

Tobacco Control in the Pacific

Evaluation of program support

Phase 1 (2003 – 2004) and Phase 2 (2005 – 2008)

NZAID

Contractor: Allen and Clarke Policy and Regulatory Specialists Ltd

**Recipient countries: Kingdom of Tonga, Cook Islands, Samoa, Vanuatu,
Tuvalu, Solomon Islands**

Evaluation: November 2007 – February 2008

Evaluation facilitation: Dr Michael Douglas, Health Insights Pty Ltd

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Michael Douglas

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The author has made every attempt to accurately reflect the facts and the views that have been provided to him. The author takes full responsibility for any errors of fact or omission, or for any inadvertent misrepresentation of material provided to him

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Executive Summary

Background

Tobacco smoking is widespread in the Pacific region. The burden upon health, social and economic elements of the community is likely to be substantial. The environment for action to redress this concern has been provided by the international efforts to establish global commitment to fight the use and subsequent harm that results from tobacco use.

In order to address population need, and their stated obligation to the international community a number of countries in the Pacific region have embarked on an ambitious and well targeted tobacco control program. To facilitate their progress, six countries, initially Cook Islands and Tonga, and subsequently Samoa, Tuvalu, Vanuatu and Solomon Islands, requested NZAID to support their efforts with technical assistance. This support (Tobacco Control in the Pacific project – TCIP) has been provided by the Wellington based company, *Allen and Clarke Policy and Regulatory Specialists (Allen & Clarke)*. It is due for completion in mid 2008.

An evaluation of TCIP has been commissioned by NZAID with two objectives:

- to assess the extent to which the programme achieved its goal and objectives,
- to identify the lessons learned, and the implication of these for further programming.

The evaluation was undertaken through background document review, a series of key informant interviews, stakeholder meetings and field observations. The process of evaluation encouraged those that have implemented the program to identify the achievements and gaps, the constraining and enabling factors, and the strengths and weaknesses, so that the lessons learned could be drawn.

Major conclusions and recommendations:

Has the work undertaken by Allen & Clarke contributed substantially to the Tobacco Control continuum within countries in support of the Framework Convention for Tobacco Control goals, and the higher level goals of Tobacco Control?

The right intervention at the right time

NZAID responded to very specific requests from a number of Pacific region countries. These were accommodated, in accordance with the requests, to deliver on a number of key areas that would provide strength to those countries' efforts in controlling tobacco use. The project goal and objectives aligned with this expressed need, and provided the timely intervention. The contract enabled the projective deliverables to be undertaken in accordance with this need.

Implementation of the project has been efficient and effective

The contractor's inputs have provided benefit through the quality of their technical inputs, and their ability to work collaboratively with their partners in the various countries. Their inputs have been planned, timed (and flexible) with in-country needs. In most settings, there has been solid progress against project objectives. This is evidence by an array of achievements in each technical area supported, and in each country. These include drafting of legislation, and strengthening policy in the control of tobacco and activities to support taxation, health promotion and community awareness, cessation programs, and development of advocacy groups. There have been inadvertent delays, in program implementation that have been outside the control of the project staff (for example, in the passage of legislation in two countries). To the extent possible, project support has worked to strengthen capacity in spite of the constraints encountered.

Areas of support prevail that will require further input to achieve expected outputs (for example, establishment of community advocacy groups in Vanuatu

and Solomon Islands). These areas continue to be addressed by project staff. While the process of planning has been most helpful, the full benefit of tobacco action plans is not realised, as staff are not reporting against the activities of these plans. These and other specific areas of technical support can be expected to be required beyond the existing timeframe of the project.

A number of beneficial impacts are likely

Currently, there are very limited means established to monitor programme performance (personnel capacity and systems are not well established within the countries reviewed). Nonetheless, the interventions achieved, particularly in the years since the project support has been provided, would indicate medium to long term beneficial health and social impacts can be expected.

Target population groups have included youth, pregnant women and adult males. Most project interventions directed toward national decision makers. There has been limited reach to rural and remote populations (some participation in workshops, and indirect reach through media and, in Solomon Islands, involvement of provincial personnel.

Regional networks have been initiated.

Why have the project interventions been effective?

- The achievement of the benefits within each country has been underpinned by a number of effective approaches undertaken by A&C and support by their partners in country. These have included: the quality of technical advisers who have been able to focus very specifically on the technical needs and support partner staff with new skills and knowledge. These have included areas of community awareness and education, legislation and enforcement, smoking cessation and community advocacy;
- The support has been very clearly focussed and responsive to recipient country needs;
- Support for community advocacy groups has been pivotal in driving development and establishment of public policy; where this does not exist, program achievements are slowed;
- Mentoring of individuals to encourage program 'focal points' and champions for the cause of tobacco control;
- Incisive and quality program intervention (for example, support with legislation; development of action plans) is evident;
- These technical supports have built in a level of sustainability – through personnel capacity and program development. It is inevitable that there will be an ongoing need for intermittent and focussed assistance to continue to support the highly technical areas of the control program (e.g. legislation).

Implications for future programming

- Regional programs need to remain 'country specific' in their approach, while maintaining the benefits of the regional program (shared resources, facility to support technical inputs, networking opportunities etc); the success of the A&C approach was underpinned by this focus (both in design, and in its implementation).
- Technical assistance should be focussed upon tasks that have been locally identified, be as brief as required, yet have continuity of input; a consistent commentary by partners of the technical support by A&C was in the benefit of this approach.
- Community advocacy groups are necessary to drive commitment from government, and facilitate community mobilisation. Their development should be a priority in program assistance;

Recommended actions

- In the progression toward an integrated NCD project, it will be important that the specific requirements of tobacco maintain some focus. A mechanism to ensure this will be needed.
 - Smoking prevalence research, and comprehensive evaluation and monitoring of programs are necessary.
1. A transitional program of technical assistance to continue to address the specific technical needs, and more generally develop ongoing capacity is needed for those countries that have been direct beneficiaries of TCIP, particularly those of the second phase. Current WHO mechanisms may support this transitional need; alternatively, the activities of the Regional NCD Framework will need to ensure maintenance of country specific achievement and an ability to meet ongoing program support needs.
 2. As support for tobacco programs becomes increasingly integrated into a “healthy lifestyles approach”, targeted achievements in the tobacco control field will be needed in order not to lose focus. An approach to achieve this is to **establish agreed country targets** (perhaps in the context of NCD), supported by an appropriate means and capacity to measure performance against these targets. Targets should be established with consideration to current country capacity (resources, technical, institutional, systems). The development of targets in accordance with this approach should form part of the short – medium term transitional strategy. Incentives to reach targets will need development, and should consider small grants (e.g. to advocacy groups), acknowledgement by award, sponsorship to conference and other similar approaches. .
 3. The centralisation of support into a **regional program should still be founded upon the specific needs of countries** in meeting their NCD program needs, and avoid a generic approach to country support. In effect, the regional framework will need to plan, support and monitor the performance of each country. Consideration should be given to assigned ‘NCD country managers’ as part of the regional support program. The regional approach should be further strengthened by establishment of a facility (of technical resources – for example, legislation, health promotion, M&E) that could be called upon to assist countries in their program implementation. It is envisaged that such a facility would harness the expertise of the region, and facilitate their use on a regular and ongoing basis in order to provide ready access to required technical support, and maintain a level of continuity of the support provided to countries and the region generally.
 4. In order to support in-country implementation of tobacco (and other NCD programs) there are several aspects will require discrete and focussed support. These include the establishment of a community/NGO advocacy group, ongoing support for drafting and enactment of legislation and the further development of policy/legislation to achieve appropriate taxing of tobacco products, and the development of sustainable program funding linked to these tax policies. It is envisaged that this level of support may be accessed

through existing development partners programs, or incorporated into the evolving Regional NCD Framework support.

5. An investment in research is needed that:
 - defines attitudes, knowledge and behaviour of segregated population groups;
 - establishes a regional formula for aetiological fractions/attribution risk for tobacco (and other NCDs);
 - determines indicators that underpin a framework for monitoring; baseline data and ongoing measurement need to be established; data should serve both country need and conform to regional/global requirements.
6. Each country strategy clearly defines its priority groups, and considers the capacity to reach rural and remote populations in this process.

Background

Project origins

The use of tobacco in Pacific countries, and indeed throughout the world, has increasingly become a public health concern. The morbidity and mortality associated with the use of tobacco and the associated human and economic costs – to individuals, families and society at large are significant. This has been recognised by a number of countries, and over the past two decades, a number of measures have been initiated in the Pacific region by specific countries to address the issue. In the late 1990s, the WHO initiated a global collaboration to provide a uniform approach and support a level of standards that would support countries to strengthen their legislation and public health programs in combating the adverse effects of tobacco use. This eventuated into the “WHO Framework Convention for Tobacco Control” (FCTC) an international treaty that provides the building blocks for country specific legislation. The development of the FCTC facilitated the formation of a Pacific forum of leaders to confront the issue of tobacco in countries of the region. The outcome of this has been the strengthening of tobacco control programs and the adoption of legislation to support these actions in a number of Pacific countries.

Numerous countries recognised that ratification of the Treaty carried responsibility to ensure that its legal obligations were fulfilled. In planning for this, then, there was recognition for a need of highly specific technical expertise, and development of capacity across systems, programs, institutions and personnel. NZAID responded accordingly to a request from the governments of Tonga and the Cook Islands to support this need. In 2003 – 2004, *Allen & Clarke* was contracted to provide this support through the programme: “Building Regional Capacity for Tobacco Control in the Pacific” (TCIP). The progress made in these countries was observed during a regional forum in late 2004. Subsequently, several other countries (Samoa, Tuvalu, Solomon Islands and Vanuatu) made similar requests of NZAID. A new contract was awarded to *Allen & Clarke* to provide a similar scope of support in these countries. The second phase of the program is due to complete about mid – 2008. It was envisaged that the second phase would further develop a regional approach to tobacco control, building on the work undertaken in Cook Islands and Tonga, and encourage networks with other stakeholder organisations.

Objectives and scope of design

The overall goal for the TCIP programme is to support the efforts of Pacific Island Countries in countering the adverse health, social and economic impacts of tobacco use. NZAID has provided approximately NZ\$250,000 (Phase One) and NZ\$870,000 (Phase Two).

The four strategic objectives of the TCIP programme are:

- 1) Assist in the building of a stronger knowledge base and understanding of the current reality *vis a vis* tobacco control in each nation.
- 2) Facilitate the process of planning, identification of priority areas, resource allocation and decision-making on measures to enhance tobacco control.
- 3) Support the development of institutional capacity within Government and NGOs to successfully undertake tobacco control initiatives.
- 4) Facilitate the establishment of a locally owned and driven, and sustainable, approach to tobacco control in the Pacific.

