHO in 2003 to becoming the world’s first tobacco free nation. The passing of the Tobacco Control Act in 2010 reinforces the Royal Government’s commitment to ensuring that tobacco control is a national health priority. The creation of the BNCA as the vehicle for the multi-sector enforcement of the Act, also illustrates the political commitment by the Government of Nepal to ensure that the necessary leadership structure is in place to sustain inter-sectoral tobacco control efforts.

**A legal mandate**

Bhutan’s first attempts to develop a countrywide strategy to enforce tobacco control failed as the NMSTF did not have the legal mandate to enforce tobacco control efforts. In contrast, the Tobacco Control Act 2010 and subsequent amendment in 2013 provided a legal mandate for the enforcement of the tobacco control laws by the various agencies and provided mechanisms to implement the rules and regulations for tobacco control.

**Defined structures for implementation**

The Tobacco Control Act 2010 and subsequent amendment, provided a definitive structure for the implementation of the Act, including the delineation of roles and responsibilities. Similarly, a HiAP response to health, in this case, tobacco control, would recommend a ‘Framed Plan of Action’ which identifies the structures and processes for the successful implementation of a HiAP response, including the roles and responsibilities attributed to each structure.

The Tobacco Control Board, for example, was established to take decisions on all aspects of tobacco control related measures. The BNCA serves as the secretariat of the TCB and is mandated to coordinate with the various demand and supply agencies to implement and monitor the tobacco control program. Responsibilities of the BNCA also include the carrying out of measures for effective
enforcement of tobacco control provisions, law enforcement training, public advocacy programs and the dissemination of information about tobacco control. In order to strengthen the implementation of the Act, the BNCA categorized the enforcement agencies into two groups - agencies for supply reduction, and agencies for demand reduction (see figure 3). In addition, the various ministries also have clearly defined roles and responsibilities. The Ministry of Health, for example, is primarily responsible for demand reduction strategies and cessation clinics. Such a clear executing framework which identifies clear roles and responsibilities of each structure and agency, could be a factor which would strengthen the implementation of Bhutan’s tobacco control efforts.

In addition, the TCB is comprised of senior representatives from the various ministries involved in tobacco control efforts (see figure 3). Their seniority illustrates that decision-making authority is present, potentially strengthening the implementation of the Act. In close consultation with its members, the TCB also identifies officers to coordinate with the various agencies to enforce tobacco control efforts effectively. These officers have the authority to enforce the provisions of the Act. For example, they can demand proof of tax and duty payment. Again, having the necessary authority to enforce the Act, would strengthen Bhutan’s tobacco control efforts.

The TBC and BNCA are the two critical mechanisms for enabling inter-sectoral engagement. In addition, the Demand and Supply Committee which is chaired by the Director General of the BNCA and is mandated to meet 3 times a year, one of which must be prior to the meeting of the Board, provides an opportunity for all stakeholders from ministries, agencies and civil society to meet and guide the Board in the implementation of the provisions of the Act. Many of the Board member agencies are represented as stakeholders on the committee. This ensures a cohesive enforcement and implementation strategy from both the administrative and enforcement sides of the tobacco control structure. The TBC, BNCA and the Demand and Supply Committee are examples of horizontal support structures, as defined by HiAP component 3, which as a multi-sectoral structures provide opportunities to facilitate dialogue for inter-sectoral health [4, p.8].

Civil Society and Religion

Buddhism has played an important role in tobacco control efforts in Bhutan. Such religious values have driven support among the population of Bhutan in support of tobacco control. Although only a handful of civil society organizations have taken part in tobacco control-related activities, namely the Youth Development Fund, Royal Society for the Protection of Nature and Chethuen Phendhey Association, there are a few specific examples of public involvement driving tobacco control efforts. The endorsement in 2004 by the National Assembly for a ban on tobacco sales, for example, was the result of a proposal by community representatives from 20 districts.

