Navigating conflicting mandates and interests in the governance of the commercial determinants of health: the case of tobacco in Fiji and Vanuatu

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Declaration of originality

I, Dorottya Patay, (11/03/2021) hereby declare that the thesis here presented is the outcome of the research project I have undertaken during my candidacy, that I am the sole author unless otherwise indicated, and that I have fully documented the source of ideas, references, quotations or paraphrases attributable to other authors.

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Abstract

The consumption of tobacco, alcohol, and ultra-processed foods and beverages is driving the global noncommunicable disease (NCD) crisis. The commercial determinants of health (CDOH) have been recognized as the practices of industries aimed at increasing the availability, affordability, desirability, and consumption of commodities that are risk factors for NCDs. Addressing CDOH requires policy coherence across multiple government sectors; however, the objectives of these sectors do not always align with public health goals, and conflicting mandates can be aggravated by the interference of harmful commodity industries. Pacific small island developing states (PSIDS) face particular difficulties among low- and middle-income countries (LMICs) in negotiating such governance dilemmas, due to vulnerabilities arising from their small population and economy, geographic isolation, and being scattered across several islands. This is a major issue, because PSIDS are currently undergoing an NCD crisis, thus it is crucial to improve understanding of how their governments can better govern the harmful commodity industries.

This dissertation is focusing on the governance of tobacco, because (i) the ways in which the tobacco industry (TI) influences governments are the most documented among the harmful commodity industries; (ii) the responsibilities of governments to control tobacco are the most binding compared to other harmful commodities; and (iii) there has been increased recognition that the ultra-processed food and beverage and alcohol industries globally have adopted similar strategies and arguments used by the TI, thus there is a growing interest in understanding the transferability of governance approaches from the tobacco control domain.

The literature points towards the importance of interests, ideas, and institutions in shaping the ways governments manage multisectoral work on the regulation of tobacco. However, little empirical evidence is available to examine how these conditions influence PSIDS. This gap is critical, because these countries have a remarkably different social, political, cultural, and economic context than other LMICs, which makes the implementation of practices recommended by health experts to regulate harmful commodities particularly challenging.

This research aims to improve understanding of the conditions that influence how governments in PSIDS address the commercial determinants of NCDs in relation to tobacco. This aim was achieved by applying

a qualitative methodology with an exploratory case study approach, with a focus on agenda setting and policy making in tobacco governance. This dissertation expands the evidence base and scholarly knowledge of the interests, ideas, and institutions which influence the way PSIDS governments – more specifically, those of Fiji and Vanuatu – address the commercial determinants of NCDs, with a focus on tobacco. Two key insights have emerged from the findings of this research. Firstly, the vulnerabilities of PSIDS must be taken into account and addressed as major structural drivers in order to successfully govern the commercial determinants of NCDs in these countries. Secondly, the dominant causal ideas must be altered to support the governance of commercial determinants of NCDs. This research has started to build the necessary empirical evidence and academic knowledge to help inform the ways a shift in interests, ideas, and institutions can be realised to enable the control of CDOH in PSIDS.

Members of Supervisory panel

Professor Sharon Friel (Primary Supervisor and Chair of Panel)

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Abbreviations

AG	Attorney-General
BAT	British American Tobacco
CEO	Chief Executive Officer
CMC	Central Manufacturing Company
CDOH	commercial determinants of health
COI	conflicts of interest
COM	Council of Ministers
CSOs	civil society organisations
DG	Director-General
FCTC	Framework Convention for Tobacco Control
FDI	foreign direct investment
FPTC	Focal Point for Tobacco Control
HiAP	health in all policies
ICA	institutional collective action
LMICs	low- and middle-income countries
MANA	Pacific Monitoring Alliance for NCD Action
MoA	Ministry of Agriculture
MoE	Ministry of Economy
MoH	Ministry of Health
MoT	Ministry of Trade
MP	Member of Parliament
NCDs	noncommunicable diseases
NTDC	National Trade Development Committee
PACER Plus	Pacific Agreement on Closer Economic Relations Plus
PIC	Pacific Island Country
PM	Prime Minister
PMI	Philip Morris International
PS	Permanent Secretary
PSIDS	Pacific small island developing state
SDC	Southern Development Company
SIDS	small island developing state
SPC	Secretariat of the Pacific Community
TCA	Tobacco Control Act
TI	tobacco industry
TPD	Tobacco Product Directive
UN SDGs	United Nations Sustainable Development Goals
UNDP	United Nations Development Programme
VIPA	Vanuatu Investment Promotion Agency
WHO	World Health Organization
WOG	whole-of-government
WOS	whole-of-society

Chapter 1. Introduction

This dissertation focuses on the governance challenge of addressing the commercial determinants of health (CDOH), which arises from the conflicting mandates and interests inherent in the regulation of harmful commodities. More specifically, this study explores the conditions that influence the ability of the governments of Fiji and Vanuatu to develop and implement multisectoral tobacco control policies, with a focus on agenda setting and policy making in tobacco governance. The research aim was to improve understanding of the conditions that influence how governments in PSIDS address the commercial determinants of NCDs in relation to tobacco.

In this dissertation CDOH are identified as the practices of industries aimed at increasing the availability, affordability, desirability, and consumption of commodities that are risk factors for health. Governance is defined as "*the processes and institutions through which decisions are made and authority in a country is exercised*" (15), and it "*determines how societies are steered and how power and resources are distributed*" (16).

A rapid rise in premature deaths caused by noncommunicable diseases (NCDs) marks the global burden of disease[1] (18). The consumption of harmful commodities, such as tobacco, alcohol, and ultra-processed foods and beverages[2], is a major contributor to the development of NCDs (20–23). Globalisation has made these products more widely available, affordable and highly desirable (1,24–28). The harmful commodity industries spend a vast amount of their resources to build demand for and supply of their products and to shape regulatory environments for their benefit (1,26,29–37). This has major consequences for population levels of NCDs and thus affects local economies through their social and economic costs to society (38). Through the United Nations Sustainable Development Goals (UN SDGs), governments globally have committed to ensure the highest attainable level of health for their people (39). It is therefore of utmost importance that states take control of these commercial determinants (40).

However, the regulation of harmful commodities and the associated industries requires more than the commitment of the health sector (41–43). Government agencies responsible for trade, industry,

[1] Burden of disease is defined as health loss from death or disability (17).

[2] Ultra-processed foods and beverages are defined as *"products are made from processed substances extracted or refined from whole foods — e.g. oils, hydrogenated oils and fats, flours and starches, variants of sugar, and cheap parts or remnants of animal foods—with little or no whole foods"* (19).

agriculture, and economy have roles in the governance of these industries, and due to their mandates and goals, they often support and advance industry interests. The resulting incoherence between health policy and macro-economic policy goals has been recognised as a major challenge for addressing the CDOH (34,43–48). More recently, scholars have been discussing how dominant neoliberal ideologies widen this policy incoherence (32,43,47,49–56). This has been accompanied by calls to shift the discourse around NCDs and the roles industries and governments play (24,32,43,47,49–55,57,58). Moreover, to address conflicting mandates and interests, health experts often emphasise the need for institutional structures which provide a level playing field[3] between the different actors of governance and ensure policy coherence for health (60–74). In short, the CDOH literature shows that certain interest-based, ideational, and institutional conditions can enable or constrain the elevation of health interests in the regulation of harmful commodities; however, the available empirical evidence on such conditions and understanding how they impact governance are still limited, and mainly limited to high-income countries.

This research explores the governance of commercial determinants of NCDs, paying particular attention to tobacco control. The tobacco industry (TI) was selected from among the harmful commodity industries for the following reasons. First, the ways in which the TI engages and influences governments are the most documented among the harmful commodity industries (2,3,75). Second, the responsibilities of governments to control tobacco are the most binding compared to alcohol or ultra-processed foods and beverages, because of the World Health Organization Framework Convention for Tobacco Control (WHO FCTC) (76). Third, tobacco control is often cited as a good example for controlling harmful commodities (2,77,78), and there has been increased recognition that the ultra-processed food and beverage and alcohol industries globally have adopted similar strategies and arguments used by the TI, thus there is a growing interest in understanding the transferability of governance approaches from the tobacco control domain (1–14,41).

Despite the global progress in tobacco control (79), tobacco remains a threat to the majority of people around the world, especially in low- and middle-income countries (LMICs) (80–84). LMICs can be easy targets for tobacco companies because of their growing middle class with disposable income, often weak regulatory environments, and their governments' desire for economic development (70,83). Among LMICs, small island developing states (SIDS) are also targeted by the TI (85,86) which gives even more reason for concern, as these countries bear a set of vulnerabilities due to (i) their "*poor natural resource endowment, small domestic markets and difficulties in generating economies of scale in production and*

[3] A level playing field is *"a situation in which everyone has the same chance of succeeding"* (59).

service provision"; (ii) they are dependent on decisions made in larger countries; (iii) their "*openness to trade and inability to influence market conditions*"; and (iv) their lower levels of access to basic services and infrastructure, and difficulties of transportation due to often being scattered among multitude of islands (87). These vulnerabilities pose distinct challenges for SIDS, both in governing commercial determinants of NCDs (88) and reaching their development goals. SIDS comprise 21% of all countries signed up to FCTC (89), therefore it is particularly important to understand the conditions influencing their tobacco governance.

SIDS in the Pacific (Pacific small island developing states, PSIDS) have declared an NCD crisis in 2011 (90,91); the exceptionally high smoking prevalence in these countries is a major contributor to the 78% of deaths caused by NCDs. The prevalence of male current smokers[4] in Kiribati was 74.1% in 2004; in Papua New Guinea, Solomon Islands, and Nauru it was between 52.9 and 60.3% (in 2007, 2006, and 2004 respectively); in Samoa, Federated States of Micronesia, Fiji, Tonga and Vanuatu it was between 45.8 and 49.4% (in 2002, 2006, 2011, 2013 respectively[5]) (93–101). This rate was lowest in the Marshall Islands with 34.7% in 2002 (102). Therefore, addressing the commercial determinants of NCDs resulting from TI activities is critical for PSIDS. However, despite the considerable volume of tobacco control literature, scholarly knowledge about the conditions that shape the response of these governments is limited. This is an important issue, because PSIDS have a particular socio-political, governance, cultural, and economic context that needs to be understood in relation to their tackling of the NCD crisis. Expanding the empirical evidence and academic literature on this topic will not only support PSIDS in regulating harmful industries but would be useful for LMICs in general.

This research recognises the need to fill this gap. It aims to improve the understanding of the ways PSIDS governments address the challenge of conflicting mandates and interests in the multisectoral regulation of harmful commodities. A qualitative exploratory approach was taken to answer the following overarching research question: "What conditions influence intersectoral governance of tobacco control in PSIDS?" This dissertation examines this question with a particular focus on the interests, ideas, and institutions in Fiji and Vanuatu. These factors are recognized as having a major influence on agenda setting and policy making in tobacco control The analytical framework developed for this purpose follows the established taxonomy of the '3-i' – interests, ideas, and institutions (103) –, and draws on four theories – Avant et al.'s (125) theory of authority, Stone's (126) theory of causal ideas, Feiock's (127) institutional

[4] WHO defines "current" as "*either daily or non-daily (occasional) use at the time of the survey*". (92)
[5] Latest available data for these countries.

collective action framework, and Croley's administrative process theory (128) – to collect, examine and explain my empirical data on each 'i'. This analytical framework is explained in detail in Chapter 4.

In the following, Section 1 introduces the research problem in detail. Section 2 describes the aim, objectives, questions, and the relevance of this research. Lastly, Section 3 outlines the structure of this dissertation.

1. The research problem

1.1. The commercial determinants of NCDs

NCDs are caused by various risk factors, including genetic, physiological, behavioural and environmental determinants (104). Tobacco and alcohol use and the consumption of ultra-processed foods and beverages contribute significantly to the development of high blood pressure, obesity, high blood sugar levels, and high levels of fat in the blood, all of which lead to various NCDs. Tobacco use alone caused 8.71 million deaths in 2019 (23).

Premature deaths and morbidity due to NCDs can be prevented to a large extent, however this requires strong opposition to powerful global actors, the harmful commodity industries (69,105). "*Through the sale and promotion of tobacco, alcohol, and ultra-processed food and drinks, transnational corporations are major drivers of global epidemics of NCDs*", explain Moodie et al. (106). The economic globalisation of the 20th and 21st centuries has enabled the greater penetration of transnational corporations into LMICs, increasing the availability, affordability, desirability, and consumption of harmful commodities. Coupled with changing demographic conditions (such as ageing and population growth), this has significantly increased the prevalence of NCDs in these countries (105). A disproportionate burden is experienced in SIDS; the small size of their economies and their often-weak public administration makes governance for health particularly difficult when they are faced with powerful players such as transnational corporations.

The commercial determinants of NCDs scholarship recognises that the practices of industries, that are aimed at increasing the availability, affordability, desirability, and consumption of unhealthy commodities, need to be regulated to tackle the NCD crisis. Such practices include a wide range of market and non-market mechanisms. The former often incorporates market expansion through trade and investment liberalisation, building domestic supply chains (e.g. through foreign direct investment, FDI), and aggressive marketing, advertisement, and promotion practices. The latter consist of corporate social

activities, such as corporate social responsibility (CSR), and corporate political activities, which include a range of discursive and instrumental strategies. While some of these practices target the consumers, many of these strategies aim at interfering with public health policy making, and during their use industries take advantage of the conflicting mandates government agencies often have.

1.2. The example of tobacco control

Attention on tobacco companies has been at the forefront among the harmful commodity industries. "*No consumer product kills as many people, and as needlessly, as does tobacco. It killed 100 million people in the 20th century. Unless we act, the death toll can reach 1 billion people in the 21st century*", warns the WHO (107). Tobacco use is one of the leading causes of mortality globally (23). The WHO addressed the threat posed by the TI by dedicating its first treaty on global health negotiated under the auspices of the organization to FCTC (108).

The FCTC is the main global regulatory policy tool for tobacco control among its 180 participating parties (108). In the form of Articles, the treaty recommends a set of supply and demand side policy measures, which include policies on price setting and taxation, regulation on ingredients, packaging, data disclosure, marketing, illicit trade, research, cooperation, awareness raising and public education (Table 1).

The provisions described under Article 5 *General Obligations* receive a lot of attention in this dissertation. Firstly, this article highlights the need for comprehensive multisectoral tobacco control policies (Article 5.1). Secondly, recognising the challenge of achieving policy coherence among multiple policy fields, it requires the establishment of a national coordinating mechanism (Article 5.2) which aims to ensure that government agencies align their approach to tobacco governance for the sake of public health. Thirdly, the article reflects the importance of addressing conflicts of interest (COI) by dedicating Article 5.3 to the protection of public health policies from TI interference. This last provision suggests that the parties of FCTC exclude tobacco companies from their national governance mechanisms, just as they were barred from participating in the development of FCTC (108). The Guidelines of Article 5.3 (74) recommend eight points to protect public health policy making from TI interference as terms of engagement: (i) awareness raising about the dangers of tobacco and TI interference; (ii) minimise interactions between the TI and public servants and implement transparency measures in case such meetings happen; (iii) reject partnerships with TI; (iv) avoid COI for public servants; (v) information provided by the TI has to be transparent and accurate; (vi) regulate social corporate activities of TI; (vii) the TI shall not receive any preferential treatment from governments, (viii) even if they are state-owned. The provisions of Article 5.3

highlight that the challenge of multisectoral governance amidst conflicting interests is recognised in global tobacco control efforts. It has been shown that achieving policy coherence between government sectors for tobacco control and protecting these policies from TI interference is of utmost importance, as the following section reflects.

Table 1 The tobacco control measures recommended by WHO FCTC

Article no.	Provision
5	**General Obligations** Development and implementation of comprehensive multisectoral national tobacco control strategies (5.1) national coordinating mechanism or focal points for tobacco control (5.2) Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry (5.3)
6	Price and tax measures to reduce the demand for tobacco
7	Non-price measures to reduce the demand for tobacco
8	Protection from exposure to tobacco smoke
9	Regulation of the contents of tobacco products
10	Regulation of tobacco product disclosures
11	Packaging and labelling of tobacco products
12	Education, communication, training and public awareness
13	Tobacco advertising, promotion and sponsorship
14	Demand reduction measures concerning tobacco dependence and cessation
15	Illicit trade in tobacco products
16	Sales to and by minors
17	Provision of support for economically viable alternative activities
18	Protection of the environment and the health of persons
19	Liability
20	Research, surveillance and exchange of information
21	Reporting and exchange of information
22	Cooperation in the scientific, technical and legal fields and provision of related expertise

In 2014 the FCTC Convention of Parties endorsed the global target of reducing smoking prevalence by 30% by 2025 set by the 2011 High-level Meeting of the World Health Assembly (109). However the latest studies on global trends in tobacco use clearly show that if the implementation of the treaty continues at

the same pace as in the last decade, only 21% of the countries will achieve this target for men and 49% for women, and by 2025 the number of daily tobacco users will be an estimated 1.1 billion (110).

The high smoking prevalence rates of PSIDS (93–102) indicate that these countries are particularly badly affected. In 2013 all PSIDS (except Micronesia) adopted the Tobacco Free Pacific 2025 goal (111), but whether they will achieve this target of zero smoking prevalence is questionable. PSIDS face particular difficulties in governing harmful commodity industries; their often-weak bureaucratic systems, arising from their smallness and low-income economies, make them easy targets for commercial influence (88,112,113). Furthermore, the enforcement of public health policies controlling the use, sale and marketing of tobacco requires considerable human and financial resources in PSIDS, because these countries are often spread across several small islands, which results in severe logistical and organisational challenges (87,114,115).

1.3. The challenge of conflicting mandates in the governance of the commercial determinants of NCDs

The governance of the commercial determinants of NCDs requires a multisectoral approach (41–43), involving not solely the health sector but trade, industry, agriculture, and economy sectors as well. For example, tobacco growing is often regulated by the Ministry of Agriculture; its manufacture usually sits within the realm of the Ministry of Industry; the distribution, sales, and marketing of tobacco products are controlled by the Ministry of Trade; while the Ministry of Economy has a role in formulating tax policies affecting the sales and trade of tobacco. The traditional scope of Ministries of Health in relation to tobacco is to educate the public about the harms of smoking, to treat tobacco-induced diseases, and to provide smoking cessation services. While tobacco governance covers all these areas of policy and regulation listed above, tobacco control itself has a narrower scope, because its aim is ultimately to reduce tobacco consumption and not to support the industry.

The example of tobacco governance shows that harmful commodities are regulated by multiple government actors, whose mandates and objectives are usually quite different. While the Ministry of Health aims to improve the population's health status, Ministry of Trade and Industry generally have the objective to boost trade and industry in a country, the Ministry of Agriculture tends to support the cultivation of cash crops, and the Ministry of Economy focuses on strengthening the economy and increasing government revenues.

This is where the challenge of governing the commercial determinants of NCDs arises besides TI interference. The objectives listed above reveal that the mandates of government agencies are often not aligned with each other (43). Public health interests dictate decreasing consumption of harmful commodities; however, government agencies in trade, industry, agriculture, and economy see value in increasing such consumption regardless of its impact on population health. For example, the Ministry of Health may provide health promotion programmes to discourage the consumption of tobacco, while the Ministry of Trade negotiates a trade agreement which facilitates the import of cheap cigarettes. As a result, policy incoherence among government sectors in the regulation of the commercial determinants of NCDs is common (34,43–48,78).

The existence of different mandates within a government should not necessarily constrain the control of CDOH; certain institutional conditions can ensure a level playing field for the benefit of population health. Health experts have been recommending the establishment of institutional structures which aim to ensure that the conflict between the different mandates of policy actors is resolved: health in all policies (HiAP) (60–65), whole-of-government (WOG) (61–63,67–69) and whole-of-society (WOS) approaches (19,116–118) are seen to support policy coherence. In order to protect policy making from the interference of harmful commodity industries, measures to address COI, such as terms of engagement, are the recommended practices (66,70,72–74,80). The role of law to solidify administrative structures has been also highlighted (42,69).

Despite the considerable attention on the institutional conditions which influence the ways mandates and interests are played out in tobacco governance, the implementation of multisectoral tobacco control policies remains difficult in many countries. Several health experts raise the importance of ideas in the ways interests and institutions are shaped in the regulation of CDOH (32,47,49–54): the ways governance actors think and discuss NCDs define how they interpret their role in the regulation of harmful commodity industries (24,32,46,47,49,49–54,67,119). Often neoliberal ideologies dominate in non-health government agencies which is commonly aligned with the rhetoric of the tobacco, alcohol, and ultra-processed food and beverage industries (46,47,50,54,67); the reliance on personal liberties and responsibility in the consumption choices of individuals has been pointed out as a barrier to the tighter regulatory measures (46,47,49–53,119).

As the above illustrates, the governance challenge of conflicting mandates and interests can be aggravated or conciliated by particular institutional and ideational conditions. Hence, this dissertation focuses on the multisectoral regulation of harmful commodities through the lens of interests, ideas, and

institutions. The analysis of interests in this research encompasses not only the preferences of private and public actors, but also the mandates and objectives of government agencies. Ideas capture the way the various actors think about NCDs and the consumption of harmful commodities; particularly cognitive, causal ideas are in the focus of this dissertation as these define which government agencies have the mandate to regulate aspects of tobacco industry and consumption. The examination of institutions interprets institutional conditions as the factors arising from the legal and administrative structures of political and governmental agencies.

The literature and the theories introduced in Chapters 2 and 3 show that the issue of intersectoral governance amidst conflicting mandates and interests has been in the focus not only of public health but also of scholarship in governance, public administration, and political science. While the tobacco control literature has been occupied with finding solutions to this issue and the FCTC explicitly addresses policy coherence and the protection of health interests in tobacco governance, the evidence on the implementation of FCTC shows that governments continue to struggle with implementing comprehensive, multisectoral policies. The persistence of this issue justifies calling on other research disciplines which have the potential to benefit and expand the scholarly understanding of the governance of CDOH. Therefore, this research takes an interdisciplinary lens to explore the conditions of multisectoral governance for tobacco control.

2. Aim, objectives, questions, and relevance of the research

The CDOH scholarship has established that interest-based, ideational, and institutional conditions play an important role in the ways governments approach the regulation of harmful industries (46,47,54,67,80,105,120–124); however, academic knowledge and empirical evidence about the ways these conditions shape PSIDS governments' responses to the commercial determinants of NCDs in relation to tobacco are limited. In light of the high smoking prevalence rates and NCD crisis of PSIDS, it is vital that this gap in the scholarly literature is filled, thus providing evidence for government officials and development workers in these countries to shape interests, ideas, and institutions to ensure that the NCD crisis is tackled.

Therefore, this research aims to improve understanding of the conditions that influence how governments in PSIDS, address the commercial determinants of NCDs in relation to tobacco. This aim is pursued through the overarching research question: "What conditions influence intersectoral governance of tobacco

control in PSIDS?" Fiji and Vanuatu have been chosen as case studies to answer this question, as these PSIDS showed recent improvement in tobacco control performance despite the presence of interests in tobacco investment. Thus, more specifically, the research focuses on identifying the interests, ideas, and institutions which shape the governance of commercial determinants of NCDs in relation to tobacco in Fiji and Vanuatu. The research objectives and concomitant sub-questions are:

Objective 1: Identify the interests that shape intersectoral governance for tobacco control in PSIDS.

i. What are the major interests at play in tobacco governance in Fiji and Vanuatu?
ii. How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?

Objective 2: Identify the ideas that shape intersectoral governance for tobacco control in PSIDS.

i. What are the dominant ideas related to tobacco in Fiji and Vanuatu?
ii. How do they influence tobacco control?

Objective 3: Identify the institutional conditions that shape intersectoral governance for tobacco control in PSIDS.

i. What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?
ii. How, and to what extent, do institutional factors ensure a level playing field in tobacco governance among stakeholders in Fiji and Vanuatu?

Prior to this research no similar work has been published on Fiji and Vanuatu focusing on the intersectoral governance of tobacco, offering an explanation of actors' interests and authority, ideas, and institutional structures while showcasing the ways these three factors interact, shape each other, and influence tobacco control. As such, the findings of this research have the potential to contribute to the academic knowledge on the governance of CDOH and provide practical strategies to professionals active in SIDS, and more widely in LMICs, on the fields of tobacco control, public health, governance strengthening, public administration, and development.

3. Outline of the dissertation

The research problem introduced in Section 1 and the aim, research question and objectives described in Section 2 are addressed in the next seven chapters. Chapter 2 provides a review of the scholarly literature on the activities of the TI as commercial determinants of NCDs, and the governance challenges faced by

government in regulating them. The literature describes how governments face serious obstacles in elevating health interests in tobacco governance, because of a range of interest-based, ideational, and institutional conditions, and highlights that there is a gap in the literature regarding these issues in SIDS. Given that SIDS, including PSIDS have a very different social, political, cultural, and economic context than other LMICs, without understanding the influence of these conditions, these states will likely continue to struggle with the NCD crisis.

Chapter 3 describes the theoretical perspectives used to guide the data collection and to examine and understand the data generated from the fieldwork. In line with the findings of the literature review, the analytical framework follows the taxonomy of the "3-i": interests, ideas, and institutions (103). Four theories from the field of political science and public administration were drawn from in the development of the analytical framework. Avant et al.'s (125) theory helps to make sense of the ways actors pursue their interests by deploying and challenging authority in tobacco control; Stone's (126) theory explains how causal ideas around tobacco use and NCDs are shaping actors' understanding and actions in tobacco control; and Feiock's (127) institutional collective action framework and Croley's (128) administrative process theory provide insights into the institutional conditions influencing policy coherence for tobacco control and the protection of public health interests in tobacco governance from pro-commercial interests. By drawing on these theories, this research takes an interdisciplinary approach to understanding governance of the public health problem of CDOH.

Chapter 4 provides a description and justification of the research design and the methods applied. A qualitative, exploratory methodology was designed to answer the research questions. The intersectoral governance of tobacco control in Fiji and Vanuatu served as the cases of the case study approach embedded into this methodology. Within-case analysis and cross-case synthesis were used for the purposes of exploring the conditions that influence how governments in PSIDS address the commercial determinants of NCDs in relation to tobacco. The primary methods applied were in-depth interviews with key informants and document analysis, which were conducted during fieldwork in Fiji and Vanuatu.

Chapters 5, 6, and 7 give a detailed account of the results. Chapter 5 presents the data about the interests shaping tobacco control in the case study countries with the help of Avant et al.'s theory of authority. It reveals the pro-health and pro-commercial interests in tobacco governance in Fiji and Vanuatu, and then continues by analysing the ways actors exert or challenge authority in tobacco control. It explains why the TI is perceived to be a legitimate partner in tobacco governance. Furthermore, it shows that the balance

of authority between the pro-health and pro-commercial actors tips towards the latter in both countries and explains why the health sector is alone in driving tobacco control in both countries.

Chapter 6 introduces data on the causal ideas present in the two states around the use of tobacco and NCDs. It demonstrates that the idea of individual responsibility is woven through discourse about tobacco control, and it explains the ways such thinking affects the involvement of non-health government agencies in the implementation of tobacco control measures. The chapter describes that the idea of CDOH is present in Fiji and Vanuatu; however, it shows that this idea has less influence over tobacco control than the idea of individual responsibility, and it explains how this affects the governance actors' approaches to tobacco governance.

Chapter 7 describes the results in relation to institutional conditions in the case study countries. It explains that the dedicated intersectoral mechanisms for policy coherence for tobacco control are multisectoral committees in both Fiji and Vanuatu; however, these committees appear to be unable to achieve this task, because of the underlying political and institutional conditions. Furthermore, the chapter offers insights into how various structural conditions shape the administrative process, influencing the ways health interests can be elevated in tobacco governance. It shows that terms of engagement with the TI are not implemented and examines the reasons behind this, and it explains how the vulnerabilities of SIDS impact policy making in tobacco control.

Chapter 8 provides a discussion of the results, and draws the conclusions and the recommendations of the research. It reflects on the literature reviewed in Chapter 2, discusses in detail how the findings resonate with the research objectives and aim, and identifies the contributions of this research. The chapter highlights the importance of causal ideas and SIDS vulnerabilities in influencing how governments address CDOH, and it provides recommendations on shifting ideas and strengthening institutional structures as means to overcome the challenge of conflicting mandates and interests in the governance of CDOH. The dissertation closes by identifying a set of directions for future research.

Chapter 2. Literature review: the governance of commercial determinants of noncommunicable diseases

This chapter presents the reviewed literature which informed this study. It gives an overview of the international scholarship on the governance of the commercial determinants of noncommunicable diseases (NCDs), paying particular attention to the tobacco industry (TI), and Pacific small island developing states (PSIDS).

Section 1 introduces the commercial determinants of NCDs. Section 2 reviews the market and non-market activities of TI as commercial determinants of health (CDOH) and contributors to NCDs. Section 3 focuses on the literature describing government action to address TI activities and elevate health interests; it reviews the academic literature on policy coherence related to multisectoral policies for tobacco control, and the literature on protecting public health policies from TI interference as recommended by the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) (76). Section 4 gives an account of what is currently known about the governance of commercial determinants of NCDs in PSIDS, mainly in relation to TI. Finally, Section 5 summarises the gaps in the literature and thus guides the direction of this research.

1. The commercial determinants of NCDs

The objectives of this section are to briefly introduce the development of the concept of the wider determinants of health, and to highlight the importance of advancing scholarly knowledge about the commercial determinants of NCDs and their governance.

1.1. From individual behaviours to a social model of health

NCDs were originally understood, and acted on, through the concepts of behavioural risk factors (29,129–133). Behavioural risk factors encompass those derived from individuals' choices regarding their lifestyle (29). This lifestyle frame places personal choice and individual responsibility in focus, arguing that people should be free to decide how they live and what they consume (29,129–133). The biomedical model

associated with this concept has focused on the treatment (and sometimes individual prevention) of health issues (29).

Some public health scholarship has been critical of the lifestyle approach to NCDs, arguing that individuals make behavioural choices that are shaped by societal level factors (134). Scholars already recognised in the 1960s and 1970s that a wide range of societal level factors influence health, and that these are often outside of the health sector (16,44,130,135,136). Scholarship on social, political, environmental and CDOH has emerged from these developments over recent years.

The social determinants of health approach refers to the conditions in which people are born, grow, live, work and age, and the structural factors which shape these daily living conditions (137). There is a large body of literature related to various aspects of the social determinants, ranging from material and psychosocial pathways, through to specific determinants such as education, working conditions, or housing (35,137–149). Regarding tobacco use, evidence shows a robust correlation between socioeconomic status and smoking (150–156). Much of the attention associated with the social determinants of health has been located within government policy, operationalised through terms such as “healthy public policy” and “health in all policies” (60–62,136,157,158).

The political determinants of health frame emerged shortly after the final report of the WHO Commission on the Social Determinants of Health (137). It helped orient research and action towards understanding political processes, such as the ideas, actions, and decisions of political actors (public or private) and their effect on health (131). Scholarly works on political economy of health (24,26,120,131,135,159–164), health political science (165), and political epidemiology (166,167) have focused on describing these factors (168). The Lancet-Oslo Commission on Global Governance for Health states that addressing the political determinants for health is crucial in closing the gap of health inequities (131), and there is a growing amount of scholarly work focusing on this concept (167,169–179).

In recent years the importance of understanding and acting on CDOH has been increasingly cited in the public health scholarship, especially in relation to the global NCD crisis (34,180–182). Maani et al.’s (148) review shows that CDOH have been often overlooked in the past as drivers of NCDs, even within discussions over the wider determinants of health. This dissertation aims to contribute to public health scholarship by improving the understanding of CDOH, particularly those contributing to NCDs. The next sub-section explains this concept in detail.

1.2. Conceptualising the commercial determinants of NCDs

While earlier works used the term "industrial epidemics" to highlight the role of commerical actors in driving epidemics of NCDs (78,161,164,183), scholars define CDOH with varying scope in the literature. Buse et al. (2017) define the concept as "*the risks inherent from consumption of, or exposure to, commercial products – such as ultra-processed foods and beverages, tobacco and alcohol*". West and Marteau (185) do not stop at these industries: they explain that the term encompasses the "*the factors that influence health which stem from the profit motive*". Kickbusch et al. (186) suggest that the concept stands for the "*strategies and approaches used by the private sector to promote products and choices that are detrimental for health*".

Industries spend considerable resources on ensuring that people consume their products, regardless of the harm they cause to public health and they interfere with policy measures which attempt to regulate their activities (1,26,29–37,69). Therefore, some scholars suggest focusing not only on the commodities, but also on the policies and activities of industries producing and selling them (1,9,148). Even before the concept of CDOH became commonly used, a significant amount of scholarly work had been done on understanding the activities of harmful commodity industries (2,19,75,187–202).

In this thesis, the commercial determinants of NCDs are defined as the practices of industries aimed at increasing the availability, affordability, desirability, and consumption of commodities that are risk factors for NCDs.

This section has introduced the wider determinants of health and the emergence of the commercial determinants of NCDs field. Drilling a little deeper into the practices of corporations will enable identification of what and how to redress CDOH. In the next section, the corporate activities of the TI are examined as CDOH, broken down according to market and non-market activities.

2. The activities of the tobacco industry

There has been growing global recognition that the commercial determinants of NCDs need to be regulated if countries want to achieve their UN Sustainable Development Goals (UN SDGs) (9,131,181). However, the influence of harmful commodity industries in policy making has been rapidly increasing in recent decades, which makes their regulation even more challenging (1,6,8,30,37,131,135,161,184,203,204). The objectives of this section are to illustrate the ways the TI

influences the demand and supply of tobacco, and thus demonstrate the challenges governments face in their attempt to control tobacco. This section introduces the market and non-market activities of the TI that are the subject of tobacco control (76). The former facilitates the supply or demand for products using market mechanisms (205). Non-market activities can be defined as "*a firm's concerted pattern of actions to improve its performance by managing the institutional or societal context of economic competition*" (206).

2.1. The market mechanisms used by the tobacco industry

In this section the market-related activities of the TI are introduced, which primarily work through international trade and investment liberalisation, the creation of domestic supply chains, and advertising, marketing and promotion, that together increase the supply of and demand for tobacco products (205).

2.1.1. Market expansion through trade and investment liberalisation

The TI increases its global and local supply and distribution of tobacco through trade and investment agreements. The industry is known to use its economic power to influence government negotiations of trade agreements in a way that enables new or more competitive markets for their products (33,161,207,208). Trade and investment agreements support the facilitation of both imports and exports by reducing the tariff and non-tariff barriers to trade[6]. Trade and investment liberalisation – "*the systematic reduction in barriers to cross-border trade and investment*" (209) – can limit the regulatory capacity of governments by imposing legal constraints on regulatory autonomy and sovereignty (25,210–214), but also by reducing financial resources (215–217), such as foregone revenue through the elimination of tariffs on tobacco products (161,218).

Foreign direct investment (FDI) in harmful commodities has been rising globally, and large multinational corporations are drawn to establishing production and processing in LMICs where regulatory and administrative oversight is often weaker than in high-income countries, and human resources can be cheaper as well (11,161). This is especially true for the TI, which has lost a lot of its influence in developed countries (19,46,80,84,161,219–221). FDI is attractive for LMIC governments because it increases tax revenues and employment opportunities, and supposedly facilitates technology transfer (161,211). Governments often find themselves balancing the immediate economic and political benefits of FDI from

[6] The former refers to maximum allowable import or border taxes; the latter refers to domestic standards, measures and regulation.

the TI and its adverse public health impact (222), and at times they underestimate the socioeconomic consequences of investment in harmful commodities (223).

The association between increased tobacco consumption and trade and investment liberalisation has been pointed out by multiple studies: scholars argue that the local production of tobacco (as a consequence of FDI) increases its availability on the domestic market, and due to the lack of import and transportation costs tobacco prices become more affordable (216,224–231). This has contributed in many LMICs, including PSIDS, to increased smoking prevalence (11,232).

2.1.2. Domestic supply chains: tobacco farming

To supply their factories, the TI contracts farmers to grow and harvest tobacco in a systematic way in most countries (233). The supply chain is fully controlled by the TI: it provides seeds, fertilisers, and technical expertise, and it buys the tobacco leaves produced directly from the farmers on their land (54,234–238). This reliable and convenient process makes tobacco farming an attractive business opportunity for farmers, who perceive tobacco growing as a profitable occupation[7].

While advertised and perceived as a cash crop, a large body of research argues that tobacco farming is far from profitable (235,236,239–245). Scholars explain that after careful consideration of all direct (e.g. costs of seeds and chemicals) and indirect costs associated with farming (e.g. extra hours of work, frequent child labour and women's unpaid labour due to the labour-intensive nature of tobacco) the actual profit is significantly smaller than initially perceived, and it leaves farmers in debt, who thus struggle to step out of poverty (235,236,239–245). Furthermore, the automation and contract system of TI leaves farmers in a weaker bargaining position as there is no other buyer for their tobacco leaves and they are already indebted to their contractor (236,246–250).

The management of the total supply chain by the TI has been shown to make governments less inclined to organise supply chains in general (47), which results in significant losses for those farmers who cultivate crops other than tobacco, such as fruits and vegetables, because they struggle to reach customers before their produce perishes. This gives even more reason to turn to tobacco growing (47,239).

[7] The global price of tobacco is more stable than other cash crops, and its income yield per unit of land is higher as well (161). Furthermore, farmers often perceive tobacco as the only viable cash crop, given its resilience in diverse weather conditions (239).

2.1.3. Marketing, advertisement, and promotion: pushing demand

The TI uses a variety of strategies to ensure demand for its products. It has developed and perfected a range of aggressive advertising and promotion practices which often target women, children, or specific ethnic and social groups (3,13,208,227,228,251–266,266–274). Hastings (8) argues that "*a key function of marketing is to mask these uncomfortable truths [about the health impact of tobacco products] by disguising inanimate corporate monoliths as benign friends under the guise of branding*". Evidence shows that the TI amends its well-tested marketing, advertisement and promotion practices to better target consumers in LMICs (275–277). For example, in several LMICs smoking is less acceptable among women than men, and thus the TI uses marketing to change such norms by framing smoking as empowering women, or delivering cigarettes to consumers' homes (275). Furthermore, in several African countries children are given free cigarettes by the TI as a way of initiating them into smoking (276).

Although regulations are in place in many countries to control the advertising and marketing of tobacco, the TI finds new ways to continue promoting its products. Online marketing (268,269,278–282) and the use of social media are common (283–287), and point of sale advertising remains a crucial marketing avenue for the TI (283,288,289). Branding, such as the creation of "premium" brands, nudges consumers to buy more expensive products, while by offering cheap or discounted products the industry is able expand or maintain its consumer base among less wealthy or less committed smokers (13,283). Other developments include super-sized, value brands with variations of 40–50 cigarettes in a pack (290). Tobacco corporations coordinate their product prices with each other and thus ensure price control (13,228).

Moreover, the TI has framed smoking as associated with desirable characteristics, such as attractiveness and masculinity (e.g. the Marlboro man) (291). In recent years companies have started to use long, descriptive or emotive product names, such as "Horizon 93mm Long", "Signature", "Hybrid", or "Longbeach Moments North Coast" (290). It uses additives in tobacco products to decrease smokers' airway irritation or make tobacco taste better (2,3,19,265). Among the newest developments are extra-long cigarettes (so-called "super kings" or "extra kings"), flavour capsules with menthol or citrus taste, mixing tobacco with menthol leaves, and innovative filters (290).

The TI has been innovative in developing new and appealing products, while adjusting to changing regulatory environments. By creating "healthy" product lines, such as "light" or "mild" cigarettes, it lures smokers into the illusion that products are safer than they are (2,3,227,292). E-cigarettes have been

developed to offer a wide range of flavours, customisation of devices to set airflow and temperature, and added Bluetooth or mobile phone features (293–299).

While market mechanisms are the most visible activities of TI, the next section shows that non-market activities are the primary avenue to influence governments.

2.2. The non-market mechanisms used by the tobacco industry

The various ways in which the TI operates to influence how it is perceived by various stakeholders and shape government policy and regulation have been extensively documented (3,58,70,71,75,80,84,135,161,189,208,265,300–309). TI interference in policy making is one of the biggest challenges for tobacco control, highlighted by the fact that FCTC among its first provisions (Article 5.3) calls for the protection of public health policy making from vested interests (79,80,244). Due to the increasing evidence that the ultra-processed food and beverage and alcohol industries pursue very similar tactics, there is growing interest in governance approaches and comparable evidence of effectiveness of key interventions (1–14,41). This section gives an overview of the corporate social and political activities the TI employs to influence the public and governments.

2.2.1. Corporate social activities

The TI aims to paint an image of itself as being socially and environmentally responsible through various corporate social responsibility (CSR) initiatives (80,121,161,274,309–312). Sponsorship also falls into this category, because they aim to shape the image of the corporation in the consumers' eyes (3,190), and thus create "*a culture in which smoking and the industry were accepted*" (3). CSR may benefit harmful commodity industries in several ways. Firstly, it advertises the company, inducing positive change in its public image, thus distracting stakeholders from the harm its business activity causes (2,161). Even the internal documents of British American Tobacco (BAT) describe its own CSR activities as "reputation management" (313). For example, Philip Morris International (PMI) delivered fresh food to poor populations in South Korea, and BAT launched smoking cessation and leadership development initiatives in the country (228). PMI also finances the Foundation for a Smoke-Free World, which is a non-profit organisation aiming "*to end smoking in this generation*" (284,314–319).