Implementation arrangements/completion

Both contracts (phase 1 and phase 2) established a series of inputs and outputs that were to be undertaken and produced by Allen & Clarke. A number of staff and subcontracted personnel were assigned to inputs. The

program implementation was to have been completed by 31 December 2006; agreements to vary this completion date in order to fulfil project inputs at a pace suitable to recipient countries have extended project timeframe to mid 2008.

NZAID has stated its intention not to extend funding for further stages of TCIP, as it plans to bring tobacco control into a wider raft of NCD initiatives within the gambit of regional organisations.

Evaluation methods

NZAID seeks to assess the overall effectiveness and efficiency of the delivery of TCIP. There are several outcomes envisaged by the evaluation. These include an assessment of the extent to which Allen & Clarke has met the overall goal, strategic objectives and outputs. The knowledge and information gained, and analysis of any lessons learned will inform policy, strategy and activities of key partners to ensure ongoing improvement in program delivery and greater future development impact.

The evaluation has encompassed the two phases of TCIP programme. The full Terms of Reference for the evaluation are provided in Appendix 1. The evaluation has been undertaken through a review of relevant documentation, discussion with key informants, field observations, and workshops approaches. The approach has been participatory, where the implementers of the program have, wherever possible determined the key areas of evaluation, and jointly identified the reasons behind strengths and weaknesses of program implementation and support. A country report (attached) was produced at the conclusion of each of the field visits, carrying agreed conclusions, and in several cases recommendations provided at the request of senior country personnel. These reports have served to provide focus on country specific actions, as well as drawing lessons learned on development support and future programming requirements. These reports encompass a wider brief than the agreed inputs and outputs of Allen & Clarke. The current report provides a more specific focus on the role of the contractor, NZAID, and partner governments in achieving the outputs of the contract specifications.

A full list of meetings is provided in appendix 3.

Findings:

Objectives and activity design

The strategic objectives of the assistance are listed above. The two phases of TCIP listed four outputs for each phase. These were similar, with the latter phase providing a focus on regional approaches.

| TCIP phase 1 outputs | TCIP phase 2 outputs |
|---|---|
| <ul style="list-style-type: none"> • situational analysis/needs assessment; • building capacity in identified areas of tobacco control need; • Support to develop National Action Plans, and review existing legislation and draft legislative amendments. • Support for implementation of the National Action Plan, this would support health promotion and smoking cessation activities | <ul style="list-style-type: none"> • Review of tobacco control capacity and identify where TC initiatives require development and assistance; • Assist in development of coordinated national action plans for TC activities, and provide support in the initial implementation phase • Utilise a variety of capacity building methodologies in areas where specific needs have been identified (e.g. taxation and pricing, health promotion and education, legislation enforcement, smoking cessation); • Promote a locally owned and sustainable, regional approach to TC through sharing of best practice and coordination of strategies and |

| | initiatives. |
|---|---|
| The strategic objectives described by the project design accurately reflected the request and need of recipient countries. | <ul style="list-style-type: none"> • The development of described outputs relate directly to the stated strategic objectives. These objectives emerge from the specific country requests. The additional activity to promote region-wide sharing in phase 2 follows from the expressed benefit that regional fora were shown to have at the conclusion of phase 1. These are set in the context of international and regional commitment to address tobacco concerns. The support/ intervention were an appropriate response to expressed regional and country needs. • The objectives and outputs are both relevant and demonstrate an internal logic. • The project outputs did not include the strengthening of monitoring and evaluation capacity, nor greater emphasis on research (e.g. target groups, interventions. These omissions were at the discretion of the recipient countries themselves, who expressed a need to prioritise on implementation. However, it should have been identified in design, that implementation without evaluation will always be weakened. • The scope of the activities was achievable within the assigned resources. The development and scope of technical assistance was contingent upon the needs identified in the initial country assessments. The subsequent activities were determined (within the resource levels described by the contract). • The contract listed performance indicators against each of the outputs. The majority of these indicators are quantitative in nature, and have been reported against through project reports. • An exit strategy was not outlined in the activity design. At the time of design, it was intended that the support would see countries through to a 'natural conclusion' – for example, the passage and implementation of legislation. While A&C have provided this commitment in the case of TCIP, the lack of an exit strategy carries risk should alternative contractors have taken a different attitude. |

Efficiency and effectiveness of activity implementation

Allen & Clarke role

The efforts of Allen & Clarke have been exemplary. While there have been several areas that specific focus may have strengthened the output, the quality of the engagement and the commitment to the task has been outstanding, comparing exceptionally well with contracted implementers of development projects more generally.

The resources provided through Allen & Clarke have been utilised effectively and in an efficient manner. For the most part, the objectives have been met and fulfilled through the support of quality technical assistance. Inadvertent delays in the passage of legislation in two countries, beyond the control and despite the efforts of A&C staff, have prevented the full benefit anticipated by this stage of support in these countries, and will likely require further support to maximise the benefit of inputs to date. It is anticipated that this support will be provided through means outside of the existing contract. Other areas of support (for example, the formation of and support of community advocacy groups) have been constrained by local factors in different country programs, reflecting the diversity of environment and pre-existing resources and capacity. Further focused technical and sustained resource support will be needed to confirm program success.

Overall, the contractor's inputs have provided benefit through the quality of their technical inputs, and their ability to work collaboratively with their partners.

Efficiency:

- Timeliness and
- The activities undertaken by A&C were entirely consistent with those described within the contracts. These were undertaken in accordance with agreed times established

| | |
|-------------------------------------|---|
| appropriateness of interventions | <p>with partner governments, and phased to enable appropriate development of capacity in accordance with need.</p> <ul style="list-style-type: none">• There are several examples, however, where local circumstances have constrained the benefit, and warrant further or additional inputs to maximise the benefit and efficiencies to date. These areas of ongoing need have emerged in spite of the project team's efforts to address them. They reflect the diversity of political, social and capacity circumstance of the different countries, and with time are expected to be addressed in a beneficial manner. They include:<ul style="list-style-type: none">• Delays in the passage of legislation in two of the countries supported. The inputs in community awareness, enforcement training, and cessation support, for example, that have already been undertaken, will not realise direct benefit until the passage of legislation is achieved;• The community advocacy groups have shown excellent development in Tonga and Cook islands, yet their establishment has not been achieved in Vanuatu and Solomon Islands. In both countries, there is dialogue now occurring that indicates progress toward establishment of these groups that promotes an optimistic outlook for these, yet they will likely warrant a greater level of resourcing to sustain these.• The development of NCD plans (as part of the regional approach to integrated programming) that has followed the development of national tobacco action plans (that had been supported by A&C) has risked duplication and confusion for some program managers. In spite of A&C efforts to smooth the transition of these plans, a need remains to reconcile current existing plans. This encroachment of new planning approaches does not diminish the value of the action plans themselves – the process in developing these plans has provided understanding and commitment in the tasks to be undertaken for Tobacco Control. |
| Standard of activity implementation | <ul style="list-style-type: none">• In-country partners and international organisations have been universally praiseworthy in the quality of technical support provided by A&C. It has been stated to have been delivered in a highly professional manner, responsive to need, and greatly strengthening the partner countries' capacity. Although several specific cases were noted where some further strengthening was desired (e.g., community advocacy groups in Vanuatu and Solomon Islands, cessation programs) within the broad scope of the technical interventions, quality has been evident. |
| Monitoring of activity | <ul style="list-style-type: none">• The contractor has provided regular reports on progress against objectives that include discussion of issues that contend with project deliverables. These reports have addressed the performance indicators given in the contract. There has been no reporting against program outcomes. 'Internal evaluation' has been undertaken• The project team has identified on numerous occasions the need for support in-country in developing the capacity of program monitoring and evaluation. The issue has been included as a standard activity in the Tobacco Action Plans, but it has been evident that in-country staff have not had the capacity nor the time to address this need. Subsequently, none of the countries visited could provide any formal assessment of achievements against action plans, and there has been no methodical approach to evaluation (e.g. baseline studies, development of indicators and measurement tools).• While not specifically related to A&C's inputs, a related issue of monitoring and evaluation is noted. International donors have been conducting ad hoc smoking prevalence surveys. While the surveys potentially provide a valuable source of data to guide program implementation and regional comparison, weaknesses have been observed in the conduct of these surveys by country program managers. These weaknesses include: little development of local capacity, not always aligned with the |

evaluation needs of the countries themselves. This deficit inhibits the development of quality program management.

- The independent evaluation identified as a need by Allen & Clarke and NZAID differs from the capacity development required within the country programs themselves.

Effectiveness:

Progress against achieving objectives

In most settings, there has been solid progress in achieving the objectives.

- Assessment of need: each country supported currently has a clear idea on where they are up to and what is required on their part to address tobacco control needs;
- Planning and prioritisation: each country has developed (stand alone or integrated) tobacco control plans; however, as noted above, there has been inadequate reporting against the progress of activity implementation. Within a number of countries, their responsibilities in funding their program is constrained by the overall perception of a lack of resources;
- Institutional capacity: each country is aware of its strengths and weaknesses. Capacity has been developed in several areas: legislation has been drafted for all countries, and passed through parliament in several of the intervention countries; policies across a range of tobacco control initiatives have been developed; health promotion materials have been developed, although in one country, pilot testing and production is planned in the coming months; cessation programs have been developed; these are still 'fledgling' in most settings, with limited resources provided by countries to establish clinical settings to assist; community advocacy is a mixed picture, with several countries developed a strong foundation for advocacy, while others have not done so.
- Localisation and regionalisation: the forum at the Oceania conference provided an opportunity for Pacific countries to showcase their achievements and share their concerns. Reports from attendees reveal the value of this. Other regional support processes that have been facilitated by TCIP have include a meeting at Nadi for key persons, support for FCTC meetings, and personnel from Cook Islands and Tonga visiting other country programs to provide insight and encouragement. However, long term capacity to facilitate networking and establish a regional resource body does not appear to have been established.

Achievements against objectives may be delayed slower than expected passage of legislation in Vanuatu and Solomon Islands. Strategies are in place to provide these countries with the best opportunity to achieve anticipated outputs.

Standard of outputs

Outputs were achieved in close partnership with in-country colleagues. For the most part, these have been consistent with best practice. As noted above, in spite of the best efforts of A&C staff, several outputs did not achieve as much as had been hoped, in most cases as a result of constraining political or environmental factors within the respective countries. These include the establishment of a community advocacy group in Vanuatu and Solomon Islands, although current discussion suggest movement on this issue; cessation programs limited by infrastructure needs. The quality and standard of technical support is evident. Partner staff commented on the attributes of the support provided. Throughout each country, there has been an overall perception that A&C support was pivotal in their program achievements. Their inputs served at least three roles:

- Provided a catalyst for elements of the program, bringing a much needed sharper focus to the program needs;
- The not inconsiderable practical support in preparing and writing programs and documents, that staff simply did not have time to progress. For all examples pursued during the review, this documentation was undertaken in a collaborative manner, ensuring the documentation reflected the needs and wishes of the key stakeholders;

- The level of technical expertise that was needed – for example in legislation, in framing the action plan, in health promotion efforts. The ongoing support (after completion of contracted inputs) for brief support (emails and telephone discussion) has been highly appreciated and provided a sense of confidence for the staff.