Lessons learned by applying the HiAP lens

The HiAP framework provides insight into factors that facilitate HiAP into action, which it refers to as components (refer to figure 1). Although these components are not rigid they offer a general guide for those interested in using the HiAP approach. Analyzing the Tobacco Control Act in reference to these six components offers unique perspectives into lessons that might help strengthen TCA implementation and pave the way of an HiAP approach across the country.
Figure 3: Structure of the TCB and BCNA

**Tobacco Control Board (TCB)**
1. Health Minister (Chairperson)
2. Secretary, Ministry of Education
3. Director General, Department of Medical Services, Ministry of Health
4. Director, Bureau of Law and Order, Ministry of Home and Cultural Affairs
5. Chief of Police
6. Director, Department of Trade, Ministry of Economic Affairs
7. Director, Department of Revenue and Customs, Ministry of Finance
8. Three Civil Society Members
9. Director General, Bhutan Narcotic Control Agency as the Member Secretary

**Supply reduction agencies (law enforcement):**[7,8]
- Royal Bhutan Police
- Department of Trade, Ministry of Economic Affairs
- Department of Revenue and Customs, Ministry of Finance
- Department of Forest and Park Services, Ministry of Agriculture and Forest
- Road Safety and Transport Authority, Ministry of Information and Communications
- Bhutan Agriculture and Food Regulatory Authority, Ministry of Agriculture and Forest
- Bhutan InfoComm and Media Authority
- Security Forces (Royal Bhutan Army and Royal Body Guards)

**Tobacco Control Office (TCO)**
TCB Secretariat
Gov directive to implement the provisions of the TCAB

**Bhutan Narcotic Control Agency (BNCA)**
Overall national coordinator including:
1. framing policies for prevention and cessation measures
2. exploring various cessation measures,
3. training of the relevant officials,
4. developing training materials

**Demand reduction agencies (prevention and cessation services):**[7,8]
- Ministry of Health
- Department of School Education, Ministry of Education
- Thromdes/Municipal Authority
- Dratshangs, Dzongkhags and Gewogs (Local Government)
- Dratshang Lhentshog
- Civil Society Organizations
- Road Safety and Transport Authority, Ministry of Information and Communications
- Security Forces
- Ministry of Home and Cultural Affairs

1) Strengthen Bhutan specific evidence and analysis

Evidence is integral to HiAP across most of its components. In Bhutan, strengthening data collection and analysis would contribute to optimizing the tobacco control response and strengthen the country’s ability to use a HiAP approach.

Currently, there is no national level prevalence data on tobacco usage and consequently no inferences can be drawn about whether Bhutan’s tobacco control efforts are associated with reduction in tobacco usage. Although the Ministry of Health collects mortality and morbidity data annually, further analysis would be required to gain an understanding of mortality associated with tobacco use.

In addition to strengthening the collection of routine data and analysis, Bhutan 2013 recommends a health impact assessment (HIA) to facilitate HiAP across all health areas. The results from HIA, will provide various sectors, including MOH an understanding of the determinants of health which they influence and potential interventions that they can employ to contribute to the better health of the country.

2) Evaluate TCA and other multi sectoral efforts

The HiAP approach (component 5), identifies that monitoring and evaluation are key to “gather evidence about what has worked and why, and to identify challenges and best practices”[4, p.10]. To date, there has been no formal evaluation of the TCA. This makes it difficult to ascertain the impact of the tobacco control plan and to know how to make the strategy more effective. Developing a robust evaluation would go a long way towards analysing what works and using that knowledge to replicate mechanisms that could be extrapolated to other inter-sectoral activities across Bhutan.
3) Enhancing civil society engagement mechanisms.

While civil society and religious groups are clearly instrumental drivers for the anti-tobacco movement, there are few formal engagement tools to foster their continued involvement within the Tobacco Control Act. As the HiAP framework highlights in its component on ‘Framed Planned Action’ [4, p.8] meaningful civil society participation at all levels promotes transparency and introduces another level of accountability.

4) Existing mechanisms like GNHC are ideal to integrate an HiAP approach

Bhutan’s policy environment appears primed to adopt, implement and promote the HiAP approach. Currently the Gross National Happiness Commission (GNHC) screens all proposed policy from different sectors with its policy screening tool, which is based on the GNH philosophy where sectoral concerns are examined and their adherence to the GNH values monitored. To ensure that the HiAP approach is sustainable, and adopted by sectoral policy makers and program implementers, the HiAP approach should consider integrating within the existing GNHC mechanism.

References


Note: The information for this article is based on the case study commissioned by WHO-SEARO, which was written by Sonam Rinchin, Thimpu, Bhutan, March 2013. The case study included information from a literature review and interviews with key informants from various ministries in Bhutan including GNH Commission. The case study (hereafter Bhutan 2013) was presented at a WHO meeting in Helsinki in June 2013.

Article prepared by Elizabeth A Owen, MPH, of Gharkamai Health Consultants