Secondly, CSR investments may function as financial incentives, and they have the capability to constrain opposition (2). For example, in the USA, PMI "neutralized" several women's groups by paying them large

sums of money to ensure they did not support tobacco control or speak up against the company's campaign to attract women consumers in the 1980s and 1990s (320).

Thirdly, CSR is a way to access policy makers: in several countries government officers are reluctant to cooperate with the TI because of Article 5.3 of FCTC, but CSR provides an opportunity for industry representatives to talk to these public servants about topics that are attractive to the government due to their inherent social benefits (189). By having the opportunity to meet and talk to policy makers regularly, industry representatives can normalise public-private cooperation, and promote a new, positive image of their industry, which can lead to political benefits for the corporations (189).

2.2.2. Corporate political activities

Corporate political activities are used by the TI to influence the regulatory environment according to its interests (13). Ulucanlar et al. (321) developed the policy dystopia model, which categorises corporate political strategies into discursive and instrumental strategies. The former includes the strategic framing of smoking, industry activities, and NCDs; the latter encompasses direct strategies aimed to persuade legislators, public servants, private and civil organisations, the media, and the public to act in the interests of TI.

Discursive strategies

The most commonly cited arguments used by the TI refer to the negative unintended consequences of tobacco control measures (56,58,75,265,321–323). The TI likes to remind governments that its presence in a country benefits the economy by bringing investment, creating jobs and increasing tax revenues (75,121,161). Thus any measure that would hurt their business endangers such economic benefits and must be avoided (58,223,265).

Scholars warn that arguments on the economic benefits of tobacco investment disregard the wider and long-term socioeconomic implications of smoking and the consequential rise of NCDs (244,324,325), noting that cost-benefit analysis of tobacco use shows that there is a considerable gap between the socioeconomic costs of smoking and the economic benefits of the tobacco trade (324,325).

Taxes on tobacco constitute a source of income for states, and the TI often warns them that increased taxes will result in decreased tobacco sales and a surge in illicit tobacco trade, which will negatively impact government revenues (161,326–328). However, several studies have shown that raising tobacco taxes do not reduce government revenues in the short and medium term, but increase them while consumption drops (188,327–334). The other common industry argument against tobacco taxes is that they increase

illicit trade in tobacco products, which in turn reduces government revenues (161,265). However, evidence suggests that the industry overstates the extent of this issue (335–337), and other factors contribute more significantly to tobacco smuggling, such as the existence of organised crime, level of corruption and the presence of informal distribution networks (326).

As an unanticipated cost to society, the TI often attempts to discredit tobacco control policies by framing the government as a "nanny state" (56,204,265,338), because the targeted measures are "*an assault on freedom and choice*" (339). This aligns with the industry's common rhetoric on individual responsibility in making free consumer choices (2,75,121,135,250,259,340–342). WHO (250) critiques this argument, firstly, because tobacco is a highly addictive substance and many smokers start when they are teenagers and struggle to quit once addicted. Secondly, consumers' information about the risks of smoking rarely originate from a balanced variety of sources: the elaborate marketing and advertising strategies of TI, together with its efforts to deny and undermine evidence on the harmful impact of smoking, make informed choices difficult (250).

The quick adaptability of tobacco companies is well demonstrated by the way they have used the language of health inequalities and social determinants of health in their arguments (81):

> *The root causes of youth smoking have little or nothing to do with tobacco advertising, displays or packaging. Instead, the principal causes include personal factors such as rebelliousness and risk-taking and other factors such as family structure and relationships, quality of schools and educational success and socioeconomic status* (343).

While the TI frequently calls for balance between commercial and health interests (2,67), scholars (19) and WHO argue that *"there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests"* (74).

Instrumental strategies

The industry also has a range of instrumental strategies, described below, which they use to try to ensure that their rhetoric is accepted by stakeholders.

Coalition management includes constituency recruitment, fabrication, and fragmentation. According to Ulucanlar et al. (321), *constituency recruitment* is aimed at creating networks of actors who are willing to support the TI. These practices can target public servants, local businesses, the public, the media and other prominent organisations (56,73,121,276,321). Savell et al. (75) and Ulucanlar et al. (321) distinguish between external and internal constituency building. The former happens when actors are brought on

board who are not directly related to tobacco production or sales. Internal constituency building happens when the TI companies collaborate, as happened when they were lobbying against FCTC (1,344,345). Mialon et al. (73) explain that the "revolving door" phenomenon – movement of employees between the government and the industry – can be a form of constituency building: when ex-industry employees are hired by the government it is a way for the industry to infiltrate regulatory agencies (73,321). Furthermore, it ensures the inclusion of TI interests in policy making while other public interests are not necessarily represented (36).

Constituency fabrication happens when the TI uses front groups as a means of indirect lobbying (56,58,321,346,347). This strategy is applied especially in countries where the industry has low credibility (75). For example, in 1991 in Australia, the Business Council of Australia, the Confederation of Australian Industry, the media, tobacco farmers and suppliers, and advertising organisations lobbied against the introduction of health warnings on tobacco products (348).

Constituency fragmentation targets the opponents of TI and aims to weaken their networks to mitigate their influence on tobacco regulation (2,75). This can be done through the critique of public health advocates, infiltrating public health agencies, creating fake civil society organisations (astroturfing), and recruiting the public and prominent civil society groups to oppose tobacco control (73). For example, PMI persuaded multiple women's groups in the USA to oppose tobacco control in the 1980s and 1990s (320).

Information management includes the production, amplification, and suppression of scientific evidence, but also encompasses credibility and reputation management to ensure that research findings produced are not linked to the TI and that public health advocates are discredited (2,10,321,321,349). The range of actors participating in these strategies includes professional organisations, "independent" scientists, research groups, and civil society organisations (CSOs) (2,161,342,347,350,351).

Direct involvement and influence in policy. The TI directly lobbies individual politicians and public servants to represent their interests in policy (13,19,58,306,307). For example, during the development of the European Union's (EU) Tobacco Product Directive (TPD) PMI spent €1.25 million on lobbying; it had more than 160 lobbyists at work contributing to a three-year delay in completion of the directive and the removal of provisions about plain packaging and point-of-sale advertisement (221). At the same time the health lobby in Brussels had only five full-time staff working on TPD (221).

Financial incentives range from offers of employment to direct and indirect financial inducement (75,161,321,350). For example, in many countries the TI finances political campaigns in return for support

in Parliament (36,80). Often public servants are offered attractive positions in the TI, which is another type of "revolving door" issue (352). Indirect financial inducement covers a range of gifts and donations (73). Threats of withholding financial support also belong to this category (321).

Collaborative initiatives, joint ventures (121) and public-private partnerships (PPPs) are classed as strategies of direct involvement in policy making, according to Ulucanlar et al. (321)[8]. Corporations support these partnerships as a policy substitution strategy to avoid strict and costly regulatory measures, to improve their public image or gain cheap advertisement, or if they recognise that the targets set by the government are achievable and/or they have already made progress towards what they want to be recognised (116). Policy substitution is aimed at softening or replacing measures constraining industries, and besides offering partnerships, it often includes proposals of voluntary or self-regulation (75,307,353–355). For example, in Colombia, Honduras, Costa Rica, and Trinidad and Tobago, BAT voluntarily increased the size of text-only health warnings on its products, which significantly delayed the introduction of pictorial health warnings in these states (276). Furthermore, the TI tends to offer alternatives to proposed measures as policy substitution (75), as happened in Australia at the introduction of plain packaging, when the industry suggested using the less constrictive EU policies instead (348).

Litigation. Corporate legal activities mainly involve the threat or application of legal action, such as dispute settlement processes based on multilateral or bilateral trade and investment agreements, and the influence of negotiations of trade and investment agreements (73,80,84,228,265,276,356). For example, PMI contested Australia's plain packaging regulations (56,323,356,357) and Thailand's pictorial health warnings (358). The threat of arbitration itself can delay the implementation of tobacco control measures (80) or discourage governments from pursuing public health policies, and cause "regulatory chill" (323,356), which means that states delay, modify or refrain from implementing certain policies in fear of arbitration (359,360). An example of this is the case of New Zealand, when it delayed the adoption of tobacco plain packaging measures until the dispute between Australia and PMI was settled (361).

Illicit trade of tobacco products. Ulucanlar et al. (321) class TI activities to facilitate or conduct smuggling of tobacco products as a type of instrumental strategy. A significant amount of evidence argues that the TI benefits from illicit trade and it places considerable effort into supporting such illegal dealings (219,276,336,362–369), because: (i) smuggled tobacco products are cheaper and thus sell in higher volumes than licit products; (ii) smuggled tobacco products are sold outside licensed shops thus under-

[8] Mialon et al. (73) list PPPs among constituency building; Savell et al. (75) consider them as a form of corporate social activities based on the notion that industry actors recognise their responsibility towards the public.

age consumers have access to them; (iii) illicit trade is an established method of entry into protected markets (e.g. high levels of tariff and non-tariff barriers); and (iv) the industry can argue that high tobacco taxes cause illicit trade, thus oppose tobacco control measures (276). According to several scholars (161,161,335–337,370–375) while the industry poses as a beneficiary of regulations on illicit trade, in reality its profits are threatened by it, and therefore it tries to undermine such efforts in the background.

Section 2 has demonstrated that the academic literature is particularly informative about the challenges governments face – including both market and non-market activities of the TI – when they aim to control tobacco. The elevation of public health interests over private commercial interests is key to regulating the TI; as the following section explains, the best chance governments have to achieve that is through forging policy coherence and implementing terms of engagement.

3. Elevating public health interests in tobacco governance

This section presents the scholarly literature relating to the two areas cited to be of most importance to achieve comprehensive, multisectoral tobacco control policies: policy coherence among government sectors and protecting public health policy making from industry interference. Their relevance is highlighted by Article 5 *General Obligations* of FCTC which is dedicated to these points (376).

The emphasis on institutional structures as a means to protect public health policy making from TI interference and ensuring policy coherence among the actors with conflicting mandates and interests are the most visible themes in the tobacco control literature. Although the role of ideas is cited frequently among CDOH scholars, ideational conditions receive much less attention in the tobacco control scholarship. This explains why this section is not able to discuss many studies on ideas related to tobacco governance.

3.1. Policy coherence for tobacco control

As noted in Chapter 1, the FCTC is the global treaty for addressing the activities of the TI as commercial determinants of NCDs (79,376). Its very first provision is the implementation of comprehensive multisectoral tobacco control policies in Article 5.1 (376). This requires multisectoral commitment, and many scholars argue that without policy coherence for tobacco control this cannot be achieved (78,377,378).

Ashoff (379) identifies two categories of policy coherence: (1) the absence of incoherences between policy sectors, when policy decisions have no negative impact on other policies; and (2) when there is a shared objective that government actors align their policies with. Throughout this dissertation Ashoff's first category is used when discussing policy coherence.

In terms of tobacco control, policy coherence requires the engagement and collaboration of Ministries of Health and others such as Ministries of Trade, Industry, Agriculture and Economy – policies related to farming, product manufacture, distribution and sales, taxes and tariffs, and enforcement are all subject to tobacco governance. However, these government agencies have different mandates in relation to TI, which often results in policy incoherence. Ensuring that all relevant government sectors are on board with tobacco control measures is essential for reducing smoking prevalence (78,377,378).

3.1.1. Collaborative approaches to achieve policy coherence

Governance for health scholarship has been occupied with policy coherence and multisectoral policies for health; as Magnusson and Patterson (88) state, "*no concept gets more emphasis in the literature on NCDs than intersectoral action*". The "health in all policies" (HiAP), whole-of-government (WOG), and whole-of-society (WOS) approaches offer slightly different alternatives to coordinate health with other sectors.

HiAP is the call for the recognition and systematic consideration of the health impacts of all public policy measures in national level governance (60–63), and one of its aims is to forge policy coherence across government sectors (64,65). This concept first appeared in the literature as intersectoral action for health and "healthy public policy" (158). The Helsinki statement renewed this idea and named it "HiAP" (60).

WOG approaches cover a range of mechanisms which connect and coordinate government agencies and sectors for the sake of policy coherence, such as multisectoral committees and stakeholder involvement in policy making processes (380); they are often seen as the way to achieve HiAP (61–63,67,68). It is generally a recommended practice when tasks are complex, interdependence is high, and shared responsibility is required among various government bodies (381). As Magnusson and Patterson (382) explain: *"NCDs call for an all-of-government response not only because many of the priority interventions will be implemented outside of the health sector, but also because broadly-based political support will be needed to secure passage of the necessary laws and budgets."* However, joint work requires strong accountability mechanisms among participant actors and well-developed institutional design (381). WOG is often recommended to regulate the TI (68,383), and the National Tobacco Control Strategies toolkit

provided by WHO FCTC and the United Nations Development Programme suggests a detailed WOG plan to implement multisectoral coordination (68).

WOS approaches expand the actors of governance to the private and civil sectors (19,384,385). However, this requires careful balancing of the influence of the involved parties (386,387), because corporate actors generally have a better chance to sway policy making towards their interests than other sectors (388). Accountable policy making relies on participation; however, the role of governments lies in levelling the playing field to deal with power imbalances among stakeholders (389–391). As Ayres and Braithwaite (392) point out, "*the very conditions that foster the evolution of cooperation are also the conditions that promote the evolution of capture and indeed corruption*." Many scholars argue that the effectiveness of collaborative approaches is questionable in the case of harmful commodity industries, because of the conflicts of interest (COI) between public and private objectives (19,41,67,116,118,190,393,394). As Lencucha et al. (395) state: "*The principal controversy remains whether governments can work with commercial interests in a way that does not sacrifice public interests to private ones, and whether private interests can serve the public good."* Magnusson (41) explains this in the following way: *"Corporations have little incentive to re-shape public tastes and existing product lines, as distinct from offering marginally 'better for you' variants, when doing so risks sacrificing existing markets and provides opportunities for competitors."* Some authors argue that the inclusion of the private sector is necessary to tackle the NCD epidemic, but they also admit that its participation in governance of harmful commodities can be effective only if a certain set of criteria is applied – although there is no agreement on exactly what those should be (19,116–118,355).

While there is debate about the adequate regulation of participation of harmful commodity industries in policy making, the FCTC stresses the need for policy coherence through multisectoral involvement, but it suggests doing so with the least possible cooperation between the TI and governments, because of the irreconcilable COI between private and public interests (74). However, in the case of other harmful commodities the collaborative approach is prevalent; it is the recommended strategy of the UN and the World Bank (39,400–402), which "*are increasingly looking to the corporate sector to fill funding gaps and come up with economic solutions to global problems*" (393). Food and beverage corporations, such as PepsiCo and Coca-Cola, participate in the Global Health Council's NCD Roundtable and sponsor UN events (403). Despite contestation, there is growing recognition among global health experts that the alcohol and food industries should be excluded from governance similar to tobacco (180), because of similar patterns of COI between private and public objectives (2,3,11,13,14)

3.1.2. Implementing collaborative approaches in tobacco control

Article 5.2(a) of FCTC requires the establishment of a national coordinating mechanism or focal points for tobacco control as a way to ensure multisectoral commitment and policy coherence (376). The 2018 Global Progress Report of FCTC (79) shows that 74% of the parties have established such a mechanism (79), but also highlights that only 67% of the 180 countries involved have implemented comprehensive, multisectoral tobacco control measures. Forging commitment for tobacco control across government sectors is challenging; common barriers include lack of coordination, low political will, TI interference, and inadequate resources (68).

There has been relatively little published about policy coherence and tobacco control, or about the structure of institutional mechanisms to implement collaborative approaches Although FCTC is cited as a success for HiAP (157), this literature review has not revealed any studies focusing on tobacco control and HiAP explicitly. The examples of WOG mechanisms on tobacco regulation in South Korea (122) and the Philippines (67) show that it is not enough to offer a balance of power in negotiations between trade and health, but health interests need to be prioritised to ensure that commercial interests do not dominate regulation. The experience of standardised packaging in Australia shows that WOG approaches can work for tobacco control as long as the TI is excluded (404).

Lencucha et al. (67) suggest that "*tobacco legislation that brings together industry interests and health objectives in order to 'balance' the two […] leads to a space of competing objectives rather than a space that can foster coherence*". The authors describe how in the Philippines the multisectoral committee for tobacco control was headed by the Department of Trade, which represented TI interests, alongside the Department of Agriculture and the National Tobacco Administration, which was a significant barrier for the Department of Health to elevate health interests over commercial interests. The authors conclude that WOG approaches for NCD prevention should clearly prioritise health objectives (67).

While most tobacco control experts focus on institutional conditions, there is an emerging but smaller scholarship indicating the importance of ideas to ensure that WOG approaches achieve policy coherence for health. Several authors state that differences in ideas about the role and mandates of government and about the cause of a problem, such as NCDs or high smoking prevalence, are major barriers to policy coherence in tobacco governance (46,47,54,67). Labonté et al. (54) explain that in Zambia, tobacco production is accepted as a legitimate means of economic development, and they argue that this has to be taken into consideration when WOG approaches are planned for tobacco control. According to their findings it is not enough to establish intersectoral mechanisms, but dominant ideas about the connection

of the TI and economic development need to be shifted to prioritise health in order to create policy coherence for tobacco control. They suggest achieving this by building evidence about the impact of the TI on a country's economy, which would prove that tobacco production is not a viable vehicle for development.

3.2. Protection from industry interference

TI interference is a major barrier for tobacco control (79,80), and it makes reaching policy coherence challenging. The FCTC dedicates Article 5.3 to addressing this issue (74); the article and its guidelines provide a list of terms of engagement to avoid COI and regulatory capture (74). Regulatory capture happens when actors who should be regulated by the state gain control over regulation (209,392,405). It is often made possible by an existing COI, which is "*a situation in which someone cannot make a fair decision because they will be affected by the result*" (196).

3.2.1. The recommended terms of engagement: Article 5.3 of FCTC

The Guidelines of Article 5.3 provide a set of measures to protect public health policy making from TI interference as terms of engagement. The recommendations on minimising interaction between the government and the TI aim to prevent industry representatives from influencing policy officers or gaining a formal or informal role in policy making (70). Furthermore, any partnerships with the TI should be rejected in light of the principle that "*because their products are lethal, the tobacco industry should not be granted incentives to establish or run their businesses*" (74). Such measures are effective only if they recognise and cover third parties acting on behalf of industries, and if they are adhered to in all government sectors, not only in health (70).

In case of the absolutely necessary interactions between the TI and the government, transparency and accountability measures need to be in place, suggest the Guidelines, for example taking and publishing detailed meeting minutes and/or having an independent third party (e.g. a CSO) attend the meetings (74). Additionally, the strong monitoring of TI political and social activities through regular information disclosure and awareness raising about them is fundamental (70,74). Furthermore, the information provided by the TI must be transparent and accurate (74).

Moreover, any COI need to be avoided by public servants. The recommended measures on one hand aim to ensure that no individual gets hired to a government position who has any interests in the TI; policies on the declaration such COI before the commencement of employment or on background checks serve

such objectives. On the other hand, public servants shall not be exposed to any new interest in the TI by receiving any financial or non-financial inducement from the industry, therefore any payments, gifts or services cannot be accepted from the TI.

3.2.2. The implementation of Article 5.3

In their recent systematic literature review, Mialon et al. (66) found that there are only a few studies focusing on how countries manage corporate influence on heath policy making, and in particular little work has been done on LMICs. However, the majority of the available evidence is related to protection from TI interference.

The 2018 Global Progress Report provides some insights into the implementation of Article 5.3: it reflects that 71% of the parties to FCTC have implemented at least one of the recommended measures. However, Fooks et al.'s (70) research shows that only 16% of the provisions are implemented, and 83% of the countries introduced less than a third of the recommended measures. Certain geographical areas have been performing remarkably low in regards to Article 5.3; for example, no PSIDS have introduced such policies as of 2019 (406,407). The Global Tobacco Industry Interference Index 2019 (80) confirms that the implementation of Article 5.3 is "*progressing slowly and far from satisfactory*". This is important, because evidence shows that those countries who do not have these measures in place struggle with TI interference (80). Furthermore, Fooks et al. (70) explain that these policies need to be comprehensive to achieve their purpose, thus having implemented only a few of the measures is unlikely to be enough to prevent industry interference.

Hawkins and Holden's (408) study on the implementation of Article 5.3 in the EU shows that the transparency and COI measures are often generic and are not operationalised as the article originally intended. Furthermore, awareness raising on TI activities is either not or poorly implemented, but the existing rules and policies are sufficient to fulfil the requirements of FCTC on paper (408). This raises the question about the sensitivity of the FCTC reporting tool to adequately measure the implementation of the convention, and it reflects that the actual implementation of terms of engagement with the TI might be worse than it is reported. Furthermore, Hawkins and Holden (408) reveal that officials in EU institutions are unaware how the TI uses front groups for indirect lobbying which has been in "excessive use" during the negotiations of TPD. Chugh et al. (72) have similar findings regarding generic rules and third party lobbying, but they also note that the TI has expanded its activities to the food industry which allows it to circumvent the existing terms of engagement.

Kuijpers et al. (123) state that the interpretation of Article 5.3 differs in countries based on which interests groups around tobacco control are dominant: in those countries where the pro-health groups are more influential, the article is interpreted strictly; in countries with more influential pro-commercial groups the terms of engagement were understood loosely, mainly focusing on transparency. Lee et al. (122) have similar findings in South Korea, where the dominance of pro-commercial interest blocked the regulation of TI CSR activities and the development of Article 5.3 policies. Furthermore, they argue that the lack of policy coherence between the laws of health and industry was also a major barrier, and TI interference further hindered the establishment of terms of engagement (122). The latter was highlighted as the reason why Article 5.3 was not even considered in Cambodia according to MacKenzie and Collin (121).

Lencucha et al. (67) explain that in the Philippines the different mandates and interests of government agencies, and the wording of the legislation on tobacco control – prescribing a balance between industry and health interests – resulted in the patchy application of Article 5.3. Several non-health government agencies were reluctant to exclude the TI from policy making, because due to their mandates, they hold themselves responsible for the tobacco farmers and the industry. This placed the pro-health actors into a difficult position, because they were unable to conduct intersectoral negotiations without breaching Article 5.3. The authors conclude that WOG approaches for NCD prevention need to exclude the harmful commodity industries and the notion of balance between commercial and health interests should be eliminated from such discussions, otherwise it is likely that policy making will be more influenced by private commercial interests than public health interests.

While Section 2 has described the literature showing that the TI interference can be a major barrier to tobacco control, Section 3 has given an account of the literature on how governments can achieve comprehensive multisectoral policies despite the influence of such private commercial interests through forging policy coherence and implementing terms of engagement. The collaborative approaches recommended and practised are HiAP, WOG, and WOS mechanisms; however, the literature shows that the inclusion of the TI need to be carefully considered due to several reasons. Firstly, there is an irreconcilable COI between the TI and public health. Secondly, the TI is usually able to represent its interests better than public health advocates do. Thirdly, collaborative approaches provide a platform for TI representatives to engage and influence policy makers who would normally try to minimise interactions with the industry in accordance with Article 5.3 of FCTC. Fourthly, the different ideas about the cause of NCDs and about the role of governments and the TI shape the attitude and decisions of the involved parties and make reaching policy coherence for tobacco control even more challenging. Furthermore, the

literature on the implementation of Article 5.3 demonstrates that although the WHO FCTC Global Progress Report paints a positive picture of the implementation of Article 5.3, countries are struggling with adequately applying terms of engagement with the tobacco industry. The listed barriers include the dominance of pro-commercial interests, the institutional conditions maintaining the involvement of TI, and the already applied tobacco industry interference in tobacco control policy making.

These findings highlight the importance of understanding the interest-based conditions which influence the intersectoral governance of tobacco, the way ideas shape these processes and outcomes, and how institutional structures ensure a level playing field among stakeholders.

4. Governing the commercial determinants of NCDs in Pacific small island developing states

This section reviews the literature on government responses to the commercial determinants of NCDs in PSIDS. SIDS are LMICs countries facing "*specific social, economic and environmental vulnerabilities*" (87) due to their small land and population size and relative geographic isolation (87,112,409–411). These conditions make development especially hard for these countries (409,412–414). Larmour and Barcham (415) add that weak public and private sector capacity allows corruption, which is a major cause of vulnerability to TI interference.

Ten Pacific Island Countries (PICs) are categorised as SIDS: Kiribati, Federated States of Micronesia, Nauru, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Vanuatu, and Fiji (416). These countries register exceptionally high smoking prevalence rates, especially among males (Figure 1) (93–102). Furthermore, there is a "*strong emphasis on partnerships as key drivers for sustainable development of SIDS*", as the Healthy Caribbean Coalition (417) points out. The UN SIDS Accelerated Modalities of Action Pathway (418) and the SIDS Partnership Framework (419) to facilitate reaching the UN SDGs are major platforms for development in SIDS, yet they fail to address the concerns described in Section 3 about balancing out interests or avoiding COIs. For these reasons, it is particularly important to understand the conditions which influence PSIDS governments in regulating the TI.

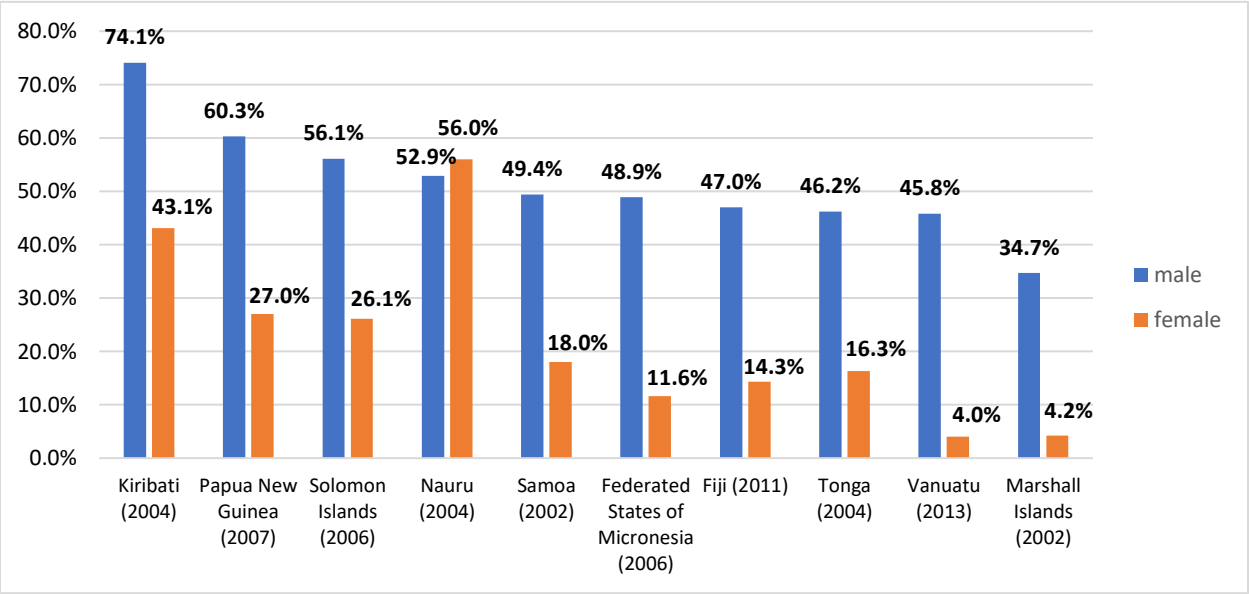


Figure 1 Smoking prevalence in PSIDS, current smokers (93–102)

Colonisation introduced tobacco to the PICs, reforming the agriculture of these islands to focus on exportation of a selected range of products, such as sugar, copra, timber, fish and tobacco (113). Since gaining independence, PSIDS have continued to build their export-oriented economies further, "*island governments encouraged cash cropping and plantation agriculture for quick returns*", and abandoned production for local needs (113). During these times tobacco use became embedded in local customs, such as kava[9] consumption or offering it as a gift (420).

The academic literature on governing harmful commodity industries in PSIDS has primarily focused on ultra-processed foods and beverages. There is a little analysis on alcohol (421–427) and some limited scholarship on the regulation of TI. Given this scarcity of studies on tobacco control in PSIDS, the literature on the governance of ultra-processed foods and beverages is briefly reviewed. This may help to map some of the regulatory issues, which can potentially be expected in tobacco control in these countries.

4.1. Regulating ultra-processed foods and beverages in PSIDS

Several authors describe the transition from traditional diets to ultra-processed foods in PSIDS which has contributed to the high prevalence of NCDs (113,414,428–435). Scholars explain this with trade liberalisation and the dependence of these countries on imported foods (113,414,429,431,433,434).

[9] Kava is a traditional drink made of kava root, which has a mild narcotic effect. Tobacco is often smoked during kava consumption.

Phillips et al. (49) examined ideas and beliefs of the public and government officers about NCD prevention in Fiji; they found that most participants had internalised the idea of individual responsibility in relation to NCDs. In another study, Phillips et al. (51) found that the current government tightly controls food policy making in Fiji, and that health policy makers "*worked within or around the neoliberal regime, rather than directly challenging it*". The authors stated that NCDs are frequently discussed in the context of economic priorities within the government, and suggested that this happens in alignment with dominant neoliberal theories. They explained that neoliberal ideologies have defined how the interests of multinational corporations are viewed as something the government needs to protect, and explained that foreign private companies are seen as important partners in the country's economic development. Furthermore, they found that the public does not seem to understand the relevance of the matter, because a healthy diet is unaffordable, civil society is weak, health literacy is low, and the dominant frame is personal choice in lifestyle (49,51).

Thow et al. (436) examined the political economy behind the regulation of food and breastmilk substitute marketing in Fiji, and found a conflict of policy paradigms driving business regulation and supporting economic development, a power imbalance between pro-health and pro-industry actors, that many government actors had limited understanding of the need for industry regulation to address NCDs, and that the health sector does not have the mandate to address food marketing issues despite their health impact. Waqa et al. (115) and Latu et al. (437) also describe how pro-commercial interests and the political environment constrain food policy development in Fiji; they agree that early engagement and collaboration with non-health sectors are essential, but further research is required to determine the best ways to do so. Waqa et al. (115) focused on the incorporation of evidence into food policy making, and found that the lack of formal intersectoral mechanisms limits government officials' access to the evidence necessary for policy development. They also stated that food policies are commonly discussed in an economic context during intersectoral negotiations. Latu et al. (437) explained that the lack of political will and weak leadership were the main barriers of regulating ultra-processed foods and beverages in Fiji. The authors described that the Solicitor General's Office had not vetted the policy on the regulation of ultra-processed food marketing to children for years, partially because of the lack of commitment of "top level" executives, and they explain that in the Cabinet "*the leaders who make the final decisions were not familiar with, and/or committed to a specific policy*". Furthermore, Christoforou et al. (390) and Waqa et al. (115) highlight that weak human capacity in the public service was a major barrier for developing and implementing multisectoral NCD policies to regulate the food industry in Fiji.

The Pacific Monitoring Alliance for NCD Action (MANA) Dashboard is a regional initiative which maps selected NCD policies in PICs (406,407). It reports that Tonga is the only PSIDS which has a multisectoral NCD taskforce in place. Waqa et al. (115) found that in Fiji multisectoral commitment to regulate food-related commercial determinants of NCDs is low in non-health government sectors, and industry interference has been a major challenge. They state that intersectoral mechanisms are not in place in general, and limited human and financial capacity was highlighted as another constraint. Mialon et al. (438) state that the food industry in Fiji has been applying a range of corporate political activities with potential to influence public health policy making. The industry used information management strategies, constituency building with the community, media, and government, and it took advantage of policy substitution strategy as well. Friel et al. (158) point out that the siloed operation of government, limited financial and human capacity, and the lack of recognition of wider determinants of health are important barriers to intersectoral collaboration for NCD prevention in the Pacific. Thow et al. (439) state that in PICs it has been possible to involve non-health government agencies in food policy making, but several institutional and political conditions need to be taken into account. For example, the more the level of political commitment was ensured, the more effective the policy became; and if the health sector was responsible for a chosen policy instrument, it was more likely to bring the desired results than if it was handled by the trade sector.

Regarding the wider SIDS literature, Murphy et al.'s (440) study on Caribbean states shows that intersectoral collaboration has been recognised as a crucial requirement to develop effective multisectoral NCD policies. However, they found that the multisectoral NCD committees appointed for this purpose lacked the necessary resources and precise definition on how and what targets such collaboration needs to achieve, thus they rarely served as a forum for decision-making.

4.2. Tobacco control and addressing the commercial determinants of NCDs in the Pacific

The academic literature on the governance of tobacco in PSIDS is more limited than on ultra-processed foods and beverages. Linhart et al. (420) and Paterson et al. (441) gave historical accounts of the introduction of tobacco to PICs during the colonial era, and describe how smoking became embedded in local customs. The scholarly works on tobacco focus on highlighting the problem of high smoking prevalence. Marshall (442) reported in the early 1990s on the issue of smoking in the Pacific, and she (443) and Martiniuk et al. (444,445) found that smoking continues to place significant burden on PICs. Odden

(425) highlights the quick pace of sociocultural and economic change in connection to tobacco use, and Quinn et al. (426) found that smoking is rapidly becoming more popular among youth in the Solomon Islands. Cussen and McCool (85) warn that today tobacco consumption in increasing fastest in the Western Pacific, among the WHO regions, and Kessaram et al. (446) state that PICs have the highest smoking prevalence in the region. Several authors find that public attitudes to smoking are favourable in the Pacific (447–451).

All PSIDS have ratified the FCTC (89), and they also established a regional initiative for tobacco control in 2013; they committed to reduce the prevalence of smoking to below 5% by 2025 under the Tobacco Free Pacific 2025 (111). The implementation of FCTC is assessed and reported through bi-annual country reports by the parties themselves; however, most PSIDS provide their reports much less frequently (89), therefore these documents offer limited data to understand the progress of these countries in tobacco control. The WHO Tobacco Free Initiative MPOWER initiative measures the implementation of a selected range of tobacco control policies on a yearly basis, thus it provides more regular updates on the countries' performance (452). The MANA dashboard reports on the tobacco control policies listed in MPOWER; it shows that there is a complete lack of measures to protect public health policies from TI interference in PSIDS (406). A major limitation of these sources is that they merely monitor and report on the progress of tobacco control implementation, but do not evaluate countries' performance. However, the World Bank (453) reports that compliance with tobacco control measures is weak in PICs, which indicates that there is a gap between the existing policies and their implementation in practice.

Only a few studies have assessed the implementation of tobacco control measures in the Pacific (85,446,447,454,454,455). Cussen and McCool (85) assess eight PSIDS, and confirm that their "islandness" makes tobacco control particularly challenging. They found that the level and strength of tobacco advertising bans vary greatly among these states, and even in those countries where such measures were introduced, there are several loopholes allowing the TI to continue its marketing activities. Growth-Marnat et al. (454) report on a community based smoking cessation programme developed by a traditional Fijian village and conclude that "allowing an indigenous culture to develop their own program" offers better results than a Western approach.

Martin and de Leeuw (455) state that Cook Islands[10], Vanuatu, Palau[9] and Nauru had achieved good progress in tobacco control because of the limited pro-tobacco interests present, strong public support

[10] Not a PSIDS.

and good policy content. However, they highlight that the pro-tobacco control coalition is small and there is little commitment in non-health government agencies. Sugden et al. (447) report on the development of an anti-tobacco media campaign in Tonga, which was considered to be a success according to the authors, although they emphasise that higher human and financial capacity would have allowed the fitting of communication to the local context. Cussen and McCool (85) and Martin and de Leeuw (455) confirm that capacity issues are common barrier for tobacco control in PSIDS.

There are no published reports or scholarly work assessing the level of policy coherence achieved in tobacco control in PSIDS and the way intersectoral mechanisms contribute to it. As for balancing out interests, only McCool et al. (456) studied how PSIDS protect themselves from TI interference. They found that in Solomon Islands and Papua New Guinea Article 5.3 has not been implemented. They suggest that government health agencies must recognise the need for terms of engagement, the guidelines have to be clear and unambiguous, and the civil society sector needs to be involved as well. They state that political commitment to tobacco control and pressure from civil society are crucial to counterbalance vested interests. Furthermore, they highlight the importance of monitoring TI activities and suggest that the involvement of other sectors is essential in this.

Expanding the focus to SIDS, the Healthy Caribbean Coalition (HCC) (417) states that Caribbean countries tend to be weak in implementing tobacco control measures, and TI interference is a major barrier. They found that in Jamaica the "islandness" of the country – its small land and population size, resulting in social proximity – facilitated Carreras, the local TI, to build close relationships with certain government officials, which led to its direct involvement in decision-making over tobacco control in 2012 (457). Furthermore, in the same year Carreras provided financial contributions to politicians in return for their support; the authors suggest that this correlates with the weakening of certain tobacco control measures. The TI runs CSR projects as well, for example in 2016 it launched a housing initiative for poor local communities (458). In Antigua and Barbados the TI managed to delay and weaken the *Tobacco Control Act 2018*, which requires the TI to be represented in tobacco control policy making (417). While corruption and industry interference are common in many LMICs, the social proximity characterising SIDS makes the establishment of informal connections between public and private actors easier than in larger countries (417).

While the HCC report illustrates the challenge TI interference poses for developing tobacco control measures, it does not offer insights into the status of implementation of Article 5.3, nor the possible reasons which hinder the development of terms of engagement. The authors suggest that for SIDS,

identifying and managing COI is even more challenging, because of their smallness and close social proximity between government and the population, their limited resources, and because these governments, based on their developing nature, often focus economic interests over public health interests (417).

The literature demonstrates that being a SIDS poses several challenges in regulating the commercial determinants of NCDs. Firstly, the small population size of these countries facilitates COI and makes industry interference easier than in other LMICs or larger states in general; because of the small size of their developing economies, these governments frequently prioritise commercial interests over health interests. The small population and economy size, together with the geographic isolation, creates even more severe human and financial capacity issues than LMICs tend to have; these further hinder the regulation of harmful commodity industries. Secondly, the literature is clear that industry interference is a problem in several PSIDS, and no measures have been implemented to protect public health policy making from such influence in these countries. Thirdly, the siloed operation and opposing mandates and interests of government agencies, and the limited recognition of wider determinants of health, have been recognised as major barriers in PSIDS to the necessary comprehensive, multisectoral regulation of commercial determinants of NCDs. Finally, while there is growing understanding of the need for intersectoral collaboration, it isn't clear what institutional conditions are most conducive to reaching policy coherence. Little is known about how PSIDS manage to achieve policy coherence for tobacco control through multisectoral coordination, and the underlying barriers to implementing measures to protect public health policies from TI interference need further investigation as well.

5. Gaps in the literature

This chapter has provided a review of the literature relating to governance of the commercial determinants of NCDs, with a focus on the TI and PSIDS. It demonstrated that there is limited understanding about the specific conditions which influence these governments in regulating the market and non-market activities of the TI and elevating health interests in tobacco governance.

Article 5.1 of FCTC calls for the development and implementation of comprehensive multisectoral policies, and the tobacco control literature emphasises the need for achieving policy coherence between policy fields, especially to elevate health interests over commercial interests. Article 5.2 of FCTC requires the establishment of a national coordinating mechanism in order to achieve this, and Article 5.3 of FCTC

highlights the importance of protecting public health policies from TI interference. Despite the attention these mechanisms receive within FCTC, the literature reviewed in this chapter shows that governments struggle to ensure that public health interests are prioritised in tobacco governance, because of a range of interest-based, ideational, and institutional conditions.

A deep understanding about the particular challenges PSIDS face in governing the commercial determinants of NCDs of the TI is scarce. This is a critical issue, because these states have a different social, political, cultural, and economic context than other LMICs, which is likely to affect tobacco control. This is especially troubling in light of the high smoking prevalence and NCD crisis in PSIDS. This research embarks on the journey to fill this gap.

This literature review guided the focus of this research and the development of the analytical framework by placing the interests-based, ideational, and institutional conditions into the spotlight. More specifically, it has shown the importance of understanding better (1) the conflicting mandates and interests in play in tobacco governance, and the ways actors influence agenda setting and policy development; (2) the ideas which define how actors perceive policy problems, regarding responsibility and authority to act; and (3) the institutional conditions which enable or limit policy coherence for tobacco control and a level playing field among stakeholders.

Chapter 3. Theoretical perspectives

Chapter 2 reviewed the literature on the governance of commercial determinants of noncommunicable diseases (NCDs) in Pacific Small Island Developing States (PSIDS), with a particular focus on regulating the tobacco industry (TI). While it is clear that various interests-based, ideational, and institutional conditions shape tobacco governance in these countries, there is a considerable gap in the academic understanding about exactly what these conditions are and what influence they have on the regulation of the TI in PSIDS.

Locating my overarching research question "What conditions influence intersectoral governance of tobacco control in PSIDS?" within the literature introduced in Chapter 2, Chapter 3 presents key theoretical perspectives from public administration and political science to help understand the ways in which interests, ideas, and institutional structures shape the governance of tobacco control in PSIDS. A critical public health approach guided the selection of the theories on which the analytical framework was drawn. Four theories were selected to help to answer the overarching research question: Avant et al.'s (125) theory of authority, Stone's (126) theory of causal ideas, Feiock's (127) institutional collective action framework, and Croley's administrative process theory (128).