Extent of benefit to the target population

From the perspective of the contractors, the primary recipient of support has been sector leaders (government and non-government); these have benefited for the technical assistance provided.

Target groups for the health promotion program benefit varied from country to country, to include youth, community leaders, pregnant women. Rural and remote populations have not figured prominently, and as a group, women have not been highlighted (outside of pregnancy). The focus on men (higher prevalence in adult populations) and youth (concerning levels of uptake) is appropriate. In the absence of research/survey data, the identification of target groups has been based upon the 'intuition' of program participants within each country. There appears little motivation or capacity within countries to reach rural population with awareness or cessation programs. Some countries (e.g. Solomon Islands) plan to use provincial based health promotion and NCD officers to support further program implementations

NZAID role

NZAID's role has been in scoping the support and providing a contracting mechanism/modality in ensuring the support can be delivered in a most beneficial way. NZAID has maintained ongoing oversight and communication with the contractor.

The contract has enabled effective delivery of project outputs, and has been engaged by NZAID in a flexible and supportive manner

As previously stated, the scope of project design was an appropriate response to need;

The contract for phase 2 follows a similar mode to that of phase 1, where there has been a clear description of inputs required and outputs specified. The contract has proven an effective modality to provide the technical support sought by the recipient countries.

Correspondence between the contractor and NZAID has been frequent and appropriate. At all decision points that have arisen, there appears to be prompt and effective communication and clarity of advice given on the issue. A level of flexibility within the contract has been evident. For example, the delay in commencement of the project in Samoa (due to local requests for delay) has been fully appreciated, and appropriate accommodation made within input and reporting requirements. Letters of variation for this and other contract issues have been established by mutual agreement where possible.

There are two areas evident where NZAID's role could have provided greater benefit: greater communication between the regional and bilateral programs, and attention in development of capacity for monitoring and evaluation

- There appears to be limited contact between the regional program (Wellington) and the bilateral program (in-country). The NZAID in-country staff acknowledged at best tacit knowledge of TCIP (with exception of Cook Islands); while fully appreciative of the division and load of work at either end, a level of collaboration and dialogue about cross sectoral matters or effective country intervention in the regional context could be beneficial;
- Capacity development in monitoring and evaluation has been tardy. There had been a proposal from Allen & Clarke to establish a monitoring and evaluation framework for the project in 2005, that could well have served as an opportunity to build capacity in M&E within each country (for example, identification of indicators, establishment of instruments, basic capacity in developing analysis skills). For reasons unclear, this did not occur. In the correspondence at the time within NZAID, there appeared to

be some confusion between a need for independent evaluation and program evaluation needs. This omission has resulted in the current evaluation largely considering issues of process, with limited capacity to identify outcome and impact, and minimal development of M&E capacity within the respective country programs.

Overall, the role played by NZAID has been beneficial for the recipient countries. The interventions were appropriate, the contracting model proven effective and the level of communication and flexibility allowed the contractor to deliver on outputs to the best of their capacity.

Partner Governments

The program has been implemented in a number of countries, across which there has been a supportive environment. As stated earlier, the Government of Samoa had requested a delay in commencement until there was a readiness to implement. Implementation in all other jurisdictions has been at the request of the respective governments.

Governments have provided full and unequivocal support to the project.

Government support in each country has been evidenced by:

- Leadership shown within the Ministry of Health. Each country has defined a point of contact within the Ministry to meet their tobacco control obligations. This has enabled technical support staff to partner with appropriate persons – both within and outside of the ministry.
- Each country has shown a commitment to legislate for tobacco control. The FCTC established the environment for this, and in general, it has been appropriately supported;
- Each country has developed a leader who has spear-headed the program. While this person may not necessarily be within the government, there has been a supportive role played by government officials.

Community advocacy groups and high level inter-sectoral government interest groups have been shown to be prerequisite for program success.

The design of the project effectively identified the need for government sectors to have the forum for discussion of policy matters that reach across sectors and that there be a group that advocates on the part of the community and non-government sector. It is evident that where these two mechanisms do not exist, the progress of the program suffers. For example, Tonga hosts a coalition group of church, community and non-government organisations that has provided the leadership, and has the ear of the national parliament. However, in both Vanuatu and Solomon Islands, such a coalition group has not been achieved as yet, although now appears to have early formation), limited both the penetration of the issue/intervention to the community, and limiting the advocacy from the community to lobby for legislation/policy. It is noted that in these same countries, the inter-sectoral dialogue across government has not been effective, where in spite of technical advisers support for government cross sectoral dialogue, the more persuasive community advocacy has been lacking. The intervention (legislation) has subsequently been slowed. It is likely that the lead time to establish the commitment and understanding of community advocacy groups takes more time than appreciated in the design framework.

Overall, the initiative and leadership by partner governments has been present and strong, and indeed an important factor in the traction that the project has been able to achieve in each country. The success within countries is limited by the organisation of senior government around the issue. This, however, is likely to have been secondary to the weaker organisation of the community sector in leading the required changes.

Development Impact

Probable long term impact

While it is believed that capacity to address tobacco control has been enhanced, the evidence for the expected benefits to health, social and economic conditions will not be available for some years.

For each country assessed, capacity to counter the adverse effects of tobacco use has been enhanced. This is most evident in Tonga and Cook Islands, earlier recipients of the project support. Health impacts (e.g. less hospitalisation, less mortality) is unlikely to be realised for a period of 10 – 20 years after the intervention; at this time, such impacts cannot be measured; economic and social impact – for example, improved productivity as a result of better health, will similarly have considerable lead time prior to measurable change. In other countries, while not as progressed with the country program implementation, the evidence appears that they too will continue to work toward the achievement of program goals

On the strength of the interventions, it is highly likely that capacity to curb the adverse effects of tobacco use will be sustained and prove to have long term benefit.

The programmatic and institutional enhancements that have been introduced are strongly supported by a body of literature that proposes that these enhancements will lead to change. These include:

- Legislation and strengthened policy in each country provides the backbone for sustained restriction on tobacco use and public exposure to tobacco smoke; this has been soundly supported, and expected that legislation will be enacted in all recipient countries shortly.
- Community awareness of the harm associated with tobacco appears to have increased. While formal survey of community awareness has not been undertaken (with the exception of Tonga), anecdotes from larger centres support the notion that IEC has been successful. There is no information to know whether this extends to rural areas. It is observed that the confidence of health promotion staff has been enhanced. For example, the programs in Tonga and Vanuatu demonstrate a greater capacity to design and produce material.
- There has been effort in each country to raise sustainable revenue sources for health proportion programs through the establishment of a fund that draws from tobacco excise/tax. The success of this is not clear, and may not be uniform; however, if achieved, will very likely consolidate the technical enhancements made.
- Cessation programs are still somewhat in their infancy. Their development will require commitment from clinical service providers for referral and clinical space. The concepts of cessation are well appreciated by MoH staff;

While the development impact highly is probable, the extent of the impact will be delayed (or weakened) in some countries by the current lack of government inter-sectoral forum, and the absence of an organised community advocacy group.

Regional organisation to address tobacco control has benefited from the limited activities to date. There is scope to expand this collaboration.

Subsequent to the early discussions on FCTC, the Pacific Islands Countries organised themselves to provide greater advocacy. There has been support provided by the contractor to maintain these networks and strengths. These have included a number of fora (listed above), and facilitating cross country movement of staff (e.g. Cook Islands, Tonga). The support provided has further enabled the confidence – both within countries and as a group – to address the issue. It is very likely that there is long term benefit from that already achieved, Arrangements for future support are currently accommodated within WHO plans, and may be absorbed within the regional NCD Framework Strategy..

Benefit upon target populations

Target groups have not been clearly defined; direct beneficiaries of project inputs have been the decision makers at national level. Target groups have been proposed, although the extent of reach to these is not certain

Although the contract/project framework does not clearly specify population sub-groups to benefit, there are levels of beneficiaries expected. The primary target groups of capacity development are the technical staff (within the Ministry of Health, other government sectors and NGOs); the secondary beneficiaries are of course the respective population groups. These have been identified in various countries as youth, adult men, and pregnant women. Several strategies have been engaged to reach these groups. Youth have been targeted within school settings and in sports; pregnant women have been addressed through information provided at antenatal clinics.

The impact of these programs has not been assessed. The global youth tobacco surveys do not have sufficient longitudinal data to provide benefit analysis. There is limited, if any, segregated data on smoking prevalence in pregnancy.

Rural populations appear to have benefited indirectly (through media and legislative measures). There is limited evidence of specific programs for awareness or cessation, for example. A&C targeted their interventions at national level (in order to reach decision makers). Program implementation in rural populations (by each country) was cited to be limited by the lack of available budget. .

Enabling of networking

The project team have endeavoured to build linkages between players at various levels:

Regional

Cross –country networks through the region: there have been several meetings supported by WHO to assist countries moved toward ratification of FCTC and develop legislation. A&C have been instrumental in a number of activities that have been effective in support cross – for example, country liaison: sponsorship of a seminar at the Oceania conference (Auckland, 2007), and facilitating personnel from successful program to support other countries who are earlier in their development (for example, Heath Promotion officer in Cook Islands visiting Tuvalu). Anecdotes suggest that this level of networking is highly appreciated, and likely to be highly beneficial. Personnel stated the value in hearing that their concerns are common to many, and they appreciate hearing the manner in which these are solved by other countries. Personnel have been gathered to discuss the development of the regional NCD program – but complaint was made that these are determined by the regional organisation rather than the country themselves – negating the opportunity to build a cohort of personnel of common interest

In-country cross-sectoral

Within countries, as it has been stated, where formal intra-government cross sectoral committees have been established, there has been greater success in proceeding with legislation. The achievement of these groups has not been uniform.

Development partners

Development partners have generally been working together to achieve the common aim of tobacco control. WHO have provided the leadership, SPC headed a program of technical assistance; these have been strongly supported by Allen & Clarke and the Pacific Action for Health project (PAHP). The cooperation between PAHP and TCIP, between WHO and Allen & Clarke, and SPC and Allen & Clarke appear to have been very effective, and is likely to be attributable to the calibre of the respective leaders of each project, and the encouragement of the ministries of health in both Tonga and Vanuatu. It appears that team leaders came together early to determine how their projects could be complementary and support commonly aspired outcomes for each country. This was executed effectively.

Technical assistance and capacity development

Observation suggests that the project has enhanced capacity at each of a number of levels. The initial 'stock take' visit in each country provided the basis for the nature and breadth of project inputs within each country; a formal 'capacity map' that documents systems and skills and outlines needs has not been sighted.