The resulting analytical framework (Table 2 on page 55) that is used throughout the remainder of the dissertation to collect, examine and explain my empirical data, follows the taxonomy of the "3-i", the interests, ideas, and institutions. This approach was first recommended by Hall (103), and has been applied by others such as Pomey et al. (459) and Schram (119) in health policy research. The selected four theories connect to the "3-i" framework in the following ways: Avant et al.'s (125) work offers useful insights to understand the interest-based conditions which influence intersectoral governance for NCD prevention by operationalising influence as authority. Their theory helps to explain why certain actors, driven by different interests, are able to dominate policy areas; moreover, it also interprets the ways causal ideas and institutional structures define the authority actors have. Ideas are analysed with the help of Stone's (126) theory of causal ideas, which explains how ideas about the causes of problems are strategically used by governance actors to achieve certain regulatory outcomes. Thus, while this theory focuses on ideas, it connects to interests by explaining how interests drive strategic framing. Finally, the theory of institutional collective action by Feiock (127) helps to make sense of the structures of intersectoral collaboration, and the theory of administrative process by Croley (128) explains government

agencies' resistance to vested interests through institutional conditions. These two theories interpret the connection between interests, ideas, and institutional structures, but they are primarily useful in understanding how institutional conditions influence the ways government agencies work together and whether they are able to resist industry interference.

The following three sections introduce the analytical framework in more detail: Section 1 explains Avant et al.'s theory of authority, Section 2 discusses Stone's theory of causal ideas, and Section 3 describes Feiock's ICA framework and Croley's administrative process theory. Finally, Section 4 presents the overarching analytical framework that has been constructed to guide the research, which is based on the theories.

1. Interests

In order to identify the interest-based conditions which shape intersectoral governance for NCD prevention, with a focus on tobacco control in PSIDS, the following two research questions were raised: (i) "What are the major interests at play in tobacco governance in Fiji and Vanuatu?", and (ii) "How do actors deploy authority to influence tobacco control?"

Avant et al.'s theory is helpful in answering these questions, explaining the ways actors exercise authority to influence policy making. This section starts by clarifying the way the theory operationalises influence as a means to pursue interests and situating it within the 3-i framework. Then it defines the meaning of authority and discusses the conditions which influence it and the ways actors utilise it to influence governance outcomes.

Actors with more influence have a better chance to change the course of events for their interests (460), and several theories focus on power to define influence (461–465). However, instead of operationalising influence as power, this dissertation chooses to focus on authority, because it offers an explanation for why some governments perceive the TI as a legitimate actor which needs to be involved in policy making. Furthermore, operationalising influence as authority can also provide insights into why certain government agencies are perceived to be in a position to contribute to tobacco governance. There are a number of theories explaining authority in governance, from the neoclassical theory of authority (466,467) to the causal theory of authority (468). While Raz (469) talks about where authority is sourced from in general – such as the time, resources, expertise of an actor –, Waldron (470) and Karp (471) focus

on political authority. While these theories offer important insights to understand authority, this research required an operational approach to analyse where authority is derived from and how it is challenged.

Avant et al.'s theory has been selected because it offers a typology of authority, explaining where actors source their authority from, how they exercise it, and why such authority ebbs or increases. This theory resides in the realm of global governance, but its interpretation of authority as a means to influence outcomes offers useful insights for national level governance as well, which is the focus of this research. The theory has been successfully applied in other public health research, including on trade and health (48). The understanding why certain actors have influence over tobacco governance in PSIDS will be advanced substantially through the application of a theory of authority, thus helping answer my research questions related to interests-based conditions.

Avant et al. define authority as "*the ability to induce deference in others*". This theory helps in understanding how and why certain actors become accepted authorities (i.e. legitimate), and how they shape policy and decision-making, using ideas and institutional processes. The authors suggest that deference to authority has multiple forms: subordination, new preferences, changes in existing preferences, or to "*mobilize new or different constituencies*". They identified five bases of authority. These are: (i) institutional authority, which comes from "*holding an office in some established organisational structure"*; (ii) delegated authority, which arises when authority is temporarily given from another authority; (iii) expert authority, coming from having specialised knowledge; (iv) principled authority, which is "*legitimated by service to some widely accepted set of principles, morals, or values*"; and (v) capacity-based authority, coming from perceived competence.

The source of authority defines the areas of influence an actor holds; an actor has the power to act only on those areas where it is seen to have legitimacy. Avant et al. explain that "*legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs and definitions.*" For example, the World Trade Organization has little authority to set the global health agenda; the World Health Organization (WHO) is seen as a primary governor on this area. At the same time WHO does not have much authority to dictate global trade matters. This is why understanding the sources of authority is helpful, because it explains the scope of matters actors have influence upon.

The authors also explain the dynamic of authority to influence and govern continuous changes. The authority of actors grows, ebbs, or shifts continuously as the relationship between the actors changes. Reasons for such changes are varied, including:

(1) Multiple authority sources within a single actor: these can enhance the actor's authority, but also cause tensions, because of possible contradictions between the responsibilities arising from the sources of authority.
(2) Relations between actors: these can either strengthen or weaken the actor's authority.
(3) Performance: whether the outcomes of the actor's actions are positive or negative can strengthen or weaken their authority.

The following theoretical constructs are included in the analytical framework (Table 2): source of authority (institutional, delegated, expert, principled, or capacity-based), and the dynamic of authority, which can change because of multiple authority sources within one governor, relations between governors, or performance. These constructs will be applied in Chapter 5 in the analysis of interest-based conditions.

The emerging theories about ideas argue that the analysis of interests cannot be complete without understanding the perceptions, norms, and beliefs which determine individual preferences (472–476). Other scholars argue that based on their interests, actors strategically shape the ideas and norms of other actors and/or the society, thus ideas should be assessed as the outcome of specific interests (126,477). These theories suggest that interests and ideas cannot be understood without taking into consideration their influence on each other. Furthermore, institutional structures can change due to the influence of interests (128,478–480). For example, authoritarian regimes are led by the interests of a small political elite, and when such governments start their transition to democracy, often they make rules on paper but in practice decision-making remains in the hands of a few in order to keep power in the hands of the few (481–483). In the following, Section 2 introduces the theory applied to help analyse ideas in connection with interests, before Section 3 discusses the theories used to interpret institutions in this research.

2. Ideas

In seeking to identify the ideational conditions shaping intersectoral governance in tobacco control, the following research questions were raised: (i) "What are the dominant ideas about tobacco in Fiji and Vanuatu?", and (ii) "How do they influence tobacco control?" To examine these questions, Stone's (126) theory of causal ideas was drawn on, which offers an operational approach to ideational conditions

through the assessment of causal ideas. This section starts by connecting ideas to the 3-i framework through locating Stone's theory in the agenda setting scholarship. It clarifies the meaning of the term "ideas" as it is used in this theory and throughout the analysis of this research, and then proceeds to introduce the theory and its connection to fulfilling the objectives of this research.

Scholarship on ideas focuses on various levels and types of ideas. Schmidt (472) differentiates between three level of ideas: policy solutions, programmatic ideas, and "deep core" ideas. The first level of policy solutions identifies an operational course of action or a policy alternative. The second level of programmatic beliefs is interpreted as paradigms, frames, policy cores, or "*program definitions that set the scope of possible solutions to the problems that policy ideas address*" (472). The third level encompasses the deepest underlying beliefs which can be called public philosophies, public sentiments or worldviews (472).

Schmidt (472) argues that there are two types of ideas which can inhabit the three levels: cognitive or normative ideas. She calls cognitive ideas causal ideas, because they explain the practical aspects of a problem; they describe "*what is and what to do*" (472). Normative ideas, on the other hand, focus on values: they evaluate policies or programmes based on their alignment with the values of society (472).

Ideas are important, because they define what issues are recognised to be solved and need to be taken into a policy agenda. The literature on agenda setting has been occupied with explaining how ideas become so dominant that they define policy actions. This scholarship traditionally has three focus areas or streams: identity and characteristics of political actors (485), nature of difficulties (486), and the use of language and symbols (487). Stone's (126) theory offers a fourth angle: it focuses on causal ideas – the stories actors tell about problems in order to serve their interests. This theory is particularly occupied with the cognitive ideas located on level two of programmatic ideas or problem definitions. Stone explains that "ideas about causation", causal ideas are stories or theories which explain why and how a given problem occurred, who or what is to blame for the issue, and who is responsible for resolving it.

Stone's theory was selected because it connects to Avant et al.'s theory on authority by explaining the ways actors use strategic framing as an expression of their authority and thus pursue their interests. In addition, the theory addresses concepts about the wider determinants of health (described in Chapter 2), which can be considered as causal ideas as they explain the root sources/causes of diseases. Furthermore, Stone demonstrates in her work the applicability of this theory on issues around substance use, such as tobacco, and her theoretical constructs about causal ideas show a strong connection with the findings of

the tobacco control literature about the use of arguments by the TI. These considerations suggest that this theory has the potential to contribute to this research. Therefore, Stone's theory of causal ideas is drawn on to understand how dominant ideas in PSIDS allocate blame and responsibility for smoking and the NCD crisis, and how this affects tobacco control.

The theory of causal ideas suggests that political actors actively seek to shape the perception of problems and their causes in order to shift blame and responsibility to their preferred actors by creating causal theories (ideas). Stone explains this in the following way: "*Problem definition is a process of image making, where the images have to do fundamentally with attributing cause, blame, and responsibility."*

Stone identifies four groups of causal ideas, based on whether the action causing the problem is considered unguided or purposeful, and whether the consequences are perceived to be intended or unintended. The accidental cause describes problems where no one is at fault, such as natural disasters. Stone explains that political actors prefer to shift problems away from this interpretation, so that blame can be directed, and control can be gained from the situation. The mechanical cause explains problems as the predictable failure of mechanisms, such as the fact that a lightbulb will burn out eventually.

The intentional cause and the inadvertent cause are more interesting from the perspective of tobacco governance. The former describes problems when a planned and deliberate action causes expected issues, but these are often hidden from the public, "*problems are the result of deliberate but concealed action*" (126). Tobacco control advocates often use these causal theories to allocate blame to the TI, which is aware of the harmful impacts of their products, yet for decades has attempted to hide it – and continues to promote sales for profit. The inadvertent causal idea interprets problems as having happened as a result of wilful action but without foreseeing consequences. Stone explains this in the following way: "*The consequences are predictable by experts, but unappreciated by those taking the actions. These stories are soft (liberal) version of blaming the victim: if the person with the problem only changed his or her behaviour, the problem would not exist*" (126). The explanation of the TI on NCDs and deaths attributable to smoking belongs to this category.

As the examples above show, for each problem several things or actors can be identified as the cause of the problem. Stone likes the example of substance users: who is to blame for the damage done as a result of drunken car accidents, or an increase in cancer in the case of smokers? She explains that the blame often shifts along the following axis:

Raw material provider – manufacturer – seller – consumer

According to Stone, identifying the "true cause" of the problem is often not difficult; "*the fight is about locating moral responsibility and real economic costs on a chain of possible causes*" (126). She calls the contestation of causal ideas a "tug of war" between policy actors, and it is easy to see how her theory can be interpreted for tobacco governance. By applying causal arguments not only can the blame be located, but the actor who has the responsibility (and thus the mandate) to resolve the issue can be identified. Stone explains that policy actors strategically shape their causal theory in a way that benefits their interests most, to achieve one or more of the following outcomes:

(1) challenge or protect the existing social order;
(2) assign responsibility to particular political actors to stop an activity or do it differently, face punishment, etc.;
(3) legitimise actors as "fixers" of the problem;
(4) create new political alliances.

The theoretical constructs from this theory that have been included in the analytical framework (Table 2) are: the causal theories present in tobacco governance; their type; the location of blame (who is blamed?); and the location of responsibility (who needs to solve the problem?). Stone's theory will be applied in Chapter 6 in the analysis of ideational conditions. Stone uses the term "ideas" interchangeably with "theories", "stories", "narratives", and "arguments", while this dissertation adheres to the term "ideas" primarily in this sense; when any of these other expressions are used in the analysis, they refer to causal ideas in this operational way.

The academic literature recognises that ideas can be shaped by the prevalent political and institutional structures (472,488–490): for example, an authoritarian regime is less likely to induce ideas in the public about participating in governance. Or if a government is focusing on economic development, often neoliberal ideologies of individual responsibility and market liberalisation dominates the thinking of public servants (47,223). However, such influence works the other way as well: once an idea becomes popular and well-known, the more likely that individuals in the government will take it on board and shape institutional structures accordingly (472,474). The following section introduces the theories applied in the analysis of institutions and the ways they connect to interests and ideas.

3. Institutions

In seeking to identify the institutional conditions shaping intersectoral governance in tobacco control, the following research questions are posed: (i) "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?" (ii) "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?"

To help examine these questions, the theories of institutional collective action (127) and administrative process (128) are drawn on, both of which belong to the new institutionalism field. This section starts by briefly positioning these theories in the wider new institutionalist literature, and then describes both of them.

Theories of new institutionalism explain governance through the structure and operation of institutions, including government agencies (491). New institutionalist theories can be divided into four categories. *Rational choice* institutionalism, which argues that institutions are "structures of incentives" (492) within which individuals act based on their calculated interests (128,479,480,491,492). *Historical* institutionalism describes the development of institutions based on the "logic of path-dependence", meaning that the ways structures are formed follow certain patterns and practices (493–497). *Sociological* institutionalism suggests that individuals within institutions act based on the "logic of appropriateness" – they follow the pressures of society in their actions (492,498–501). *Discursive* institutionalism argues that individuals follow the norms, beliefs, and ideas dominant in their institution (472,474,492,502,503).

Feiock's institutional collective action framework and Croley's administrative process theory belong to the rational choice institutionalist theories, arguing that calculated interests drive decisions within institutions (127,128,504). These theories allow the analysis of institutional conditions shaping the intersectoral governance of tobacco from the angle of mandates and interests. This perspective aligns with the focus on tobacco control and governance in the health literature on setting up institutional procedures to achieve policy coherence and protect health policy making from vested interests. Furthermore, they also help explain how government agencies with conflicting mandates work together. In light of these theories, this dissertation defines institutional conditions as the factors arising from the organisational structures of political and governmental agencies and their operational procedures.

3.1. The theory of institutional collective action

Achieving policy coherence for tobacco control is a challenging task, as Chapter 2 shows. Feiock's (127) theory of institutional collective action (ICA) is useful to understand the success or failure of government efforts to forge policy coherence for tobacco control. The research question this theory helps to answer is the following: "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?" This section aims to introduce the theoretical constructs of the ICA framework, and explains why this theory was selected to guide the analysis of institutions in Chapter 7.

Multiple theories focus on collaboration between governance actors (505–511); however, the ICA framework is unique, because it analyses collaboration risk as a major contributor to the failure or success of solving an institutional collective problem (504). This is a particularly important feature for this dissertation, because the literature review (Chapter 2) has demonstrated that conflicting mandates and interests and the limited commitment of non-health government agencies are common issues in multisectoral initiatives of tobacco control.

Feiock's ICA theory starts from the idea that institutions will naturally advance their own interests, which they prioritise over the collective good of other institutions. While Olson (1971) believed that either coercion or ideological motivations could make individuals act for the common good, Feiock suggests that institutions are willing to cooperate with each other if a certain set of conditions are present. He explains that when multiple government agencies are tasked with regulating an actor or product in different policy fields at the same time, it is likely that their policies will have an unplanned impact on other policy fields. This is called an externality, and it can be negative or positive for the objectives of the other government actors. He argues that the presence of such unplanned impacts may make government agencies recognise that harmonising their policies and actions can be mutually beneficial, inspiring institutional collective action – which is highly relevant when concerned about issues of policy coherence, as is the case with tobacco control.

Feiock identifies three types of institutional collective dilemmas. Horizontal collective action problems happen when a government agency is too small or too large to provide a service efficiently alone or the externalities of their service affect other jurisdictions. Vertical collective action problems arise when the action or its impact of different hierarchical levels of government agencies overlap each other. The most relevant for this dissertation are functional collective action dilemmas, which arise when the externalities occur between government agencies with different functions on the same level. The case of tobacco governance performed by Ministries of Agriculture, Trade, Industry, Economy and Health is an example

of this, because the decisions of each of these sectors on tobacco regulation have important implications for other sectoral policies.

Feiock categorises these intergovernmental mechanisms based on two characteristics (Figure 2). The first, the authority of the integration mechanisms (horizontal axis) explains what makes the actors work together: they are socially embedded, or work together because of a legal or contractual agreement, or because of a political authority. The more their interests align and the more they are committed to working together, the mechanisms of the left side of the horizontal axis should be useful for them, according to the author. The second characteristic is the complexity of the mechanism (vertical axis); this shows whether it encompasses a wide range of policies and policy areas with more actors involved, or it focuses on a narrow set of issues and operates with only a few actors. The more actors and policy areas need to be aligned, the more challenging the collaboration becomes, therefore stronger incentives or authority are needed to make the government agencies to work together.

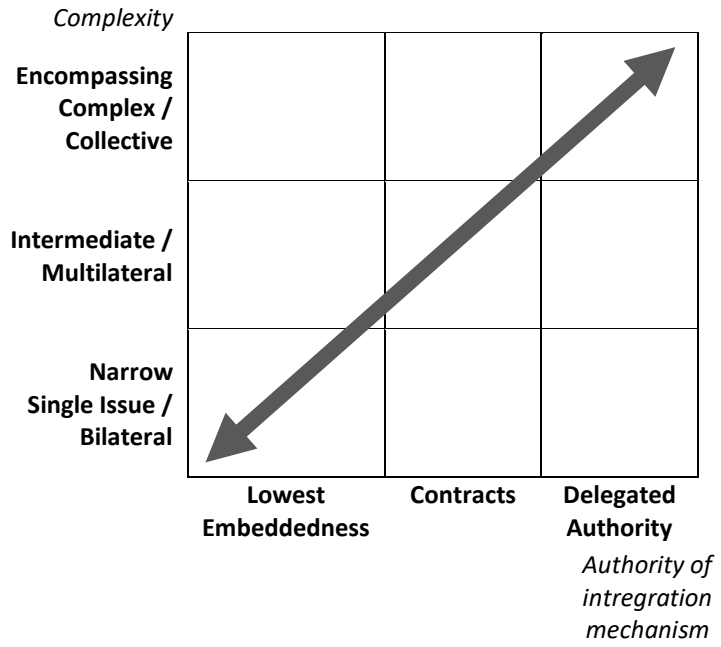


Figure 2 Integration mechanisms and transaction costs (127)

Feiock explains that whether government agencies choose to work together to solve their collective problem depends on the risk of collaboration and the anticipated net benefits. The risk of collaboration is defined by three factors: (i) the specific nature of the dilemma, (ii) the distribution of preferences among

participants, and (iii) the political and institutional structures.

The first factor, the nature of the dilemma, will most likely be one of the following: (a) a coordination problem when the government agencies need to organise their activities to align with each other; (b) a division problem when the share of tasks and benefits needs to be decided while the interests of the actors are still very much aligned; and (c) a negative externality problem when the parties have opposing interests, thus the decisions made through the collaboration can result in unwanted impacts for one or more participating actors. The severity of the risk of collaboration increases from problem (a) to (c). The higher risk the collaboration carries, mechanisms with stronger authority and higher embeddedness are likely to be more effective in ensuring that the collaboration does not break down.

The second factor, the distribution of preferences, shows the divergence of the actors' interests, and the economic, demographic, and ideological similarity between them. The more homogeneity there is between the actors, the easier it is for them to work together, because as Feiock explains, "*homophily provides a safeguard against political and economic power asymmetries that would advantage one of the parties and create problems for negotiating fair division of benefits*".

The third factor, the political, legal, and institutional structures, sets the strategies available and incentives for each government agency to advance their interests and minimise their costs. For example, centralised government structures often do not give space to voluntary collaboration, while decentralised structures facilitate it.

The net benefit gained from participation – the gains minus the transaction costs[11] – is the primary incentive for government agencies to collaborate. The more formally imposed the mechanism, the more centralised decision-making powers are set, and more actors it involves, the higher the transaction costs become, but the more likely it will be that it effectively solves the ICA dilemma even when the collaboration risk is high. However, when the collaboration risk is low, there is no need for costly and complex mechanisms.

While multiple studies use the ICA framework to examine the horizontal types of dilemmas in interlocal governance, more recent works have successfully applied this theory to assess functional collective action dilemmas between government agencies in different sectors (504). For example, Swann and Kim (512)

[11] Feiock (127) identifies four types of transaction costs: information costs, external decision costs, enforcement costs, and external decision costs. Kim et al. (504), in their interpretation of the ICA framework, suggest categorising transaction costs into two groups: autonomy costs, "*associated with sacrificing localised autonomy*", and decision costs, "*associated with information-searching, bargaining, and negotiating integration mechanisms*".

used the ICA framework to study functional government fragmentation, and more recently, Greer et al. (513) studied how silos between water, agriculture, and food sectors can be broken down with the help of Feiock's theory.

I draw on the ICA framework to help examine and explain why government agencies regulating tobacco are able to work together efficiently, or not. The perceived net benefits and the collaboration risk surrounding tobacco governance, together with the intergovernmental mechanisms for intersectoral engagement applied, can explain the success or failure of efforts to reach policy coherence for tobacco control, thus helping answer my research question on "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?" The following constructs were included in the analytical framework (Table 2): perceived net benefits as the aggregation of transaction costs and expected gains; the collaboration risk, which is defined by the type of the dilemma, the distribution of preferences, and the political and institutional structures; and the applied intergovernmental mechanisms. The ICA framework is applied in the analysis presented in Chapter 7.

3.2. Administrative process theory

The tobacco control and governance for health scholarship highlights the importance of protecting public health policy making from TI interference. In seeking to answer the research question on "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?", Croley's (128) administrative process theory offers an explanation on what conditions help government agencies resist vested interests.

Multiple theories – for example public choice theory (479), the neopluralist approach with the theory of competition (514), public interest theory (515), and the civic republican account (516) – have sought to explain regulatory capture i.e. when the regulated actor gains control over the regulator agency. The most notable is public choice theory, which argues that because government procedures are designed to ensure stakeholder involvement in most democratic countries, well-organised interest groups with a narrow agenda are able to capture legislators (479). They in turn use their direct influence to force government agencies to make policies which support the interests of the groups that captured them, which results in the government agencies' failure to protect public interests (479). Thus, the theory argues that the only solution to regulatory capture is downsizing regulatory agencies (479). The problem with public choice theory is that it does not explain those cases when regulatory agencies do not fall into the hands of vested interests despite all the efforts of influence, and they continue to regulate with a focus on public interest.

Public choice theory could not have predicted the progress of tobacco control all around the world (79). Also, the concept of commercial determinants of health defies the call for the withdrawal of regulatory government as it argues that weak regulation of unhealthy commodity industries is a major driver of the current NCD crisis (9,45,517,518). When trying to understand the conditions which influence the resistance of government agencies against regulatory capture, this research requires theory which offers explanation of the positive deviance cases. Croley's (128) administrative process theory does exactly that. This theory investigates the following questions:

> *Under what set of conditions can regulatory bodies […] deliver broad-based benefits – "public interest" or, better, "public interest"' rather than "special interest" regulation? What channels of agency authority – that is which decision-making procedures – are insulated from the usual consequences of interest-group politics? And why do they at times seem to deliver broad-based benefits even over the strong opposition of well-organized and well-funded interests? (128)*

To Croley "special interest" regulation means that regulation benefits a narrow segment of the population which results in net social losses for the society in large. "Public-interested" regulation aims to increase the overall welfare of the population; the benefits offered by the regulation outweigh any negative impact on the society (128).

The theory was developed based on the political and government system of the United States of America (USA) (128), which shows several similarities to those of Fiji and Vanuatu (519–521), including the structure of government[12], briefly explained in the following. Before launching into the explanation of Croley's theory, it is important to clarify the various government functions and actors discussed in this dissertation in accordance with the political and government system of Fiji (519) and Vanuatu (523) to avoid confusion. The term "government" can be used in two ways: it can refer to the three branches of government which include the Executive, Legislative, and Judiciary, or only the Executive (524). The Executive branch includes administrative agencies, such as different ministries and background organisations. The public servants working in these institutions are commonly called administrators or bureaucrats. These actors are responsible for policy development and implementation, and regulation on an operational level. The Parliament represents the Legislative branch of a government, where Members of Parliament (MPs, legislators or Parliamentarians) make laws and represent the public. The third branch of the government is the Judiciary (i.e. the Courts) where the judges enforce laws. It is important to

[12] For example, in the USA, Fiji, and Vanuatu, the executive (i.e. the government or administration), the judiciary (i.e. the court), the legislative branch (i.e. the Parliament), and the presidential office oversee each other's work, which is called the "checks and balances" (522).

highlight that throughout this dissertation when the term "government" is used, the Executive branch is being referred to. When other branches are discussed, the reference to them will be explicitly stated.

The administrative process theory suggests that administrative structures within the government enable broad interests to win over narrow interests. Croley argues that legislators are likely to be swayed by interest groups, but administrators have the skills to recognise what regulatory practices serve the public good, and most of the time they have the motivation to serve public rather than private interests. Having the opportunity to consult with the public and interest groups is important; however, policy making procedures should balance out the influence of stakeholders.

Croley offers five propositions, which explain why certain governments are able to resist TI interference by ensuring that private interests are not prioritised over public interests. The administrator motivation claim argues that administrators have a tendency to place public interests first. The agency autonomy claim suggests that administrative bodies are not fully controlled by legislators and they are independent from the influence of their regulatee. The institutional environment claim states that extra-legislative mechanisms such as judicial reviews and presidential oversight help maintain the autonomy of administrative bodies. The administrative neutrality claim argues that government bodies can apply administrative procedures which level out interest group influence on policy making. Lastly, the social welfare claim states that administrative policy making processes allow proper information gathering by monitoring and evaluating the issue at hand and are able to assess the costs and benefits of policy alternatives.

The administrative process theory claims that legislators do not necessarily have close control over bureaucratic decision-making and regulation which seeks to serve the public interest instead of short-term political interests – if a certain set of conditions come together. Croley studied several cases of bureaucratic regulation where legislators' influence could not deter administrative agencies from implementing policies for the sake of public interest. He found that public policy officers are often independent and represent interests of public good (administrator motivation claim). At the same time legislators often do not have the capacity to directly manage bureaucratic processes, and even if they do, if administrative processes are participatory and transparent, they will not be able to exert their influence over regulatory decision-making without a strong system of justifiable arguments (administrative neutrality claim). These conditions would not be enough without the agency bearing autonomy and authority (agency autonomy claim, institutional environment claim). Also the organisation would need to have adequate resources to prepare for decision-making by collecting and analysing data to develop policy

alternatives which allow the selection of the decision which carries the greater benefit for the public (social welfare claim) – this also entails informational independence from those parties who have the biggest stake in the outcome of the regulatory decision. The convergence of all these conditions is needed to ensure that regulation serves the public good. For example, if the first claim (administrator motivation claim) is not in place, public policy officers simply direct administrative processes towards their own rent seeking. Thus, the theory explains regulatory capture as a failure to have all the five conditions in place, instead of the inherent failure of the policy making process to ensure public-interested regulation. With its claims, the administrative process theory offers an explanation why some government agencies are able to resist TI interference.

This theory was used by Croley in his study on the US Food and Drug Administration's Tobacco Initiative (128). It helped in understanding why the agency was successful in ensuring that public health interests drive tobacco governance and that vested interests do not interfere with their policies. This demonstrated contribution to tobacco control governance suggests that the theory has the potential to support my research in Fiji and Vanuatu, and provide important insights into my research question "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?"

To this end, the following constructs were included in the analytical framework (Table 2): public-interested administrators, bureaucratic autonomy, institutional environment, administrative procedures balancing out interest group influences, and cost-benefit analysis of policy alternatives. The theory of administrative process will support the analysis presented in Chapter 7.

As the theories introduced above explain, institutions are shaped by interests and ideas, but they are also able to change the ways people think and what they prefer. Therefore, analysing only the institutional conditions of the governance of commercial determinants of NCDs would not provide a complete picture; instead, the focus on all three "i"s – interests, ideas, and institutions – is necessary as these three actively influence each other.

4. Analytical framework

Based on the theoretical perspectives presented above, the following analytical framework was developed to guide the data collection and analysis of this dissertation, examining the interests, ideas, and institutions that influence intersectoral governance of tobacco control in Fiji and Vanuatu. The

framework draws from the four theories of authority, causal ideas, institutional collective action, and administrative process. Table 2 summarises the analytical framework and presents its alignment with the research objectives and questions.

The "interests" part of the framework focuses on the distribution of interests and the authority that various actors wield and exercise to pursue those interests in tobacco governance. The typology and the dynamic of authority from Avant et al.'s theory operationalises influence and thus helps to explain why certain actors are better at pursuing their interests in tobacco governance than others. The research questions this part of the framework helps to answer are: "What are the major interests at play in tobacco governance in Fiji and Vanuatu?", and "How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?"

The "ideas" part of the framework examines the ways ideas influence intersectoral governance of tobacco control. The theoretical structures derived from the theory of causal ideas help in understanding how the dominant causal ideas direct the blame of the NCD crisis and tobacco use to certain actors and identify the parties who should be responsible for resolving these issues. These theoretical perspectives on causal ideas aim to shed light on the following research questions: "What are the dominant ideas about tobacco use and NCD crisis in Fiji and Vanuatu?", and "How do they influence tobacco control?"

The "institutions" part focuses on two areas of tobacco control governance. First, it explains the political and institutional structures which influence how actors can work together to achieve policy coherence. Second, it offers insights to understand whether such structures are conducive to create a level playing field in tobacco governance among stakeholders. The theoretical constructs derived from institutional collective action help with the former, while the latter is achieved through administrative process theory. Thus, the following research questions are explored through this analytical lens: "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?", and "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?"

Chapter 4 now explains the methodological approaches used, including the application of the analytical framework, to achieve the objectives of the study. Chapter 5 presents the results on interest-based conditions with the application of Avant et al.'s theory of authority. Chapter 6 focuses on the findings on ideational conditions with the help of Stone's theory of causal ideas. Chapter 7 explains the results on institutional conditions with the use of Feiock's ICA framework and Croley's administrative process theory.

Table 2 The analytical framework and its alignment with the research objectives and questions

Focus	Research Objectives	Research Questions	Theories	Theoretical Constructs	Result Chapters
INTERESTS	Identify the interests that shape intersectoral governance for tobacco control in PSIDS.	What are the major interests at play in tobacco governance in Fiji and Vanuatu? How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?	Avant et al.'s theory of authority	Sources of authority Dynamic / changes in authority	Chapter 5
IDEAS	Identify the ideas that shape intersectoral governance for tobacco control in PSIDS.	What are the dominant ideas related to tobacco in Fiji and Vanuatu? How do they influence tobacco control?	The theory of causal ideas	Type of causal idea Direction of blame (what/who caused the problem) Solution (how to solve the problem) Location of responsibility (who should solve the problem)	Chapter 6
INSTITUTIONS	Identify the institutional conditions that shape intersectoral governance for tobacco control in PSIDS.	What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?	The theory of institutional collective action	Perceived net benefits Collaboration risk Applied intergovernmental mechanism	Chapter 7
		How, and to what extent, do institutional factors ensure a level playing field in tobacco governance among stakeholders in Fiji and Vanuatu?	The administrative process theory	Public-interested administrators Institutional environment Bureaucratic autonomy Administrative procedures balancing out interest group influences Cost-benefit analysis of policy alternatives	

Chapter 4. Methodology

Chapter 4 describes the research design and methods used to answer the research questions of this dissertation. Section 1 briefly provides a reminder of the research aim, objectives and questions. Section 2 describes the research design and Section 3 describes the case selection process which led to the inclusion of Fiji and Vanuatu as relevant cases to assess intersectoral governance in tobacco control. Section 4 describes how data was collected in these locations, followed by an explanation of the data analysis as informed by the analytical framework. Finally, Section 5 describes the limitations of this methodology.

1. Study aim and research questions

The aim of this research is to improve understanding of the conditions that influence how governments in Pacific small island developing states (PSIDS), address the commercial determinants of noncommunicable diseases (NCDs) in relation to tobacco.

The overarching research question is "What conditions influence intersectoral governance of tobacco control in PSIDS?" The objectives and concomitant sub-questions are:

Objective 1: Identify the interests that shape intersectoral governance for tobacco control in PSIDS.

i. What are the major interests at play in tobacco governance in Fiji and Vanuatu?
ii. How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?

Objective 2: Identify the ideas that shape intersectoral governance for tobacco control in PSIDS.

i. What are the dominant ideas related to tobacco in Fiji and Vanuatu?
ii. How do they influence tobacco control?

Objective 3: Identify the institutional conditions that shape intersectoral governance for tobacco control in PSIDS.

i. What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?
ii. How, and to what extent, do institutional factors ensure a level playing field in tobacco governance among stakeholders in Fiji and Vanuatu?

2. Research design

This research applied a qualitative methodology with an exploratory case study approach for the purposes of exploring the conditions influencing intersectoral governance of tobacco control.

The case study approach can be described as "*the detailed examination of an aspect of a historical episode to develop … historical explanations that may be generalisable to other events*" (525). Or as Gerring (526) explains, "*the case study [is] an intensive study of a single unit for the purpose of understanding a larger class of (similar) units."* Case studies have particular advantages for the inquiries that this dissertation addresses; they are useful to answer the type of "how" and "why" questions that this research focuses on (527). Furthermore, the concentration on a small number of cases allows deep examination and appreciation of the complex context of governance in PSIDS by gaining an "insider's viewpoint" (528), which is indicated in the literature as being important in understanding the conditions that influence tobacco control (525).

This research used a two-case design (529): it employs the case of tobacco control in two PSIDS. While a larger case number would further strengthen the conclusions by creating more reliable and robust evidence (530), the temporal and financial restrictions of this PhD research limited the cases to two. However, as Yin argues (529), a two-case design already raises the analytical strength of the research, because the results arising from the two cases can be contrasted (530). This improves the accuracy and generalisability of the findings and reduces uncertainty (525,528). This design allows the exploration of the conditions surrounding the intersectoral governance mechanisms of tobacco control in two countries with similar contexts (527,531,532). The suitability of Fiji and Vanuatu as case studies for this study is explained in Section 3 of this chapter.

The two-case design is used in combination with within-case analysis and cross-case synthesis. This approach enables analysis of the findings from the two cases within a single analytical framework (525). Such a study design is particularly efficient for in-depth analysis of the conditions behind governance mechanisms (533), thus it suits this exploratory study well.

Within-case analysis is defined as "*the in-depth exploration of a single case as a stand-alone entity*" (528). Such an approach allows deep analysis of the interest-based, ideational, and institutional conditions characterising tobacco control governance in both contexts (528). The findings of each case contribute to the conclusions of the entire study, while they are examined as individual units. This is beneficial because the intrinsic aspects of the cases can be revealed, which may either be generalised to other cases or found

to be unique (528). Furthermore, this approach might reveal components that could have been missed in a comparative case study due to a focus on designated themes (528). Furthermore, within-case analysis, due to its in-depth exploration of individual cases, can result in the generation of a preliminary theory, as it enables the exploration of patterns that are prevalent in the examined cases.

A cross-case synthesis – combining evidence from the two cases (534) – was applied to aggregate the findings of each within-case analysis. This allows a case-based approach rather than a variable-based approach, because it synthesises the results without reducing the data to variables, thus keeping their holistic features (529). This enables the synthesis of within-case patterns while keeping the integrity of each case (529). Furthermore, it allows the definition of similar and different patterns which can then be utilised to develop a preliminary theory (528).

A case study approach has been applied in other works on the regulation of harmful commodities in PSIDS (115,428,437), and Martin and de Leeuw (455) successfully used the multiple case study approach with within-case analysis for their research focused on exploring conditions influencing the implementation of tobacco control policies in selected PSIDS. Their research was similar to this project, with its focus on in-depth analysis of conditions around tobacco governance; the main difference is that it studied implementation, while this dissertation places more focus on agenda setting and policy making. These successful applications of the chosen research design suggest that the approach is fit for the purposes of my study.

3. Case selection

This section provides an overview of the selection process and the applied selection criteria, before introducing Fiji and Vanuatu as the case study countries purposively chosen for this study.

3.1. The selection process

Recent improvement (between 2011 and 2017) in tobacco control performance was nominated as the primary criterion to allow the selection of countries which possibly overcame the governance challenge of conflicting mandates and interests in tobacco governance. To incorporate the possible contestation of interests between health and other sectors, the presence of the tobacco industry (TI) or interest in tobacco investment was identified as the secondary criterion. Following the selection of countries based on these two criteria, the feasibility of conducting the fieldwork was also taken into account, based on

research networks and organisational connections. The remainder of this section explains more about the selection criteria.

Criterion 1. Improvement in tobacco control performance

Three key data sources were considered to identify PSIDS' improvement in tobacco control performance. The first source, the publicly available World Health Organization Framework Convention on Tobacco Control (WHO FCTC) Global Progress Reports did not provide details at the country level (79,89,535–539) (with the exception of the 2014 report (540)). The second source, the WHO Tobacco Free Initiative (541) MPOWER monitoring system provides measures of the following: monitor tobacco use and prevention policies (M); protect people from tobacco use (P); offer help to quit tobacco use (O); warn about the dangers of tobacco (W); enforce bans on tobacco advertising, promotion and sponsorship (E); and raise taxes on tobacco (R). This monitoring system provides data that is comparable in time and between countries and regions, and it is collected by the WHO Country Offices (and then endorsed by the country's government). The third source, the Pacific Monitoring Alliance for NCD Action (MANA) dashboard, reports (91,542) contain a set of indicators on the implementation of the same set of tobacco control policies listed in MPOWER. At the time of the case selection stage of this research, reports on many PSIDS were not yet complete.

The MPOWER data was chosen to select the PSIDS with the most improvement in tobacco control between 2011 (the first MPOWER report) and 2017 (the year of the case selection for this study) (543,544). The MPOWER reports offer data on each category of measures with a colour-code system; they do not provide an aggregated score of tobacco control performance. The candidate translated the colour-codes of the MPOWER data to scores by allocating numbers from 0 to 4 as the colour of the indicator deepened, 0 being the lightest colour and 4 the darkest, reflecting the 4 levels of shades used as colour-codes in the reports[13]. By adding the individual indicator scores together, a composite index was created to show the status of tobacco control in a given year in a given country. As this research is concerned about policies to control tobacco industries, only those themes within MPOWER were taken into account that directly relate to industry regulation. Thus, the composite index was calculated using the monitoring (M), health warnings (W1), advertising bans (E) and taxation (R1) measures. After calculating the status of tobacco control in 2011 and 2017 in those 10 PSIDS which are covered in the reports, the values of 2017

[13] The only exception was the indicator of monitoring (M), where only 3 levels were differentiated in the MPOWER reports; thus, for this indicator the maximum score was 3.

from the values in 2011 were subtracted to gauge the amount of progress (see Appendix 1 for detailed calculations).

It would have been useful to use levels and trends in smoking prevalence to offer insights into the performance of tobacco control within PSIDS. This was not possible for two reasons. First, in the majority of PSIDS there are no data on smoking prevalence from recent years (Table 3). Second, it is difficult to compare smoking prevalence data among PSIDS, because these states do not monitor tobacco use with a set frequency nor with fixed variables (e.g. Niue measures adult smoking in the population over 15 years of age, and their latest survey was done in 2011; while Solomon Islands' last report with data on tobacco use came out in 2006 and covers the population between 25 and 64 years of age) (93–102).

Table 3 Smoking prevalence in PSIDS, current smokers (93–102)

SIDS	Both sexes	Male	Female	Year of data collection
Kiribati	58.0%	74.1%	43.1%	2004
Papua New Guinea	44.0%	60.3%	27.0%	2007-2008
Solomon Islands	41.4%	56.1%	26.1%	2006
Nauru	49.7%	52.9%	56.0%	2004
Samoa	34.6%	49.4%	18.0%	2002
Federated States of Micronesia	30.5%	48.9%	11.6%	2006
Fiji	30.8%	47.0%	14.3%	2011
Tonga	31.0%	46.2%	16.3%	2004
Vanuatu	23.7%	45.8%	4.0%	2013
Marshall Islands	19.8%	34.7%	4.2%	2002

Criterion 2. Presence of tobacco industry or interest in tobacco investment

The second selection criterion was the presence of the TI or their interest in tobacco investment in the country. Three categories of TI interests in SIDS were defined by the candidate, that allowed the assessment of intersectoral governance of tobacco in presumably different stages of commercial influence: countries where there is an established TI (category A); countries where there is active interest or lobbying to establish TI (category B), and countries where no interest is present or interests are not publicly known (category C). Countries were identified from categories A and B. The presence of the TI was assessed through tobacco-related exports as the percentage of GDP in the PSIDS; this was calculated as the proportion of total value of tobacco export (545) in the total net GDP (546). (The original data and the calculations are presented in Appendix 2.) This allowed the identification of countries with already

established TI (category A). For those PSIDS where the export data didn't indicate an established TI, a Google search was conducted to scope the interests in foreign direct investment (FDI) in tobacco with the application of a key word search of "tobacco investment" and the country name (category B). If no such interest was revealed in this search, the SIDS was classed as category C.

Table 4 presents the PSIDS and their values of primary and secondary criteria. The selection process started with the application of the primary criterion, which ranked the countries based on their progress in tobacco control. As the next step, tobacco-related exports were added to each country, which allowed the identification of countries in category A. The countries that had the most progress in tobacco control despite an established TI were Fiji and Samoa. Since Fiji had the higher values on both criteria, it was nominated as the ideal PSIDS for category A. To identify a country for category B, a scoping Google search was conducted on prospective FDI in tobacco in PSIDS with zero tobacco-related exports but with demonstrated progress in tobacco control (Kiribati, Vanuatu, Nauru, and the Federated States of Micronesia). The search revealed that Vanuatu has been under pressure from foreign investors to establish a TI (which at the time of the selection process was still unsuccessful) (547), while such information was not found for the other states. Therefore, Vanuatu was nominated as the ideal country for category B.

Table 4 The application of selection criteria on PSIDS

PSIDS	Criterion 1 **Change in tobacco control implementation** change in score of MPOWER measures on industry regulation, WHO Report on the Global Tobacco Epidemic, 2017-2011 (Appendix 1)	Criterion 2 **Economic interest for tobacco growing and manufacturing** tobacco related export (% in GDP) in 2014 (Appendix 2)	Criterion 2 **Category of TI interests** A – TI presence; Category B – No TI presence but TI interest; Category C – No TI presence and no TI interest publicly expressed
Kiribati	5	0.00000%	C
Fiji	4	0.03727%	A
Vanuatu	4	0.00000%	B
Samoa	3	0.02939%	A
Nauru	3	0.00000%	C
Federated States of Micronesia	1	0.00000%	C
Solomon Islands	1	0.06372%	A
Tonga	0	0.06504%	A
Marshall Islands	0	0.08689%	A
Papua New Guinea	-2	0.00428%	A

From a feasibility perspective, due to the temporal and resource limitations of a PhD research project, when the list of countries was created using criteria 1 and 2 and the selection was made, these were checked to ensure that the candidate had the necessary scholarly and professional connections through her academic institution. As a result of this process, Fiji and Vanuatu were selected as case studies for this research. The following section provides a brief introduction to these PSIDS.

3.1.1. Fiji

The Republic of Fiji, with its population of 884,887 people (548) and 332 islands is one of the largest of the PSIDS (Appendix 3). The population mainly consists of two large ethnic groups: 56.8% indigenous Fijians, so-called iTaukei, and 37.5% Indo-Fijians (549), the descendants of the Indians who were brought to the islands during the British colonial era between 1874 and 1970 (550). The median age[14] of the population is 27.6 years (551).

After gaining independence in 1970, Fiji became a parliamentary representative democratic republic. However, its political history since then has been characterised by a so-called *coup culture*: the government has experienced four military coups – two in 1987, and one each in 2000 and 2006 – when pro-iTaukei and pro-Indo-Fijian governments were grappling for power (521,552,553). Fiji started its return towards democracy in 2014 when elections were held and democratic institutions, such as the Parliament, were re-established. The Economist Intelligence Unit classes Fiji as a hybrid regime, suggesting that it is in transition from an authoritarian political structure to democracy[15] (554).

The health context

In Fiji almost every second man regularly consumes tobacco, while 14% of Fijian women smoke (in 2011, latest available data) (99). Linhart et al. (420) show that in Fiji the trends in smoking prevalence have been following the decrease visible in high-income countries; however, this positive trend has stalled over the past 10 years. Almost a thousand men die in Fiji from tobacco-caused diseases every year, which constitutes 15% of all deaths in the country; among women this rate is 7% (556).

[14] Age that divides the population distribution into two equal parts – that is, 50 percent of the population is above that age and 50 percent is below it.

[15] The Economist Intelligence Unit defines a hybrid regime in the following way: "*Elections have substantial irregularities that often prevent them from being both free and fair. Government pressure on opposition parties and candidates may be common. Serious weaknesses are more prevalent than in flawed democracies—in political culture, functioning of government and political participation. Corruption tends to be widespread and the rule of law is weak. Civil society is weak. Typically, there is harassment of and pressure on journalists, and the judiciary is not independent"* (554) (555).

The Fijian population is generally at high risk for developing NCDs: 65% of Fijians are overweight or obese, 31% of them have raised blood pressure, 30% of them have raised blood sugar, and 16% of them drink alcohol regularly (99). The Global Burden of Disease Database (557) shows that these risk factors caused most disabilities (disability adjusted life years, DALYs[16]) in Fiji in recent years. 84% of deaths are caused by NCDs (558). 60% of these NCD deaths are premature[17] (559). Diabetes and cardiovascular diseases are responsible for most years of life lost (YLLs)[18] in Fiji (557), but the number of cancer cases has been increasing rapidly in recent years (560). Life expectancy at birth was 70 years in 2016 (561).

The economic context

Fiji is an upper-middle income economy with US$5.1 billion GDP in 2017. GDP per capita is US$5,589, and its economy showed 3.8% growth in 2017 (546). Almost half, 44.2%, of Fijians work in agriculture, and nearly the same amount of people (41.6%) work in services. Industries such as manufacturing, energy production, and construction employ only 14.3% of the labour force (549). While services bring in 69.1%, industries earn 17.4%, and agriculture contributes 13.5% of GDP (549). Based on data from the International Trade Centre, tobacco-related exports are around 0.04% of Fiji's GDP (545,546). The country's main income is from tourism and overseas remittances.

The tobacco industry

The TI was officially established in Fiji in 1973 when Carreras and the Fiji Tobacco Company merged to create the Southern Development Company (SDC). In 1992 the Central Manufacturing Company (CMC) purchased SDC, and in 2000 British American Tobacco (BAT) bought CMC (562). Since then BAT has controlled the entire supply chain of tobacco in Fiji. It is the second largest multinational tobacco corporation in the world after Philip Morris International, with net sales of 26.1 billion US$ in 2018 (563). Today, BAT Australasia covers Australia, New Zealand and PICs, and its head office is based in Sydney. The company manufactures tobacco in Suva, and it started developing another plant in Nadi in 2019 (564). It is challenging to estimate the number of people employed or contracted by BAT in the country. According to a recent report by the Cancer Council Australia (565), BAT's Suva office had 130 employees in 2003 and 380 contracted farmers; Paterson et al. (441) state that in 2004 the company contracted 251 farm holders.

[16] "*DALY is disability-adjusted life year. DALYs equal the sum of years of life lost (YLLs) and years lived with disability (YLDs). One DALY equals one lost year of healthy life"* (17).

[17] Premature death according to WHO happens before the age of 70 (559).

[18] "*Years of life lost (YLLs) are years lost due to premature mortality. YLLs are calculated by subtracting the age at death from the longest possible life expectancy for a person at that age"* (17).

According to Fijian government reports, tobacco is not considered a major agricultural product[19]. The Ministry of Agriculture and the Ministry of Commerce, Trade, Tourism, and Transport omit tobacco from their plans (566–572). According to the Tobacco Atlas, "*tobacco growing is only a small fraction of agriculture in Fiji, with only 0.14% of agricultural land devoted to tobacco cultivation*" (556); the production trends hover around 400 to 500 tonnes a year.

Besides the local production in Fiji, the country has been importing increasing amounts of tobacco over the past 10 years, with a value of more than a million US$ in 2018 (Figure 3) (573). It is unclear how much of the imported tobacco gets consumed or used in production. The Foreign Investment Regulations require that at least 75% of the tobacco used by the industry should be locally grown (574).

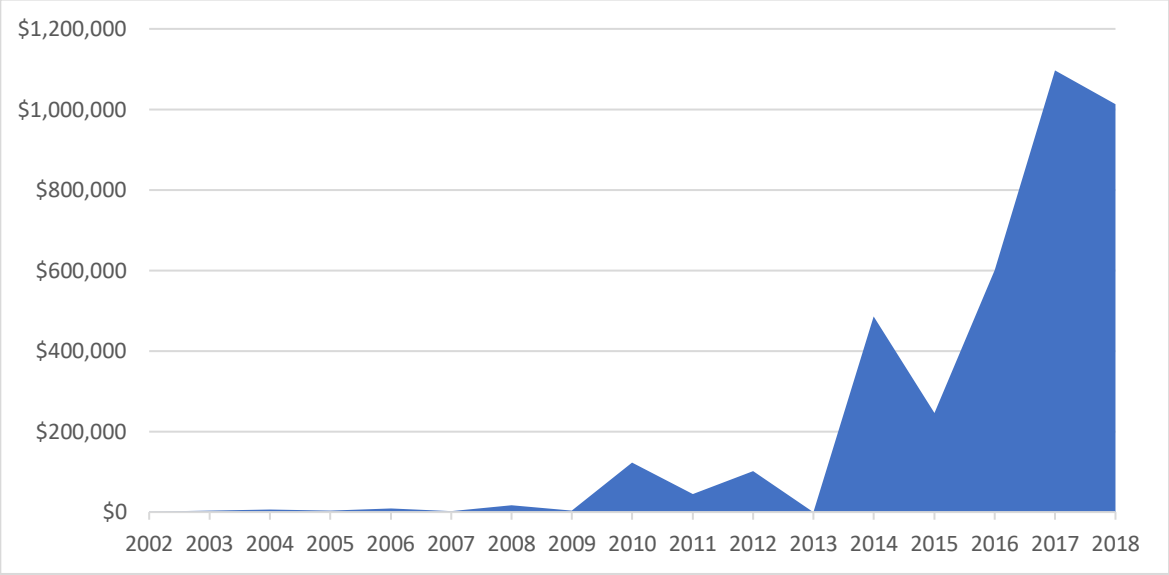


Figure 3 Products of tobacco, substitute, other, extract, essences, import value (US$) in Fiji (551)

The status of tobacco control

Figure 4 summarises the milestones of tobacco control in Fiji. Tobacco control first entered into legislation in 1998: the Tobacco Control Decree regulated the advertising and promotion of tobacco products; labelling to contain textual health warnings, tar and nicotine content; and restrictions on the sale and smoking of tobacco (575). This was followed by the Tobacco Control Regulations in 2000 which covered measures of point of sale advertising, exemptions to sponsor events and advertisement, labelling

[19] According to the Ministry of Agriculture, the major agricultural products of Fiji are sugarcane, copra, ginger, tropical fruits, vegetables; and beef, pork, chicken, fish (549).

regulations, and announced that work places, classrooms, and shops would be smoke-free areas (576). The next milestone was the ratification of the FCTC which entered into force in 2005 in Fiji (577).

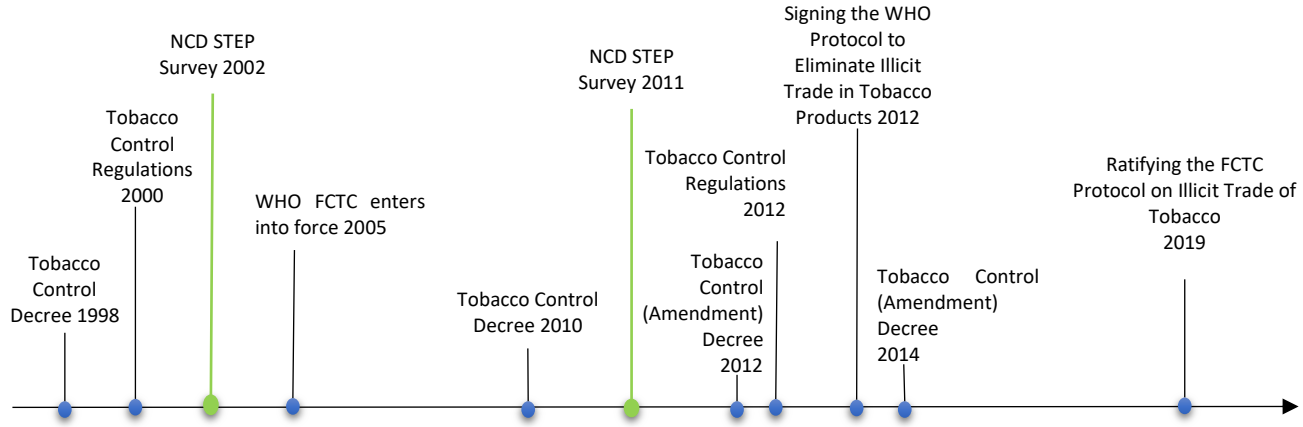


Figure 4 The milestones of tobacco control in Fiji

Although the treaty was ratified in 2005, the government only updated the relevant legislation in 2010, when the Tobacco Control Decree (578) tightened measures on smoke-free places, advertising, promotion and sponsorship, and packaging and labelling to comply with some of the provisions of the Convention. Regulations were developed over the subsequent two years with implementation from 2013. Once the country returned to democratic governance after its elections in 2014, the Tobacco Control Decree became an Act, and to date this, its consecutive amendments, and the Tobacco Control Regulations 2012 are in force.

In addition, in 2013 Fiji signed the WHO Protocol to Eliminate Illicit Trade in Tobacco Products (Protocol[20]) and ratified it in 2019. The Protocol is an international treaty developed in 2012 to address the growing international illicit trade in tobacco, and it entered into force in June 2018 after the required 41st country signed it (579).

3.1.2. Vanuatu

The Republic of Vanuatu has a population of 288,000 (549). Almost all, 99% of the inhabitants are indigenous ni-Vanuatu who mostly live in rural areas scattered over 65 islands (of the 80 belonging to the country) (Appendix 4). The median age is 22 years (580). The country was under the rule of both the British

[20] Throughout the dissertation the terms "treaty" and "Convention" are used when referring to FCTC, and the term "Protocol" when the WHO Protocol to Eliminate Illicit Trade in Tobacco Products is discussed.

and French Empire as an Anglo-French Condominium until its independence in 1980. Since then, the Vanuatu government has been operating as a constitutional democracy with a representative parliamentary system (520). The Global Democracy Index does not provide any data on Vanuatu, but according to Veenendaal and Corbett (411), the political context of the country, to a great extent, is typical to other SIDS where politics is localised due to the scattered geographical provinces, and where clientelism[21], patronage[22], and the lack of political ideologies result in frequent political changes (581).

The health context

Smoking prevalence among men is high at 46% in 2011 (101). Only 4% of women smoked regularly in 2011 (101). Tobacco use is responsible for 18% of male deaths (582). Smoking and unhealthy diet are major contributors to the NCD crises in Vanuatu (101): 51% of ni-Vanuatu are overweight or obese, 29% have raised blood pressure, and 21% have raised blood sugar (101)[23]. According to the Global Burden of Disease Database (557) NCDs cause 74% of deaths in Vanuatu, out of which 52% are premature (559)[24]. Life expectancy is 67 years (557).

The economic context

Vanuatu is a lower-middle income country with an economy of US$870 million GDP (official exchange rate, in 2017), with US$2,700 per capita GDP, and a growth rate of 4.2% (549). In 2018 most people, 65% of the population, worked in agriculture. Services such as tourism employed 30% of the work force. Industries (i.e. manufacturing, energy production, and construction) employed the least amount of people (5%) (549). While agriculture was the largest employment sector in 2017, it made up only 27.3% of GDP. Services brought in 60.1% and industries 11.8% of GDP (549).

The tobacco industry

Tobacco is grown on a very small scale in Vanuatu – so insignificant that it does not appear in any national or global databases, although this might change due to the recent developments in tobacco investment in the country. The local and Australian media reveal the efforts the tobacco industry has been making to

[21] Stokes (2011) defines clientelism "*as the proffering of material goods in return for electoral support, where the criterion of distribution that the patron uses is simply: did you (will you) support me?*"
[22] Patronage means the "*exchange of a public sector job for political support*" (Stokes, 2011).
[23] These reports, which rely on data from 2011, are the latest comprehensive source of information on NCDs in these countries at the time of writing. The new STEPS reports are expected to be conducted in 2020–2021 in both countries.

establish itself in the country since 2012 (547). Until recently the industry hadn't been successful, but in 2019 the construction of the first tobacco factory, co-owned by a Chinese businessman and a local businessman, began in Port Vila. However, the construction was stopped by the Water Department, because the plant would have endangered local water supplies (583). A more recent news article suggests that the Minister for Health himself supports the project (584).

Vanuatu has been importing around US$100,000 worth of tobacco into the country per year (Figure 5) (585). This value is expected to grow if the country signs the Pacific Agreement on Closer Economic Relations (PACER) Plus free trade agreement, because during its negotiations Vanuatu agreed to drop duties on tobacco products to zero as of 2052 (586).

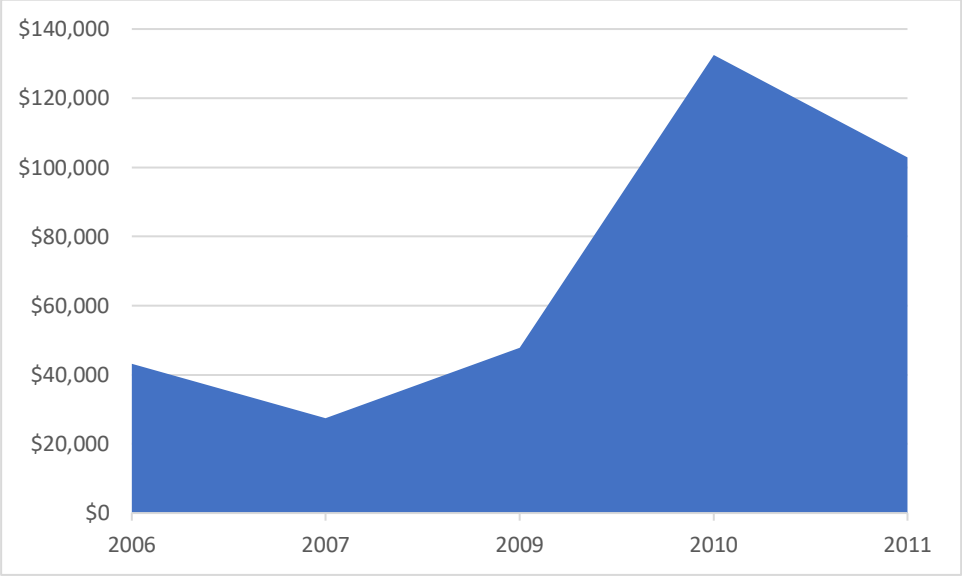


Figure 5 Cigarette or pipe tobacco and tobacco substitute mixes, import value (US$) in Vanuatu (563)

The status of tobacco control

The milestones in tobacco control in Vanuatu are depicted in Figure 6. Tobacco first appears in the country's legislation in 1984, when the *Import of Goods (Control) Act* states that only licensed traders are allowed to import tobacco. Between 1984 and 1988 tobacco prices were kept intentionally low through a series of *Price Control (Tobacco Products) Acts*.

Vanuatu's first tobacco control policies were embedded in the *Public Health Act 1994* (PHA) under the "Control of Smoking" section. The measures included smoke-free government buildings, enclosed public

spaces, and domestic airline flights; bans on cigarette advertising; textual health warnings on packaging; and maximum tar and nicotine content.

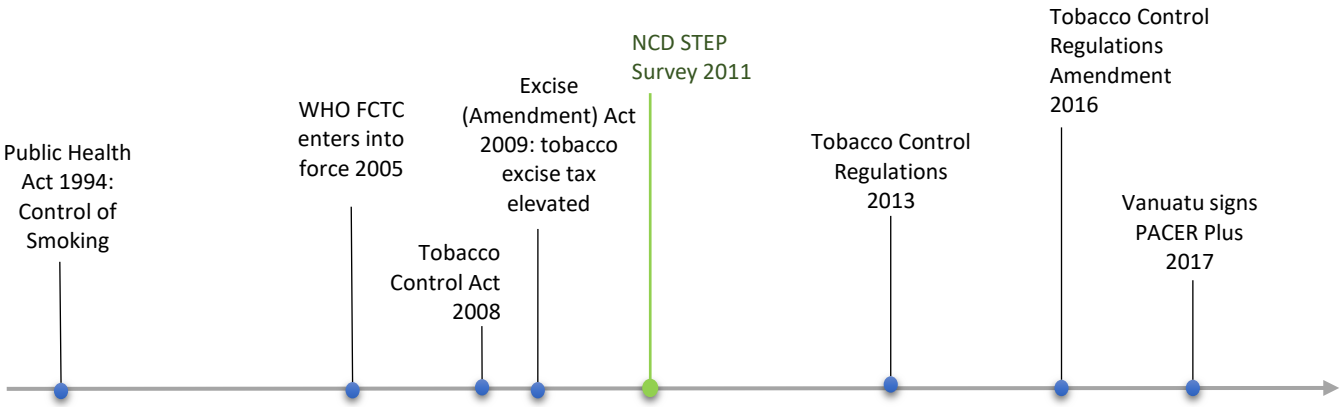


Figure 6 The milestones of tobacco control in Vanuatu

In 2005 Vanuatu ratified the FCTC, after which the *Tobacco Control Act 2008* (TCA) was developed and enacted. The TCA widens the scope of policies contained in PHA, and the consecutive Tobacco Control Regulations 2013 facilitated its implementation. The newly introduced measures include expanded bans on tobacco advertising, promotion, and marketing; labelling (including pictorial health warnings); reporting and limitations of contents; expanded smoke-free places including public places, restaurants, licensed premises, health and education institutions, public transport and flights; ban on sale to minors, in single sticks, and through vending machines. With the enactment of TCA, the section on "Control of Smoking" in the PHA was withdrawn.

In summary, both Fiji and Vanuatu had high male smoking prevalence before the latest regulations entered into force following the commitments to FCTC, and the burden of NCDs is high. Agriculture is a major employer in both countries despite its relatively small contribution to GDP. Both states are under pressure from the tobacco industry. In Fiji the TI has a long history, while in Vanuatu tobacco investment is in its early stages. Despite challenges, both countries have demonstrated major progress in the development of tobacco control policy in recent years according to the MPOWER reports.

4. Data collection and analysis

Document analysis and in-depth interviews with key informants were used to collect data on tobacco control governance in Fiji and Vanuatu. The candidate was located within each country for the duration of the fieldwork. The data collection and analysis applied both deductive and inductive approach and was driven by an analytical framework developed for the purposes of this research, based on the literature review and relevant theories (see Chapter 3). This enabled the collection and examination of the case data along the lines of the theoretical constructs relating to interests, ideas, and institutions.

4.1. Document analysis

The document analysis involved tobacco control and industry regulation related global and national policy and legal documents, reports, or any sources which might be of relevance to understanding tobacco governance in the selected countries. The document search was conducted online, and primarily focused on reports of Parliamentary Debates; plans, policies, and reports of government agencies involved in tobacco governance; global, regional, and country reports on tobacco control produced either by the government of these countries or by development partners. The relevance of the documents was established based on whether they contained any reference to tobacco, smoking, or NCDs.

The parliamentary debates of Fiji and Vanuatu were studied, because these reports document the way tobacco and NCDs are formally discussed by legislators and high-level government officials. In Fiji, copies of the Daily Hansard are accessible in English online (587). In Vanuatu, most debates after 2012 are available only in hard copy in the Parliamentary Library (588), and the reports are not available in English for all sessions. The soft copies of the Fijian Hansard permitted the use of key word search: “tobacco”, “smoking”, “British American Tobacco”, “noncommunicable”, and “NCD”. The Vanuatu Hansard required a lengthier reading as their hard copy format didn’t allow word search; furthermore, they do not provide a word by word description of all speeches, and not all sessions are transcribed in English (as debates in the Vanuatu Parliament are conducted in Bislama, one of the official languages besides English and French), and it was not possible to make copies of the reports or to borrow them from the Parliamentary Library. These issues made the use the Vanuatu Hansard more challenging for the analysis of tobacco governance. When quoting the speeches of legislators from the parliamentary debates, the appropriate Daily Hansard is referenced as source.

The plans, policies, and reports of government agencies accessible online in both countries were assessed in order to map their roles, mandates, and activity on tobacco regulation. The legislation concerning tobacco was attained through the Pacific Islands Legal Information Institute website (589), where key word searches for "tobacco" and "smoking" were applied to identify relevant legal documents.

Data about tobacco control in the selected countries were analysed with the help of the WHO FCTC Country Reports: for Fiji such reports are available for 2012 and 2007, for Vanuatu for 2016 and 2012 (89). The MPOWER reports (543,544,590,591) and the MANA Dashboard (406) provided further sources of data on the countries' progress toward tobacco control.

4.2. Key informant interviews – study participants and recruitment

Key informant interviews are an effective qualitative method (592,593) to collect information on participants' personal experiences, perceptions, behaviour and practices – all of which are important to understand and explore the various interests, ideas and institutional conditions influencing tobacco governance in the case countries.

To ensure objectivity and accuracy of the data collected through the interviews, participants were selected using a purposive and snowball process which targeted a wide range of stakeholders (594). This sampling process is explained below:

National tobacco governance involves multiple actors, including various government agencies (e.g. Ministries of Health or Trade), the tobacco industry, civil society or non-governmental organisations (CSOs or NGOs)[25], and development partners – intergovernmental organisations (e.g. WHO) and the governmental agencies of donor countries (e.g. the Department of Foreign Affairs of Australia). Representatives of these actors were invited to participate in the interviews. Initially, key informants from these organisations were purposefully identified and recruited through academic connections, which was then followed by a snowball selection process (596): each interviewee recruited was asked to suggest other individuals or organisations who could provide relevant information to the research. The snowball sampling process enabled preliminary data analysis during the data collection, which helped me to identify when saturation was reached (i.e. no more new insights were gained from the data) (597), and thus no

[25] Although the terms CSO and NGO were often used interchangeably by the participants of this research, these organisations are not the same. NGOs are organisations without any connection to the government; CSOs are organisations run by "civilians" but they might be commissioned by the government (595).

more interviews were needed.

Consent forms including names and signatures were completed by the participants prior to the interviews. The interviews were conducted in person when feasible. When it was not possible, they were done over the phone or on Skype. On average an interview took between 30 and 90 minutes. Due to the exploratory nature of this study, semi-structured questions informed by the analytical framework and open-ended questions helped to ensure the open character of the interviews (598). Table 5 presents the interview guide[26]. The interviews were recorded digitally when practical to do so and only if consent was received from the participants. In those cases when the interviews were not audio recorded due to participants' concerns, consent for written recording was given, and the contents of the interview were noted down in a notebook.

The period of data collection was from April 2018 to August 2019. The main phase of the data collection in Fiji was 3.5 months and in Vanuatu it was 6 weeks. This was followed by a follow up of one week in the former, and 4 weeks in the latter. The difference in the planned time period for this fieldwork and in the number of interviews is explained by the size of the administration in these countries: due to its larger government, more participants were involved in Fiji than in Vanuatu. Some interviewees located in the former were working for development partners active in the latter as well, thus the information they provided was applicable to both countries.

By the end of the data collection phase 70 interviews had been completed: 42 in Fiji and 28 in Vanuatu (Table 6). In Fiji, 14 interview requests were declined: within the government two in the health sector, three in the trade sector, two in the agriculture sector, and three in the women and youth sector; among development partners three individuals refused to participate. Notably, BAT also declined to be interviewed. In Vanuatu seven interview requests were declined: two in government (economy sector), one in local government, one faith-based organisation, and one development partner. The majority of the interviewees in both countries were public servants working in the government agencies responsible for tobacco regulation, followed by participants working for development partners. There were no CSOs focused on tobacco-related issues in either country, which explains the low numbers of interviewees from that sector, and only one academic institution offered expertise on health governance issues in the two countries.

[26] The higher proportion of questions in the Institutions section reflects that two theories are applied within this domain.

Table 5 The interview guide

Domain	Theory	Theme	Example questions
Interests	Avant et al.'s theory of authority	The interests, influence and authority of actors around tobacco control	- Which government departments, organizations, development partners, private actors are usually supportive of tobacco control regulations? Why? - Which government departments, organizations, development partners, private actors are usually not supportive of tobacco control regulations? Why? - Who sets the agenda in tobacco governance? How are the priorities determined? - What authority does your unit hold to perform its responsibilities? Have there been any changes in these in the last decade?
Ideas	Stone's theory of causal ideas	The cause of high smoking prevalence/NCD crisis in Fiji/Vanuatu, the responsible parties	- What is the reason for the NCD crisis of Fiji/Vanuatu in your opinion? - Is smoking an issue in Fiji/Vanuatu? - What is the reason that people smoke in Fiji/Vanuatu? - How does tobacco control perform in Fiji/Vanuatu in your opinion? - Who is responsible for the high smoking prevalence/NCD crisis in Fiji/Vanuatu? - What should be done to curb smoking?
Institutions	Feiock's Institutional Collective Action framework and Croley's administrative process theory	The structure of policy and legislative process of tobacco control, avenues of intersectoral cooperation, implementation of terms of engagement with the tobacco industry	- What roles and responsibilities does this unit have in tobacco governance? - Toward whom and what does this unit report to? What about reporting towards the public? How much autonomy does this unit have? - How are policies made? • Are there negotiations with other departments, ministries, development partners, industry, hospitality sector, etc. Are the minutes of these negotiations made public in any form? Are the meetings announced and can observers attend? • Is there a participatory process e.g. notice-and-comment process • Who makes the decisions? Is there any form of publishing the reasons for decisions? - With which other government departments, organizations, development partners, private actors are you working together with? In what way? Are there any intersectoral mechanisms? - Is Fiji/Vanuatu part of any trade or investment agreement or negotiations which has any relation to tobacco? • What do these agreements prescribe related to tobacco? • How do these agreements impact the development and implementation of trade or investment policies? • How do these agreements impact the development and implementation of health policies? - Is any self-regulatory or voluntary regulatory measure applied to the tobacco industry? - How is conflicts of interest handled? - Are there any lobby transparency measures in place?

Table 6 The participants of in-depth interviews

Country / type of actor	**Fiji** organizations (interviews)	**Vanuatu** organizations (interviews)
Government agencies	17 (25)	13 (21)
Local CSOs & academic institutions	3 (3)	1 (1)
Development partners	7 (14)	6 (6)

To both enrich the data and provide findings back to the policy community, engagement was maintained with the participants in both countries; 19 follow-up and feedback sessions were conducted with key informants, either through personal meetings, phone or Skype calls, or e-mails. During the feedback sessions the preliminary insights were shared and discussed with the participants, and additional questions and clarification were asked. There were 13 additional meetings conducted in Fiji and 6 in Vanuatu. Out of the 70 completed interviews 27 were audio recorded in each country (altogether 54); the rest of the interviews were based on written recordings.

4.3. Coding and data analysis

Interview notes and transcripts contained no identifying information. Only the primary investigator had access to participant interviewee data. A participant was only identified if written consent had been obtained to do so: otherwise, during data collection and subsequent analysis the identity of the participant interviewee was captured and stored anonymously. Depending on the interviewee's consent, some interviews were audio-recorded; these were de-identified with a unique identifier and saved on the university cloud drive, which is password protected. The recordings were deleted from the audio recorder after they were transferred to the university secure cloud.

The interview recordings were transcribed with the help of Otter.ai online software, but in several cases manual verbatim transcription was necessary due to the inaccuracy of the programme for different English accents. In those cases when the interviews were recorded in writing, the notes were later transcribed into MS Office Word (2016) documents and stored on a secure password-protected computer and the university cloud drive. The original notes were stored in a locked cabinet in a locked office. When data from such interviews are presented in the results, direct quotes are not possible, therefore the participants' words are paraphrased, and the participant identifier code is provided.

The transcribed interview data was imported into QSR Nvivo12.0, which is a software package used for coding and analysis (599–604). The data analysis applied both deductive and inductive approach. First, the interviews were coded against the constructs of the analytical framework. Three parent nodes were created based on whether the construct related to interests, ideas, or institutions, and in some cases additional sub-nodes were added to particular nodes where further categorisation was needed, such as in the "perceived net benefits" or "collaboration risk" nodes, as suggested by the framework (Table 7). Second, this was followed with inductive analysis, drawing on additional insight from the data to refine the analytical framework to complete the constructs drawn from the theories already introduced (column

H, Table 7), to answer the research questions (column G) and the overarching research question (column D). For example, "solution (how to solve the problem)" was added to the theoretical constructs (column I, Table 7), and "legal authority" was added to the "sources of authority" construct.

Ensuring confidentiality and anonymity in such small policy environments is challenging, therefore throughout this dissertation when referring to specific participants, identifier codes (e.g. F1 or V2 – the capital letter signifying the country where the interview was conducted) and blanket terms (such as "government official", "interviewee working in Ministry of Health", or "participant working for a development partner") are used. (In those cases when after a quote no country identifier F or V letter is used, the source of data is not an interview but a parliamentary debate; thus the corresponding Daily Hansard is referenced.) While it would provide an additional richness for my data to further specify seniority within an agency or the sector of a development partner, such details would endanger participants' anonymity, therefore they were included in the text only in those cases where the interviewee gave consent.

Table 7 The summary of methodology

Problem (A)	The Gap (B)	The Aim (C)	Overarching Research Question (D)	Focus (E)	Research Objectives (F)	Research Questions (G)	Theories (H)	Theoretical Constructs (I)
Rising prevalence of NCDS in Pacific Small Island Developing States as a consequence of commercial determinants of health	Limited scholarly knowledge and empirical evidence on how PSIDS governments address the challenge of conflicting interests in the multisectoral regulation of unhealthy commodities	To improve the understanding of the conditions that influence how governments in PSIDS, address the commercial determinants of NCDs in relation to tobacco	What conditions influence intersectoral governance of tobacco control in PSIDS?	INTERESTS	Identify the interests that shape intersectoral governance for tobacco control in PSIDS	What are the major interests at play in tobacco governance in Fiji and Vanuatu?	Avant et al.'s theory of authority	Sources of authority
						How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?		Dynamic / changes in authority
				IDEAS	Identify the ideas that shape intersectoral governance for tobacco control in PSIDS	What are the dominant ideas related to tobacco in Fiji and Vanuatu?	Stone's theory of causal ideas	Type of causal idea
						How do they influence tobacco control?		Direction of blame (what/who caused the problem)
								Solution (how to solve the problem)
								Location of responsibility (who should solve the problem)
				INSTITUTIONS	Identify the institutional conditions that shape intersectoral governance for tobacco control in PSIDS	What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?	Feiock's theory of institutional collective action	Perceived net benefits
								Collaboration risk
								Applied intergovernmental mechanism
						How, and to what extent, do institutional factors ensure a level playing field in tobacco governance among stakeholders in Fiji and Vanuatu?	Croley's administrative process theory	Public-interested administrators
								Institutional environment
								Bureaucratic autonomy
								Administrative procedures balancing out interest group influences
								Cost-benefit analysis of policy alternatives

5. Limitations

The methodology used in this research has a number of limitations. While case studies are useful to uncover whether and how certain conditions play a role in plausible causal mechanisms, they are inadequate for measuring the frequency or representativeness of the variables (525). However, the primary aim of this research is to uncover new information about policy processes, not to test causal relationships or examine construct validity.

Focusing on a single harmful commodity – tobacco – limits the generalisability of the findings to all commercial determinants of NCDs. However, such a singular focus was necessary because of the temporal and financial limitations of a PhD research project. Furthermore, the inclusion of only two cases can be also argued to constrain the generalisability of the findings (529); however, the low number of cases reduces the chances of error during the synthesis of results (528), and the previously mentioned limitations of this PhD research allowed no further cases. Furthermore, the exploratory nature of this research should allow such limits, as future, larger research activities derived from this study will be able to produce further evidence through focusing on the governance of several harmful commodities and employing more cases.

Although the participants were assured that all possible measures would be undertaken to ensure confidentiality, there is a likelihood that some interviewees were afraid to provide critical information about certain governance actors in fear of reprimand. This possible limitation was addressed by interviewing several participants from the same sectors to triangulate the data as much as possible.

The following chapters present the results of this research. Chapter 5 describes the analysis of interest-based conditions, Chapter 6 shares the results on ideas, and Chapter 7 discusses the institutional conditions which influence PSIDS governments in addressing the commercial determinants of NCDs in relation to tobacco.

Chapter 5. The interests shaping intersectoral governance of tobacco in Fiji and Vanuatu

Chapter 5 is the first of three results chapters based on the analysis of key informant interviews and collected documents in Fiji and Vanuatu. The focus of this chapter is on the interests involved in shaping intersectoral governance of tobacco in Fiji and Vanuatu. The key research questions are: (i) "What are the major interests at play in tobacco governance in Fiji and Vanuatu?", and (ii) "How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?"

"*If a pattern of policy is to be sustained, it must advance the interests of broad segments of society*", suggests Hall (103). It is important to identify the dominant interests at play in tobacco governance in Fiji and Vanuatu in order to better understand how to develop, implement, and sustain multisectoral tobacco control policies. Starting with this, in Section 1 the chapter describes the major actors involved in governing any aspect of tobacco, from cultivation to control. In doing so, the analysis identifies the contestation of mandates and interests involved in tobacco governance in each country. Section 2 examines the ways different actors pursue their interests in tobacco control by analysing how they execute and challenge authority, and how these interests appear to be influencing decision-making processes in tobacco control.

1. Interests at play in tobacco governance

Two major groups of interests emerge from the data. One group of actors is driven by health interests, while the other is led by commercial interests. The data shows that in both countries almost the same government agencies inhabit these groups, therefore they are discussed together in this section. Although the national ministries in the two countries operate under different names, the scope of their mandates are similar. Thus, for the sake of simplicity, this dissertation refers to each under the following short forms:

- Ministry of Health (MoH) – refers to the Ministry of Health and Medical Services in Fiji and the Ministry of Health in Vanuatu.
- Ministry of Trade (MoT) – refers to the Ministry of Commerce, Trade, Tourism, and Transport in Fiji, and the Ministry of Trade, Commerce, Industries and Tourism in Vanuatu.

- Ministry of Agriculture (MoA) – refers to the Ministry of Agriculture in Fiji and the Ministry of Agriculture, Livestock, Forestry, Fisheries, and Biosecurity in Vanuatu.
- Ministry of Economy (MoE) – refers to the Ministry of Economy in Fiji and the Ministry of Finance in Vanuatu.
- Customs – refers to the Fiji Revenue and Customs Service and Vanuatu Customs and Inland Revenue Department – it operates under the direction of MoE.

1.1. Pro-health interest

In both Fiji and Vanuatu, the actors who prioritise health interests in tobacco governance are, not surprisingly, MoH and the World Health Organization (WHO). The primary mandate of these actors is to improve population health, and they advocate for the implementation of tobacco control measures as agreed by both Fiji and Vanuatu when they ratified the Framework Convention on Tobacco Control (FCTC). The objective of these agencies in tobacco governance is to achieve multisectoral commitment and policy coherence for tobacco control.

Multiple government agencies support MoH in certain tobacco control tasks in Fiji and Vanuatu; for example, police officers join environmental health officers in enforcement activities, and the Ministry of Education includes classes on the harms of smoking in its teaching plans. However, MoH remains the sole driver of tobacco control within the government in both countries, and other ministries usually act as passive observers when decisions are made about tobacco governance. As MoH officials explain: "*Apart from Health [MoH] I do not think that anyone else is lobbying for tobacco control*" (F06); *"They will be there [to] support us, but they want Health to push"* (V06).

The Office of the WHO Representative in the South-Pacific, a sub-regional office of WHO based in Fiji, is the primary development partner supporting tobacco control in PSIDS including in Fiji and Vanuatu. Participants state: *"WHO is here, we have a strong collaboration with them. Lots of assistance. That makes our work easy. We do not work with others on tobacco"* (F03); *"WHO has always been a strong partner to MoH"* (V22).

MoH in both countries has a wide range of collaborations with other development partners, such as the United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and the Secretariat of the Pacific Community (SPC). However, tobacco control is seen as the expertise of WHO, therefore the other organisations do not engage in this area with MoH [paraphrased, F27].

1.2. Pro-commercial interests

The data reveals that the group of actors who usually act based on their pro-commercial interests in tobacco governance consists of the tobacco industry (TI), British American Tobacco (BAT) in Fiji and recently Double Pigeon Ltd. in Vanuatu, and the MoE, MoA, and MoT. These government agencies tend to prioritise commercial interests in tobacco governance for various reasons, but their collective interest is economic growth and development, and they are open to achieve that from any industry without having it in their mandate to think about health consequences.

The tobacco industry

The biggest loser from effective tobacco control is the TI. BAT, one of the largest tobacco companies globally, dominates tobacco production in Fiji. As Fijian participants describe: *"Tobacco industry, there is only one huge manufacturer here, BAT. I think they control 99% of the whole market"* (F15). *"BAT bought the whole supply chain and they control the farmers and the sales"* (F25). Another interviewee explains BAT's control over tobacco farming in the following way: *"BAT provides the seeds; they provide the fertiliser. It's organised planting, unlike other crops we have. BAT comes, organises everything, even the harvest, they pay you. The land is owned by the farms, but BAT gives everything"* (F30).

In Vanuatu, Double Pigeon Ltd., a Chinese-ni-Vanuatu[27] co-owned tobacco company, has recently commenced the construction of a tobacco factory (583). Prior to this company, there was no commercial tobacco production in the country.

The commercial interests of these corporations run counter to health interests as their profits depend on sales of tobacco. In both countries, efforts by the TI to influence tobacco control were often cited by interview participants. As a government official in Fiji states: *"Tobacco control is one of our successful programmes. It is so successful that we get complaints from the tobacco importers. It's a constant battle with the tobacco companies*" (F01). The participants recall various forms of TI interference in Fiji:

> *The TI had a strong lobby; it wanted to come in to try to put its claim on the table on what it wants, saying that you cannot do this [raise the excise tax on tobacco]* (F05).
>
> *Things happened like renovating wards in hospitals which were funded by the only manufacturer [BAT] in Fiji. They really infiltrated the Ministry [of Health]* (F04).