Institutional strengthening

The hallmark of institutional strengthening has been the development and (in some countries), the passage of legislation. This is supported by government and community advocacy interest groups in several of the countries. These have been a core focus of the project support and have been mostly successful. The efforts to develop a Health Promotion Foundation, or other funding mechanism, in each of the countries to establish sustainable funding has met with variable levels of success across the countries.

One weakness appears to have been in the area of NGO advocacy; in some countries (Tonga and Cook Islands) this has been very successful (noting the longer lead time), but in Vanuatu and Solomon Islands, for example, a tardy commitment by the local NGO umbrella groups (which appears to be now changing in both countries) has delayed the establishment of a local community advocacy group. These delays are likely to have significant impact on the pace of reform in the respective countries.

Systems development

The breadth of systems development was confined by the project design that rationalised project outputs. Systems development (for example, data capture capacity in health and customs, tobacco taxing) has been more limited, although there are again important areas of success. The breadth of systems strengthening does not appear to have been well articulated by the project (acknowledging that development in these areas were NOT specified as project deliverables), nor well understood within the respective ministries. The lack of progress in development of monitoring systems is a result of the lack of focus within the project design. The development of tobacco action plans, albeit with some duplication subsequently experienced through the development of NCD plans, has provided strength through both the process and the product that provides clear direction for country programming. There has been strong advocacy and support for tobacco pricing policies to be adopted, although it is expected that this issue will require a long lead time in addressing local political concerns.

Personnel capacity development

Personnel development is evident. Key focal persons have emerged in each of the countries reviewed. They state to have benefited from working with the technical advisers assigned, and this seems to be primarily as a result of the way in which technical support was given (outlined below). A formal approach to capacity assessment and charting skills development was not identified.

Universally, there has been a high level of praise for the calibre of technical assistance provided. Specific technical inputs have been most effective when focussed upon specific areas of technical need (for example, drafting of legislation, mobilisation and coordination of NGOs). This input is highly valued when it delivers on program areas that are consistent with program planning and is provided at the request of the host agency. The elements of good technical assistance provided through the project include:

- A receptiveness and respect to local players, a willingness to listen.
- Commitment to the task, and working with the local team to achieve the job required;
- Professionalism and level of expertise;
- High level of responsiveness and efficient response to requests for support.
- Continuity of advisers – avoiding changing visiting personnel
- Short, sharp inputs (and possibly more frequent) are favoured over

prolonged stays in order to minimise the burden on local partners.

Workshops as a means to strengthen personnel capacity have been effective in most circumstances, but some risks are observed. If the workshop is an isolated event, without the program context requiring subsequent inputs and follow-up, the outcomes of the workshops are likely to be limited. The delay on legislation, for example, is likely to restrain the maximal benefits of the workshops conducted. The project implementers are mindful of this and have since planned contingencies.

Value for money

While unable to be quantified at this time, the value gained for the services of the contractor is substantial.

The potential (and likely) health, social and economic benefits of effective tobacco control are substantial. The quantification of these benefits has not been assessed, although it is highly probable that current smoking levels will likely contribute to 15 – 20% of deaths in each country. Hospitalisations and economic losses due to illness further this social burden. The interventions provided, supported by a wide body of international literature, are expected to significantly address these concerns. The benefits expected in human, social and economic terms are substantial.

The cost of the support – about a quarter of a million NZ dollars in phase one, and less than 900,000 NZ dollars in phase two, provides a differential of benefit in orders of magnitude. To view this from a country level, for several inputs from several advisers over the 2 – 3 years, the assistance has enabled considerable steps forward in curbing the tobacco problem. A number of senior personnel commented on the level of benefit gained from so few technical inputs.

Sustainability

The continuation of benefit after the project has been completed is considered from a technical, financial and institutional perspective. The completion of inputs (late 2004) for the phase one countries (Cook Islands and Tonga) provide for examination of some level of sustainability. It is observed that the tobacco control program has remained strong, with ongoing refinement and strengthening of legislation, strong community advocacy groups, and firm commitment from the respective ministries of health. Time has allowed these programs to further strengthen. While the other countries present different challenges, it is considered that the establishment work undertaken will be sustained, although these countries will require further support in the short term to ensure this sustainability.

Technical capacity Technical skills have been developed in the areas of health promotion, cessation, enforcement, and community advocacy. These are observed most valuable, where the technical adviser has worked closely with an individual(s). There are some strong and confident individuals that have emerged to demonstrate leadership in tobacco control, both within the Ministry of Health and in some countries, in community organisations.

The use of workshops to impart skills and knowledge has experienced mixed fortunes. The knowledge imparted in those workshops, and as an opportunity to bring the key players together, has been highly valued. However, when conducted as an isolated activity, without clear linkages to an ongoing program of support, or in the absence of further contact, the benefits of workshops will not be sustained. This was seen particularly in the cases of Vanuatu and Solomon Islands, where, as a result of delay in the passage of legislation, community awareness programs lost momentum, and enforcement programs not followed up with enforcement activities. Knowledge retention and skills are likely to be quickly lost in this setting. Project team members have been aware of these risks, and have endeavoured to address them by additional country inputs and ongoing desk support.

The cessation support program has been effective in imparting core knowledge and achieving a level of enthusiasm in staff. However, the support infrastructure (e.g. clinical space) has not been committed in any of the countries – constraining the achievements of the improved personnel capacity. There are limited activities in Solomon Islands (local purchase of NRT)

and Tonga (hospital clinic) that show some positive signs of absorbing the project initiatives within the capacity of local resources.

A&C funded a position in Health Promotion in Solomon Islands to serve as tobacco focal point in the country. This has subsequently been absorbed within the government positions – an excellent outcome in terms of sustainability. The incumbent remains uncertain of the current management arrangements – suggesting that the maximal benefit of this position may be strengthened by some broader management development.

Financial capacity

Currently, the tobacco control programs within countries are undertaken on very limited budgets. This is a reflection of poorly resourced health sectors, and is not confined to the tobacco control, or non-communicable disease programs.

The project has responded to this by assisting in the establishment of “Health Promotion Foundations” (or similar funding mechanisms) in each country. The progress of these funding mechanisms varies between countries, but do represent the most likely and sustainable source of program funding, and is strongly supported within Ministries of Health.

Institutional capacity

Within the Ministries of Health, the tobacco control program is generally operated from the Health Promotion section. With the exception of the larger Solomon Islands, the countries are small, and the personnel within these sections carry a number of responsibilities. The response has been a shift toward integrating the programs into the more generic non-communicable disease program. There is an ambivalence expressed about this by technical advisers (both *Allen & Clarke* and others), where the specific issues and effort in confronting tobacco as an issue warrant focus that may be lost if diffused in other programs. Already, there has been an integration of tobacco control plans into NCD strategies for several countries, and it appears inevitable that this will continue. The regional support program (WHO/SPC) is promoting as such. The legislation achievements have firmly bedded tobacco control as a public health strategy, and are likely to continue. The risk is recognised, however, that the program efforts may be diluted amongst other sector programs.

Phase out strategies/ongoing requirements

Observation in Tonga and Cook islands shows that there is a continued need for specific (and focussed) technical support on an ongoing basis (e.g. with prosecution). *Allen & Clarke* have continued to provide this (partly through goodwill, and partly on a retainer basis with WHO). The highly specific nature of legislative capacity is unlikely to be held in the foreseeable future within countries of this size – hence access to this expertise will be necessary.

In those countries where there has been delay in the passage of legislation, it is expected that there will be a need for support in community and retailer awareness and enforcement training above what has been received so far. It is expected that there will be an accelerated phase of activity when legislation is passed. Currently, there is no contingency to provide funding for this, although A&C have shown intention to continue technical support.

NZAID have indicated that it is likely that its support of tobacco control on an ongoing basis will be through the ‘Pacific Framework for the prevention and control of NCD’, coordinated by WHO/SPC. Some reservations exist about the potential benefit of this to benefit specific country needs. Negotiation will be needed to ensure that the short – medium terms needs of the tobacco program can be met to capitalise on the project inputs to date. Further, part of the role the regional program must take is to establish a body of technical support that countries may draw on where specific and highly technical need is required.

Overall assessment: conclusions, recommendations and lessons learned

The impact of tobacco on human health, social and the economic fabric, while not quantified in the Pacific, is considered to be high. Smoking prevalence rates are high, and limited analysis of health data that has been undertaken indicates the magnitude of the consequences of this. Allen & Clarke was requested to support the efforts of a selection of countries, focussing their efforts on very specific objectives: (1) a situational analysis, (2) facilitating the planning and resource allocation to address priority areas, (3) assist to develop capacity to undertake tobacco control initiatives and (4) facilitate the establishment of a locally owned, regional program for tobacco control.

As a result of the outputs of the Allen & Clarke support, considerable progress has been made towards the achievement of these strategic objectives. In brief:

- Each country, with the exception of Samoa, has a solid awareness of its progress toward tobacco control initiatives. Support for Samoa will be forthcoming in 2008.
- Each country has a tobacco control plan, either as a stand-alone plan, or integrated into an NCD plan. The process of preparing these plans appears to have been of most benefit. This is a varied approach to utilisation of the plans. A significant weakness in the implementation of the plans is an absence of reporting against progress of activities. Limited resources have been allocated to the plans by Ministries of Health in the presence of little overall sector finance.
- Capacity has been supported in a number of key areas to facilitate the country's approach to tobacco control. These include legislation, where all countries supported have draft legislation that has passed or is ready for passage through respective parliaments; tobacco-related harm awareness programs; cessation programs commenced and in several of the countries; a community/NGO body that advocates for tobacco control has been established in several countries, and proves to be an important conduit for change;
- Initiatives to bring to together key players from across the Pacific have been appreciated, although at this time, there is little in the way of institutionalisation of this.

To this end, while not complete and with the exception of Samoa, solid progress has been made toward the objectives and goal in each country. The extent of progress is not uniform, with Cook Islands and Tonga the most developed.

Strengths and weaknesses

The following strengths and weaknesses of the project and implementation are noted:

- The leadership shown by WHO in setting an agenda for WHO and promoting a high level of participation in the preparation of the FCTC has established tobacco control as an important public health issue in the Pacific.
- The incisive technical inputs by Allen & Clarke and the manner in which these have been delivered have been an important strength. Notably, there has been a clear understanding of the task, and well articulated approach to this task. The manner in which technical support has been provided has been perceived as supportive, yet not intrusive, and provided a sense of confidence in the partners that have been the recipients of the support. Where workshops are an element of technical assistance, integration into a planned program of events with follow-up activity will consolidate learning;
- Organised community advocacy groups provide a facilitative role in allowing the programs to reach the community country-wide, as well as providing an opportunity to lobby policy development. Support provided to the development of community advocacy groups showed strength in

consolidating and providing direction for where groups existed, however, in Vanuatu and Solomon Islands, it has been slower in mobilising commitment where the advocacy groups had not yet formalised.