[27] The Indigenous population of Vanuatu is called ni-Vanuatu.

MoH officials in Vanuatu also state that *"the TI tried to intervene [with the raise of excise tax on tobacco]"* (V23) and that *"we do not have any evidence against them, but we know it's happening"* (V30).

As the following sections demonstrate, the TI has a close relationship with the other members of the pro-commercial interest group.

Tobacco farmers

Tobacco farmers usually oppose tobacco control in Fiji. While in Vanuatu commercial tobacco growing hasn't commenced yet and there is no constituency of farmers depending on it, in Fiji BAT contracts local farmers to grow tobacco. Decreasing smoking prevalence results in less tobacco leaves being bought by the TI, and Article 17 of FCTC (376) requires a shift from tobacco to other viable alternatives. Although recent evidence shows that other crops can be more profitable (see Chapter 2), since no published research is available on this topic in the Pacific, this cannot be stated with certainty in the case of Fiji and Vanuatu, argues a participant working for a development partner [paraphrased, F26]. Most interviewees emphasise that farmers prefer to continue farming tobacco: "*The farmers are not happy when they are told that they shouldn't grow any more tobacco*" (F05).

Several Fijian participants cite the high profitability and convenience of tobacco growing as the primary reason for farmers' reluctance to shift to alternatives.

> *Tobacco is a cash crop, investment crop, it brings a lot of money. Tobacco farmers are the only ones who have high eligibility points, they get loans more easily from banks than other farmers. Because it's a high return crop and the price is set. With tomatoes there is no guaranteed market. Tobacco farmers do not have to worry about their market. They plant and that's all they have to do. You do not even have to worry about transporting the harvest, because BAT collects it from the source. Farm-gate system: we plant and harvest the leaves at the farm. It's like a contract with BAT, it's guaranteed* (F25).

No other crops have such an automated and reliable system in place as tobacco, which may explain why farmers oppose any measures which would endanger tobacco growing. Furthermore, the Fijian media provides encouragement to farmers by picturing tobacco growing as a better alternative to vegetable and fruit production. News articles with titles such as "*Benefits of growing tobacco in Fiji 'immense'"* (605) and various reports on people leaving traditional crops behind to turn to tobacco farming are often published (247,606,607).

Vanuatu does not have a strong constituency of farmers who would advocate against tobacco control for now, but MoA and MoT are making efforts to introduce commercial tobacco growing and manufacture to the country, as the following sections show.

Ministry of Agriculture

The data reflects that MoA in Vanuatu perceives tobacco farming and production as a means to boost agriculture. A government official in MoA explains this in the following way:

> *The primary core function for the department is to ensure that there is enough food for the people, and also looking at promoting, encouraging especially farmers to plant more cash crops. […] We do not have tobacco farming, but there are some interested investors. […] It's a high value crop […] For economic purposes it will benefit the country* (V02).

MoA actively increases its capacity in cultivating tobacco: it has requested assistance from China (608), and the agency is developing a policy on tobacco farming. A government official in MoA states: *"We have a new legislation that's been passed in the Parliament on the newly introduced crops, and we will have a policy on regulating tobacco farming in Vanuatu"* (V02). This is a serious issue for tobacco control, because FCTC directly requires shifting farmers away from tobacco to viable alternative crops (376).

MoA in Fiji also supports tobacco farmers. The agency has a close working relationship with BAT, and the current Permanent Secretary[28] (PS) for Agriculture is the former Chief Executive Officer (CEO) of the company (609,610). A MoA official explains the reluctance of moving away from tobacco growing and the difficulty of finding an alternative:

> *The question with Ministry of Agriculture and tobacco growing, is that if we take away tobacco, what are we going to replace it with? Tobacco and marijuana give them [farmers] fast cash. That's why they are moving away from sugarcane, because it's slow and very labour-intensive. With tobacco, they [BAT] bring the seeds and fertilisers to their home, it's very easy. Just like fast foods. It's affordable, accessible and fast. That's the economy behind it: its fast money, and they just sit there and the TI just brings them everything. […] You need to find a replacement. Whatever they are doing it has to be fast* (F02).

Another government official suggests that *"MoH should come up with an alternative if they want to move them [MoA] away from tobacco farming; that would be the only way to convince them"* (F15). However,

[28] Second in command in a ministry after the Minister. In Vanuatu the Director-General (DG) is the equivalent position.

in Fiji MoH does not work together with MoA and MoT in addressing the issue of substituting tobacco farming with viable alternatives [paraphrased, F26].

Ministry of Trade

MoT in both countries supports the TI and perceives tobacco control measures as a threat to trade. A participant working for a development partner explains that the Department of Industry and the Department of Trade in Fiji are representing the interests of tobacco manufacturers, importers, distributors and sellers; furthermore, the Department of Tourism, as the regulator of hospitality services has been traditionally against tobacco control, because hotels, restaurants and bars profit from the sales of tobacco products [paraphrased, F26]. A MoT official argues that *"we are not supposed to decline support from them [tobacco farmers], because it's a livelihood thing"* (F15), referring to the small business grants distributed by the ministry.

MoT in Vanuatu sees a good opportunity in starting up TI in the country and is actively working together with MoA on this front. A participant working for the Department of Industry in Vanuatu summarises the approach of MoT to tobacco:

> *The benefit is that if we can produce something for export, then it is a good idea. We have many people smoking in Vanuatu, and thus maybe tobacco will be cheaper for them than the import cigarette. It will provide employment. If the industry comes and helps people to grow tobacco, then it's good for the economy. Tobacco is not good for the health, but many people smoke. But it would be a good revenue for Vanuatu, if we could export it* (V16).

An interviewee suggests that the interest of BAT is kept in mind when MoT and the Ministry of Foreign Affairs of Fiji ensure that tobacco remains on the exempted list in free trade agreements: "*Trade [MoT] looks at protecting its own interests: local importers as opposed to foreign importers*" (F01), states the government official. He suggests that BAT applies its influence on trade negotiations to ensure that it maintains its monopoly in Fiji [paraphrased, F01]. High duty rates on tobacco products are part of the tobacco control measures, and tobacco being exempted from the free trade agreements aligns with pro-health interests; however, in Fiji this serves the local pro-commercial interests as well.

Ministry of Economy

In both countries the primary mandate of MoE is to accelerate economic development, and participants indicate that economic and commercial interests are prioritised over health interests. As a Fijian government official says: *"they are in an economic curve, and they are saying 'wealth is health'"*, (F02).

The data demonstrates that MoE sees the TI as a partner to improve the country's economy. The first reason to do so is the employment and investment arising from a local TI. The Minister for Economy in Fiji emphasises that "*British American Tobacco is putting an $8 million facility in Nadi*", thus providing important investment for the country's economy (564,611). Another official states that *"from a business point of view, while they [BAT] may be in the business which is not ideal for the health, but in the economy they are providing employment and income to the people"* (F22). Furthermore, Parliamentary Debates reflect that in Fiji MoE is seen to support the harmful commodity industries (612,613).

The tax revenues the TI generates are the second reason why MoE prefers commercial interests in tobacco governance: *"You do not want to restrain items which create a good revenue base. […] Particularly in the developing world, governments look at the fiscal side of those sin products more than their health side"* (F33). As a Ni-Vanuatu government official argues: "*It's something that is bad that is bringing good right so or the other way around: you raise taxes for tobacco or you lower the taxes of tobacco, at the end of the day, the government must make money. It is to generate revenue"* (V09).

The interviews demonstrate that it is a common understanding among government officials in both countries that tobacco control measures negatively impact government revenues:

> *When I was young and was not working here, we heard people say, why do not government just close down the tobacco factory? Why do not we just ban this thing? But there is lot of revenue coming from this product, and Ministry of Economy is very conscious that if the prices increase, it will negatively affect the revenue* (F13).
>
> *Tobacco is a powerhouse for the government to generate revenue. And it will not be easy for the government to just give this up very easily* (V22).

This understanding remains dominant in both countries despite the opposing arguments of tobacco control advocates. As a MoH official in Vanuatu recalls: *"When we did the excise tax, there was a bit of push back from the Parliamentarians worrying about the revenue going down. But WHO assisted us and helped to argue that it won't happen and in the long term it will be beneficial"* (V23). Or as a Fijian legislator argues:

> *There are issues about revenue, issues about tax, and issues about promoting business but if you look at all these together, Madam Speaker, we may find that the indirect cost and some of the direct cost of high incidents of NCDs [noncommunicable diseases] in Fiji could very easily outweigh the gain in revenue (614)*.

Despite these arguments, the findings illustrate that MoE more often finds its economic interests aligned with commercial interests in tobacco governance. However, it should be noted that the commercial

interests of the government agencies can be different from the private commercial interests of the TI. For example, the excise tax on tobacco serves the interests of the government because it generates revenue. For the TI it is harmful, because consumers might buy less of their products due to their higher price.

1.3. Malleable priorities

The membership of the pro-health and pro-commercial interest groups in Fiji and Vanuatu are not set in stone, as the following examples from both Fiji and Vanuatu demonstrate.

Customs and MoE on excise tax

The excise tax policies on tobacco products were developed in both countries in alignment with tobacco control. In Vanuatu, Customs decides on the value of taxes and tariffs on tobacco products; the agency initiated cooperation with MoH when developing its new excise tax policy in 2013 [paraphrased, V20].

In Fiji, MoE also made important concessions to health when it raised the excise tax on tobacco between 2016 and 2019. (While in Vanuatu Customs makes these decisions, in Fiji MoE has this authority.) An officer working in the Fiscal Policy Unit of MoE explained that the excise tax and duty rates of harmful commodities are set in consideration to public health concerns, because they recognised that:

> *there are two fights, two options. One option is, that you increase taxes, you lose revenue, but on the other hand you save a lot of money, because people won't get sick, so you save on the public health cost. As a government, we decided to do this. The other way would be to keep the taxes low, so revenue will stay high, but you will spend that money on public health expenses* (F13).

Reflecting this way of thinking, in 2015 MoE agreed to a rapid raise in excise tax on tobacco with the condition that it would reassess the need for further increase after this period. However, the 2019/2020 tax policies show that MoE decided to not raise the excise tax on tobacco further (615), although its rate at 33.8% in 2019 was still far from the recommended WHO value (at least 70% of full retail price to be excise tax) and is low among PSIDS (590,615,616).

Customs on trade and tobacco control

Customs in both countries have demonstrated support for tobacco control in trade matters. The Vanuatu Customs invited MoH to express its suggestions for the Pacific Agreement on Closer Economic Relations

(PACER) Plus[29] negotiations, where health officers advocated for the exception of tobacco products[30] [paraphrased, V20]. Although the agency took this pro-health stand in relation to tobacco in the negotiations, tobacco didn't make it to the exempted list in the final version of the agreement (586), and Vanuatu agreed to gradually decrease the duties on tobacco products to zero by 2052 [paraphrased, V01]. The pro-health interests didn't prevail in the PACER Plus negotiations, yet it is important that Customs invited MoH to consult on a trade matter and accepted its views. As Section 2 demonstrates, other government agencies rarely involve MoH in trade-related decisions in Vanuatu.

Customs in Fiji supported tobacco control during discussions over the ratification of the WHO Protocol to Eliminate Illicit Trade in Tobacco Products (617) in 2018. Participants in Fiji (F06, F18, F26) explain that smugglers use tobacco to test the tightness of the border controls in a given country, and if they find that it is easy to smuggle in tobacco, they follow on with drugs [paraphrased, F18]. Therefore, Customs had a good reason to advocate for the Protocol [paraphrased, F18]. Furthermore, the Attorney-General's (AG) support is necessary for any international treaties to be tabled in the Parliament (F17), and he came on board when MoH and Customs proposed the ratification [paraphrased, F06].

Minister for Health supporting the tobacco industry

The Ministers for Health in both countries occasionally decide to support commercial interests in tobacco governance instead prioritising tobacco control. As mentioned earlier, in Fiji, Article 16 of FCTC on shifting to alternative crops from tobacco has not been implemented so far. The following quote from the Parliamentary Debates demonstrates that the Minister acknowledges the farmers' interests in tobacco growing:

> *While we understand that there is a need to limit the smoking of tobacco because of its harmful effects on people's lives, but at the same time, we have to balance this with the livelihood of people. I think over the long term, if possible, we will need to think and look as a nation, to see people to move away from crops that can harm people's lives but for the time being, we need to live with realities (614)*.

As discussed earlier, MoA does not collaborate with MoH in any way on crop substitution, and the above quote shows the reluctance of the Minister for Health to implement such measures. While the Minister

[29] PACER Plus is a regional free trade agreement between certain PICs, New Zealand and Australia. Although Vanuatu signed the agreement in 2017 – which means that negotiations for the schedule of commitments are completed – it hasn't been ratified yet by the Parliament, because many legislators are dubious about the benefits of the treaty [paraphrased, V25].

[30] The exception of tobacco products mean that their tariffs won't change due to the agreement. This is an important matter for tobacco control, because it ensures a higher price for imported tobacco, which is a recommended measure of FCTC (Article 6) and contributes to the decrease in consumption.

for Health supports tobacco governance, there is evidence of concessions being made if measures would have negative externalities for tobacco farmers. A MoH official reflects: "*We can change the laws, but not at the expense of business*" (F02). Such priority of commercial interests is a major obstacle to achieving policy coherence for tobacco control.

The Minister for Health in Vanuatu went further than his colleague in Fiji to endorse commercial interests: he provided the TI with letters of support on several occasions for setting up a tobacco factory, which is the final administrative requirement needed for an investor.

> *They wanted to build a tobacco farm. Even the Minister for Health at the time wrote in favour of tobacco. The Minister of Agriculture wrote that it will be good for the economy and will provide jobs, and then the Minister for Health wrote that letter that he supports it* (V23).

This is a significant issue, because the opposition of MoH has been one of the main barriers to the TI investing in Vanuatu. Overcoming this last hurdle, in 2019 the Double Pigeon Tobacco Co. Ltd commenced the construction of the first tobacco factory in the country[31].

These examples show that priorities of interests can change, and that this has implications for policy coherence. Several participants (V15, V30, F03, F04, F05, F06, F26) argued that tobacco control is beneficial for the economy and there were occasions when MoE was convinced by that. However, at other times MoH was persuaded to prioritise commercial interests over health. MoH is often the last bastion of health interests in tobacco governance, and if pro-commercial interests manage to sway MoH to support the TI, the main advocate for tobacco control is neutralised.

In summary, Section 1 identified the major mandates and interests prevalent in tobacco governance in Fiji and Vanuatu. The actors who mostly follow pro-health interests in tobacco governance and thus advocate for tobacco control are MoH and WHO in both countries. The actors who make decisions based on commercial interests and oppose tobacco control are MoA, MoT, MoE and the TI. However, these lines of interests may shift or blur when actors are influenced by each other. As the examples of Customs, MoE and the Ministers for Health show, interests can be shaped towards or against tobacco control. The next section will show how the exertion of authority influences actors to adjust their priorities.

[31] In August 2019 the construction was halted by the Water Department because the site was unsuitable for industrial use with potential impacts on Port Vila's water supply (583). In early 2020 the Minister for Health signed another supporting letter to encourage the investment (618).

2. Exerting and challenging authority in tobacco control

Section 2 aims to answer the second research question: "How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?" The following analysis explains the ways different actors pursue their interests by executing and challenging authority and how these appear to be influencing decision-making processes in tobacco control. Avant et al.'s (125) theory aids the analysis, which operationalises influence through the construct of authority (described in detail in Chapter 3). The focus on authority helps in understanding why the TI is perceived as a legitimate actor in tobacco governance in Fiji and Vanuatu and why certain actors have more or less authority than would be expected in tobacco control.

Avant et al. identified five categories of authority: institutional, delegated, expert, principled, and capacity-based authority. Institutional authority is derived from the rules and mechanisms of institutional structures. Delegated authority arises when authority is temporarily placed upon an actor. Principled authority is sourced from accepted morals, values, or principles. Capacity-based authority is derived from perceived competence. Furthermore, the authors argue that the authority actors have can change based on their relationship to each other, their performance, and whether their authority is derived from multiple sources at the same time.

The analysis of the data from Fiji and Vanuatu reveals that of the five types of authority, three of them – expert, institutional and capacity-based – are relevant in tobacco control in both countries. Furthermore, the data highlighted the importance of legal authority, similar to the findings of Townsend et al. (46), which were based on the international laws and treaties a government has obligations to fulfil and which thus provide weight to domestic laws operationalising them.

This section focuses only on those actors that actively influence planning and decision-making around tobacco control based on the data: MoH, WHO and the TI in both countries, and the AG and MoE in Fiji. The authority of the other actors detailed in the previous section is discussed in relation to these four actors. The final section describes the limited authority of the civil society, explaining why its voice is hardly heard in tobacco control in Fiji and Vanuatu.

2.1. Authority within the government

The primary government actor with authority to shape tobacco control is MoH in both counties; however, this is challenged and overshadowed by other government agencies. In Fiji, the AG plays a particularly important role in tobacco governance.

2.1.1. The legal and expert authority of MoH

MoH in Fiji and Vanuatu wields authority in tobacco governance, because the *Tobacco Control Act* (TCA) mandates the Ministry to implement tobacco control measures in accordance with the country's obligations to FCTC. Furthermore, MoH is considered to be the expert on noncommunicable disease (NCD) prevention.

Legal authority

The legal authority of MoH for tobacco governance derives from FCTC and the concomitant tobacco control laws and regulations. Participants frequently stated that FCTC gives them a reference and a basis of authority to develop and implement tobacco control measures:

> *We have a lot of opposition from tobacco, but one of our strengths is that we can say 'look, we signed this convention and the government has to follow it'* (F02).

> *Basically, I told them in our meeting with the tobacco companies, that we got this book [FCTC] in front of us and our interaction should be based on this* (F05).

The FCTC is operationalised in Fijian and Vanuatu laws through the TCA. However, the Act and the regulations have some gaps in both countries – e.g. they do not address tobacco farming or the establishment of TI – which makes tobacco control vulnerable against commercial interests. A MoH official explains:

> *One of the gaps in our law is actually locally grown tobacco. This is a criticism that we always receive. Not that we forgot about it. But when the tobacco control law was developed many years ago, we did a lot of consultations, and it became a very contentious issue. So we said, 'well, one thing at a time, let us pass this one, and then later on, we tighten up the gaps, will add locally grown tobacco'* (V17).

This hasn't happened since then, and several high-level government officials in Vanuatu highlighted that the newly developed agricultural policy on introducing tobacco farming outweighs the country's commitments to tobacco control (V02, V16, V25). The Minister for Foreign Affairs explains that a MoH policy would be enough to ban tobacco investments in the country: *"If MoH came up and said, 'we will not accept, there'll be no tobacco production in Vanuatu', and made a policy then that would stop that right"* (V25). However, without such policy MoT and MoA do not see why they shouldn't allow tobacco investment: *"So it's good for Vanuatu, but for the health it's not good, but we do not have any regulation which would ban TI in Vanuatu"* (V16).

Expert authority

MoH is the government agency considered to have expertise on population health. Furthermore, as tobacco control is viewed as a health issue both in Fiji and Vanuatu, the ministry has considerable expert authority on this matter. However, the multisectoral nature of these policies places the ministry in a difficult position when it needs to exert influence on non-health sector policies. Avant et al.'s theory of authority explains that the authority of an actor can be diminished if its performance is perceived to be poor or if the focus of regulation is outside of the actor's expertise. In the case of MoH in Fiji and Vanuatu, both of these situations appear to be relevant, as the next two sections show.

Low performance diminishing authority

In Fiji and Vanuatu, the authority of MoH is tarnished by the perception that the agency does not operate well in terms of tackling the NCD crisis. According to several participants the reputation of MoH in both Fiji and Vanuatu is poor regarding its performance. "*Even within government some say that MoH is not doing its job if such an NCD crises can happen"* (F28). In Vanuatu several participants state that MoH does not perform well. Statements such as "*there's a lot of legislation but nothing's enforced"* (V15) were common among the interviewees. Another interviewee suggests that "*MoH needs to function first in a way that it is more efficient and effective for it to be able to start to reach out and start coordinating with the other ministries and line departments within the government*"(V27).

Some of the participants (F06, F27, V09, V15) suggest that the human and financial capacity constraints of MoH are one reason behind the issues of performance. An interviewee working for a development partner states that while in larger LMICs often an entire unit is responsible for tobacco control, in SIDS there is often only one person dedicated to NCDs or to tobacco control, hence smoking is likely to receive little attention [paraphrased, F27]. A MoH official in Vanuatu explains this in the following way:

> *Our problem with the Pacific is that we are always under capacity, we do not always have a good quantity of enforcement officers who are in place because, there's also other areas that enforcement officers must look into, like you have to ensure food safety, they have to make sure water standards, you have to make sure building standards, to make sure you know how the areas like tobacco and alcohol, operating hours and everything. (V09)*

Some interviewees (F23, V25, V29) argue that performance management and accountability issues are the reasons for the performance problems of MoH, while others (F03, V06, V12, V17, V19, V21, V30) suggest that it is logistically difficult to provide services in the geographically scattered provinces of SIDS. (Chapter 7 investigates such structural conditions in detail.) Additionally, a fourth opinion was present

that MoH is perceived to have a low performance because it is blamed for the NCD crisis [paraphrased, F28]. (This idea is discussed in detail in Chapter 6.)

In Vanuatu the perception of low performance of MoH on tobacco control negatively impacts its authority on tobacco governance matters, as the following quote regarding the issue of potential tobacco investment demonstrates:

> *I'm not sure in terms of tobacco whether Health [MoH] would be willing to work with MoA. If it's production and it's purely for export... It could probably be because already cigarettes and tobacco use in Vanuatu is high, and the implemented measures do not work* (V18).

There is a perception that MoH has failed to adequately fulfil its mandate to protect health, resulting in an NCD crisis, which challenges the agency's expert authority in this space. The data introduced later in Chapter 6 will reveal that a reason behind such perception is the dominant causal idea which holds MoH responsible for the NCD crisis.

Lacking authority outside of the health sector

Tobacco control requires multisectoral policies; however, the data demonstrates that MoH is not seen to wield authority on policy fields outside of health, which diminishes its influence to persuade other government agencies to prioritise health interests.

The discourse on tobacco control in both countries focuses on its economic impact. *"We do not use the health but the economic argument: this is the money NCDs costs, this is what costing your economy every year, this is what goes in health care, this is what is lost in productivity"* (F28). However, MoH is not perceived as having authority on economy related issues – it is the realm of MoE – thus taking on the discourse on economic impact of tobacco control measures is a particularly challenging task for MoH.

Tobacco control also has important trade aspects; however, MoH is seen as an agency without authority on trade issues: *"I think the weakness is in health itself. Health [MoH] does not have any understanding about the trade policies"* (F01). MoH representatives are not present in the National Trade Development Committee in Vanuatu, which is a multisectoral committee setting the trade priorities of the country. When asked about why MoH is not invited, a participant explained that "*there's already lots of people, which can make it difficult at times to have a proper strategic discussion as opposed to just general updates*" (V24), indicating that MoH is not perceived as an actor with expertise on trade matters.

In Fiji participants state that MoT and MoE are reluctant to collaborate with MoH because of its low expert authority within the government:

> *When MoH calls for a multisectoral meeting, Trade [MoT] does not go, because they say, 'Who is MoH to call us for a meeting'. The same for Finance [MoE]; especially them. […] The politics within ministries and within the departments is very important, the dynamics of this politics* (F28).

It appears in Fiji that MoH does not have expert authority to make decisions on trade matters, such as refusing to give a licence to trade or manufacture tobacco. As a participant expressed that in Fiji, *"at the moment, if anyone applies for a licence, the power is not there to say 'no, we do not give you a licence'. So the Minister and the Permanent Secretary [of Health] has no power to refuse tobacco companies"* (F03).

The data reflects that although MoH in Vanuatu is not invited to the trade circles, it has more authority on trade than in Fiji. While there is no health policy or legislation in place banning tobacco investment, in Vanuatu MoH was able to decline approvals to establish TI in the past (547,619). This shows that the Minister for Health has the ability to resist tobacco investors, unlike his colleague in Fiji. Furthermore, the agency is not disregarded by other government agencies, such as MoA, MoT or the Vanuatu Investment Promotion Authority (VIPA), concerning the introduction of TI investment to the country. In some cases, VIPA permission was granted without contacting the relevant ministries and as a result, *"VIPA got into trouble with the Ministry of Health"* (V18). As another interviewee states, tobacco investment *"needs a lot of discussion between the two ministries"* (V02). A similar situation seems unlikely in Fiji.

MoH wields low expert authority in agriculture in Fiji and Vanuatu. In both countries when the TCA was developed, there was a lot of opposition from MoA to include locally grown tobacco, thus MoH yielded under the pressure, explains a participant working in the Vanuatu government [paraphrased, V17]. Given that to date no tobacco control measure has been introduced in agriculture in Fiji and Vanuatu, and no collaboration between MoH and MoA has happened on this matter according to the interviewee data (V02, V15, V16, V17, F02, F03, F06, F15, F26, F28), MoH has either no authority over agriculture or it decided to prioritise commercial interests when it came to tobacco farming. Either way, the farmers' interests seem to prevail against tobacco control. This is particularly interesting in light of the minor contribution of tobacco growing to the agricultural output of Fiji and Vanuatu, and even more that agriculture does not contribute much to the country's GDP (see Chapter 4). This would indicate that tobacco farming is not an important agricultural sector, yet the interests of this group have significant

weight in tobacco control in Fiji. This could be because tobacco farmers and BAT are represented by MoA within the government.

This data highlights an important finding: since most government agencies do not identify the trade, agriculture, or economy sectors as responsible parties to mitigate tobacco-induced NCDs, these sectors do not perceive MoH as a party they should talk to. This shows that the framing of a problem is important in defining who has the expert authority and who is allowed to participate in decision-making. Since tobacco control is debated mostly on economic terms, MoH has much less authority to elevate health interests. Furthermore, since MoH is seen as not performing well in handling the NCD crisis, it has low expert authority and it has limited opportunities to engage in debates about trade, agriculture, or economic policies which would be important to control the commercial determinants of NCDs. The role of ideas in this area is assessed in detail in Chapter 6.

According to Avant et al.'s (125) theory, MoH could strengthen its authority through synergistic relations with other actors. If MoE or any other relevant agency in economy, such as Customs, sides with their pro-health arguments, that increases the expert authority of MoH, as happened in the case of the excise tax increase on tobacco in both countries and at the ratification of the Protocol in Fiji. Furthermore, the expert authority of MoH is strengthened by its close relationship and support by WHO: *"All this has been possible because of the FCTC, and WHO working continuously with MoH"* (F06).

2.1.2. The institutional authority of the Attorney General/Minister for Economy

This section focuses on the high concentration of institutional authority within the hands of a single person in Fiji: the AG (the head of the Ministry of Justice), who is also the Minister for Economy, and the Minister for Civil Service and for Communication. While MoE in Vanuatu is not perceived as an important actor on tobacco control, in Fiji the AG[32] is seen as the most influential actor in the government: *"The Ministry of Economy is the most powerful"* (F28).

This data from Fiji shows that the authority for decision-making is centralised in the hands of the AG:

> *Really there are maybe two ministers who control everything… The way that people talk about it is that there is two: the PM [Prime Minister] and the AG. My view is that it is really the AG, the PM not as much, certainly from a policy perspective. Everything*

[32] For the sake of simplicity, in the following only his most commonly used title – the AG – indicates his person, reflecting the way the Fijian participants refer to him, regardless whether the discussed function is related to the AG's Office, MoE, Ministry of Civil Service, or Ministry of Communication.

> *is really centrally controlled, even when it is related to individual actions of ministries, nobody takes any step forward unless it's approved by him* (F34).

In Fiji, the AG wields considerable institutional authority on policy making due to being the chief decision-maker on what gets legislated and financed. The interviews identified that decision-making runs along a heavily centralised process within the government in Fiji (assessed in detail in Chapter 7), which results in the concentration of institutional authority in the hands of the AG. The approval of the Cabinet, most importantly the Minister for Economy, is necessary for passing any policy [paraphrased, F01], and in the case of legislation, the AG's and Solicitor General's Office[33] have strong control over which bills gets passed on to Cabinet and later to Parliament for debate. A government official explains the connection between the AG's and SG's offices as follows: *"The AG's Office is the political office but the SG's Office works very close with the AG"* (F17). The institutional authority of the SG's Office is explained in the following way: *"Most of the ministries do not have lawyers, because all the legal work is channelled through the SG's Office. […] When a ministry wants to draft a policy or amendment, they work with the drafting team of the SG's Office very closely"* (F21).

A government official, when asked about the power of the SG's Office in policy making, replied that *"it [SG's Office] can just decide to say no to it [submitted bill], and that's it"* (F10). Another participant adds that 18 health sector bills were waiting for vetting at the SG's Office [at the time of the interview], some for more than 4 years and among them a bill on banning the advertisement of ultra-processed foods for children [paraphrased, F02]. Furthermore, the AG is the only person with the authority to propose the debate of any international treaty or convention in the Parliament:

> *Under the Standing Orders of Parliament, when there is convention or a protocol we want to exceed to or ratify, the AG moves a motion in Parliament and then sends through the protocol or the convention to the relevant Standing Committee to review* (F17).

In addition, the 5-year National Development Plan is developed by a unit of MoE [paraphrased, F09], which suggests that the Minister for Economy has a considerable amount of power in setting the direction for the country and for each government sector as well. As a MoH official describes: *"We have to work together on this [strategic planning] with the MoE. We work very closely with them, it's all in consultation"* (F09).

[33] The Solicitor General is the Chief Executive Officer of the AG's Office, the main advisor of the AG.

Furthermore, the ministries are tightly controlled by the AG and the Prime Minister (PM) through the Public Service Committee (PSC) that nominates and contracts the PSs for each ministry. At the time of the data collection, the PS for Health was also the Cabinet Secretary, in which role she reported to the PM on a daily basis [paraphrased, F07]. The interviewee data suggests that the PS is a powerful person within MoH: *"The PS is the administrative head of every ministry and his finger is on every pulse of every department or section in his ministry"* (F07). Furthermore, as a government official explains, "*the PS has financial accountability towards MoE*" (F09). An ex-government official recalls a story when the PS had blocked efforts to increase the capacity of the Tobacco Control Enforcement Unit despite the availability of the requested resources:

> *An enforcement unit needs a vehicle. […] At that time the Minister supported it very much. […] The Head of NCD Unit said, 'I give you FJ$30,000 from the NCD account.' The Chief Inspector said, 'I fully support you, I give you FJ$50,000 from the Central Health Board Account.' I had FJ$80,000 already, and the price of the vehicle was FJ$75,000. I put it down into a proposal, sent it up to the PS, I included in the letter that the Minister approves, but he declined. I went to him, and I asked what happened and that the Minister already approved it. He said, 'I do not care, I'm the chief accountable for the budget of the ministry'. He was politically appointed person. I replied: 'With all due respect, the money is here already, you just need to approve it.' I got out of his room, made an appointment with the Minister again, and I told him that the PS didn't approve. The minister talked to the PS but nothing happened. So it's the PS who stopped the process* (F04).

The MoH executive committee, which reviews and endorses the final policy drafts, does not have a standard membership, the list of attendees depends on the priorities of the current PS [paraphrased, F07]. A high-level government official explains that PSC hires the PSs who are accountable to the Committee, especially towards the Minister for Economy; if they do not deliver what the committee wants, their contract swiftly gets terminated [paraphrased, F02]. This statement is supported by the fact that within MoH there have been four PSs between 2015 and 2018.

Furthermore, many actors are afraid of speaking up against the authority of the AG: *"From a stakeholder perspective some of them are quite reluctant to say things which are negative, even though that's their position"* (F34).

This data reveals that a significant amount of institutional authority is centralised in the hands of the AG. The close relationship of the MoE with BAT further increases the influence of pro-commercial interests on tobacco governance. Furthermore, MoT and MoA share the same commercial interests to support the TI; thus, the pro-health interest group in Fiji is left to face large and influential opposition to tobacco control.

Furthermore, the fact that the discussions on tobacco control are frequently conducted on economic terms nominates MoE as the chief authority on apprehending the impact of tobacco control decisions on the economy. As an MoH official argues:

> *We have all the support from the ministries, but it does not help because you still need to go through the Attorney-General, and if he is very pro-trade… that is exactly the wall we are facing, because he is pro-trade, he is also the Minister of Economy. He is holding the two big portfolios we need to crack* (F02).

The legal and expert authority of MoH is set against the institutional authority of MoE in tobacco control in Fiji, and the data suggests that there is a stark imbalance between them:

> *When the two ministries [MoH and MoE] got their opposite agendas... but then ultimately who makes the final decision? Either the PM, or the MoE. They are the ones who will make the final decision in terms of the policy formulation* (F21).

Although the AG's position on tobacco is mostly perceived as a barrier to tobacco control in Fiji, an interviewee working for MoH sees opportunity in his high authority – if the pro-health interest group could convince him to prioritise health interests over commercial, it would immediately turn the tide: *"We have an opportunity, because the current powerhouse of Fiji, the AG, is actually changing laws every day. I want to use that space"* (F02).

2.2. Authority outside of government

This section presents an analysis of the ways non-governmental actors exercise authority in tobacco control in Fiji and Vanuatu. In doing so, it helps explains the absence of civil society in this domain in these countries.

2.2.1. The expert and capacity-based authority of WHO

WHO is seen by the other development partners as the expert on tobacco control in the region. In addition, the organisation wields capacity-based authority due to its provision of considerable resources. In both countries the agency provided significant support to MoH in terms of technical assistance in policy development for tobacco control (F02, F03, F06, F26, F27, F28, V17, V22, V23, V30). Further assistance is received through the Special Service Agreements[34] in both Fiji and Vanuatu (F06, F26, V30).

[34] Special Service Agreements allow local staff to work in the ministry, their salaries paid by WHO. The idea is that this agreement gives the ministry a few years to budget for the salary of these officers in their plans, after which it

As the provider of considerable resources, the question arises whether WHO can directly influence the government in these countries. *"There are competing demands of what DFAT*[35] *wants done, what WHO wants done and it is just a lot of constraints"* (V17), states an ex-MoH official in Vanuatu. By supplying expertise in policy fields where needed, international organisations have the ability to steer governments to fulfil their obligations in tobacco control, argues an interviewee:

> *As an external agency, we are trying to remind them what they signed up to – international agreements. We are also trying to tell them what is possible and not possible when they want to make some regulations; inform them when there are some trainings about the intersection of trade and law, or public health and law; so they are aware of what countries are doing or can be done, and pushing more stringent tobacco control regulations. Can they do plain packaging or not, what is the implication with WTO, etc.* (F28).

However, other government officials (V06, V17, F01, F02, F03) in MoH in both countries strongly stated that their relationship with WHO is based on the mutual understanding that MoH indicates the area where they need support, and that is when and where WHO steps in [paraphrased, V06].

A participant working at a development partner active both in Fiji and Vanuatu explains that the mandate of WHO allows the agency to engage directly only with MoH; it does not have the mandate to liaise with other government sectors [paraphrased, F26]. Therefore, the organisation is unable to directly influence decisions on tobacco, except through MoH. The participant added that if WHO finds that this is not enough to reach other sectors, sometimes it collaborates with UNDP or SPC [paraphrased, F26]. UNDP has a mandate to act in a variety of policy fields, including health, which allows it to reach out to non-health government agencies on NCD-related issues: *"We support WHO and other health specialised agencies, because we can open doors that they not necessarily can. Because our direct counterpart is the Ministry of Economy, Trade, Environment, Agriculture, Planning, Finance; for WHO it is only MoH"* (F28).

Thus, the synergistic relationship of WHO to UNDP and SPC increases its authority and mitigates the limitation of its singular access to MoH. The relationship between WHO and MoH in both countries is a strengthening factor for their authority on tobacco governance, and according to several interviewees (F02, F03, F06, F26, F27, F28, V17, V22, V30) it is an important reason behind the progress in tobacco control.

takes over paying these officers' wages. In reality the ministry often does not receive the required budget allocation, and WHO keeps covering the remuneration (F26, F28, V15, V30).

[35] Department of Foreign Affairs and Trade of Australia, an important development partner in the Pacific region.

2.2.2. The expert and capacity-based authority of the tobacco industry

The TI in Fiji has had a well-established role in tobacco governance; its influence on the government derives from its expert and capacity-based authority. In Vanuatu the industry is new, but it has managed to persuade most of the government about the commercial and economic benefits of tobacco production, and gained support from the Minister for Health as well. The data reveals little of the authority exercised by Double Pigeon Ltd. to achieve this; it had more to say about the sources of influence BAT has in Fiji.

In Fiji MoA sees BAT as the expert in tobacco farming and in agriculture in general, which gives considerable expert authority to the company. This is illustrated by multiple facts: (i) the CEO of BAT was elected as the Permanent Secretary (PS) for Agriculture in 2019 (609,610); (ii) the candidate was immediately referred to BAT when inquired about tobacco governance at MoA; (iii) BAT is the head of a public-private committee on agriculture; (iv) BAT assists MoA with other non-tobacco related agricultural projects. The following quotes demonstrate how BAT also holds capacity-based authority, because it provides resources to the government.

> *We have a **small committee, headed by BAT** from the private sector and it involves some of the key stakeholders in agriculture and of course tourism is a big component of this. I have spoken about high value agriculture and most of this high value agriculture commodities that are imported, these are the ones that we are targeting**. I did mention about BAT because it is perhaps the best state of the art nursery in Fiji**, but they only use that nursery for about three to four months, after that, Madam Speaker, the nursery is idle for the rest of the year. **They have given this facility to the Ministry of Agriculture without any cost** to utilise that facility, generate the seeds from there, and then distribute to our farmers* (Parliament of the Republic of Fiji, 2018e, p. 14 – emphasis added).

> *I did mention yesterday that we are working together with BAT and they assisted us with eight tomato varieties from India last year (621)*.

Furthermore, BAT is also perceived as an expert on economic matters, as the following quote from the AG demonstrates:

> *Generally, in Fiji we see there is a huge level of poaching that is taking place between different agencies. […] Everyone wants the best people. […] We ourselves are doing that. For example, the Head of Procurement in the Ministry of Economy now, is someone who has come from the British American Tobacco (622)*.

The following quote from a government official in Fiji illustrates that BAT is perceived as a legitimate actor in tobacco governance:

> *We just interestingly had a very short meeting with BAT a few weeks ago. […] The higher the taxes are, the harder it is for the businesses: the costs will go up and it will need to be paid by the customers. BAT has been here for many years. If the taxes are not sustainable for them, it has an impact on them long term – it was one of the issues they raised. […] They [BAT] calculated the threshold beyond which it [tobacco excise tax] won't be sustainable for them. It's something what the government has to take into account* (F22).

Additionally, the following quote from an ex-government official in Fiji reflects that the TI is confident in its influence over the Fijian government:

> *When I was there, I had to take all these meetings, even Customs was in. The manager from the [tobacco] manufacturer was in. It was for compliance purposes. They came to ask many questions. At one time the* ***manager of BAT said that you will be kicked out by the Minister [for Health], because he was not happy the way I answered his questions.*** *They were telling me that the regulations cannot be applied to local context. I said that this is our law, that's it* (F04, emphasis added).

These findings demonstrate that although the tobacco control community globally perceives the TI as an illegitimate actor needing to be excluded from tobacco governance, in Fiji and Vanuatu it is a provider of expertise and capacity – both of which are scarce in these countries due to their SIDS vulnerabilities. While LMICs tend to have limited financial and human capacity, in the case of Fiji and Vanuatu (as SIDS) such weakness is even more profound; participants explain that the small, local education sector offers only limited options for acquiring skills or expertise, and the geographic isolation and the population's low income make it challenging to study abroad [paraphrased, F04, F09, F23, V09]. Due to these weaknesses, Fiji and Vanuatu potentially rely on the capacity and expertise offered by the TI more than other LMICs do. As the data shows, in both states, government actors (sometimes including MoH) have the tendency to prioritise commercial interests which are aligned with the interests of the TI. This demonstrates that the capacity-based and expert authority of this industry cannot be disregarded in SIDS.

2.2.3. The capacity-based and institutional authority of the civil society

In many countries governance actively involves the interplay of various state and non-state actors, including civil society, which has been important to the global progress of tobacco control (623). Given that Fiji and Vanuatu are reported to be high performers in tobacco control, it could have been expected that the local civil society organisations (CSOs) would play a role in their achievements. However, in Fiji and Vanuatu it was reported that there are no CSOs – nor faith-based organisations – that engage in tobacco control. An ex-MoH official suggests that "*maybe it is because we were doing it [tobacco control] effectively thus there was no need for a CSO. They had no area they had to pick up [laughter]"* (F05).

Some of the data reflects that CSOs have little capacity-based authority in Fiji and Vanuatu. A participant working for a development partner suggests that the limited resources common in SIDS are the reason behind this.

> *Not only in tobacco, but they do not have any CSOs which are looking into NCDs at all. […] There is a big CSO network across the Pacific; we asked them why they do not do anything on health, but they said that they do not have any support or funding to involve someone. And we are talking only about health, not even NCDs or tobacco* (F27).

Another participant confirms this statement: "*In the health sector, they [CSOs] are relatively weak"* (F29).

In Vanuatu civil society has started to develop, but it is not strong enough yet to influence governance according to a participant: *"There are few groups that are forming, but it's another 10 years before you can see the public holding people accountable"* (V29).

Other interviewee data suggests that CSOs have little institutional authority: participants argue that CSOs are in the process of finding their place in the current government and political structures. According to some of the interviewees the Fijian civil society is going through a transition, they are not sure what their role is in terms of advocacy, and often lack capacity or understanding on how they can influence governance:

> *For a long time civil society played a specific role in Fiji in the sense of between 2006 and 2014 [during the military government], there was a perception by some that civil society was effectively the opposition, because there was no Parliament with an official opposition. So after 2014 [the return to democracy], some civil society groups have had to go through transition to try and find a space. So what is the role of civil society, are they doing oversight, are they a watchdog, are they to criticise the government, or work with the government, or...? I think also some of the groups struggle to understand the policy making and governance structures* (F29).

It was also suggested in the interviews that the current political structures in Fiji make it difficult for CSOs to consult with legislators, and consultations with the Parliamentary Standing Committees are the only option for them to influence governance outcomes.

> *There is some discussion that some CSOs find it difficult to directly interact with MPs [Members of Parliament, i.e. legislators] as they do not want to be perceived to be supporting one side or the other side. With the political system at the moment, there is no local MP for you to go to. So sometimes if you are a small CSO in a city you would approach your local MP whichever party they're from, to raise a local issue but you do not have that local representative in Parliament here. […] So at the moment, the*

> *majority of the interaction between MPs and civil society comes through the Parliament [Standing] Committees* (F29).

While CSOs in general try to use their legal opportunity to contribute to the legislative process in the hearings of the Parliamentary Standing Committees, the quote below suggests that the legislators do not perceive the CSOs to have capacity-based authority to contribute to the discussed issues:

> *One of the criticisms from the Members of Parliament side, it's that some do not see the value of CSO engagement. And that's partly because when, for example, they scrutinising a bill on disability, some of the people who come to give evidence do not want to talk about the bill of disability and just want to raise issues, because they see this is the only way of seeing the MPs and raising something. So the MPs then sometimes get frustrated saying, having this open system of letting people come to give evidence is wasting our time, they haven't even read the bill, and they come to give evidence on it* (F29).

The suggestions of a participant working for a development partner reflects that CSOs need to strengthen both their capacity-based and institutional authority in Fiji:

> *So it's a little bit on both sides that I think to a certain extent, civil society capacity for analysis and policy development needs to be strengthened, as well as understanding the different avenues for influencing and providing information on policy and equally on the parliament* (F29).

The weakness of the civil society in Fiji and Vanuatu has important implications for governance for health. As another participant explains, *"public opinion would be important to reach national governance levels to be set as priority. At the moment there is not much debate on the health impact of tobacco at the non-expert levels in the Pacific"* (F33). The public and civil society could use government consultations to directly express their interests. However, when public consultations were held on tobacco control matters in Fiji, only a few people attended [paraphrased, F04], which shows that Fijians do not tend to utilise their opportunity to influence policy making on this matter.

Other participants suggested that the public rarely speaks up in Vanuatu: *"In Vanuatu people are in peace, they accept the laws the government makes. The regulations, nobody says anything about it"* (V22). Although an interviewee suggests that in Fiji *"there are specific instances where civil society and others have actually managed to stop legislation to be passed"* (F29), another participant states: "*when it comes to alcohol and tobacco, consumers they just simply want those products be more affordable*" (F21).

An interviewee working for a development partner explains that civil society participation is crucial to make the government prioritise health interests over commercial and cites that the current imbalance of representation weighing towards private corporations is a barrier to this happening:

> *As long as you do not have a mass of consumers behind the government, they are just going to go with the powerful – the massive companies who are employing thousands of people, that are giving them a lot of revenue, who are pumping sugar into the country; they still going to go with them until there is counter-power, and they realise that maybe they should also pay attention what people want. These changes happen when societies are ready, not necessarily when we have a plan to make it happen* (F28).

The lack of civil society participation on tobacco control in Fiji and Vanuatu is particularly important, because the pro-health interest group is needed to balance out the authority of the pro-commercial actors. While a whole-of-society approach is often recommended in both countries to tackle the NCD crisis (see Chapter 7), it can be a difficult approach to successfully implement if the "society" is not involved, but the TI is heavily represented. With such an imbalance of interests in intersectoral governance for NCD, prevention is likely to be challenging.

The analysis in Section 2 presented the findings for the research question "How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?" Firstly, the debate on tobacco control is mostly about its economic impact rather than health impact, which leaves little authority for MoH to elevate its interests, and allocates authority to pro-commercial actors. Secondly, the dominant idea that MoH is responsible for the NCD crisis further diminishes the agency's authority (since it does not have enough expertise to handle the issue). Furthermore, this idea masks the responsibility of the commercial actors in the NCD crisis, which makes it challenging for MoH to make a case for the regulation of unhealthy commodity industries. Thirdly, in the case of Fiji the centralisation of institutional authority in the hands of the AG shows that if the institutional structures do not create a level playing field among stakeholders, trade and economic initiatives can receive higher priority than NCD prevention. Fourthly, the TI is seen as a legitimate source of expertise and capacity in both countries, and while they are involved in governance, the civil society which could make a case for population health remains unrepresented.

3. Summary

This chapter described the major mandates and interests at play in tobacco governance in Fiji and Vanuatu, which focus on pro-health and pro-commercial interests (Figure 7). The different types of authority exerted by these actors to influence tobacco control are presented in Table 8.

The findings show that in Fiji the institutional authority to influence tobacco control is centralised in the AG's hands. This authority is strengthened by the agency's close relationship to BAT, which is perceived to have high expert and capacity-based authority on tobacco governance. MoT and MoA (and the tobacco farmers they represent) are supportive of the same commercial interests as BAT, and they oppose tobacco control. MoE is recognised as the government actor with the most authority in the country, thus the fact that the agency usually prioritises commercial interests in tobacco governance is a crucial constraining factor for tobacco control.

The little authority that MoH in Fiji has on tobacco governance is mainly sourced from its legal obligations to FCTC and the support of WHO, whose expert and capacity-based authority lessens the disadvantage of MoH within the government. The perception that MoH performs poorly, and is understood to be a contributor to the high prevalence of NCDs, is crucial to its diminished expert authority. The dominant causal idea which is behind this notion is discussed in detail in Chapter 6.

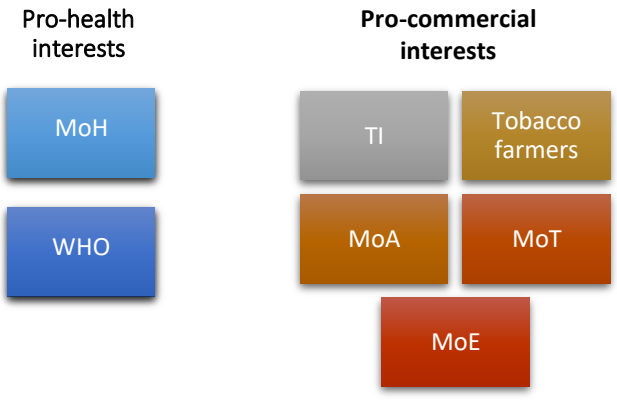


Figure 7 The pro-health and pro-commercial interests in tobacco governance in Fiji and Vanuatu

Table 8 The sources and the increasing and decreasing factors of authority in tobacco control in Fiji and Vanuatu

Actor	Type of authority	Increasing factors	Decreasing factors
MoH	Legal authority	FCTC, domestic tobacco control laws	Gaps in the tobacco control laws, e.g. establishment of tobacco industry is allowed
	Expert authority	NCD and tobacco control is understood as a health sector issue	Limited human and financial capacity (SIDS vulnerability)
			Logistical and financial challenges of implementing tobacco control policies across multitude of islands (SIDS vulnerability)
			Performance management and accountability issues
		Close working relationship with WHO	Perceived low performance
			The implications of tobacco control measures are discussed primarily in economic terms
MoE (in Fiji only)	Institutional authority	Centralisation of decision-making authority in the hands of AG	
WHO	Expert authority	FCTC	
		Close working relationship with UNDP and Secretariat of Pacific Community	No mandate to liaise with non-health government agencies.
	Capacity-based authority	The organisation provides substantial funds for MoH programmes and projects.	
TI	Expert authority	Close working relationship with MoA, MoT, and MoE	
	Capacity-based authority	BAT supports various MoA projects and lends assets (e.g. nurseries) to the ministry (in Fiji only)	
CSOs	Capacity-based authority		Limited funds for tobacco control (and for NCD advocacy in general).
	Institutional authority		Institutional structures to the involvement of CSOs in governance are limiting

In Vanuatu, the distribution of authority is more balanced than in Fiji. While there are differences in authority in certain areas, no actor holds significantly more influence than the others over tobacco governance. Although the expert authority of MoH is diminished by its reputation for low performance, its legal authority based on FCTC and the support of WHO with expert and capacity-based authority balances out this weakness. However, the agency's commitment to tobacco control was significantly damaged when the Minister for Health assured the TI of his approval by signing official letters of support for setting up a local TI.

The findings show that MoE in Vanuatu does not interfere with tobacco governance as much as in Fiji; Customs, its subordinate agency, has demonstrated support for pro-health interests several times in the past, such as by raising excise tax on tobacco products and suggesting their exemption in PACER Plus. However, the results indicate that MoA and MoT have more authority in tobacco governance than MoH: the legal authority of MoA derived from a new policy supporting tobacco farming is the deciding factor between the two agencies. Double Pigeon Ltd., the new tobacco corporation in Vanuatu, which has acquired all the necessary approvals and commenced building a tobacco factory, does not possess as much authority as BAT in Fiji yet, but its authority was sufficient to make the Minister for Health yield to commercial interests.

Civil society is absent in tobacco control in both Fiji and Vanuatu. At the same time the TI is perceived as a legitimate private actor with expertise and capacity – both of which are very much needed in these countries due to their SIDS status.

The SIDS vulnerabilities are likely to facilitate the distribution of authority among the different actors in tobacco governance. The small population and geographic isolation limits human capacity in the government of Fiji and Vanuatu which is a common issue in SIDS. Due to their small size they have difficulty in maintaining a bureaucracy which covers each policy areas as it usually done in larger LMICs. Furthermore, providing services across a multitude of scattered islands is logistically challenging and costly, which further diminishes the resources of government agencies of Fiji and Vanuatu. These vulnerabilities enable the TI to appear as a legitimate source of expertise and capacity – more so than in other LMICs.

These findings highlight three important points regarding the interest-based conditions which shape intersectoral governance for NCD prevention. Firstly, the framing of a problem is a crucial determining factor in who has the authority to decide on tobacco governance. In Fiji and Vanuatu, the NCD crisis is primarily perceived as being due to MoH not performing well in educating the population and treating NCDs. Framing the issue in this way has two major consequences for the authority of MoH: seeing the agency as a low performer decreases its expert authority, and the lack of recognition of the commercial drivers of NCDs disables the ministry from engaging in trade and economic policy making – in which the MoH does not seem to have expertise. Furthermore, the discourse within the government is primarily focused on the economic impact of tobacco control, which further diminishes the pro-health interests' authority on this matter and strengthens the influence of those actors who already dominated the debate,

the pro-commercial actors. The ways ideas influence tobacco control in Fiji and Vanuatu are analysed in detail in Chapter 6.

Secondly, governance mechanisms which allow the centralisation of authority in the hands of a single individual are a major threat to tobacco control – but only if the individual prioritises commercial interests over health. As the examples of excise tax or the Protocol on illicit trade have demonstrated, once this actor is persuaded to be become an ally, it clears the way for pro-health interests. The ways political and institutional structures shape tobacco governance in Fiji and Vanuatu are further discussed in Chapter 7.

Thirdly, although the TI should be excluded from governance based on Article 5.3 of FCTC, in Fiji and Vanuatu it is seen as an authority not only on agricultural matters, but on trade and economic matters as well. The examples in this chapter shows that PSIDS governments tend to rely on TI expertise or capacity and thus perceive them as legitimate governance actors. This is especially important in light of the limited participation of civil society in tobacco control; the involvement of the TI without the necessary counterbalance of pro-health interests is a threat to NCD prevention. Is it a coincidence that in Fiji, where BAT is actively involved in governance, the majority of the interests are centred around tobacco production and trade? Or that ideas on tobacco and NCDs in both countries are aligned with the common rhetoric of the TI (see Chapter 2) and leave MoH without much authority to address the commercial determinants of NCDs? Analysis of the ideas around tobacco and NCDs is discussed in Chapter 6. The institutional complexities of balancing out commercial and health interests and the protection of public health policies from TI interference are examined in Chapter 7.

Chapter 6. The ideas shaping intersectoral governance of tobacco in Fiji and Vanuatu

This chapter presents the findings on the ideational conditions shaping the governance of tobacco control in Fiji and Vanuatu. Previously, Chapter 5 examined the interests involved in tobacco control governance in the two countries, and it identified ways in which authority is wielded by actors to pursue their interests and influence tobacco control. Schmidt (472) argues that "*interest-based behaviour certainly exists, but it involves ideas about interests that may encompass much more than strictly utilitarian concerns*". The findings presented in Chapter 5 suggest that this might be true in tobacco governance in Fiji and Vanuatu. Therefore, the research questions being explored in this chapter are the following: (i) "What are the dominant ideas about tobacco use and the NCD crisis in Fiji and Vanuatu?", and (ii) "How do they influence tobacco control?"

Schmidt's (472) classification of ideas differentiates between three levels: policy solutions, programmatic ideas, and "deep core" ideas. She argues that there are two types of ideas that can inhabit the three levels: cognitive and normative ideas. She calls cognitive ideas causal ideas because they explain the practical aspects of a problem (see Chapter 3 for more details about this theory). Based on this classification, the ideas that this chapter examines are cognitive causal ideas, because they describe the cause of an issue and define the responsible actors (126). Normative ideas are not of concern in this research, because this analysis does not focus on how tobacco policy making is aligned with the values of society, but the ways ideas define policy and decision-making from an operational perspective.

Stone's (126) theory of causal ideas offers an operational way to analyse such ideas and their influence on tobacco control in Fiji and Vanuatu. Stone theorises ways in which actors identify and frame problems to serve their own interests by stating not only the issue but also its cause. Causal ideas therefore work to define the responsible actors who should be regulated and the agencies with the necessary authority to address the problem. The strategic use of causal ideas allows interest groups to increase their influence and undermine the authority of others. This theory is aligned with Avant et al.'s (125) arguments suggesting that an actor's authority can be strengthened or weakened by ideas and perceptions. As explained in the previous chapter, the framing of smoking and the NCD crisis in Fiji and Vanuatu plays a

role in determining the influence of different interest groups on tobacco control, and this chapter sets out to understand this role as it relates to governance.

The remainder of the chapter is organised as follows: Section 1 introduces the causal ideas that are prevalent in tobacco control and NCD prevention in Fiji and Vanuatu. Section 2 examines the dominance of these causal ideas and specifically the ways they influence tobacco control. The last section concludes the chapter by summarising the findings on the ways these ideational conditions shape intersectoral governance for tobacco control in Fiji and Vanuatu.

1. The causal ideas in tobacco control in Fiji and Vanuatu

According to Stone's theory of causal ideas, actors aim to frame a problem in a way that serves their interests by identifying the cause of the issue and the responsible party to resolve it. Stone explains that four types of causal ideas are most common in governance: intentional, inadvertent, mechanical, and accidental. The main difference between these ideas is where they direct blame. Intentional causal ideas argue that an actor was aware of the consequences of its actions and yet decided to pursue its activity. Inadvertent causal ideas suggest that actors were unaware of the impact of their actions. Mechanical causal ideas explain that something without a will or based on programming (e.g. a machine) functioned as it intended and has caused a problem. Accidental causal ideas state that what happened was unintentional and by accident. (See Chapter 3 for more details.)

The data from Fiji and Vanuatu exhibits two dominant causal ideas – intentional and inadvertent. The problems that these ideas aim to explain is the high smoking prevalence and the concomitant NCD crisis in Fiji and Vanuatu – *"we regard tobacco as one of the critical issues that we need to deal with, and as a risk factor for NCDs"* (V17). It is these that this chapter terms the "problem" or "issue" in the following. The next two sections introduce these ideas and explain where they direct blame, what solution they suggest, and who should be responsible for delivering such solutions.

1.1. The idea of individual responsibility

The cause: individual's lifestyle choices

The idea that was most pervasive in the collected data is that the high smoking prevalence in Fiji and Vanuatu is caused by individuals choosing to consume tobacco, either because they are unaware of its harm or disregard it. As the Minister for Health in Fiji states, *"if an individual wants to smoke and contract*

these NCDs, it is up to them" (612). The lifestyle choices of individuals are perceived to be the root of NCDs as well. The speech of the Minister for Health in the Fijian Parliament reflects this idea: *"We are facing a growing epidemic of noncommunicable diseases, sometimes called 'lifestyle diseases', which stem from changes in our diets, our exercise habits and our use of tobacco and alcohol"* (624). Another legislator in the Fijian Parliament expresses: *"Noncommunicable diseases are on the rise because of the ignorance of people to maintain the lifestyle of older generation"* (625).

In Vanuatu, the interviewee data reveals the same idea; as a government official states: *"the high NCD prevalence is due to people not having awareness"* (V27). A participant working for a CSO in Vanuatu explains that high smoking prevalence stems from people underestimating its harms: *"It's a massive issue and people have no idea what it's doing. […] Because young people feel invincible. They do not think they're going to die. So they just carry on doing whatever they want to do"* (V13).

The solution: health promotion and awareness raising

In Schmidt's three classification levels, the causal idea of individual responsibility in high smoking prevalence and the NCD crisis (from now referred to as the idea of individual responsibility) can be considered programmatic because it points towards a solution, which is that individuals need to take responsibility for their health. As a Fijian legislator argues: *"I am a firm believer that everyone needs to take greater responsibility for their own health*" (626). Similarly, the Minister for Health of Fiji stated in a Parliamentary speech in 2016:

> *We must acknowledge that each one of us plays a vital role in protecting and promoting our own health, and the health for our families and our loved ones. NCDs are a challenge that can be successfully mitigated if each one of us takes responsibility for eating well, exercising and avoiding smoking and alcohol (627).*

A ni-Vanuatu participant working for a development partner confirms that this idea of individual responsibility is also deeply present in the Vanuatu government regarding tobacco control: *"it's on the assumption that everyone can quit smoking 'cold turkey' which, you know, the government expects"* (V27).

According to several government officials in Fiji and Vanuatu, the government should empower the public to take responsibility for their health through health promotion and awareness raising: *"Fijians are in dire need of being steered away from their usual norms, and should be educated tirelessly on the perils of unhealthy lifestyle habits"* (21).

The statements of government officials in Vanuatu are aligned with their Fijian colleagues' approach: *"A lot of promotion makes people become aware about the harms of smoking; it gets a bell ringing in their*

mind" (V02). A ni-Vanuatu MoH official suggests that "*once they understand its [tobacco use] effects on their lives, they will slowly quit"* (V23).

The Minister for Health regularly argues in the Fijian Parliament that health promotion, awareness raising on the harms of consuming tobacco and other harmful commodities, is the way to induce behaviour change for a healthier lifestyle:

> *NCDs can be prevented with proper diet, physical activity and, of course, discipline when it comes to getting regular checks and taking their medication. […] The Centre for Noncommunicable Diseases […] is creating a lot of awareness programmes within our communities but at the end of the day, if I may say, it is about choices, lifestyle and it is something that we all know, but we want to draw inspiration from someone else to tell us what to do (628)*.

The responsible party to deliver the solution: MoH

Within both the Fijian and Vanuatu governments, MoH is seen as the responsible party to provide health education. An interviewee in Vanuatu explains this duty in the following way:

> *Noncommunicable diseases are becoming a big issue for the government of Vanuatu. […] We want to make sure that, both sides of public health and curative services somehow meet so that we deliver to people the requirement that* ***they not only treat but they also educate people about the changes they need to do in their life*** (V09, emphasis added).

The idea of individual responsibility is closely connected to the biomedical paradigm about NCDs – the understanding that diseases are caused by genetic and behavioural factors (see Chapter 2) – and it determines the health sector strategy to tackle NCDs in Fiji and Vanuatu (629–632). As a high-level MoH official states in Vanuatu*: "The core business of MoH is awareness, the PEN*[36] *training, and screening"* (V17). The quote below from the Minister for Health in Fiji demonstrates this connection between the idea of individual responsibility and the biomedical paradigm:

> *A key to the Ministry's response to NCDs in Fiji is improvement to its primary health care system, that is the delivery of services at all its nursing stations and health centres. […] Some examples of the Ministry's activities in these areas include: Firstly, promoting healthy lifestyle in childhood from conception to 18 years, through community health workers, antenatal clinics, maternal and child health services; and secondly, school health programmes. [...] The Ministry of Health is committed to achieving its vision of*

[36] PEN stands for the "WHO Package of Essential NCD Interventions", a toolset promoted by WHO to diagnose and treat NCDs in resource poor settings (633).

> *a healthy population by empowering everyone to take responsibility for their health (612).*

The idea of individual responsibility is pervasive not only within the government but also among some development partners. Participants working for such organisations explain that health promotion activities and the strengthening of primary health care are the most common focus areas of development (V07, V26, V29, F26, F27). An interviewee at an intergovernmental organisation expresses belief in the responsibility of MoH for changing the behaviour of the public: *"I think it's very challenging for the Ministry [of Health] to motivate the community to be able to start taking some more responsibility and understanding what the impact of the decisions they take now have"* (F34).

As the agency responsible for delivering health promotion and curing diseases, MoH is often held accountable for the NCD crisis – particularly in Fiji. The inquiry of a legislator in the Fijian Parliament reflects this: *"Can the Honourable Minister for Health inform this House why noncommunicable diseases appear to be increasing; and what is being done to curb this?"* (613). Several governance actors suggest the poor performance of MoH is the reason behind the NCD crisis [paraphrased, F28]. A government official explains how non-health government agencies tend to interpret the role of MoH in the rising prevalence of NCDs:

> *Health is a big part of the government budget. If it's not managed properly, it can affect the government budget significantly. Thus, the government tries to deal with minimising this going forward in the future generations.* ***Making NCD awareness across the country is really important.*** **[…]** ***If MoH does not do well with educating the public, the families in the household, then that can be a burden for the government in the years to come*** (F22, emphasis added).

However, some government officials working in MoH revert back to the role of individual responsibility: they express their opinion that the agency can offer education to the public, but ultimately it is up to individuals to heed to the advice. *"You want to smoke, this is your choice. We have given you everything you wanted to know"* (V22) (referring to the health promotion activities). *"Some people know [about the harm of smoking], but they are addicted already, so they just continue"* (V23). A participant in Fiji states the following about the attitude of MoH officials, *"to them tobacco is a legal product, if people want to smoke…[shrugs]*" (F06).

Figure 8 summarises what the data shows about the causal idea of individual responsibility. The figure reflects the theoretical constructs of Stone's theory: what is the cause, and who is responsible for solving the issue? The data suggests that in Fiji and Vanuatu the idea that high smoking prevalence is the result

of bad individual choices about tobacco use defines that individuals taking responsibility for their own health has to be the solution. The government can enable this through educating the public, and the agency responsible for this is MoH. However, the perception based on the interviewee data and Parliamentary Debates is that the agency is not doing a good job of this. Nevertheless, officials working within MoH like to argue that health promotion is provided, but whether individuals follow the advice is up to them – thus, ultimately individual responsibility remains in the centre of attention.

Based on Stone's theory, the idea of individual responsibility belongs to the category of inadvertent causal ideas, because individuals' consumption of tobacco and other harmful commodities have a predictable negative health impact which is either not understood or disregarded by the individuals themselves. The idea of individual responsibility directs the blame solely to the consumers. Stone argues that blame is usually shifted on the *raw material provider – manufacturer – seller – consumer* axis in the case of substance use, and when the consumer is argued to be the cause of the issue, it is often called "victim blaming".

1.2. The idea of commercial determinants of health

The other idea around the high prevalence of smoking and the NCD crisis in Fiji and Vanuatu is that they

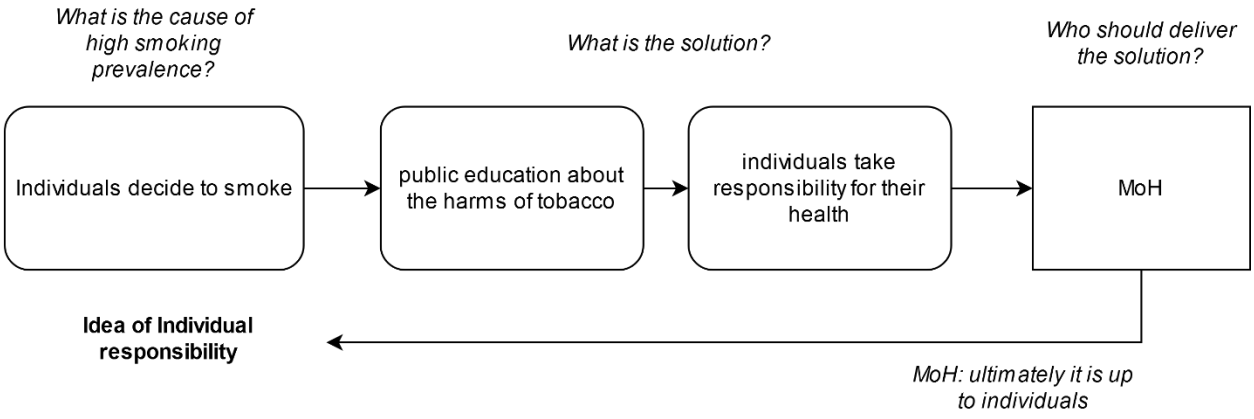


Figure 8 The causal idea of individual responsibility in tobacco control in Fiji and Vanuatu

are driven by commercial determinants. This idea is closely related to the concept of commercial determinants of health (CDOH) described in Chapter 2.

The cause: wide availability and affordability, and addictiveness of tobacco products

Several participants (F03, F05, F26, F28, V17, V27, V30) expressed the view that the increased availability and affordability, and the addictiveness of tobacco products are responsible for the high smoking

prevalence in Fiji and Vanuatu [paraphrased, F26]. Others (F02, F10, F21, F22, V09, V19, V17) added that harmful commodities in general have been easier to access in recent years – *"everyone can access now rubbish food"* (V22) – which contributes to the rise of NCDs [paraphrased, F02]. A legislator in the Fijian Parliament speaks about this in the following way:

> *The health environment had undergone a massive transformation over the last two decades which has promoted countries to invest in research to respond accordingly.* ***Our people are being exploited to more cheaper goods that are unhealthy, people are eating under-nutritious meals, increased tobacco and alcohol consumption, work stress and lack of physical activities*** (26, emphasis added).

Multiple participants in Vanuatu highlighted the affordability and availability of harmful commodities. Government officials explain that tobacco and ultra-processed foods are cheap, and one can buy them everywhere. They express their understanding that while they are educating people about healthy choices, regarding diet, in the end people eat what they can afford [paraphrased, V22 and V19]. Other interviewees stressed the highly addictive nature of tobacco products [paraphrased, V23 and 27]. As a Fijian participant suggests:

> *Our population, the knowledge is there, but whether that knowledge is enough to change behaviour, that is something else. […] Maybe knowledge is not enough, what our population have, in order to make that positive behavioural change* (F10).

Several participants direct the blame to the trade sector: *"Trade is the problem, as three out of four NCD risk factors are trade factors"* (F02), argues a high-level MoH official in Fiji, referring to tobacco, alcohol, and ultra-processed foods and drinks. In Vanuatu, the Minister for Foreign Affairs and External Trade agrees with this: "*we need to stop some of these things coming in"* (V25). A government official in MoH in Vanuatu suggests: *"We need to convince the government to realise that anything that is being brought into the country will affect health determinants"* (V09). As a Fijian legislator says about this:

> *If the Honourable Minister and the Government of the day are more serious with alleviating NCDs, then they must weigh their political will with* ***economic demand from business entities****,* ***especially those who contribute toward increasing NCDs*** *(612)* (emphasis added).

The language used by the participants describing the responsibility of the tobacco industry and other harmful commodity industries (e.g. *"business entities […] contribute toward increasing NCDs"* (612)) is very much aligned with the concept of CDOH (described in Chapter 2). Although government officials do not explicitly use this term, the data describes tobacco availability, accessibility, affordability, and addictiveness suggesting that the concept of commercial determinants is a present idea in tobacco control

in Fiji and Vanuatu. From here this idea is referred to as the idea of CDOH.

The solution: regulation of tobacco industry

Similar to the idea of individual responsibility, the idea of CDOH can be classed as a programmatic idea, because its problem definition offers a solution. Participants in Vanuatu suggest shifting attention from health promotion to regulating the "enabling factors": *"There are a lot of campaigns, there is a lot of information sharing, a lot of health promotion, sport in radio, in TV, in posters, in training, screening. It is more to do with enabling factors"* (V29).

In 2018 a Fijian legislator pointed out in the Parliament the tendency of the government to focus on individual responsibility in the NCD crisis, and explained his idea about shifting attention to CDOH:

> *Sometimes when we want to address NCDs, we just talk about telling people to make the right choice. That is the difficult thing to do, to just tell people 'You have got to eat right. You do not drink this, you drink that. Make sure you put this gas into your lungs rather than that gas' […] But what Government can do is to create an environment in which people are encouraged to make the right decisions (635)*.

A government official in Vanuatu suggests a similar approach: *"There are two things [we should do]: giving options [of different products], and individuals need to be empowered to make the good choice. Both are needed, education and availability of options"* (V19).

In 2017 the Minister for Employment (who was earlier the Minister for Health) expressed his idea in the Fijian Parliament that besides health promotion the issue of the affordability of harmful commodities needed to be addressed:

> *These three products – cigarettes, alcohol and tobacco – are the biggest causes of NCDs. If you look at the amount of money that Government spends in hospitals for inpatients, most of it is because people are taking too much of these things. What we need to do in our country is to try to create an environment where people are compelled to do the right thing. How do we do that? Firstly, yes, we promote; we have programmes with schools; and we get people to come out and do visits. Secondly, we get things that are leading to these diseases to be more expensive* (27).

Price and tax policies are commonly discussed in both countries as effective ways to make tobacco and other harmful commodities less affordable for the public:

> *In the Ministry of Health, we have welcomed the increases in the price for cigarettes, alcohol and sugar-sweetened beverages. […] through this way, we hope that we will be able to encourage people to indulge less in this these risk factors and also help pay for the cost of running the hospital services (637)*.

Although the exact origin of the idea of CDOH in these countries is unclear based on the interviews, the FCTC is based on the understanding that both demand and supply side measures of tobacco control are needed to address the issue of high smoking prevalence (376); this supports the prevalence of the idea of CDOH in Fiji and Vanuatu. Furthermore, WHO has been providing significant assistance in developing rules around tobacco control, and it has emphasised the need to regulate the TI instead of merely focusing on health promotion [paraphrased, F26]. In Fiji there have been several capacity building workshops and events organised by the Secretariat of the Pacific Community, the United Nations Development Programme and WHO, where government officials and Parliamentarians were taught about the interface of health and trade and their connection to NCDs [paraphrased, F28]. While the term CDOH was not used by the participants working for these development partners during the interviews, the explanations they gave on solutions align with this concept, as they emphasise the need for regulating the activities of the TI (and other harmful commodity industries).

However, as the data introduced in Chapter 5 demonstrates, it is difficult to regulate the TI because of industry interference [paraphrased, F26]. Another participant in Vanuatu speaks about the food industry posing a similar obstacle to public health policies:

> *The food that is allowed to be sold in stores, like sweet canned drinks, are just poison really, and probably shouldn't be allowed. But we've become so used to them and it's such a big industry, the food industry is so powerful that it's very hard to stop* (V13).

The leader of Opposition argued in 2017, in the Fijian Parliament, that commercial interests need to be kept in check by the government to solve the NCD crisis. His speech demonstrates recognition that the interests of harmful commodity industries are impeding the government of Fiji in its effort to address NCDs.

> *The reality now, is that, at the same time the Ministry of Health is preaching about eradicating NCDs, the Government is promoting and encouraging advertisement and marketing of junk food and drinks, like Coca-Cola, Fiji Bitter, Fiji Gold and many more. [...] Raising taxes may be politically challenging for Government, however, if it wants a gain in the public health by alleviating NCDs, then it needs to sacrifice the political pain by raising taxes on products that most contribute to NCDs, including tobacco, alcohol and unhealthy foods and sugar-sweetened beverages (612).*

The responsible actor(s) to deliver the solution: MoT, MoE, MoA, and MoH

The data reflects that regulation of TI and other harmful commodity industries is seen as the solution by those who adopted the idea of CDOH. This idea dictates that government agencies other than MoH need to become involved, because the health sector does not have the mandate to regulate sectors such as

trade, economy, and agriculture. A participant in Vanuatu speaks about the need for multisectoral commitment in the following way:

> *The issue now is that we get this issue and we put it with the **Minister for Health**. But **a lot of these issues are beyond his control**, to make regulations **to stop imports of things** – it is not his responsibility. That is why tobacco control for example, is very difficult, because when you look at the Tobacco Control Act, a few of them like health promotion and things fall directly within the mandate of Ministry of Health. But when it goes beyond like inspections, ensuring that packets of singles are not sold, that's not MoH. We need the support of other policing in agencies* (V29, emphasis added).

Following this line of thinking, an ex-Minister for Health argued in Parliament in 2017 that MoH cannot tackle NCDs alone and called for multisectoral involvement: *"NCDs present a significant challenge to the health of our people and to the economic wellbeing of our country. As I have said, NCDs must be tackled by all sectors and not the health sector alone"* (612). Interviewees in both countries emphasised the need for stronger engagement from non-health government agencies: *"It has to be more than the MoH doing the enforcement. Currently they see it as the responsibility of MoH. I think it is broader than health; we need to look at border control, police, society"* (F02).

A government official in Vanuatu suggests that in tobacco control the point-of-sale regulations should be implemented by MoT and the Ministry of Internal Affairs or Local Government, and the health-related provisions by MoH [paraphrased, V05]. Another ni-Vanuatu government official argues the same and speaks about the need for policy coherence:

> *We have Agriculture, Finance, Customs, and Trade; they have their own jurisdictions, Health has its own. If you look at the policies, some of them are things which we [MoH] do not have control over. Like sales of cigarettes for MoH, it is actually a trade matter, but the TCA [Tobacco Control Act] falls into health. From my personal point of view, if you become sick, your treatment is my responsibility, and the same for the promotion for healthy practices. That's under my control, I have the skills and knowledge. Trade is more about controlling the market and buying, so you end up in a position that you can control the sale of the products. […] We need to get our roles to its proper places, so we do the best jobs to our skills, and we leave the others to those who are specialised on it and have the mandate to do it. That way we are seeing ourselves to be playing the same tone of music, so everyone can hear the same. You do your part, I do my part. But for the same cause* (V19).

This emphasis on multisectoral action and policy coherence is connected to the idea of CDOH, because it implies that only multiple actors from different sectors can solve problems caused by factors outside of the health sector. The data indicates that participants see the need for assigning responsibility to the trade, economy, and agriculture sectors as well as health, which is a major difference from what is

suggested by the idea of individual responsibility, where MoH is seen as the only actor accountable for solving the NCD crisis.

In summary, the concept of CDOH in light of Stone's theory can be interpreted as a causal idea, because it defines the cause of NCDs – the products and activities of harmful commodity industries – and the solution – the regulation of these industries. The idea of CDOH can be classed as an intentional causal idea because the tobacco industry is aware of the harm it causes to population health by the sale of its products. The data indicates that in Fiji and Vanuatu many participants have adopted this idea, even though they do not use the term CDOH. However, while the scholarship on CDOH blames the harmful commodity industries, in Fiji and Vanuatu the participants placed more focus on the government agencies that are responsible for delivering the solution. When this fails, the regulator becomes the "scapegoat", and the blame is shifted to them from the industry.

Figure 9 summarises the data presented in this section. It shows that the causal idea of CDOH in regard to tobacco control in Fiji and Vanuatu is based on the understanding that the cause of the high smoking prevalence is that tobacco products are widely available, affordable, and highly addictive. This idea defines that the solution is to regulate these products. The data demonstrate that multisectoral action is seen as the way to do this, which would require the involvement of MoT, MoA, and MoE.

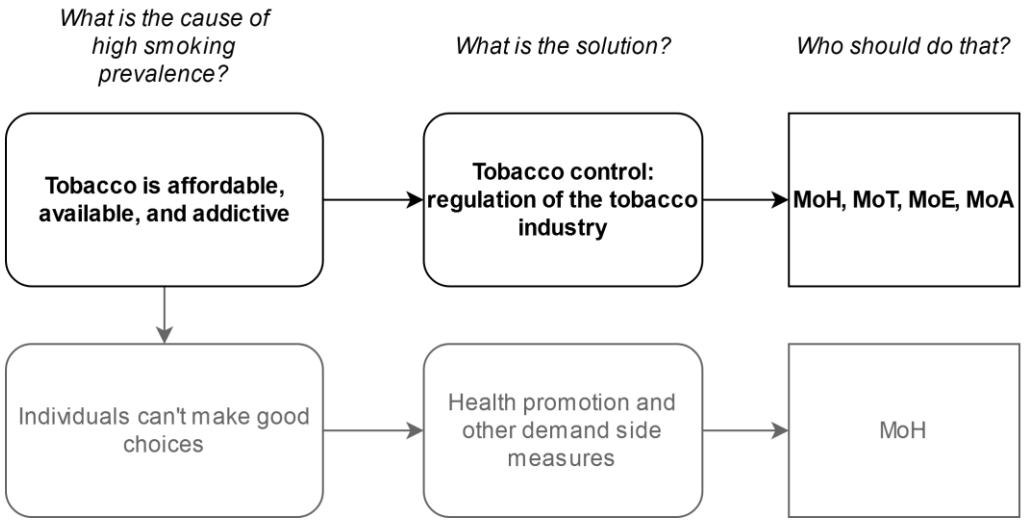


Figure 9 The idea of commercial determinants of health in tobacco control in Fiji and Vanuatu

2. The influence of causal ideas on tobacco control in Fiji and Vanuatu

The previous section discussed two causal ideas common in Fiji and Vanuatu around high smoking prevalence and the rise of NCDs: the idea of individual responsibility and the idea of CDOH. The idea that becomes dominant has crucial implications on tobacco control, because it defines what actions are taken, who is regulated and who has the authority to do that.

Many interviewees (V07, V13, V17, V22, V23, V27, V29, F02, F04, F06, F26) agree that in recent years MoH in Fiji and Vanuatu have been struggling with enforcing the regulations. Besides human and financial capacity challenges, in both countries the main issue cited by the participants was that MoH is the only government agency that proactively implements tobacco control measures. As a government official working in MoH in Vanuatu explains, "a *lot of time it [tobacco control] is just translated to MoH policies. It should get it into other sectoral policies and implementation plans*" (V29). Another participant in Fiji adds that non-health government agencies rarely consider the health impact of their policies in both countries: *"Those little things that we think every ministry they can tailor their policies to have the NCD focus – nah, that's not happening"* (F14). These data suggest that the idea of CDOH is less spread throughout the governance circles of Fiji and Vanuatu, compared the idea of individual responsibility.

The following comment from another interviewee working for a development partner confirms that many actors seem to act based on the assumption that MoH should solve the issue of smoking prevalence and the NCD crisis alone:

> *I think they are not deaf to the public health argument, but they are still thinking in silos. Health is MoH's problem. Our problem is to build the economy. They are receptive when you tell them that NCD crises causes a lot of premature death and this is costing a lot of money, so the sort of economic analysis. They listen to it but still it does not mean that they necessarily are going to act on it, because they simply do not see it as their mandate* (F28).

An interviewee working for MoH suggests the same issue in Vanuatu:

> *We need to initiate if we want something. For example, if we want restrictions on Chinese imports in certain products or to strengthen our border protection, Health has got to play that role, to push for that role. They do not want to be pushing certain agendas: if it's related to health, it has got to be pushed by MoH* (V06).

The data demonstrates that the idea of individual responsibility with its focus on health sector action is more dominant among high-level government officials than the idea of CDOH. As a MoH official in Vanuatu explains *"we know what the health issues are, but we cannot control the determining factors. Some of our leaders, maybe they need to understand that NCDs and these issues depend on other things"* (V19).

An interviewee suggests that in Fiji the AG has adopted the biomedical approach to NCDs: "*He [AG] is a key person. He does not seem to be able to link NCDs to lifestyle, tobacco, alcohol; the way he is talking he is moving into setting up tertiary hospitals, dialysis, etc.*" (F02).

Stone's theory argues that the influence of the promoters of a causal idea has a major impact on the idea becoming dominant. As discussed in Chapter 4, the AG in Fiji is among the most influential individuals in the government, and also the Minister for Communication. According to a participant working for a development partner, the Fijian media is closely monitored by the government [paraphrased, F26]. This gives an advantage for the AG to use the media to propagate his preferred ideas, and news articles such as "*Tobacco control requires community efforts"* (638) or *"NCDs Linked To Parents' Negligence"* (639) support this assumption.