- The role in facilitating the development of the National Tobacco Action Plan in each country has been instrumental in focussing the attention of key players on defining their actions in achieving their goals. It is observed, however, that there is very limited formal reporting on the progress of activity implementation.
- In spite of effort on the part of Allen & Clarke to develop pricing policies on tobacco, there has been limited progress made to date. Success in this aspect is likely to be linked with the presence of an informed high level government committee. There has been some important progress made where this has been the case.
- Cessation programs have made an important contribution in providing the knowledge and skills in the breadth of cessation activity; each country, however, has found difficulty in gaining 'traction' for their programs – limited demand, lack of clinical space, and the absence of pharmaceuticals. Further integration into clinical programs will be needed.
- Coordination with other donor activities to avoid duplication and extend program support has been evident. This has been particularly so in the cooperative relationship with PAHP, and the ongoing liaison that A&C has had with WHO and SPC in establishing the regional approach.
- There has been little emphasis on information collation and research by A&C, a deliberate choice made (in design and implementation) as a result of countries' expressed priorities and the activities supported by other development partners. International surveys have provided some baseline information in several of the countries, but there is very little segregated data on smoking prevalence, inconsistent data on tobacco imports, no published analysis of morbidity or mortality, and now survey of knowledge and attitudes to smoking. Further, the strengthening of tobacco control planning in recent years recognises the need, but is still to strengthen capacity in evaluating the effectiveness of the interventions.
- The forum for networking at the Oceania conference (and other sponsored initiatives) provided an opportunity for country representatives to learn of tobacco control initiatives in other regional countries, giving a sense of confidence and support in their own efforts. It is not clear how this level of networking will continue.

Factors for success or failure

There are a number of factors that support success – where these are not present, programs are likely to falter. Across the countries involved in TCIP, a mixture of these is observed. These include:

- WHO leadership and the manner in which they involved countries in understanding the FCTC created a sound environment within each country to address the issue; this had then been appreciated by the respective countries who sought assistance.
- The design of the intervention is country-specific, in spite of being a regional program. In effect, although termed 'regional', the program has been a series of six bilateral supports, with the opportunity to share lessons and facilitate networking across the region. This model has been considered highly by partner countries. A&C was very deliberate in its support to ensure each country was enabled in accordance with its own specific needs;
- Technical assistance that is supportive, and responsive to country needs has been a critical element in development of capacity. This has been a key strength of the A&C support;
- Individual leadership, particularly where there has been the personal interest of a senior personnel (e.g. health minister), strongly supports the public support and government for the program. Mentoring support, or the provision of opportunities (e.g. support to attend conference/meeting, country personnel to visit other countries of the region) have been shown as important elements in achieving this;

- An active community advocacy group facilitates community support, and is an important driver of public policy. Where these groups are active, it is observed that the government inter-sectoral dialogue is more focussed upon the delivery of results;
- While funding levels of country programs is currently low, the technical support provided has managed to keep program activity moving; in the absence of long term and sustainable funding levels, however, this progress will be challenged;
- Where support from other government agencies exists, it is an important factor in achievement of policy; conversely, if other agencies are not included and informed, it is difficult to achieve policy reform.
- Specific constraints, which vary in degree from one country to another, will persist to confront progress effectiveness. These include the lack of role models amongst leaders (government, church, chiefs, family), low levels of literacy and efforts by the tobacco industry to prevent control approaches.

Lessons learned

Regional approach An underlying concern in several of the countries reviewed is that they are poorly served by regional programs that have been initiated and/or supported by development partners. Personnel cited that regional program activities (for example, HIV programs) tend to be generic, and often out of their own setting, so the specific problems of their country are not dealt with. TCIP was effective in that, although at a regional level, it was focussed specifically on each country's needs and supported these accordingly. In the transition to "Healthy Pacific Lifestyles" as the focal point of NCD (including tobacco control) programs, it is imperative that it is rolled out in a manner that is dedicated and responsive support required in each of the 22 countries it serves. Regional agencies that are supporting implementation of the NCD Framework must identify the specific needs of each of the 22 countries it plans to support, and develop approaches consistent with these needs, and congruent with the changing development environment of these countries (e.g. those engaging in a Sector Wide Approach). While this may demand a greater level of resourcing of the implementation program for the NCD Framework (in planning, support and monitoring), its outcomes are likely to be contingent upon both the detail and the appropriateness of resourcing.

Regional approaches are shown to have important advantages – in particular, providing an opportunity for networking between countries, and providing the basis of accessible technical support at the call of countries of the region.

Technical assistance Experience of donor-funded aid throughout the world is littered with reports of well meaning but poorly focussed technical assistance that provide little in the way of outcome. The technical assistance provided through TCIP was valued, and appears to have given significant progression to the issue of tobacco control. The benefit of these inputs can be attributed to several mechanisms:

- the inputs have been very specifically focussed;
- the inputs have been brief (several days on any one occasion), and recurrent, allowing time to absorb previous lessons, and providing opportunity for follow up;
- there has been continuity of advisers for respective technical areas, allowing the development of professional and mutually respectful relationships;
- The inputs have been provided in a facilitatory manner – identifying the needs, responding to and developing approaches in an iterative manner.

Local personnel value the assistance given for both the technical expertise, and the ability to provide documents and materials that reflect their wishes in an expedient manner.

The conduct of workshops is frequently an important element in technical assistance – transferring information, developing skills, providing opportunities for networking.

Their effectiveness is dependent upon being factored into a program with subsequent follow-up support in a field setting.

Coordination and cooperation between development partners will minimise the risk of duplication and provides the opportunity for synergies between programs. Although donor-funded programs may operate on related areas in specific geographical settings, early cooperation is fundamental and can achieve improved outcomes.

Community advocacy

A well organised coalition of community voice (e.g. church leaders, community representative, NGOs) is one of the pivotal elements of program success. Such a group is able to penetrate throughout the country, and has the capacity for advocacy on policy formation. The absence of such a group may seriously retard progress of a program. It takes not only effort and drive, but the interest and key players in the country of support, and with the appropriate lead time to achieve establishment of groups upon solid ground. The experience in TCIP has seen progress in each country of support, although the depth of achievement has been dependent upon factors that are required to address constraints specific to each setting. These will determine the level of success. An advocacy group is facilitated by a small level of resourcing to encourage communication and coordination of member bodies.

In a similar vein, collaboration across government sectors, bringing heads of departments to focus on the specific policy needs of tobacco is equally important in achieving policy change. It is noted, however, that those countries where there is weak community advocacy, are those where inter-sectoral government bodies are also weak. It is likely that the presence of strong community groups may drive the accountability of government sectors.

Local leadership

A program must be driven by local interest. Should this not prevail, the program will not gain credibility and is not likely to succeed. Numerous examples exist where local leaders (in senior community or government positions) came forth with interest after exposure to an international forum. Careful selection of local leaders and developing these in a sound understanding of the issues at hand will be central to a program's success.

Integrated programs

For reasons of both expediency and efficiency, most Pacific Islands Countries have few staff allocated to health promotion and NCD programs. Tobacco programs have gained out of the specific platform that it has had through the FCTC – substantial measures have been made since the WHO launched its global commitment to tobacco control. Integration risks losing this focus; the tobacco program is far from established, particularly in those countries that are yet to pass legislation – these countries will need focused support in the context of a wider integrated strategy. One means to ensure this is to give emphasis within the reporting framework of that strategy.

Program information, monitoring and evaluation

There is little appreciation for monitoring of activities, or evaluation of program outcomes within the countries of support. The TCIP design/implementation minimised its level of support for this element in consideration of countries stated priorities and rationalisation of resourcing. The consequence of this has been limited documentation of achievements and the subsequent difficulty in refining plans to focus upon areas of greatest need. Strengthening this aspect of implementation (through greater emphasis in the design, and subsequently contracting to deliver on this) would have provided greater benefit for the capacity developed in planning.

In spite of important initiatives by development partners in support of smoking prevalence studies (e.g. STEPwise, Global Youth Tobacco Survey), there remains a paucity of knowledge of smoking prevalence and the subsequent target groups that interventions should be aimed at. The consequences of smoking having not been quantified locally, and subsequently, have provided limited leverage to bring attention to the issue. Ongoing failure to strengthen program research and monitoring and evaluation capacity will constrain program outcomes.

Harmonisation and

There is variable capacity to development and utilisation of action plans.

**utilisation of
program plans**

Unfortunately, in some countries, the one program may have more than one plan, aggravating the lack of confidence in using plans to guide program implementation. The lack of reporting against plans furthers their frequent perception of unnecessary but required activity. Program plans need to be rationalised to meet core programmatic needs, and should be developed at the behest of those who use them.

Merit of overall activity

The progress made in tobacco control over the past 5 – 6 years has been commendable. The foundation for this was laid by international bodies (for example, WHO, SPC) that encouraged the commitment of countries of the region (and globally). NZAID was asked for specific support by a selection of (eventually six) individual countries to enable them to meet their obligation in legislature, and progress the tobacco control programs. NZAID responded positively with a commitment to support in accordance with the request to enhance capacity in these countries and in the region with technical support specifically focused on tobacco control. Allen & Clarke was contracted to provide the technical support. The goal and objectives of the support have proven consistent with need, and the execution of technical assistance has largely delivered on the outputs required in a quality manner and with satisfactory outputs. Each country supported, with the exception of Samoa (which is now to commence its support), has advanced in its understanding of need, developed plans in response to this need and are at various stages in implementation of these plans. The net result has been a strengthened position to deal with tobacco control in each of the countries. The benefit gained (in health, social and economic terms), likely to be realised in the medium to long term, will be significant, particularly in view of the relatively small investment.

The work is not complete. Several of the countries supported are still poised to see their legislation passed in parliament. As this occurs, there will likely be a need for increased technical support across a range of programmatic areas. In at least the settings of Vanuatu and Solomon Islands, the absence of a strong coalition of NGOs and community groups, and the limited inter-sectoral networking at heads of government level on tobacco policy matters continue to threaten the pace of tobacco control initiatives. These, too, need concerted effort to ensure ongoing progress.

Not only have countries benefited from the support provided, but the region generally can be viewed to be in a stronger position. Limited opportunities for sharing of programs between countries have testified to the benefit of sharing, and shows potential of ongoing regional strength.

Has the work undertaken by Allen & Clarke contributed substantially to the Tobacco control continuum within countries in support of the FCTC goals, and the higher level goals of tobacco Control?

The focussed and quality support provided through NZAID by Allen & Clarke has made an important contribution to tobacco control. This has been achieved through a clear mandate of task with specific focus that was called for by the countries concerned, a commitment to the issue and encouragement of leaders to a similar position, quality technical support characterised by responsive and supportive relationships, and endeavours to institutionalise the approach in both community and government settings.

The future of tobacco control program in the Pacific region is likely to be in an integrated program, conducted at the regional level. The success of this strategy is important in order to consolidate the gains made through TCIP. It will be contingent on the ongoing ability to meet specific country needs, and persist with a clear focus on the unique nature of tobacco in spite of the broader setting of 'Health Pacific Lifestyles'.

Implications and future actions to be incorporated into similar regional activities

The implications for NZAID as a result of the activity bear upon its relative success. Recipient countries, and possibly the regional bloc, have greatly appreciated the strength of the support that NZAID has provided has provided. As NZAID moves toward a closer partnership with WHO/SPC and other development partners in supporting the NCD Regional Framework, and in doing so, shift towards a regional program that is less specific in its technical focus, it is imperative that it encourages the implementation of the regional program to be centred on country-specific needs, with clear directions and targets within each of those countries. Several recommendations are provided to assist this transition, and support the broader delivery of assistance in achieving tobacco control:

1. **A transitional program of technical assistance** to continue to address the specific technical needs, and more generally develop ongoing capacity is needed for those countries that have been direct beneficiaries of TCIP, particularly those of the second phase. In the short – medium term, this support should be discussed with WHO and SPC (identified as taking the lead role in framing the future program).
2. As support for tobacco programs becomes increasingly integrated into a “healthy lifestyles approach”, targeted achievements in the tobacco control field will be needed in order not to lose focus. An approach to achieve this is to **establish agreed country targets** (perhaps in the context of NCD), supported by an appropriate means and capacity to measure performance against these targets. Targets should be established with consideration to current country capacity (resources, technical, institutional, systems). The development of targets in accordance with this approach should form part of the short – medium term transitional strategy. Incentives to reach targets will need development, and should consider small grants (e.g. to advocacy groups), acknowledgement by award, sponsorship to conference and other similar approaches. .
3. The centralisation of support into a **regional program should still be founded upon the specific needs of countries** in meeting their NCD program needs, and avoid a generic approach to country support. In effect, the regional framework will need to plan, support and monitor the performance of each country. Consideration should be given to assigned ‘NCD country managers’ as part of the regional support program. The regional approach should be further strengthened by establishment of a facility (of technical resources – for example, legislation, health promotion, M&E) that could be called upon to assist counties in their program implementation. It is envisaged that such a facility would harness the expertise of the region, and facilitate their use on a regular and ongoing basis in order to provide ready access to required technical support, and maintain a level of continuity of the support provided to countries and the region generally.
4. In order to support in-country implementation of tobacco (and other NCD programs) there are several aspects that will require discrete and focussed support. These include the establishment of a community/NGO advocacy group (that may need a level of resourcing), ongoing support for drafting and enactment of legislation and the further development of policy/legislation to achieve appropriate taxing of tobacco products, and the development of sustainable program funding linked to these tax policies. It is envisaged that this level of support may be accessed through existing development partners programs, or incorporated into the evolving Regional NCD Framework support.
5. An investment in research is needed that:
 - defines attitudes, knowledge and behaviour of stratified population groups;
 - establishes a regional formula for attributable fractions for tobacco (and other NCDs);
 - determines indicators that underpin a framework for monitoring; baseline data and ongoing measurement need to be established; data should serve both country need and conform with regional/global requirements.

6. Each country strategy clearly defines its priority groups, and considers the capacity to reach rural and remote populations in this process.

Appendices

Terms of reference for evaluation

Framework for evaluation

List of consultations and dates of evaluation



Approved Contractor Scheme

Name of Assignment: Evaluation of the 'Building Regional Capacity for Tobacco Control in the Pacific' (TCIP) Programme

1 Background

Tobacco use is a major cause of ill-health and mortality in the Pacific Region. Approximately half of all smokers die prematurely from the effects of tobacco smoke, and tobacco use is a key risk factor identified in non-communicable diseases (NCD) such as cancer, obesity and diabetes. These diseases in turn are responsible for over half of the disease burden in the region.

The Allen & Clarke "Building Regional Capacity for Tobacco Control in the Pacific" (TCIP) programme was developed in response to this major regional health concern. Funded through the Pacific Regional Health Programme (NZAID), the TCIP programme has involved two phases: Phase One took place from 2003-2004 in Tonga and the Cook Islands, with Phase Two being implemented over 2005-2007 in Samoa, Solomon Islands, Vanuatu and Tuvalu. The overall goal for the TCIP programme is to support the efforts of Pacific Island Countries in countering the adverse health, social and economic impacts of tobacco use. NZAID has provided approximately \$250,000 (Phase One) and \$870,000 (Phase Two).

The four strategic objectives of the TCIP programme are:

- 1) Assist in the building of a stronger knowledge base and understanding of the current reality *vis a vis* tobacco control in each nation.
- 2) Facilitate the process of planning, identification of priority areas, resource allocation and decision-making on measures to enhance tobacco control.
- 3) Support the development of institutional capacity within Government and NGOs to successfully undertake tobacco control initiatives.
- 4) Facilitate the establishment of a locally owned and driven, and sustainable, approach to tobacco control in the Pacific.

NZAID's support to the TCIP programme is in line with the Agency's Health Policy *Ending Poverty Begins with Health*, which has identified NCD prevention as a key priority in the elimination of poverty in the Pacific. Effective tobacco control programmes are an important element in the reduction in the incidence of non-communicable disease. They are also seen

by Pacific nations as integral to the “Healthy Islands” vision. Formulated in 1995, this vision is concerned with improving the political, social, cultural, economic and physical determinants of health. The TCIP programme is underpinned by the first international legal instrument, the *WHO Framework Convention on Tobacco Control* (FCTC). This was designed to reduce tobacco-related deaths and disease by encouraging governments to reduce the supply and demand of tobacco.

Phase One was requested and supported by the Ministries of Health in Tonga and the Cook Islands Ministries of Health. Envisaged as the first stage in the development of an effective regional approach to tobacco control, the approach involved identifying tobacco control advisors in each country, conducting initial scoping studies, preparing specific tobacco control action plans, NGO and government participation in training sessions, developing a health promotion package and training in smoking cessation. A qualitative self-assessment was undertaken by Allen & Clarke at the end of Phase One, with the key findings including: strong commitment to and engagement in the project on the part of the two countries (at both a community and government level), successful delivery against key project outputs, engagement by and contribution to resources by other donors.

Following the successful implementation of Phase One, requests were received from Samoa, Solomon Islands, Vanuatu and Tuvalu for support in developing and implementing tobacco control strategies and programmes. Phase Two used the same approach and also introduced a greater degree of regional collaboration with proposals for the exchange of ideas and approaches, mutual support and mentoring among the four countries and with the Cook Islands and Tonga. It has also linked directly with efforts by the WHO to support a Pacific response to diet and physical activity challenges as part of wider NCD efforts.

The primary stakeholders in this programme are NZAID as the donor, Allen & Clarke as the primary implementing agency, and participating countries (the Ministries of Health, other relevant partner government departments, and in-country non-government organisations). There is also a range of stakeholders with close links to the TCIP programme including the World Health Organization (WHO) and Secretariat of the Pacific Community (SPC)¹, as well as a wider group of stakeholders with an interest in the results of this evaluation².

It was intended that a consultant would be contracted to develop a Monitoring and Evaluation Framework at the beginning of Phase Two (2005), which would have assisted with the setting of baseline data and clear monitoring goals from the outset. This would have also enabled Allen & Clarke, in their work with partner governments, to ensure that the relevant data and information for an end-of-project evaluation would be collected throughout implementation. While a draft terms of reference was developed jointly by NZAID and Allen & Clarke, it was not progressed.

¹ This group of stakeholders include other consultancy firms and individuals from whom Allen & Clarke drew expertise for the initial design, including Harbour City Healthworks, Zebra Associates (Health promotion), Pacific Islands Heartbeat (Smoking cessation), Te Reo Marama the Maori Smokefree Coalition (previously known as Apaarangi Tautoko Auahi Kore) and ACA Audit and Investigation (compliance and enforcement).

² Interested stakeholders including donors, other Pacific Island Governments considering or implementing tobacco control programmes, as well as other regional and global funders of tobacco control such as the WHO, agencies which manage Bloomberg funds for tobacco control, and members of the *international Tobacco Control Funders* group, a recent ad hoc grouping of agencies.

The TCIP programme is due for completion by June 2008. While NZAID remains committed to tobacco control in the Pacific, it is not considering funding any further stages of TCIP as it is expected that tobacco control will be included in the wider NCD programme that is currently under design by regional organisations in the Pacific.

2 Purpose

With the TCIP programme near completion it is timely to assess the extent to which Allen & Clarke has met the overall goal, the strategic objectives and project outputs as stated in its proposal that formed the basis of the Contract For Services. Addressing the operating principle of accountability, this evaluation is to assess the overall effectiveness and efficiency of the delivery of this programme.

NZAID envisage that the findings of this evaluation will be used by project partners to guide future support to tobacco control. The knowledge and information gained will be fed back into relevant policies, strategies and activities of key partners ensuring on-going improvement to programme delivery and greater future development impact. NZAID will use the findings to guide learning and ongoing improvement of tobacco control programmes (and wider NCD risk factor control efforts) of a range of stakeholders by defining the lessons learned and developing relevant and useful recommendations for best practice.

3 Key Outcome of the Evaluation

To evaluate the TCIP programme and the extent to which Allen & Clarke has achieved the overall goal, the strategic objectives and project outputs as stated in its proposal. Based on this assessment, provide lessons learned for other stakeholders involved in tobacco control

4 The Scope of the Evaluation

This evaluation covers the TCIP programme from the beginning of Phase One (2003). It will assess the performance of the TCIP in meeting the programme's goal and objectives and in line with the performance indicators outlined in the Contract for Services. It will also identify lessons for future tobacco control programmes in the region.

The evaluation will take place between October 2007 and February 2008 and will involve up to 30 working days. It is envisaged that that 20 days will be spent conducting field research in selected participating countries, with the balance used for reporting activities, as outlined in Section 9 below.

5 Objectives of the Evaluation

Objective 1: To assess the extent to which the programme achieved its intended goal and objectives (as defined in section 1).

Objective 2. To identify lessons learned and their application for on-going tobacco control programmes in the region.

6 Evaluation Methodology

In order to ensure that the evaluation will contribute in a meaningful way to the improvement of the tobacco control policies/programmes of a range of stakeholders, the consultant is expected to develop a participatory framework for the evaluation that takes into account the information needs of a range of stakeholders. The evaluation framework should therefore be developed in consultation (through email and/or phone calls) with key stakeholders. The framework should ensure that field visits are conducted with a representative of the key

partner agency and that a range of participatory approaches are used in consulting with stakeholders. This should include an end of visit workshop to feedback findings to key stakeholders. The evaluation framework should be discussed and agreed with NZAID prior to further work being undertaken.