While the above examples can be interpreted as structural fragmentation in the government, the data suggests that the strong understanding that MoH is responsible for handling this issue is behind the siloed accountability of MoH. The following quote from the Parliamentary Debates in Fiji demonstrates that it is politically challenging to direct blame to other government agencies, even when the role of CDOH is made fairly clear (613). The quote reflects that the idea of MoH responsibility is strongly embedded in the Fijian Parliament: when a member of the opposition questions the AG's decisions on supporting tobacco industry investment, the Speaker of the House directs the question to the Minister for Health.

> *MEMBER OF PARLIAMENT (MP): There are a few issues which I would like to raise with the Government regarding NCDs because* ***the Honourable Attorney-General****, he is talking, he* ***opened a tobacco plant facility two weeks ago in the West, so I am puzzled as to whether he is supporting smoking or he is against that****.*
>
> *The other issue is uncontrolled advertisement of liquor. We see it on the board here in the City and also sponsorship by junk food companies of sports events, like Coca-Cola, Twisties, et cetera, so what is the Government's view on this? Are they supporting things which cause NCD or are they against it?*
>
> *SPEAKER OF THE HOUSE (SPEAKER).- Honourable Member, the Minister for Health is the one who is answering the question.*
>
> *MP.- Yes, I am asking the Honourable Minister.*

> *MINISTER FOR HEALTH.- Thank you, Honourable Speaker. I was a bit confused because he was asking the Honourable Attorney-General, but anyway, I had said earlier ….*
>
> *SPEAKER.- I will make the correction. He was asking the Honourable Attorney-General, yes, but the Honourable Attorney-General was not answering the question in the first place that was asked.* ***You are the Minister responsible for this*** *(613)* (emphasis added).

The interviewee data also suggest that the strong attachment to siloed thinking is not present when other topics are on the agenda: in Fiji, the AG frequently makes decisions on other health sector matters. A participant recalled a case when the MoE made a policy on pharmaceutical regulation; MoH was informed and consulted only a couple days before it was introduced to Cabinet, and thus no major adjustments were made to accommodate the concerns of the health sector:

> *There was one example of a health-related legislation; from recollection it was something like changing the regulation around pharmacies. Basically the amendment was proposed, drafted, all in the absence of MoH. Virtually a night before it was proposed to Parliament, someone gave a copy to MoH: 'just let you know, this is what's going to happen tomorrow.' And there were actually some other implications which haven't been considered, so then there was a bit of a mad scramble from health to try to influence at least a certain extent, like 'uhh, have you thought about x, y, z'. But that is probably an example of how things happen here (F34).*

Other interviewees mentioned a case of a recent tender by MoE on running two hospitals in Fiji; they explained that the decision on the winner was made without the involvement of MoH [paraphrased, F23, F35]. The data implies that the idea of individual responsibility is often applied in a strategically calculated way to support particular interests. These findings suggest that, at least in Fiji, the siloed approach to MoH responsibility in NCDs is strongly connected to ideational issues and based on the dominant idea of individual responsibility.

The weakness of the idea of CDOH within the governments of Fiji and Vanuatu is demonstrated by the fact that the non-health government agencies seem to appreciate the socioeconomic costs of NCDs, but they either do not recognise or are not willing to admit the impact of trade, agricultural and economic policies on NCDs. As a government official states, *"for economic purposes it will benefit the country, but maybe we need to not consume locally, but export"* (V02). The interviews suggest that until the non-health ministries recognise the effects of their policies on public health, and fully appreciate the negative impact of NCDs on reaching their objectives, they will not engage with tobacco control.

> *If you can make the argument that this is something we need to tackle for economic reasons, then you say, 'okay, well, how do we tackle', then you can scare people. But if*

> *you haven't won the argument that governments think we have to do something about this for economic reasons, then they will be probably less likely to accept the sort of different change* (F29).

Further reflecting the dominance of the idea of individual responsibility, the interviewee data suggests that most measures implemented focus on consumer demand, while the regulation of the TI is not in focus. According to a number of interviewees, measures on smoke-free places, labelling, and health promotion are generally seen as successfully implemented policies in both countries, but the enforcement of several other regulations such as point-of-sale measures, and registration fees and penalties, are often seen as inadequate (V07, V13, V17, V22, V23, V27, V29, F02, F03, F04, F06, F26). In Fiji, the bans on tobacco industry sponsorship and advertisement are especially problematic as the government itself regularly breaches the law[37] when posting news articles citing various projects funded by BAT (640).

The limited understanding of CDOH results in blaming the public and MoH for the high smoking prevalence or NCDs, as the idea of individual responsibility implies that only MoH has the mandate to act on such matters. This results in MoH trying to implement tobacco control mostly alone (except for the taxes on tobacco which are collected by MoE). The data indicates that tobacco control in Fiji and Vanuatu is influenced by the ideas of both individual responsibility and CDOH. However, the interviewee data suggests that in higher government circles the former is more dominant, and their opinion on the implementation of tobacco control measures implies that there is more focus on policies targeting the public than on the tobacco industry itself.

3. Summary

This chapter has provided an analysis of the ideational conditions that influence intersectoral governance for tobacco control in Fiji and Vanuatu. It sought to answer two questions: (i) "What are the prevalent ideas about the NCD crisis in Fiji and Vanuatu?", and (ii) "How do they influence tobacco control?"

The two prevalent ideas in tobacco control in Fiji and Vanuatu are summarised in Table 9. The idea of individual responsibility explains the roots of the NCD crisis as the fault of citizens making unhealthy lifestyle choices and places the responsibility for government action with the MoH as the lead for health promotion. In contrast, the idea of CDOH argues that harmful commodity industries drive the NCD

[37] Part 2, Section 5 of the *Tobacco Control Act 2010* – which allows sponsorship from the tobacco industry, but forbids naming the contributor (578).

epidemic, and the sectors that regulate these private actors should be kept in closer check to ensure that their policies are aligned with the objectives of public health.

Table 9 The influence of causal ideas on tobacco control in Fiji and Vanuatu

Causal Idea	Individual responsibility	Commercial determinants of health
Type of causal idea	Inadvertent cause	Intentional cause
Who/what is the cause of the problem?	Individuals choose to live an unhealthy lifestyle	The tobacco industry and their affordable and widely available products
Who/what needs to be regulated?	The public	Primarily the tobacco industry, but the public as well.
How does it need to be regulated?	Health promotion	Primarily industry regulation (supply side measures), but measures targeting the public are needed as well (demand side measures).
Who is responsible for this regulation?	MoH	MoT, MoA, MoE, MoH
Who is blamed for the success/failure of this regulation?	MoH/public	MoT, MoA, MoE, MoH

The interviewee data suggests that the idea of individual responsibility has more influence over tobacco control in Fiji and Vanuatu than the idea of commercial determinants. Although adherence to FCTC requires the implementation of multisectoral policies through the involvement of a wide range of government agencies, an approach that is more connected to the idea of commercial determinants, MoH is left alone to implement tobacco control in Fiji and Vanuatu, which implies the dominance of the idea of individual responsibility.

Having now looked at interests (Chapter 5) and ideas (Chapter 6), Chapter 7 examines how institutional conditions influence the governance of commercial determinants of NCDs in relation to tobacco.

Chapter 7. The institutional conditions shaping intersectoral governance of tobacco in Fiji and Vanuatu

Chapters 5 and 6 discussed the interests and ideas important in tobacco control in Fiji and Vanuatu. The focus of this chapter is on the institutional conditions that influence the intersectoral governance of commercial determinants of noncommunicable diseases (NCDs) in relation to tobacco in these countries.

The literature reviewed in Chapter 2 highlights the importance of institutional structures in enabling policy coherence and protecting public health policy making from vested interests. While the former focuses on the actors and interests within the government, the latter concentrates on the influences coming from external sources. Both are argued to be necessary in order to implement comprehensive, multisectoral tobacco control policies. Therefore, the objective of this chapter is to identify the institutional conditions that shape intersectoral governance for tobacco control in Fiji and Vanuatu with a particular focus on forging policy coherence and resisting tobacco industry (TI) interests. This chapter discusses institutional conditions as the factors arising from the legal and administrative structures of political and governmental agencies.

Section 1 focuses on the question: "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?" The analysis is informed by the theory of institutional collective action (ICA) (127), and it reveals that the multisectoral NCD committees in Fiji and Vanuatu are not the ideal intersectoral mechanisms to achieve policy coherence in tobacco governance. In Section 2 the question being investigated is "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?" The administrative process theory (128) is used in answering this question, and it explains why the institutional structures in their current form do not ensure the elevation of health interests in tobacco governance. Section 3 summarises the results presented in this chapter and reflects on how institutional conditions intersect with the different interests and ideas discussed in the earlier chapters.

1. Policy coherence for tobacco control

Article 5.2 of the FCTC requires that countries create a national coordination mechanism which ensures the development and implementation of multisectoral tobacco control policies (376). Such a coordinating mechanism can include a national Focal Point for Tobacco Control (FPTC) (376). The interviewee data shows that a Ministry of Health (MoH) officer receives such a title in both countries. In Vanuatu, the designated FPTC declined to participate in this study, and the interviewee data from other MoH officials revealed no specific role for this individual in facilitating multisectoral collaboration on tobacco control. In Fiji an ex-MoH official explains that during the development of tobacco control regulations (641) the FPTC organised consultations with the affected sectors:

> *First it was consultations when we were looking at changing the policies. […] We had first quarterly meetings, we informed them what's happening, what's the progress. Also, this is where we agreed on the time they need to comply with the new regulations* (F04).

However, these regular meetings have not been organised since the regulations were passed in 2013. As a MoH official in Fiji states: *"We have meetings on an* ad hoc *basis when we need to talk. And lots of informal discussions"* (F03).

Participants cited multisectoral committees on NCDs in both countries as the dedicated mechanism to forge policy coherence for tobacco control (F02, F03, F06, F26, V12, V17, V22, V23). The analysis presented in the next three sub-sections reveals how these committees function in regards to intersectoral collaboration in Fiji and Vanuatu. Section 1.1 identifies the institutional collective action (ICA) dilemma that the multisectoral committees in Fiji and Vanuatu are dedicated to resolving. Section 1.2 introduces the way this intersectoral mechanism operates in the two countries. Section 1.3 analyses how institutional conditions influence the ability of these multisectoral committees to address the ICA dilemma.

1.1. The institutional collective action dilemma: policy incoherence in tobacco governance

The ICA dilemma in tobacco governance in Fiji and Vanuatu is the issue of policy incoherence. While it is outside of the scope of this study to determine the level of (in)coherence between policy fields in tobacco governance, the collected data reveals that it is indeed a problem in Fiji and Vanuatu. As described in detail in Chapter 5, the pro-health actors are working towards better tobacco control, while the pro-commercial actors aim to support the TI. Participants working for (different) development partners

suggest that in Fiji policy incoherence in tobacco governance is a major issue between government sectors (F28, F26). One of them explains this in the following way:

> *MoH is trying its best to implement the FCTC, while the Ministry of Agriculture gives grants to farmers to grow tobacco. And the commerce [Ministry of Trade], I assume is casual with BAT [British American Tobacco], who is a rich company, providing grants to farmers, free seedlings, free fertilisers, so there is no coherence* (F28).

In Fiji, besides the tobacco control laws, there has been only one piece of legislation passed since the 2005 ratification of FCTC that is concerned with tobacco: the Foreign Investment Regulations 2009 of the MoT requires domestic tobacco manufacturing to use locally grown tobacco (574). This legislation supports tobacco farming in the country by encouraging manufacturers to buy their crops. This measure is contrary to the efforts of Article 17 of FCTC, which requires a shift from tobacco farming to viable alternatives (376).

Government officials (V01, V02, V16, V17) in Vanuatu also admit that MoT and the MoA work against the interests of MoH when they support tobacco investment. The regulations to facilitate tobacco farming, once developed, will be the first legislation besides the TCA and the Excise Tax law (642) affecting tobacco governance. While the latter two align with the aim of supporting tobacco control, the former will work against it.

Reaching policy coherence in tobacco governance in Fiji and Vanuatu is a functional collective action dilemma and more precisely a negative externality problem, because the policies of the different government agencies responsible for aspects of tobacco governance have a detrimental impact on each other's work. Furthermore, the opposing mandates of the actors involved raise a defection problem that means that there is a high likelihood that certain actors will decide to not participate in the collaboration. Feiock (127) argues that these types of issues are the most difficult to solve, and thus the risk of collaboration breaking down is high. Therefore, such a problem requires that significant authority be applied in the intersectoral mechanism to ensure that the involved parties are committed to solving the issue together. In both Fiji and Vanuatu, the dedicated intersectoral mechanisms to resolve this problem are the multisectoral NCD committees organised by MoH.

1.2. Issues with the multisectoral committees

A participant working for a development partner explains that due to their small size and resource constraints, Pacific small island developing states (PSIDS) rarely have a dedicated unit or working group

solely for tobacco control; instead, NCD prevention and the regulation of unhealthy commodities are usually discussed together [paraphrased, F27].

In Fiji, the National Multisectoral Taskforce on NCDs is a committee organised by MoH, and involves Customs, MoE, Department of Tourism and the Department of Trade of MoT, and the Ministry of Local Government, Housing and Community Development [paraphrased, F26]. The WHO and the Secretariat of the Pacific Community are invited to attend the meetings [paraphrased, F26]. A MoH official explains that the taskforce is set to meet twice a year: "*we try to have a 6 monthly working group"* (F06).

A high-level MoH official states that *"the traditional way to get sectors to work together is to form a council, and you regulate it in such a way that all the PSs [Permanent Secretaries] have to attend. That has proven not to work"* (F01). The interviewee data shows that the committee struggles to bring all the necessary actors together. Participants confirm that it is difficult to engage some of the agencies, particularly MoT and MoE: *"when MoH calls for a multisectoral meeting, MoT does not go. […] The same for Finance [MoE]; especially them"* (F28). *"We were finding it hard to get them on board, because Trade [MoT] is pro-tobacco"* (F06). Another MoH official states: *"Trade is the problem. […] They do not come to the table now, they refuse to come"* (F02).

In Vanuatu a high-level MoH officer states that there is a multisectoral NCD taskforce to facilitate policy coherence in tobacco control:

> *We have a national NCD taskforce. It is supposed to be a multisectoral working group that meets every month, and discusses matters relating to especially NCD prevention and control. So, obviously, we do not only talk about tobacco because we want to do things in an integrated manner* (V17).

However, other current and ex-MoH officials (V12, V15, V22) explain that the taskforce is not in operation anymore:

> *In the NCD plan phase 1 and 2 during the review there was a multisectoral committee, but in the last one there is not. So in the past year and this year I do not see this committee functioning* (V12).

> *I'm not sure that a multisectoral collaboration ever really took off. There was one meeting but after that, I'm not sure if anything's been undertaken* (V15).

This data shows that in Vanuatu the multisectoral NCD taskforce, which would facilitate policy coherence for tobacco control, is not functioning. However, the country has another multisectoral committee intended to harmonise trade policies with other sectors: the National Trade Development Committee

(NTDC) serves as a multisectoral mechanism where decisions are made on the trade priorities of the country, including trade in tobacco.

A government official explains that *"NTDC is the biggest committee on trade held three times per year, it consists of the public and private sectors, donors and CSOs. This is where we get direction for the [trade] negotiations. The committee is chaired by the Deputy Prime Minister"* (V01). When asked if the health sector is involved in this multisectoral forum, the participant replies: *"MoH… we missed them somehow… They never attend the NTDC."* A high-level MoH official (V17) and a MoT official (V24) confirm this statement as well.

This is significant because the NTDC had an important role in the negotiations of the Pacific Agreement on Closer Economic Relations (PACER) Plus agreement between Vanuatu, Australia and New Zealand. PACER Plus has significant implications for tobacco control due to Vanuatu agreeing to drop the duties on tobacco products from 55% to zero until 2052 (586). This means that if these provisions enter into force, imported tobacco products will likely be cheaper in Vanuatu. This is contrary to the efforts of tobacco control, and a classic example of policy incoherence[38]. It is therefore important to understand why MoH is not involved in the multisectoral committee that discusses such trade matters in the government[39].

The data indicates that the multisectoral committees introduced above face challenges in forging policy coherence in tobacco governance: they are either not functioning or not all necessary parties attend relevant meetings. This is important, because there is no other mechanism in place in Fiji and Vanuatu which would be tasked to achieve policy coherence for tobacco control. As the next section demonstrates, examining the institutional conditions that influence the operation of these multisectoral committees is key to understanding why they struggle to fulfil their purpose.

[38] While some government officials (V01, V20) explain that the excise tax will be increased to ensure the high price of tobacco, another participant (F26) working for development partner organisations explains that LMICs often are unable to administratively implement domestic taxes.

[39] The interview data shows that before the PACER Plus negotiations Customs liaised with MoH to learn about the health priorities for the treaty. During these discussions an agreement was reached between the two agencies that tobacco will be placed on the exempted list, which means that the duty rates of these items will not be affected by the treaty. This would have ensured that the price of imported tobacco remained high once the treaty enters into force. While Customs have represented the arguments of MoH in the discussions with MoT, during the negotiations Vanuatu gave up its stance on tobacco due to pressure from Australia and New Zealand, and tobacco was removed from the exempted list. After the negotiations MoH was not informed about this development, and in the time of data collection public health officers were confident that tobacco had made it to the exempted list.

1.3. The institutional conditions behind the operational issues

Feiock's ICA framework (127) argues that whether an intersectoral mechanism is able to serve its purpose and solve an ICA dilemma depends on a set of conditions. This section analyses these conditions in regards to policy coherence for tobacco control and the multisectoral NCD committees in Fiji and Vanuatu.

According to Feiock, the more actors need to be involved and the more legal force an intersectoral collaboration has, the higher the transaction costs are going to be but the more effective the mechanism is to resolve the dilemma. But not all problems require an expensive or forceful process in order to be resolved. If an issue has low collaboration risk - because the preferences of the involved parties are set close to each other, or the nature of the problem is more about coordination and less about conflicting benefits, or the political and institutional structures are supportive - then a more simple collaboration is likely to be effective, especially if the perceived net benefits are higher than the expected transaction costs (See Chapter 3 for more details).

1.3.1. Authority and complexity

Feiock categorises intersectoral mechanisms based on the range of actors and issues involved and the authority of its integration mechanism. The Fijian multisectoral NCD committee introduced in section 1.2. can be classed as a multilateral mechanism encompassing an intermediate range of actors: six government agencies from the health, economy, trade and industry, tourism, and local government sectors, and two development partners (F06, F26). In Vanuatu, the number of potential participants is unclear from the data, and thus it is difficult to estimate the complexity of multisectoral NCD committees when/if they were to happen.

As for the range of issues, just within tobacco control at least five policy areas need to be covered in Fiji and Vanuatu: price and tax measures; smoke-free policies; contents and packaging of products; advertising, promotion, sponsorship; and point of sale measures (376,578,643–646). However, food and alcohol policies need to be discussed as well in these NCD committees, which means that altogether a high number of issues need to be handled by this intersectoral mechanism.

Regarding integration, a participant explains that these committees do not legally force their invitees to attend the sessions [paraphrased, F26], therefore they function as working groups rather than official partnerships. This is reflected in the language used by the MoH officials, who call these meetings a "working group" (see quotes from V17 and F06 in Section 1.2).

Figure 10 locates the multisectoral NCD committees on the axis of authority and complexity based on the ICA framework. As Feiock (127) explains, the closer a mechanism sits to the left side of the figure, the less authority propels the involved parties to participate in intersectoral work. Furthermore, the higher the mechanism is located on the figure, the more organisation is required, which raises transaction costs. Altogether, the closer the mechanism is to the upper end of the arrow, the more effective it is to solve the collective action dilemma.

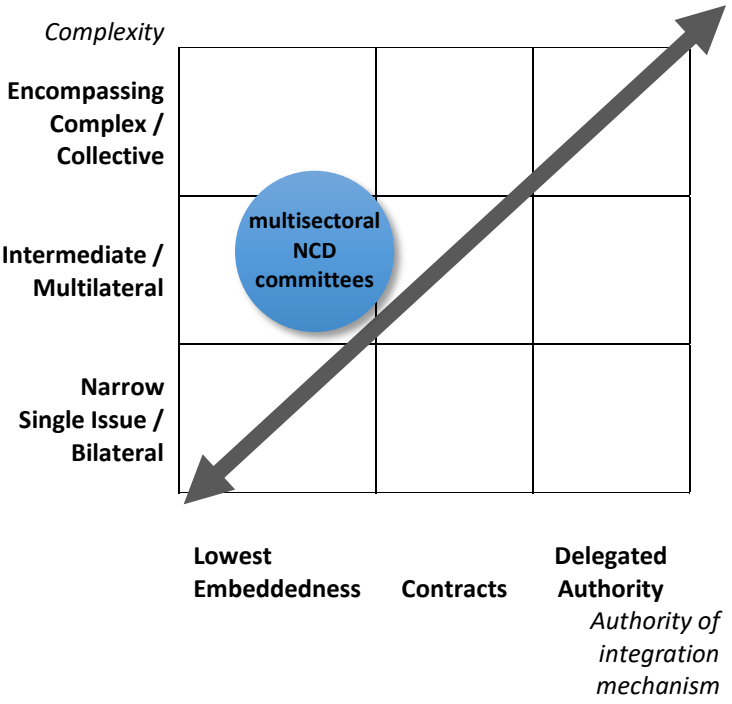


Figure 10 Intersectoral mechanisms by complexity and authority based on the ICA framework and the location of the discussed multisectoral committees

As Figure 10 shows, based on the ICA theory and the available data, a multisectoral committee aiming for policy coherence in tobacco governance encompasses a medium range of actors and is not very strong at compelling actors to participate. The data shows that in Fiji the multisectoral NCD committee does not have the authority to compel MoT to attend the sessions. An interviewee suggests that MoT, MoA and MoE will not work together with MoH "*unless there is leadership coming from the top-top level, from PM [Prime Minister] level, cabinet level, who says, 'I want you guys to work together, coordinate together, and I want coherence between your policies'*" (F28).

This analysis implies that the multisectoral NCD committees in Fiji and Vanuatu bear medium transaction costs and have medium efficiency to solve a problem. Whether this is enough to reach policy coherence

for tobacco control depends partly on the parties' perceived net benefits and the transaction costs, as discussed now.

1.3.2. Perceived transaction costs and net benefits

High transaction costs are not necessarily a barrier for a collaboration to be successful, but the parties need to perceive that the benefits gained are worth the expense. However, as the data demonstrates below, in Fiji and Vanuatu the actors often find the net benefits too low for collaboration.

According to an ex-MoH official a common reason that multisectoral collaboration does not happen often in Vanuatu is because it requires extra financial resources: "*Multisectoral collaboration stalls when it comes to the conversation of who's funding it. Because there's a bit of that idea that whoever raises the idea of multisectoral collaboration should be funding whatever it's done"* (V15).

The expected transaction cost can be other than financial resources, like the cost of losing autonomy: officials both in Fiji and Vanuatu are afraid that working together with other government agencies endangers their jobs, which results in territorialism – guarding one's mandate in their own policy field. As an MoH official in Vanuatu expresses: *"We need to make sure we do not step over and do the work of others. And also not Agriculture [MoA] coming and doing the work of MoH"* (V21). Another high-level MoH official confirms that territorialism is a barrier to multisectoral collaboration for preventing NCDs in Fiji as well: *"The main hindrances in multisectoral approaches is territorialism"* (F07).

Regarding the perceived benefits, often MoT, MoE or MoA do not recognise the benefit in engaging with MoH for NCD prevention. An ex-MoH official in Vanuatu describes this issue of conflicting mandates in the following way:

> *As for intersectoral cooperation, what I found that when it was fortuitous and beneficial for both sectors, that worked really well. But when it came to things like encouraging [the Ministry of] Internal Affairs or someone to look at how we could tax or change behaviour around the consumption and production of Tusker beer, it was a lot harder to do, because we were directly contradicting what another sector was doing, and asked him to help us without having really any kind of carrots to swing over them* (V15).

A MoT official in Vanuatu explains that the organisers of NTDC do not see the benefit in inviting MoH, because the health sector is perceived to be irrelevant in trade matters [paraphrased, V24].

This data shows that, particularly, pro-commercial actors tend to perceive the benefits of collaboration with MoH as low. However, according to the ICA framework, this would not necessarily be a barrier for intersectoral work, as long as the preferences of the actors are not too different.

1.3.3. Distribution of preferences

Feiock (127) argues that the distribution of preferences among the actors is an important defining factor in solving the ICA problem. As mentioned in the previous point, collaboration is particularly problematic from this perspective for two reasons. Firstly, the pro-health and the pro-commercial tobacco interests directly oppose each other. As the analysis in Chapter 5 showed, the former group of actors seek to control tobacco and ultimately reduce smoking prevalence, while the latter's interests lie in maintaining or increasing the current rates of tobacco consumption. Secondly, as Chapter 6 illustrated, there are major differences in the ideas which lead the two groups of actors in their approach to tobacco governance, the idea of commercial determinants of health shaping the approach of many of the pro-health actors, and the idea of individual responsibility (and the underlying neoliberal ideologies) influencing the pro-commercial actors.

Some of the data particularly highlights the connection between the differences in the mandates and ideas of the pro-health and pro-commercial actors as barriers to intersectoral collaboration. Participants working for different development partners state that because of the perception of opposing mandates, MoT, MoA, and MoE are often reluctant to participate in multisectoral NCD committee meetings [paraphrased, F27, F28]. Another high-level government official explains that the AG's understanding of "wealth is health" is a reason why it is so difficult to involve MoE and MoT officials in intersectoral collaboration for NCD prevention [paraphrased, F02].

1.3.4. Political and institutional context

Characteristics of the political and institutional context define the likelihood of intersectoral collaboration by increasing or decreasing the collaboration risk, according to Feiock (127). While Section 2 of this chapter will provide a detailed analysis of the administrative process in regards to balancing out interests in Fiji and Vanuatu, the following paragraphs give an account of the particular characteristics that influence the operation of multisectoral committees.

Performance and accountability issues. Weaknesses in performance management and accountability may cause organisational issues which result in the committees not meeting. Some of the data indicates that in Vanuatu the low efficiency of the performance management and accountability mechanisms is the

reason that the NCD multisectoral committee is not in operation. A MoH official in Vanuatu suggests that it is just a matter of organisation: *"It depends on whoever is taking leadership on NCD coordination. It's not a matter of resources. It just needs to be facilitated"* (V12). Another participant who used to work for MoH suggests that the lack of coordination happens because the ministry itself does not operate effectively:

> *We need to strengthen it [MoH] first, before we can start having MoH reach out and coordinate amongst the other government line ministries and departments, because if they are themselves fractured and cannot work effectively and efficiently within themselves as a unit, then it's going to affect how they associate and cooperate with other units to make something work* (V27).

Such issues were not mentioned in Fiji regarding the organisation of the multisectoral NCD committee.

Issues of delegation. Another issue area emerging from the data is that the delegates sent on behalf of the invited agencies often do not have the necessary skills or authority. Participants in Fiji and Vanuatu explain this in the following way:

> *When they say that they invited the right stakeholders, it does not necessarily mean that the person that actually comes is the right person that will be carrying out this. Sometimes the person is just there for participation issues to show that they showed up* (V27).

> *When MoH calls Finance, Trade, Planning to come for a meeting, these guys do not even come or they send a small officer who cannot take any decision* (F28).

Imbalance of authority. The imbalance of authority between the pro-health and pro-commercial actors discussed in Chapter 5 is a common reason why MoT, MoE or MoA do not participate, or send an inadequate delegate to the meetings organised by MoH in Fiji. A participant argues that MoT and MoE *"say 'Who is MoH to call us for a meeting'"* (F28). An interviewee in Vanuatu expresses a similar complaint on inadequate mandates: "*All along through the FCTC, it just came through to MoH. I think if we tried to have a committee that had Customs and that, I felt like there was not enough mandate*" (V29). This data suggests that it is important that the organiser of the committee meetings have the necessary level of authority which propels invitees to attend or to send the appropriate level of delegate.

Historical remnants. In particular cases other political circumstances can be barriers to the multisectoral meetings happening. An interviewee suggests that in Fiji there is a reluctance for intersectoral outreach, because during the reign of the military government gatherings of officials were seen as a sign of potential political unrest:

> *Under the military government there was a prohibition – do not know how formal or informal – on a group meeting together as a leadership group. The concern was that public service, at least from the view of government, was highly politicised, and those individuals were not necessarily supportive of the government, and if you get those people together, they will essentially collude and will take down the government* (F34).

The reluctance for meetings between high-level government official remains an issue in Fiji, as a high-level government official explains: *"they [Permanent Secretaries] need to be encouraged; the AG [Attorney-General] always encourages them [to consult]"* (F07).

To summarise Section 1, the analysis focused on the research question: "What institutional conditions influence the forging of policy coherence for tobacco control in Fiji and Vanuatu?" The data showed that multisectoral committees are the primary governance mechanisms dedicated to forge policy coherence in tobacco governance in Fiji and Vanuatu. However, this mechanism has issues in fulfilling this task in both countries: the meetings either fail to happen or some of the important invitees do not attend. A reason behind this is that the issue of tobacco governance carries a high collaboration risk because the involved parties have opposing mandates and interests, which results in a high risk of defection. Also, these committees bear medium level effectiveness in solving the ICA dilemma, because they are characterised by low authority for integration, medium range of actors and issues, and medium transaction costs. Moreover, the political and institutional context of these countries tend not to be supportive of intersectoral work on tobacco control. There is an imbalance of authority between the actors which makes the attendance of high-authority actors (MoE, MoT, MoA) less likely in meetings organised by low-authority actors (MoH) or an inadequate delegate is sent. The weakness of performance management and accountability results in failure to organise the meetings; and in Fiji the historical remnants of the prohibition on gatherings causes further issues.

This section has focused on the formal structures dedicated to make government actors work together despite their different mandates. However, as Chapter 2 highlighted, intersectoral collaboration itself is not sufficient to ensure that narrow interests do not dominate decision-making; the administrative procedures should safeguard "public-interestedness" in the development of all policies. The next section investigates how institutional conditions support this in Fiji and Vanuatu.

2. The protection of tobacco control policies from commercial interests

The literature reviewed in Chapter 2 highlighted the issue of TI interference as a major barrier to tobacco control. Chapters 5 and 6 demonstrated that the TI has close relationships with several government agencies in Fiji and Vanuatu, and together they form a pro-commercial interest group which has significant influence over tobacco governance through its authority and the dominant causal idea of individual responsibility. In the midst of such interest-based and ideational conditions, pro-health actors face a major challenge in ensuring that health interests are prioritised in tobacco governance and that vested interests do not infiltrate policy making in this space.

This section focuses on examining the roles institutional conditions play in protecting tobacco control from private commercial interests. The administrative process theory (128) is helpful here; it argues that the institutional structures of administrative agencies should ensure that governance is not dominated by small interest groups and instead that the general interests of the public are served. This requires public-interested administrators (administrator motivation claim); administrative procedures balancing out interest group influences (administrative neutrality claim); an institutional environment ensuring a system of checks and balances (institutional environment claim); bureaucratic autonomy (agency autonomy claim), and cost-benefit analysis of policy alternatives in policy making (social welfare claim). In the following sections these conditions are analysed in terms of tobacco control in Fiji and Vanuatu.

2.1. Public-interested administrators

Participants in Fiji and Vanuatu argue that government officials at the highest levels are caught up in politics, which often has detrimental effects on their "public-interestedness" – how much they are driven by public interests, instead of being influenced by vested interests. An ex-MoH official suggests that *"the commitment and the energy to do what needed to be done was there [to sign FCTC]. What I feel now is that the politics, the landscape has changed, that causes a lot of stalling"* (F02). *"People up the top there, they do not take it seriously enough. Who is on top? PS [Permanent Secretary] and Minister for Health"* (F06). An interviewee in Fiji states that short-term economic benefits serve high-level government officials' political interests more than long-term health benefits: *"Now it's only the 'technicians' who want to move things, but there is not a real drive from the top. The top is focused on winning the elections and building economic growth"* (F28).

In Vanuatu participants (V11, V13) suggest that the politicisation of the government affects the "public-interestedness" of administrators. They explain that because of the smallness of the country and its geographical layout, being scattered over several islands – both small island developing state (SIDS) vulnerabilities –, clientelism[40] and patronage[41] are issues:

> *Politics is localised. Basically, every small place tries to choose someone from their area in the hope that that person will bring them something or they'll accept some form of bribe to vote to that person again, because it's the only thing they see, they do not get much in services* (V13).

An interviewee working for a development partner states that the legal regulation of the ways political parties and the Parliament operates is weak [paraphrased, V11], and as a result, there is an abundance of political parties who focus on local interests and are rarely driven by political ideologies. In 2014, 24 parties were operating, although in 2016 this number decreased to 17.

> *There are many different political parties, and the majority government is a coalition. Basically when going to the election you won't have a big major party; people run as candidates because they are from the area. Officially they will be under the political party flag, but it will really be their own. And then in Parliament you need to build a majority, so the main group in power will try to build a coalition and they will just buy off the people: 'Come I will give you a minister post, that will give you chairmanship of a committee'* (V11).

The need for the legal strengthening of the political system of both Fiji and Vanuatu has been recognised and development partners engage both governments on this matter.

> *One of the answers is to work on the political parties regulation: who is allowed to have a political party? Or how do you create the political party? And how do you fund the political party as well? Because there is a lot of that, there are not that many positions to give. what I just said, you know, when you want to build a coalition, so what do you give them. Usually money. So, that's one of the reasons why corruption is an issue. money for political purposes. what's the answer to that? try to regulate that. (V11)*

The weakness of the regulation of the political system, and the SIDS vulnerabilities of small population size and being scattered over a multitude of islands have a detrimental impact on the government of Vanuatu: interviewees state that as a result of clientelism and patronage, important positions in the

[40] Stokes (2011) defines clientelism "*as the proffering of material goods in return for electoral support, where the criterion of distribution that the patron uses is simply: did you (will you) support me?*"
[41] Patronage means the "*exchange of a public sector job for political support*" (Stokes, 2011).

government are often given to people who are not skilled, nor have the experience for the job, but who have political connections.

> *I do not think there's anything that's in the decision-making in the government that is not politicised. Even hiring people, especially jobs that are high-level positions. It's not actually what you can bring to the table, but it's who you know* (V27).

As a result, "public-interestedness" is often not the virtue on which public servants are selected, as participants in Vanuatu suggest:

> *There was a Minister for Health who had previously been a minister, left for a while, and then came back, because ministers receive healthcare services in Australia – it's part of their package as a minister. He knew that he was quite unwell and had liver issues. So he became a minister again, so that he'd have access to those services* (V15).

> *The Ministers of Health over many years have been all sorts of people who do not have any interest or knowledge* (V13).

A participant explains that these appointees are aware of how short-lived such nominations are, therefore, they try to make the most of their temporary powers [paraphrased, V11]. Consequently, high-level government officials often do not keep the public interest in mind: *"One of the issues is that most of them only think about their political interests, parties' interests, but not national interest"* (V11).

However, some of the data indicates that in lower executive levels in MoH this is not an issue: "*The DG [Director-General[42]] has been kind of steering a steady ship at times that has been captured by ministers that do not really understand health in any way, shape, or form*" (V15). Furthermore, the Director of Public Health has been often cited as a public-interested leader (V12, V15, V17, V19, V22, V23). In Fiji some mid-level managers in MoH also enjoy a good reputation, according to several interviewees (F04, F26, F27, F28).

These findings indicate that "public-interestedness" has likely been an issue among the highest level of government officials in Fiji and Vanuatu, particularly within MoH. This is likely to be fuelled by the vulnerabilities of SIDS, such as small population size and the country being scattered over several islands, as well as the weak regulation of political parties, which facilitate clientelism and patronage. Croley (128) suggests that legislators tend to be motivated by political interests and are more easily captured by interest groups, and in contrast, government officials are more likely to follow public interests. The data shows that the politicisation of government in Fiji and Vanuatu results in high-level MoH officials who are

[42] Equivalent to the Permanent Secretary in Fiji, second in command after the Minister.

not necessarily motivated by public but rather personal or political interests. According to Croley, this increases the likelihood that policy making in tobacco governance follows the interests of small, well-organised groups rather than public interests. Following the assertions of the tobacco control scholarship that tobacco control serves the public interests, the Minister for Health's repeated decisions in Vanuatu to support the building of a tobacco factory demonstrate how TI interests are able to gain dominance over public interests.

2.2. Administrative procedures

Croley's administrative neutrality claim argues that administrators should remain independent from interest group influences to ensure public-interested regulation. He explains that it is imperative that administrative procedures level out the imbalance of authority between interest groups. In order to achieve this, the process of policy making should involve multiple stages where interest groups and the public can express their preferences. In tobacco control there are an extra set of measures which are required under the FCTC: Article 5.3 on the terms of engagement with the TI to protect public health policies from interference. In order to understand the institutional conditions influencing the elevation of health interests in tobacco governance, section 2.2.1. focuses on the policy process in Fiji and Vanuatu; section 2.2.2. assesses the ways terms of engagement are in use in these processes.

2.2.1. The policy process

While on paper the policy process of Fiji and Vanuatu balances out the influence of stakeholders through a set of measures, in practice the process is not necessarily followed, as discussed below.

The policy process – *en jure*

On paper, the planning of health policies officially follows the same procedure in Fiji and Vanuatu. It starts by identifying a problem which needs to be rectified. This is followed by the establishment of a technical working group tasked with working out the details of the policy, explains a MoH official in Fiji [paraphrased, F09]. Several participants (F02, F04, F09) state that stakeholder[43] involvement is an essential part of the policy development process: once the policy is drafted, all affected actors are identified and invited to consultations. This is the first opportunity for intersectoral consultation. Once the final policy draft is completed, the executive committee of MoH reviews and endorses it.

[43] Stakeholders can be private actors, civil society organisations (CSOs), faith-based organisations, development partner organisations, other government agencies or the public.

Participants state that in Fiji before 2018 policies without multisectoral implications could be implemented once the Minister signed off. However, since 2018, regardless whether they affect other ministries or not, they have had to be approved by the Cabinet (F03, F06, F09, F07, F19). Interviewees explain that this happens because the Minister for Economy has to agree to allocate the required funding to carry out the policy (F07, F17). The Council of Ministers (CoM) in Vanuatu has the same role; however before that step the draft needs to be discussed and endorsed by Departmental Committee of Officials which is an inter-ministerial body where all Ministers, their DGs and political advisors sit (V05, V12, V17). These high-level meetings provide the second opportunity for intersectoral consultation.

Participants explain that in case the policy needs to be embedded into legislation – in a form of law, regulation, or amendment – the policy draft must to be vetted by the Solicitor General's Office in Fiji and the State Law Office in Vanuatu (F03, F06, F09, F07, F19, V05, V12, V17, V23). Once the bill is finalised by the legal team, it is sent to the AG's Office for vetting. After this step the bill is ready to be presented and decided upon in the Cabinet/CoM.

Once the Cabinet/CoM approves the bill, it is debated in the Parliament. The Parliament usually assigns the bill to the relevant Standing Committee, which holds consultations. A government official describes this as follows: *"From Parliament it [the bill] goes to the relevant Standing Committee, which opens it up to the public, the public comes in to submit on the piece of legislation, then the Committee tables their report in the Parliament"* (F17). Although specific stakeholders are invited to participate in the hearings, they are also open to the public, thus all engaged actors receive the opportunity to have their say [paraphrased, F17]. This step provides the first opportunity for the public to engage in the legislative process and exert its interests directly. The second opportunity that citizens have is to address the legislators, because the report resulting from these consultations is debated and voted upon in the Parliament. If the bill passes, it gets signed off by the President. With that the bill becomes a law, and is enacted by an agreed commencement date:

> *There is a debate in Parliament and there is a voting, and then it gets enacted. The President signs off to the legislation, and then there is a commencement date. It could be that an act or amendment is passed in the Parliament, but for various reasons the enactment is three months after* (F17).

The policy process – *de facto*

While the policy and legislative processes in both countries are carefully planned to involve consultations, the interviewees suggest a gap between the rules on paper and the actual ways in which policies are

made. *"We have a lot of policies [on how to develop policies] and whether decision makers use them to implement or make decisions is another question"* (V25). In Fiji participants recalled occasions where MoH was only involved at the last minute in the planning of their own health sector policies: one of them describes how a regulation about pharmacies was developed by MoE, and MoH was notified only the day before it was proposed to Parliament [paraphrased, F34]; another story recalled by two interviewees (F23, F35) similarly states that MoE organised the tendering for two hospitals in Fiji and decided the winner, while MoH allegedly had no say in the matter [paraphrased, F23].

When asked about how such policies are planned if MoH is not involved, a participant suggested that the Attorney-General (AG) sets the direction and makes the final decision:

> *It will be really just decided by the AG. […] There is a very small group of trusted advisors. My sense is that they do not so much advise but rather receive instructions. Generally, it's 'this is what I want to achieve, this is what I need you to do, go and do it'* (F34).

In Vanuatu an ex-MoH official explains that most ministries invite stakeholders to comment only in the final stages of the policy draft. However, in the case of the *Excise Tax Act,* which involved taxes on tobacco, Customs invited MoH into the process at a much earlier stage (V15): "*Just the fact that they were willing to involve other sectors in their review was unlike things I've seen in other sectors*" (V15).

In both countries participants (F04, F23, F26, F28, F34, F35, V05, V11, V15) suggest that although consultations are held, whether they are effectively run or involve an adequate number of people, is not checked. *"Just a few people came in […] But it does not matter if people come or not, we just had to prove that it was done"* (F04). Policy makers sometimes just want to "tick the box" so they can fulfil the requirement of holding consultations, and participants often complain that their feedback is not taken into consideration.