The evaluation will include a desk review of documentation in relation to all participating countries and field study in three or four countries. Countries to be visited will be determined following completion of the desk study and in consultation with NZAID. The basis for determining the countries to be visited should primarily focus on where the best learning can be obtained. This does not necessarily mean where the programme has performed best.

The evaluation is expected to include consideration of the extent to which the programme has reflected NZAID's goal of poverty elimination, policies (including cross cutting policies such as gender equality and human rights) and operating principles.

Questions to consider under each objective include:

Objective 1:

- How was local ownership of the programme obtained in establishing and implementing the programme in each country?
- How were existing resources and needs identified in each country?
- To what extent were National Tobacco Control Action Plans developed in each country? What was the process for developing these Plans? Who participated and how? To what extent were Plans linked with other national and regional initiatives in NCD prevention? What progress has been made in resourcing and implementing them and how and by whom are they monitored?
- How has the programme contributed to the development of legislation, policies, and regulation in relation to tobacco control in each country?
- How has the programme contributed to health promotion and advocacy on smoking cessation? To what extent did health promotion activities target particular groups (including for instance young women as well as men, pregnant women...)
- How has the programme built or strengthened relevant networks both within countries and regionally? How has the programme encouraged sharing of information, experiences and learning at both the national and regional levels?
- What specific capacity building activities or other technical assistance have been provided under the programme and how effective have these been? What steps were taken to ensure the capacity building/technical assistance was sustainable (e.g. systems as well as skills development)?
- What constraints were faced in implementing the programme and how were these addressed?
- What longer term impacts from the programme can be identified? Did the TCIP Programme contribute to changes in tobacco policy in the target countries? What evidence is there of the programme positively changing behaviours, actions and relationships in relation to tobacco control/smoking cessation?
- To what extent did the outcomes and impacts from this programme represent "value for money"?

Objective 2.

- What were the major successes of the programme? What were the major challenges? What approaches worked and what did not? How might the design, implementation and monitoring of the programme have been improved?
- What, if any, unintended outcomes, both positive and/or negative, did the programme have?
- What lessons can be learned from the TCIP programme that are of relevance for other tobacco control programmes in the region?
- What are the key factors that should be taken into account in developing and implementing a tobacco control programme?

7 Management of the Evaluation

The NZAID Pacific Regional Health Programme will be responsible for the contracting of the consultant and will be the primary contact point for the evaluation. The Regional Health Programme will work closely with relevant NZAID bilateral programmes.

An Evaluation Advisory Group (EAG) will be established to support the consultant undertaking the evaluation by providing feedback at key points including the submission of methodology and reporting. The EAG will comprise representatives from the NZAID Pacific Regional Health Programme and Allen & Clarke, with input on an ad hoc basis if required, i.e. WHO and SPC.

8 Assignment Outputs

The consultant is required to produce the following outputs:

- Output 1: A participatory evaluation framework that the consultant proposes to use to evaluate the TCIP programme (for discussion with NZAID prior to commencing the evaluation).
- Output 2. In each study country, a consultation workshop to report back evaluation findings to key stakeholders (project stakeholders as well as NZAID Manager at Post).
- Output 3: A draft written report within ten working days from completion of field research. This report is to include:
- Contents (including figures and tables)
 - Abbreviations and Glossary
 - Executive Summary (1 to 4pgs): A summary of the findings, to include an assessment of achievement of original goals and objectives, the developmental impacts and the sustainability of the achievements. Lessons for feedback into other projects, sectors, and countries should also be highlighted.
 - Introduction: To include background information on the history of the project, including findings of earlier studies and reviews, as well as the purpose and method of the evaluation.
 - Project Description: This is the original design for the project and should include a brief description of the project components, and the economic and social development context and constraints. The relationship to partner government activities and those of other donors should be described.

- **Assessment:** To include an assessment of achievement of original goals and objectives, an assessment of the contribution of the original design and implementation processes to the success (or otherwise) of the project
- **Analysis of the impact and outcomes,** identification of lessons learned and recommendations on best practice for future tobacco control programmes in the region
- **Conclusions:** This section will include an overall assessment of the sustainability of the developmental impacts of the project and any recommended changes to project design and/or management processes for future projects.
- **Appendices:** These should include any extensive background materials or papers, an itinerary, a list of people consulted and a copy of the Terms of Reference for the Evaluation.

Output 4: A verbal debrief with the EAG in Wellington on the completion of the draft report.

Output 5: Based on feedback from the EAG, the final written report.

9 *Quality indicators*

The Contractor shall ensure that the assignment is carried out with all due diligence, efficiency and economy in accordance with the time specified in this Contract, observing sound management and technical practices, and complying with professional consulting standards recognised by relevant professional bodies.

10 **Key Dates**

| Date | event | milestone | fees due |
|------------------|--|------------------|-----------------|
| 2 November 2007 | Start date of contract | - | - |
| 5 December 2007 | Completion of Output One (Participatory Framework) | #1 | 25% |
| 5 February 2008 | Completion of Output Four (final written report) | #2 | 75% |
| 26 February 2008 | End date of contract | | |

* Please note that completion dates for output 1 and 2 are flexible.

Appendix 2: Evaluation of Tobacco Control in the Pacific (TCIP) programme

Framework for analysis - December 2007

Background

The TCIP programme arose from direct request from Pacific countries seeking assistance with tobacco control in their respective countries. To date, it has been undertaken in a two phased approach - an initial stage conducted in Tonga and Cook Islands, and subsequently expanded at request to Tuvalu, Vanuatu, Solomon Islands and Samoa. The program has worked in with other stakeholders to support the needs and wishes of the respective host countries. It is expected that tobacco control will be encompassed in a wider regional initiative in non-communicable disease in the coming year.

Some principles:

- NZAID is committed to the *Paris Declaration of Aid Effectiveness* – working in a harmonious manner with development partners to support considered policy objectives of each respective country. Further, development partners and recipients of aid are held mutually accountable to each other, and jointly assess mutual progress in implementing agreed commitments on aid effectiveness.
- While specific accountability needs are required on the part of NZAID in assessing contractor performance, overall assessment of impacts and outcomes can not necessarily draw attribution to contractor inputs and outputs. Aid is provided in an environment of partnership with a number of stakeholders.
- Poverty elimination and meeting the needs of vulnerable groups are at the core of NZAID's primary goals. These will form and integral part of the evaluation process.
- The approach adopted is one of participatory evaluation. Participatory evaluation provides for active involvement in the evaluation process of those with a stake in the program. This will include those who have had direct responsibility for program implementation, and those who have had close links with the program³. Support and participation will be sought at each stage of the evaluation process. In addition, it seeks to enhance knowledge of evaluation processes, supporting country programs in their implementation.

Aims and objectives of the evaluation

The aim is to evaluate the TCIP programme and, more generally, limited analysis of the progress of tobacco control initiatives in the region

The objectives of the evaluation are to:

- assess the extent to which Allen and Clarke has achieved the overall goal and the strategic directions
- identify lessons learned and their application for on-going tobacco control programmes in the region

³ Stakeholders and closely linked partners include: NZAID, Allen and Clarke and various subcontractors, Ministries of Health in each of the countries involved, in addition to other NGO and civil society representatives, and regional and global players (e.g. WHO, SPC, AusAID)

Pre-planning

- Literature and document review (international papers, local and regional assessments and studies, program specific studies)
- Stakeholder input – (eminent persons of Pacific tobacco programme)
- Field assessment of availability of information sources; development of evaluation questions (Tonga)
- Development of framework
- Communication of process with each country

Data gathering

- Field visits to Cook Islands, Vanuatu, Solomon Islands; questionnaire for Tuvalu, Samoa
- Partner with local colleague/s in gathering local information;
- Techniques will include:
 - workshop to explain process, walk through concepts, identify key areas of evaluation, gather data
 - Collect background information on smoking prevalence and morbidity, and summarise progress against FCTC obligations.
 - collection of data from quantifiable sources where relevant
 - key informant interviews
 - mini-surveys
 - community focus group discussion (in select countries)
- discussion and feedback within each assessment country
- documentation of findings and analysis at country level

Reflection and action

- Regional level thematic analysis, discussion with stakeholder groups
- Identify lessons learned and implication for future programming
- Draft report

Process:

Country-level evaluation

1. A summary of recent and current behavioural, smoking prevalence and morbidity measures will be provided for each country to provide context and where possible, baseline for future evaluation activities.
2. A situational assessment of each country's current status in tobacco control, largely determined by the articles of the Framework Convention for Tobacco Control. A matrix for this assessment is shown. This assessment serves the need to describe current situation, and will not attempt to link that situation to the inputs of Allen and Clarke. If it is feasible, an assessment of the situation prior to the introduction of TCIP will be undertaken.

| Strategic area | Relevant FCTC article | Obligation/Activity | Country achievements (list points) |
|--------------------------------|-----------------------|--|------------------------------------|
| Political leadership | | | |
| | 5.2a | National coordinating mechanism | |
| | 5.2b | Effective executive/legislative authority | |
| Policy | | | |
| | | National Policy and/or action plan | |
| | | Ratification of FCTC | |
| Demand reduction | | | |
| | 6 | Price measures | |
| | 7 | Development of legislation and regulations | |
| | 8 | Passive exposure | |
| | 9 | Regulation of tobacco content | |
| | 10 | Tobacco product disclosure | |
| | 11 | Tobacco labelling | |
| | 12 | Public awareness of tobacco control efforts | |
| | | Tobacco uptake reduction | |
| | 13 | Tobacco marketing and sales controls | |
| | 14 | Cessation | |
| Supply reduction | | | |
| | 16 | Sales to minors | |
| Research and evaluation | | | |
| | 20 | National system for epidemiological surveillance | |

3. An assessment of the activities/outputs undertaken by Allen and Clarke forms the central platform of the evaluation. This assessment will address each output separately, concerned with what was done ('input'), how it was done (process/quality) and what was achieved as a result of the activity ('output'). For each of the four outputs (of respective phases), this assessment will consider the strengths and weaknesses of the approach, sustainability, networks, the level of focus of target groups, constraints encountered and the value gained for the cost of the activity. This is summarised in the following table:

| Enquiry | Issues to consider |
|---|---|
| What was done? | Describe activities |
| How was it done (process/quality)? | Participatory Local ownership Use of existing resources Contribution to local policy and legislation Ongoing monitoring |
| What was achieved as a result of the activity? | |
| Focus on target groups | Pregnant women, youth, young women, men |
| Strengths and weaknesses of the approach | |
| Sustainability of activities/approach | Technical Financial institutional |
| Networks/linkages with other players | Use of existing networks, new networks, inter-sectoral groups and liaisons, other partner contributions |

| |
|--------------------------------|
| Constraints encountered |
| Value for money |

4. This assessment will be analysed with an overall summary of the activities implemented:
 - Were the planned outputs delivered?
 - What were the merits/major successes of these?
 - What is the likely contribution to longer term impacts?
5. Thematic analysis and lessons of implementation will be undertaken by country
 - Development
 - a. technical assistance
 - b. networks and roles of partners
 - c. addressing poverty/target groups
 - d. value for money
 - Enabling and constraining factors
 - Sustainability
 - a. Financial
 - b. Technical
 - c. institutional
 - Unintended outcomes (positive and negative)

Regional analysis: Tobacco Control in the Pacific

An overall analysis, incorporating findings from the four countries visited (and the other two countries surveyed, if data is available). This will include:

(a) Findings and conclusions:

1. Activity assessment

- Allen and Clarke role
 - Quality and timeliness of inputs
 - Working relationships within country and with other stakeholders
 - Effectiveness of monitoring systems
 - Significant positive and negative issues

Overall assessment of strengths and weakness of activity implementation

- NZAID role
 - Design and contracting mechanisms/modality of support
 - Support and communication
 - Significant positive and negative issues

Overall assessment of strengths and weaknesses of NZAID's involvement
- Partner Governments
 - Readiness and support for assistance
 - Leadership

Overall assessment of strengths and weakness of activity implementation

2. Development Impact

- Probable long term impact
- Benefit upon target populations

- Enabling of networking (intra- sectoral and cross-sectoral, other partners)
- Technical assistance and capacity development
- Value for money

3. Sustainability

- Technical
- Financial
- Institutional

Phase out strategy/ongoing requirements

(b). Overall assessment

- Extent to which Allen and Clarke has achieved the overall goal and the strategic objectives of TCIP
- Strengths and weaknesses
- Factors for success or failure
- Merit of overall activity
- Lessons learned
- Implications and future actions to be incorporated into similar regional activities

Reporting

Two levels of reports will be provided: There will be a country level report (see outline attached), and an overall regional report (see outline attached) . A brief exit report will be provided at the conclusion of each country input. The draft TCIP evaluation report (regional analysis) will be forwarded to the Evaluation Assessment Group, and other persons eminent in the field of tobacco control, for review of content, and provide a perspective of lessons learned and the shaping of future development support for tobacco and other programs in the Pacific. Finalisation will be undertaken thereafter.

Summary of consultations

| Key informant interviews | | Stakeholder meetings | |
|---------------------------|---|--------------------------|---|
| Cook islands | | | |
| Edwina Tangaroa | A/manager, Health Promotion Public Health Division Ministry of Health | Rongo File | Tobacco Control Working Group, National Council of Women |
| Maina Tairi | Health Promotion Officer | Rangi Tairi | Ministry of Health |
| Ngapoko Short | TC focal point, Formerly Director Public Health | Mary Kata | Tobacco Control Working Group |
| Karin Tairea | Nutritionist, Ministry of Health | Munay Pare | Ministry of Health (kitchen) |
| Polly Cabia-Togia | Ministerial Liaison Officer for Health Office of the Deputy Prime Minister | Tania Avare | MoH (Nutrition) |
| Stephanie Knight | NZAID, Manager Cook Islands | Bobby Turua | Tobacco Control Working Group Office of Prime Minister |
| Tearoa Iorangi | Health Statistician, Rarotonga Hospital | Mereana Taikoko | Te Kainga Mental Health Services Cessation group |
| Ngapoko Ngatamaine | Chief customs officer | Tereapii Rautana | Public Health Nurse |
| Dr Aumea- Herman Tepae | Director Community Health Services | Mine Benaimina | Senior PHN |
| Dr Roro Daniel | Secretary, Ministry of Health | Teio Kea | Senior PH Nurse |
| | | Edna Potoro | PH Nurse |
| | | Tereapii Kavana | Health Inspector |
| | | Tania Avare | Nutrition |
| | | Mainsa Tairi | Health Promotion |
| | | Moetuma Nicholas | Executive assistant |
| | | Tereapi Teina | Eye/ear nurse |
| | | Rai Healthier | Public health nurses |
| | | William Taripo | Health Inspector |
| | | Roimata Herman | PH Nurse |
| | | Charlie Ave | Chief Public Health inspector |
| | | Rufina Titai-van Eijk | PH Nurse |
| | | Tereapi Taurarii | PH Nurse |
| | | Charlie Ingaua | Health Inspector |
| | | Tae Nootai | Health inspector |
| | | Tama Joseph | Health inspector |
| | | Tuaine Teokotai | Health inspector |
| | | Teina Savage | Health inspector |
| | | Karin Tairea | Nutritionist |
| | | Edwina Tangaroa | Health Promotion |
| | | Dr Aumea Herman Tepai | Director Community Health Services |
| Vanuatu | | | |
| Jean Jacques Rory | Health Promotion | Jean Jacques Rory | Health Promotion, MoH |
| Len Tarivonda | Director, Public Health | Len Tarivonda | Director of Public Health, MoH |

| | | | |
|------------------------|---|--------------------------------------|---|
| Maurice Amos | Senior Health Inspector | Pakoa Rarua | Senior Health Inspector , MoH |
| John Silik Sala | Deputy Director of customs services and Enforcement | Tony Arthur | Senior Municipal Health Inspector |
| Dr Bernard Fabre-Teste | WHO Liaison Officer | Bruno Leikon | Director of radio program, VBTC |
| James Toa | Development Programme Coordinator NZAID | Mari Noelle Kaltack | Journalist VBTC |
| | | Ioan Borora | Health Promotion, MoH |
| Jean Marc | Department of Statistics, Ministry of Finance | Petro Kaloris | Mental Health Masculinity Project, FSP |
| George Iapson | General Secretary Vanuatu Football Federation | Graham Tabi | Coordinator, Pacific Action for Health Project |
| Hilson Toaliu | Save the Children Australia | Ruth | Public Health Nurse |
| Mr Henry Vira | Secretary General, VANGO | Akuma | Senior Customs and Inland revenue officer |
| Angelyne Glenda Saul | Parliamentary Counsel, State Law Office | Elise Saila | Senior Project Officer, SCA |
| Miriam Abel | Director General, Ministry of Health | Andrew Napuat, | Senior Project Officer, SCA |
| | | George | Private nursing consultancy |
| | | Uriel Willy | Substance abuse, Police Department |
| Solomon Islands | | | |
| Ms Nevalyn Laesango | NCD Coordinator, Ministry of Health | Nevalyn Laesango | National NCD coordinator, MoH |
| Watson Bana | Smoke free coordinator | Watson Bana | Health Promotion Tobacco Coordinator |
| Alby Lovi | Director Health Promotion | Aloysius Erobaea | SI Youth Organisation ph: 92565 |
| Dr Divi Ogaoga | Under secretary Health Improvement | Joy Dyer | SI Christian Association – community health |
| Mr Peter Rapasia | Manager Revenue, Customs Department | Mavis Kwanairana | NCD Facilitator |
| Nick Gagahe | Government statistician | Jackson Beikerakei | NCD program officer Guadal Canal Province |
| Tom Nanau | Chief health inspector, Honiara City Council | Julia Dalfour | NCD/Diabetes Program Officer – Honiara City Council |
| Mr James Pango | Marketing manager Z FM | Rudgard Palapu | School of Nursing P: 38078 |
| Mr John Haurae | Contracted by GoSI to draft legislation | Steve Larry | Health Promotion, Honiara City Council P: 28470 |
| Stella | Development Services Exchange | Nacock Henry Savekana | ADRA P 23247; kanahenry@gmail.com |
| Dr George Malefoasi | Under-Secretary, Health Improvement | Dulcie Darcy | National Diabetes Centre, National Referral Hospital |
| | | Members of Aruligo community | |
| Tonga | | | |
| Nuku'Alofa, Tonga | | | |
| Eva Mari | Senior Health Promotion Officer, Ministry of Health | P: 54892 E: eva_mafi@yahoo.com.au | |
| Naomi | Health Promotion Officer | E: naomi_fnz@yahoo.co.nz | |
| Dr Paulo Vivili | Director, Health Promotion, Ministry of Health | E: psvivili@gmail.com | |
| Dr Viliami Tangi | Minister of Health | T: +676 28233 F: +676 21337 | |

| | | | |
|--------------------|---|---|--|
| | | E: billmoh@kalianet.to | |
| Sione Launiss | Tobacco cessation officer, Ministry of Health | | |
| Niu Fakakovikaetau | Tobacco enforcement officer, Ministry of Health | E: nfakakovikaetau@health.gov.to | |
| Sione Vanisi | Tobacco cessation officer, MoH | P: 58358 E: svanisi@health.gov.to | |
| Kelemete Vahe | Manger Imports, Division of Customs | P: 77643 | |
| Ata'ata Finau | Director, Statistics Department | P: 22517 E: finau@stats.gov.to | |
| Sela Moa | Ministry of Justice | P: 24055 E: selamoa@hotmail.com | |
| Gloria Poleo | Ministry of Justice | P: 24055 E: gloria_guttenbeil@yahoo.co.uk | |
| Sione Hufanga | Health Statistics officer, Ministry of Health | E: shufanga@health.gov.to | |
| Dorothy Fauonuku | Salvation Army, member of tobacco sub-committee | P: 23760; 8786354 E: Dorothy_Fauonuku@nzf.salvationarmy.org E: analaugh@gmail.com | |
| Dr Malakai Ake | Director of Health, Ministry of Health | P: E: make@health.gov.to E: drmalakaiake@hotmail.com | |

Wellington

| | | | |
|---------------|------------------|----------------|----------------------------------|
| Megan McCoy | NZAID | Anna Gribble | Allen and Clarke |
| Marion Quinn | NZAID | Brent Rapson | Allen and Clarke |
| Matthew Allen | Allen and Clarke | Heather Kizito | Allen and Clarke (subcontractor) |
| | | Denise Barlow | Allen and Clarke (subcontractor) |
| | | Iutita Rusk | Allen and Clarke (subcontractor) |
| | | Matthew Allen | Allen and Clarke |
| | | Marion Quinn | NZAID |
| | | Megan McCoy | NZAID |

Other correspondents

| | | | |
|----------------|---------------|--|---------------------------|
| Harley Stanton | Formerly SPC | | HarleyStanton@bigpond.com |
| Tony Lower | Formerly PAHP | | tonylower@gmail.com |
| Burke Fishburn | WHO | | Fishburnb@wpro.who.int |

Dates for evaluation

Initial consultations (telephone/correspondence) – 8 November 2007 –

| | |
|--|------------------------------|
| Briefing Wellington: | 21 November, 2007 |
| In-country assessment Tonga | 21 – 24 November 2007 |
| Workshops with Allen and Clarke staff: | 29 January 2008 |
| In-country assessment: Cook Islands | 29 January – 2 February 2008 |
| In-country assessment: Vanuatu | 6 – 9 February 2008 |

In-country assessment: Solomon Islands 10 – 14 February 2008
Tabling of draft report: 29 February 2008