> *Some stakeholders said that they feel that the consultations happen for the sake of it, they do not feel that they were listened to. Or the consultation happens in the very last minute, government is not very prepared, it's clear that somebody just said, that 'no, no, you need to go and talk to whoever it is, Chamber of Commerce or whatever', that happens. Only to tick a box but it's not a genuine relationship* (F34).

The data indicates that the time and extent to which a stakeholder is invited is important for the outcome and quality of the engagement. It appears that in both countries there is a tendency to involve the health sector too late in the planning process, which results in the limited consideration of its interests. Thus, processes are followed without the meaningful engagement of other stakeholders.

Furthermore, these quotes give the impression that the involvement happens this way not because of capacity or organisational issues, but because the agency does not have any real intention of considering other opinions and interests.

> *The government is not used to a process of consultations before they make decisions. So there have been a number of decisions which have sort of just popped up in government, and stakeholders feel like that they are blindsided about the policy changes. I think the government is making some attempts to change, but I think in some areas they do not want to consult. They know the policy change they want, and they just go ahead and do it* (F34).

In Fiji this is explained as a remnant of the military regime, while in Vanuatu there is often no intention to implement the policy paper itself – which results in writing it in the quickest way without caring for other interests:

> *In Vanuatu there is a certain understanding what policy is and what strategy is, they make it such a big task, but no one wants to be involved in actually doing it. It gets written and then five years later, someone else will come in and write the next one. It's just kind of 'all right, let's get the policy document in place. And then we'll go on with the work we were doing anyway', rather than identifying it as an opportunity to put in place some real change* (V15).

In Vanuatu, the interviewees reflect that not only non-health government agencies have the tendency to not consider the health sector, but the efforts of MoH to involve stakeholders are questionable as well. A participant suggests that a lack of time and lack of real intention to engage other actors is the reason behind this.

> *My boss was a bit like 'we just need a policy, we just need a strategy, the other ones are out of date', and the DG was on his back to get one done prior a certain forum. It was like, we just need to write something, and the more people we involve, the more time it will take, and we do not have time* (V15).

This quote also reveals that policy making does not necessarily start with problem definition, but is the result of pressure to produce policy documents. Other participants (V05, V06, V12, V23, F09, F23) suggest that one of the aims of policies is to support funding requests towards development partners.

An ex-MoH official in Vanuatu explains that when consultations are held, they do not necessarily bring the desired input from other stakeholders:

> *We took it [the policy draft] to a stakeholder consultation after it was written. They were generally like, 'yeah, looks good'. Again, I still do not think people in that room*

> *read it. […] There was about 40 stakeholders from across the public sector, NGOs and to the private sector* (V15).

This quote also indicates that even if stakeholders have the opportunity to discuss the planned policies, they do not necessarily have the capacity to do so.

A government official in Vanuatu suggests that the reason that non-health government agencies rarely take part in implementing the TCA, is because MoH failed to conduct effective consultations with the public and the other ministries beforehand. In Fiji, some high-level MoH officials suggest that the reason behind the lack of buy-in from other agencies is the inability of the health sector to address non-health sectors on their own terms and to provide concrete, operational recommendations.

> *I think the weakness is in Health [MoH] itself. In terms of health does not have any understanding about the trade policies. […] Lot of the health people just go and tell what the disadvantages of NCDs are. But currently governments already understand that there is the NCD problem, but they want to know how can you help them in achieving their own objectives* (F01).

> *I think also that we are just not arguing well enough. We need people in that area, and they will be not doctors – we need people of trade and law who help us put it into place* (F02).

The findings show that although the policy process in Fiji and Vanuatu has the potential to ensure a level playing field among stakeholders, the mechanisms are often not followed. The main reasons for inadequate stakeholder involvement in policy planning are (i) limited intentions to incorporate stakeholder interests or join discussions – both towards and from the health sector, (ii) the capacity issues of meaningfully contributing to the planning process of another sector, (iii) limited time, and (iv) the pressure to create policy documents is not necessarily coupled with a real intention of implementing the policy. The problem of limited time can be interpreted as a capacity issue: the units do not have enough human power to fulfil all duties without rushing. In this sense, it is a result of a SIDS vulnerability. Alternatively, limited time might reflect time management issues, which relates to the problems of performance management.

2.2.2. Terms of engagement with the tobacco industry

While a well-planned and implemented policy process can ensure that all interests are considered in policy making (128), in tobacco control it has been established that the involvement of the TI has a direct negative impact on public health policies (67,74,80,189). A major focus of Article 5.3 is on the exclusion of the TI from policy making. As such, no government agencies should maintain any working relationship with the

TI, and the amount of interaction between them should be minimalised (74). The more space industry representatives have to engage with government officials, the higher their chance is to interfere with policy making (189).

According to the Pacific Monitoring Alliance for NCD Action (MANA) Dashboard, Vanuatu has no TI interference policies in place, but Fiji is in the process of developing one (406). Some of the participants in MoH in Fiji cited their commitment to protect public health policies from TI interference:

> *We could talk to them about the requirements of the law, but not anything else.* […] *When I took over the office, I really demarcated myself from the retailers, manufacturers, never to affiliate with the manufacturer. […] I said no, you cannot accept any funding by them. Not even to renovate wards* (F04).

However, neither the interviews nor the document analysis reflected any intention for developing official terms of engagement with the TI. This is particularly problematic in light of the close relationship between the TI and government agencies in Fiji and Vanuatu (discussed in Chapter 5), and because in both countries the legal procedures – for obtaining and maintaining registration and licensing of the TI – requires MoH to interact with industry representatives. As a government official explains: *"They [tobacco related businesses] renew their licences through the ministry [MoH], so if they have any issues with the packaging or that kind of things, they have to liaise with the ministry"* (F06).

In Vanuatu, the TI registration and licensing process is not regulated under the existing tobacco control legislation, but investors need to receive approval from the Minister for Health before starting up tobacco farming or production. A government official explains this process in the following way:

> *Firstly, they have to go to the Vanuatu Investment Promotion Authority to apply for a permit. Then they apply for a business licence from the Vanuatu Financial Service Commission, and then they need a business licence from Customs. If it's a manufacturer, the Department of Industry [of Ministry of Trade and Industry] also provides an industrial permit. They have to find a place, a land to establish their farm. They need to negotiate with the village, with the locals to use their lands. The Department of Industry [of MoT] comes in when it comes to processing tobacco, but for the planting they need to talk to MoA. They also need to talk with the MoH to see their regulations* (V16).

These procedures offer an opportunity to the TI to interfere with public health policy making, because they grant direct access to high-level MoH government officials. This carries important implications for tobacco control, especially because, as an MoH official explains, there are no transparency measures in place during these meetings [paraphrased, V17]. Although in Vanuatu the Department of Public Health

(DPH) attempted to establish the practice that the Minister consults with them when any such meeting is requested: *"The protocol is that only the DG talks with the minister. The DPH told the DG that if anyone comes from the TI to talk to the minister, you will be the first one to notify the DPH"* (V23).

However, this process wasn't followed on those occasions the Minister for Health signed supportive letters to the TI. An MoH official states that during the meetings between the Minister and industry representatives no transparency measures were taken, no one else was present, and DPH was notified only after the supporting letters were signed, despite their request to be consulted on any such matters [paraphrased, V17]. The participant explains that the DG and the Director of Public Health had opposed the Minister on several occasions when this happened; however, the supporting letters had not been withdrawn (584,618), and construction of the first tobacco factory in Vanuatu commenced in 2019 (583).

Participants in Fiji explain that MoH has a procedure in place to screen prospective administrators for conflicts of interest (COI) in relation to the TI (F06, F04, F03). As a government official states:

> *They are very careful about it; they do not employ people coming from pro-tobacco sector. They do a very throughout check on the applicants, especially for manager positions. If they see someone who previously worked with them, that's a straight 'No'* (F06).

However, such a mechanism is not applied in MoE or MoA, as the hiring of ex-BAT employees to high-level positions indicates (609,610,622). In Vanuatu, the interviews reflected no process in place to filter out applicants with COI.

Article 5.3 recognises that TI interference can be avoided by the oversight of third parties (CSOs or development partners) or the public. This means that they are either invited to observe meetings between the TI and the government, or meeting minutes are shared. These processes are meant to increase transparency and accountability, but they are not practised in Fiji or Vanuatu [paraphrased, F26].

Furthermore, both countries lack any TI watchdog or tobacco control related CSOs (F02, F06, F26, F28, F29, V07, V13, V17, V26), nor do they have any monitoring of industry political and CSR activities by the government (F06, F26). A participant working for a development partner explains that neither Fiji nor Vanuatu has any activities on awareness raising of industry interference practices, and no lobby transparency measures are in place either [paraphrased, F26]. A participant in Fiji explains this as follows: "*The only monitoring happens by the NCD officer at WHO [Sub-regional Office in Suva]. She Googles it and then lets MoH know. But in the ministry nobody cares, nobody does it*" (F06).

According to Croley's theory, oversight or participation by the public is a crucial condition to ensure public-interested policy making. However, the findings presented above show that in Fiji and Vanuatu this does not happen in tobacco governance for two main reasons. Firstly, the civil society is silent on tobacco control in these countries. There are no CSOs active on tobacco control, and the public rarely gets involved in consultations, even when they are organised by the government. Secondly, there are no transparency measures in place to monitor either the meetings between the TI and the government agencies or tobacco political activities in general.

2.3. Institutional environment

Croley's institutional environment claim argues that public-interested regulation is supported by executive and judicial oversight, as the system of checks and balances which characterises democratic governments. This should ensure that the government is kept in check not only by the Parliament but also by the Judiciary and the President.

In Fiji the Parliament was reinstated in 2008 after a series of military coups. A participant working for a development partner explains that capacity building of the Parliament has been in progress ever since [paraphrased, V11]. Although Vanuatu has had democratic institutions since its independence in 1980, its Parliamentary mechanisms are still under development: not only the legislators need to be trained but the capacity of the Standing Committees needs to be improved.

> *No one is really knowledgeable in the Parliament at the moment. […] They do not have proper mandates for the [Standing] committees. So then nobody knows what they should be doing. They do not have a calendar, so they do not know when they should be doing it. So they do not know what, do not know when, and then they do not have any support, because there is no committee staff, which are the spine of the work in committee* (V11).

As a result, the Parliament in Vanuatu is considered weak and the government has control over it: *"About the autonomy of Parliament, there's a huge lack to that extent in Vanuatu. Government is completely controlling the Parliament"* (V11). This weakness has been recognised by both the Parliament and development partners, and there have been joined efforts for parliamentary strengthening (647–649).

In Fiji a high-level government official's statement suggests that the accountability of the government towards the Parliament is not very strong because of strict confidentiality regulations:

> *Whatever decisions do not reach the Parliament from the Cabinet, it is mostly because it is confidential. Secrecy is paramount when it comes to Cabinet discussions. Our*

> *freedom of information laws and the Official Secrets laws safeguards the confidentiality of the Cabinet. Cabinet information is only released after prior approval from the PM and the Secretary of the Cabinet. Only relevant information goes to the requesting party, which is usually a government department. No Cabinet information gets released outside of the government. Once an information becomes public, then it can go to Parliament* (F07).

Participants (F35, V31) explain that in both Fiji and Vanuatu judicial oversight over policy and law making is practised only when Constitutional rights are affected; other than that, the courts do not check whether the policy process was properly followed. "*If to be a watchdog, to make sure that all the government functions are operating, no, the court does not do that"* (V31). At the same time the Supreme Court in Vanuatu has been noted to be independent from the legislators and has regularly prosecuted a high number of legislators for corruption (650,651). The same proactivity is not so visible in the Fijian judiciary; a participant suggests that possibly the AG has influence over the courts [paraphrased, F35]. These indicate that the judiciary in Vanuatu tends to control corruption among legislators, but does not exercise much oversight over the administration. Furthermore, participants (F23, F34, F35, V22) suggest that the executive oversight by the President hasn't shown any relevance, either in Fiji or Vanuatu.

The system of checks and balances embedded into democratic governance is muted in Fiji and Vanuatu. The Parliament, the Judiciary and the President in both countries have limited control over the government. The implication for tobacco control is that MoH is only weakly supported by these institutions in elevating health interests in tobacco governance. As the next section shows, in Vanuatu this is less of an issue, because there is no such heavy centralisation of decision-making embedded into the policy making process, allowing MoH to maintain its autonomy; however, in Fiji this enables the AG to keep a close control over MoH.

2.4. Bureaucratic autonomy

Croley's agency autonomy claim focuses on the autonomy of government agencies from legislators as a means to ensuring that legislators captured by vested interests are unable to influence policy making. However, based on the findings in Chapter 5, it appears that in Fiji and Vanuatu the elevation of health interests is endangered by commercial interests present within the government. Therefore, this section focuses on the bureaucratic autonomy MoH and the units responsible for tobacco control have within the government.

In Fiji, administrative procedures render high dependence of the government agencies on the AG and MoE. Chapter 5 discussed the ways institutional authority is centralised in these two agencies and thus in the hand of a single person. Several interviewees state that in Fiji government agencies in general rarely initiate their own ideas but wait for the AG and the Prime Minister (PM) to identify priorities and issue areas. According to a participant *"some of the more traditional policy development type of functions what ministries would perform are really muted here [in Fiji]. In lot of instances ministries won't actually provide or do any policy development"* (F34).

Although decision-making should be practised at each administrative level vertically during the development of policy, these layers of decision-making are missing in MoH, and the PS is the sole person who decides on important matters, according to several participants (F04, F07, F08). An interviewee working for a development partner explains this by the risk-aversion culture so heavily present in the Fijian civil service [paraphrased, F34]. The participant adds that most officials try to avoid making any decisions to ensure that they do not make any mistakes which would result in losing their job [paraphrased, F34]. Given how often PSs change in MoH – arguably, the person who makes most decisions within the agency – it looks like a realistic fear: within MoH there were four PSs between 2016 and 2018, which shows that keeping a PS position in this ministry is a challenging task. A participant suggested that the Public Service Commission (controlled by the AG and the PM) changes the PS of MoH as soon as enough time has passed for the individual to understand how the sector works, because that's when they could start to have independent ideas [paraphrased, F02]. A participant describes the low bureaucratic autonomy in the government in the following way:

> *It makes for a very difficult environment for civil servants to say, 'we knew that was not the right way to go, but in fact we could not even provide that advice because it was not received that way'. Its interpreted as 'you are not being supportive of what I want to do'. It only has to happen to a civil servant once, and from then they do not provide any advice the way it should be* (F34).

Thus, by avoiding the responsibility for decision-making, the necessary layers of accountability are also lacking. As a consequence, participants (F23, F34) raised that administrators lack proactivity in policy development:

> *You will need to have the ministers to be prepared to listen to what the public servants has to say. Ministers are saying that 'nobody does anything until I ask them to do it'. But if anyone acts in a proactive way, they are not sure how they going to be received, therefore there is very little will from the public servants to be proactive* (F34).

As a result, bureaucratic autonomy within government agencies is generally low in Fiji. A participant describes this in the following way: "*Ministries do not seem to be empowered to do things on their own. The way currently works, is that they really need the guidance, the support and the agreements to take on particularly the more challenging areas of reform"* (F34).

The consequence of the limited bureaucratic autonomy of the departments within MoH is that with frequent changes in the top leadership of the ministry, the strategic direction of units change often as well. The participants note that "*sometimes when leaders change, even if internal levels, it makes things difficult*" (F10), or "*the expectations to our department changes all the time, as the management changes, the action plan changes"* (F09).

Vanuatu's political space is characterised by the frequent rotation of government. The Prime Minister changed seven times between the elections in 2008 and 2012, and four times between 2012 and 2016. The frequent changes in the head of government were followed by changes in ministers. Particularly in the case of MoH, the rotation was quite intensive: it was rare that a minister stayed in power for at least a year. A participant recalls "*we had a change of minister about five times while I was in MoH in that two years. Which is incredibly frustrating*" (V15). Similar to Fiji, this rotation highly impacted policy making because of the limited bureaucratic autonomy of the MoH departments:

> *You'd see some things come through, when the minister said that we need to work on this, and you're like, 'Okay, but it's not in the policy, It's not in the strategy, nor is it in our business plan for this year. So do we really need to work on it now?' And it was 'well, yes.' So if the things that come from below their level, they generally got a fair bit of autonomy to do what they like, but for things that come from above by the DG or the minister, they generally a bit more propelled into doing it, whether they agree with it or not* (V15).

Participants (F14, F08, F34) explain that the Ministry of Civil Service (headed by the AG) recognised the nuisance of the lack of autonomy which resulted from the missing layers of decision-making and accountability; it has attempted to salvage this issue through a series of public administrative reforms since 2016. However, the way the reforms are planned already contradicts their aim to give more responsibility to lower level executives. The PSs are responsible for planning and implementing such reforms in their respective ministries, and according to interviewees (F08, F14, F34), in MoH even the Deputy Secretaries and Department Directors are excluded from this planning and decision-making process.

> *It's part of the narrative you hear from the AG and the PM that they want to do things differently in order to achieve better results for the community, and ultimately to achieve different results, you got to act in different way. […] I can also understand that moving from a military style government where you just make the decisions and got on with things and you do not need to bother with that sort of annoying consultation part, moving into a new government is a very different way of doing things and they are learning to how to do it in a genuine way* (F34).

Nevertheless, the findings show that the lack of autonomy from legislators is not an issue in Fiji and Vanuatu. However, this does not necessarily mean that MoH is free of the control of other agencies from within the government. Particularly in Fiji, decision-making powers are centralised in a section of the government – or rather in the hands of a few individuals: the AG and the PM – which poses major limitations on the bureaucratic autonomy of MoH. As a result, even if administrators are "public-interested", they have little autonomy to ensure that health interests are elevated in tobacco governance. The dependency of the government agencies on the AG and MoE allows considerable control for the pro-commercial interests. In Vanuatu, the limited bureaucratic autonomy of MoH departments is likely to allow the frequent changes in the top management of MoH to disrupt the strategic elevation of health interests in intersectoral governance.

2.5. Capacity for cost-benefit analysis to determine public interest

Croley's social welfare claim argues that government agencies should not rely only on the information provided by the interest groups, but should do their own analysis to determine the most beneficial policy alternatives for the public. In order to conduct such work, the agency needs to have adequate human and financial resources. However, the data indicates that the MoH in both Fiji and Vanuatu face the capacity issues often visible in SIDS (see Chapter 2), which impair their capability to perform a cost-benefit analysis. As a participant in Vanuatu states: "*In MoH capacity has been a weak area"* (V21). Furthermore, there are limited resources dedicated to tobacco control within MoH in both countries, as the following paragraphs explain.

In Vanuatu there is only one MoH officer focusing solely on tobacco control; other officers cover a range of areas in relation to NCD prevention. An interviewee explains that while in larger LMICs often an entire unit is responsible for tobacco control, in SIDS there is one person dedicated to NCDs or tobacco control, thus smoking is likely to receive little attention [paraphrased, F27]. The small size of the team of the DPH in Vanuatu makes it difficult to implement all policy plans:

> *It's quite a small team to implement the plans. So if something else comes up, the whole team jumps over and for a month the entire team is working on that, they do not do anything else. It is staffing capacity issues mixed with an inflexible budgeting system* (V15).

Fiji is an exception to this trend with its dedicated Tobacco Control Enforcement Unit, where they have 13 positions allocated for environmental health officers to work on tobacco. In addition, there is one more officer working on tobacco control within the Health Promotion Unit. However, many of the positions (including the unit head) within the Tobacco Control Enforcement Unit were not filled during the data collection period.

The data indicates that the high number of vacant positions within MoH in general has a detrimental effect on the performance of the agency: *"If somebody leaves, nobody replaces the person. The same amount of work is continuing with a very minimum staff. The quality of work is deteriorating, because they do not fill the positions on time"* (F06).

The interviews reveal that one of the reasons for the slow hiring process is the low number of candidates with the required skills. While Fijians can choose from a limited amount of medical and public health courses at the Fiji National University (F08, F09), in Vanuatu there is only a nursing school; to qualify for other health professions ni-Vanuatu usually go to New Zealand, Australia, Cuba, Papua New Guinea or Fiji (V06, V15). Because of this classic SIDS constraint the improvement of human capacity in the public service and in MoH requires careful planning, explains an ex-MoH official [paraphrased, V15].

Besides the human capacity issues, participants complain that tobacco control in both Fiji and Vanuatu suffers because of the low financial resources dedicated for NCDs in MoH: "*Even though the government declared that there is an NCD crisis, not only in Vanuatu but in the whole Pacific, when it comes to sharing the funds, still communicable diseases receive more money*" (V12). The limited financial resources affected the way policies were planned and implemented, as an ex-MoH official explains:

> *In terms of what went into the policy and strategy for NCDs, we deliberately didn't attach costings to it, we attach kind of organisational names in terms of who should be working on it. It was the concern that if we attached finances, people would say, 'where are these coming from?', acknowledging that we didn't have them, and then realising that nothing would work* (V15).

In Fiji tobacco control enforcement received FJ$170,000 (approx. AU$116,000[44]) annually between 2012 and 2014 from the government budget; since 2015 this sum has increased to FJ$200,000 (approx.

[44] Based on the exchange rate on May 20, 2020 available on *www.xe.com*.

AU$136,570[7]) (616,652,652–657). The participants in MoH had differing opinions about whether this amount was sufficient to fulfil the duties.

The interviewee data indicates that in Vanuatu capacity issues are not the sole challenge MoH faces. Issues of performance management and accountability are often cited as constraints: *"It's not a finance issue. Yes, there are capacity constraints, but I'm not sure increasing the number of personnel will fix it*" (V15). The Minister for Foreign Affairs argues that there are no available positions for the skilled work force, because the administration is not able to get rid of low-performing employees:

> *I do not think we have enough good people in the right positions in government. I think the workplace culture in Vanuatu in the government is not very conducive to having performance determine your position. Basically people can be underperforming and it's never picked up, and it happens all the time* (V25).

The findings illustrate a range of issues – from inadequate human and financial resources to performance management – affecting the capacity of MoH in Fiji and Vanuatu to perform a careful cost-benefit analysis every time a policy decision needs to be made. Several of these issues stem from the SIDS vulnerabilities of these countries. Although human and financial resource problems are conditions commonly observed in LMICs, the data demonstrates that in Fiji and Vanuatu such issues are aggravated by geographical isolation, the small size of the population and its economy, and the logistical and financial challenges of distributing services across several small islands.

When a careful analysis of the policy alternatives is not conducted, policy makers remain vulnerable to the information provided by the interest groups they aim to regulate. For example, in Vanuatu the Minister for Health was not supported by such assessment when he signed the supporting letter to the TI in 2018. The administrators did not have the opportunity to provide any input, because the decision was made in one sitting without the involvement of any MoH official than the Minister, as explained by an MoH official [paraphrased, V17].

Section 2 investigated the research question "How, and to what extent, do institutional conditions impact the protection of tobacco control from tobacco industry interests in Fiji and Vanuatu?" The findings show that in Fiji and Vanuatu the institutional conditions are unlikely to support the prioritisation of health interests in tobacco governance, for the following reasons. Firstly, the politicisation of the government allows the nomination of high-level officials who prioritise their personal or political interests. Secondly, the policy process on paper in both countries supports the creation of a level playing field, but the procedures are not followed as intended, which allows well-organised interest groups to heavily influence

policy making. It appears that the underlying reasons for this gap between rules and implementation are the weakness of performance management and accountability in Vanuatu and the heavy centralisation of decision-making authority in Fiji. Additionally, the lack of civil society involvement in tobacco control further reduces the chance of elevating health interests. Furthermore, terms of engagement with the TI are not implemented, which increases the vulnerability of health interests in tobacco governance. Thirdly, the muted checks and balances in both countries leave the government with limited oversight to ensure that public interests are followed. Fourthly, the low bureaucratic autonomy in Fiji indicates that the high centralisation of decision-making in the government leaves little opportunity for administrators to secure public interests. The low authority of MoH in the government further aggravates this issue and makes the elevation of health interests in tobacco governance challenging. Fifthly, MoH in both countries faces capacity issues due to their SIDS status, which impairs their ability to perform careful cost-benefit analysis to determine the policy alternative benefitting the public most. These findings are important because they explain why it is so challenging to ensure that decisions in tobacco governance prioritise public health interests over private commercial interests.

3. Summary

In Chapter 2 the literature suggests that policy coherence and protection from TI interests are key to the control of commercial determinants of NCDs related to tobacco. This chapter's (Chapter 7) starting point was the recognition, as demonstrated in Chapters 5 and 6, that pro-commercial interests heavily influence tobacco governance and undermine policy coherence, because they have greater authority and more persuasive ideas than the pro-health actors. Chapter 7 extended the analyses of interests and ideas, focusing on institutional factors in Fiji and Vanuatu and their influence on achieving policy coherence and protection from TI interests. Figure 12 offers a simplified diagram of how institutional conditions effect tobacco control in these countries.

With Section 1 the chapter began with an analysis of ways in which existing intersectoral mechanisms enable policy coherence in tobacco governance in these countries. The findings show that the commonly used multisectoral NCD committees are not sufficiently effective to ensure policy coherence for tobacco control. There is a high risk for the collaboration to break down, because several of the parties perceive the net benefits as low and the mandates of the actors involved oppose each other, and the loose integration mechanism of these committees does not ensure that parties with opposing interests

meaningfully contribute to the meetings. Furthermore, the political and institutional contexts of Vanuatu and Fiji are not particularly supportive of intersectoral collaboration for tobacco control.

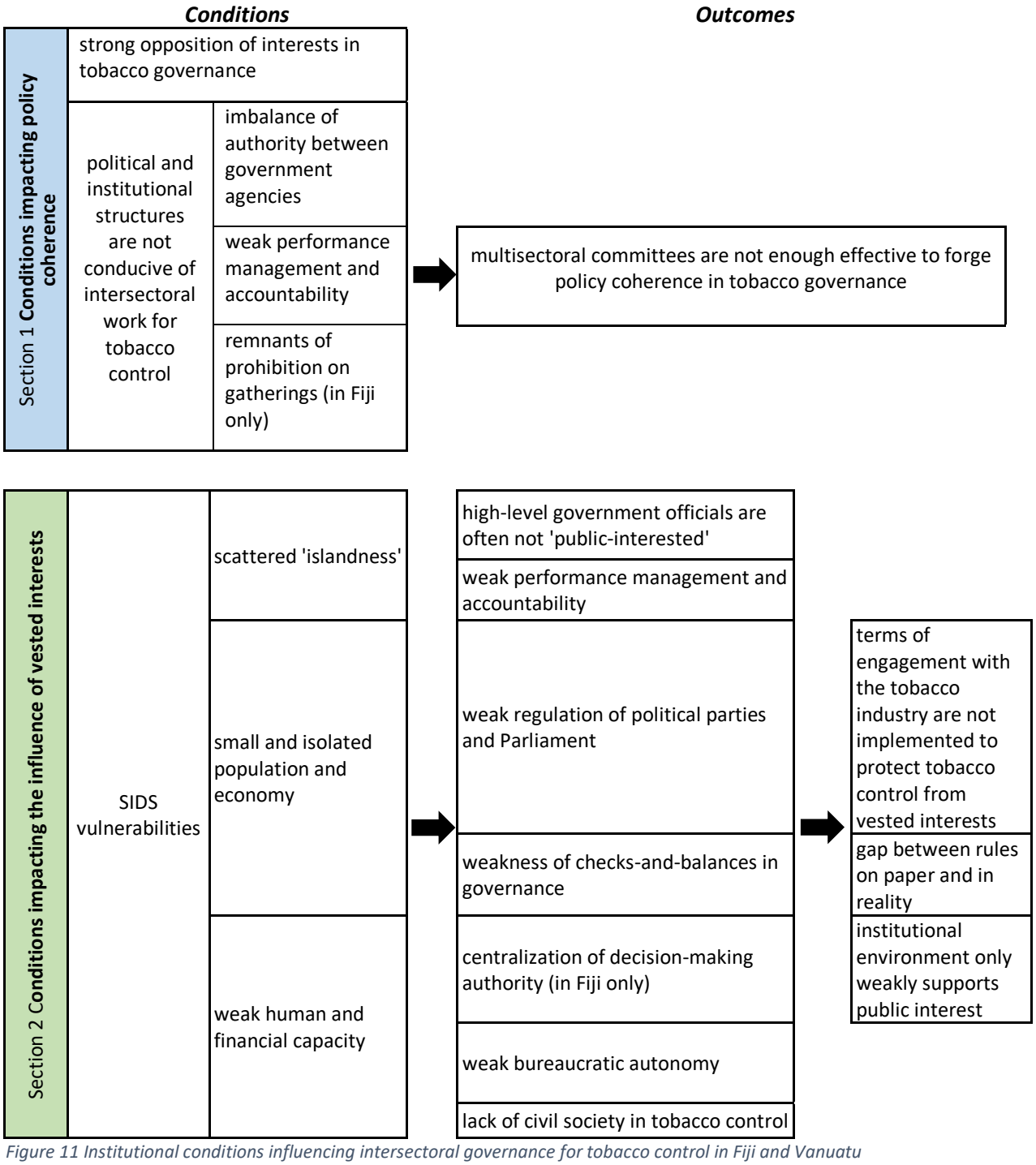


Figure 11 Institutional conditions influencing intersectoral governance for tobacco control in Fiji and Vanuatu

Section 2 of the chapter examined the administrative processes and their ability to elevate health interests in tobacco governance. The findings show that the institutional conditions in Fiji and Vanuatu allow well-organised interest groups with narrow interests to influence governance outcomes while leaving less influential interest groups on the periphery. The SIDS vulnerabilities of small population and the country being scattered among several islands, and the weak regulation of political parties allow clientelism and patronage to impact the "public-interestedness" of government officials' serving in executive positions. This contributes to weak performance management and accountability, which are likely to enable a gap between the rules of policy making and the ways policies are actually implemented. Furthermore, due to the weakness of civil society and the lack of terms of engagement with the TI, the elevation of health interests in tobacco governance is not ensured by the administrative processes. The above listed vulnerabilities of SIDS of Fiji and Vanuatu contribute to a political context in Fiji and Vanuatu which results in low bureaucratic autonomy at the MoH department level, and the muted system of checks and balances offers limited protection for policy making from vested interests. Finally, being SIDS aggravates the weak human and financial capacity commonly observed in LMICs because of the geographic isolation and small population size; these further limit the government of Fiji and Vanuatu in ensuring their independence from vested interests.

By this stage in the dissertation a particular question becomes inevitable. If it is indeed so challenging to elevate health interests in tobacco governance, what explains the reportedly high performance of Fiji and Vanuatu in tobacco control? Chapter 8 discusses the connection between the findings and the reports on these countries' performance in implementing FCTC and offers an explanation for this anomaly.

Chapter 8. Discussion and Conclusions

This research set out to improve the scholarly knowledge about the conditions that influence the governance of the commercial determinants of noncommunicable diseases (NCDs). Specifically, it has sought to answer the research question: "What conditions influence intersectoral governance of tobacco control in Pacific small island developing states (PSIDS)?"

This chapter first provides a brief reminder of the research problem and the applied methodology, and a summary of major findings (Section 1), which is followed by a discussion on the meaning and relevance of these results (Section 2). The chapter then continues by comparing the findings with other similar studies, highlighting the contribution of this research to the scholarly literature, and discussing some of the unexpected results (Section 3). Next, Section 4 outlines the recommendations of this dissertation. Section 5 gives an account of the limitations of this study, and Section 6 proposes three different research directions for future work. Finally, the conclusions of this research are covered in Section 7.

1. Approaching the research problem

1.1. The Problem

As discussed in Chapters 1 and 2, in 2013 most Pacific small island developing states (PSIDS) declared that they were in an NCD crisis that urgently needed to be addressed (658). The consumption of harmful commodities such as tobacco, alcohol, and ultra-processed foods and beverages are major risk factors for NCDs (104,659), and almost every second man in PSIDS uses tobacco regularly (93–102). The United Nations Sustainable Development Goals (660) push governments to ensure that their populations have the highest attainable health status, but for PSIDS this is especially challenging because of the vulnerabilities arising from their small land, population, and economy size, geographic isolation, and often being located on several scattered islands (87).

There is growing recognition that the practices of harmful commodity industries – aimed at increasing the availability, affordability, desirability, and consumption of their products – drive the NCD crisis (19). Recently there has been a convergence in the public health scholarship to address such issues under the

banner of commercial determinants of health (CDOH). The comprehensive and multisectoral measures which are known to be effective in controlling harmful commodities (40,43,88) require the commitment of various government agencies, many with different mandates, and reaching policy coherence across these sectors can be difficult (43,46,78,240,387,661–667). Furthermore, the regulation of harmful commodities goes against the interests of their industries, which thus aim to interfere with public health policies. This is a major challenge, because most PSIDS governments fail to implement terms of engagement to protect policy making from vested commercial influence (542). The literature review in Chapter 2 pointed towards the importance of interests, ideas, and institutions in shaping the ways governments can manage multisectoral work on the regulation of tobacco. Much of that work was conceptual, with little empirical evidence available to examine how these conditions operate generally, and it was non-existent in PSIDS. Addressing this gap is critical, because these countries have a remarkably different social, political, cultural, and economic context than other LMICs, which makes the implementation of practices recommended by public health experts to regulate harmful commodities particularly challenging. Given the severity of the NCD crisis in PSIDS, it is crucial to improve understanding on how their governments can better govern harmful commodity industries through comprehensive and coherent public policies.

1.2. The research approach

This research has deepened the understanding of the conditions that influence the ways governments in PSIDS address the commercial determinants of NCDs in relation to tobacco through the case study of Fiji and Vanuatu. Interdisciplinarity was a core feature of this work, drawing on public health, governance, public administration, and political science scholarship.

Two PSIDS, Fiji and Vanuatu, were selected as case studies to explore the conditions shaping the governance of commercial determinants of NCDs. An analytical framework was developed analogous to the "3-i" framework (103). *Interests* were examined through the questions "What are the major interests at play in tobacco governance in Fiji and Vanuatu?" and "How do actors deploy authority to influence tobacco control in Fiji and Vanuatu?" Avant et al.'s (125) theory of authority helped in this part of the analysis. *Ideas* were explored through the questions "What are the dominant ideas related to tobacco in Fiji and Vanuatu?" and "How do they influence tobacco control?" Stone's (126) theory of causal ideas supported the investigation of these questions. *Institutions* were analysed through the questions "What institutional conditions affect policy coherence for tobacco control in Fiji and Vanuatu?" and "How, and

to what extent, do institutional factors ensure a level playing field in tobacco governance among stakeholders in Fiji and Vanuatu?" Feiock's (127) institutional collective action framework and Croley's (128) administrative process theory provided useful insights in this process. The data collected through key informant interviews and relevant legal and policy documents allowed the in-depth analysis of interests, ideas, and institutions.

2. Key findings and contribution to academic literature

The WHO reports on tobacco control in Fiji and Vanuatu (89,544,590,591) suggested that these countries are high performers in tobacco control and that they had managed to elevate health interests in tobacco governance despite the presence of tobacco industry (TI) interests. Based on the tobacco control scholarship, such an achievement should be possible because of the good institutional structures in place, fostering policy coherence for tobacco control and ensuring that public health policy making is protected from vested interests (54,67,68,70,78,122,378). However, the Pacific Monitoring Alliance for NCD Action (MANA) Dashboard showed that Fiji and Vanuatu do not have an NCD taskforce in place and no terms of engagement are implemented (406); furthermore, the World Bank reported that compliance with tobacco control measures was weak in many PSIDS (453). The literature on the governance of CDOH in SIDS suggested that the vulnerabilities these countries have –their small population, economy, and land size, geographic isolation, and limited human and financial capacity (87,409,412–414) – make the development and implementation of comprehensive, multisectoral tobacco control policies challenging (85,417). These sources underlined the importance of improving the understanding of how PSIDS governments address CDOH arising from the TI.

Based on the reviewed literature the expectation was to find that tobacco control in Fiji and Vanuatu was deeply challenged by interest-based, ideational, and institutional conditions, but as the WHO reports suggested, these governments have managed to overcome these barriers and developed comprehensive, multisectoral policies, which might be difficult to implement due to the capacity issues common in SIDS. Contrary to these expectations, the findings of this research show that both Fiji and Vanuatu struggle with addressing CDOH in relation to tobacco.

2.1. Summary of key findings

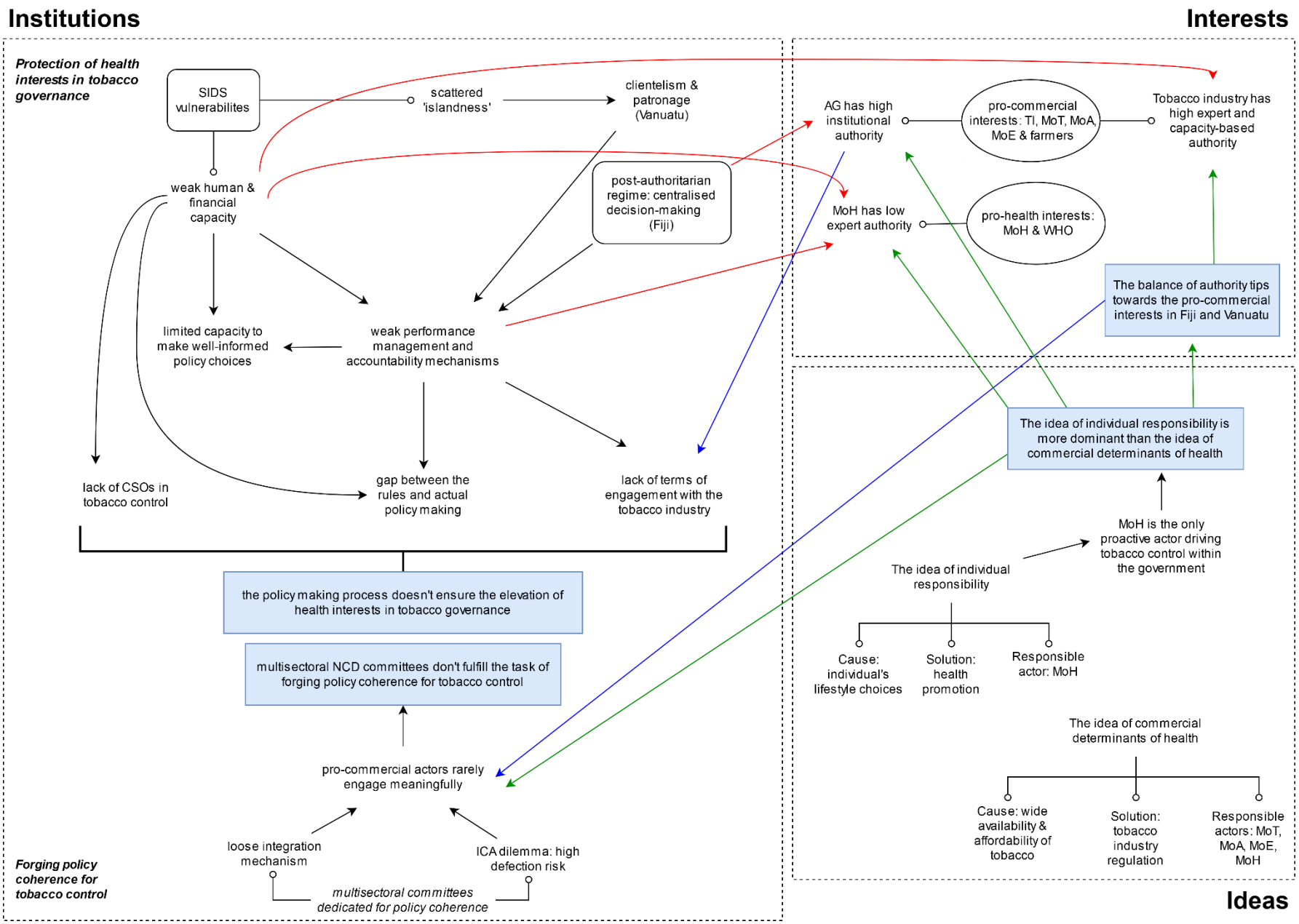
The interest-based, ideational, and institutional conditions that influence tobacco control in Fiji and Vanuatu and the way these relate to each other are summarised in Figure 12.

This research revealed that in Fiji and Vanuatu there are two major groups of interests in tobacco governance: pro-health and pro-commercial interests. The former consists of the Ministry of Health (MoH) and WHO; the latter is made up of the tobacco industry (TI), Ministry of Agriculture (MoA), Ministry of Trade (MoT), and Ministry of Economy (MoE) in Fiji.

In Vanuatu, the authority these interest groups hold is fairly even; only recently the development of a MoA policy to support tobacco growing tipped the balance of authority towards pro-commercial interests. While MoH should hold most expert and legal authority in tobacco control matters in both countries, the perception that the agency is not performing well in controlling NCDs diminishes this authority. The underlying factors of such perception are the dominant idea of individual responsibility, which deems MoH responsible for the NCD crisis; furthermore, the financial and human capacity issues arising from a small population and economy, and the logistical challenges of providing services and implementing policies in several scattered islands – all common vulnerabilities of SIDS – constrain the ability of MoH to fulfil its duties. In Fiji authority is centralised in the hands of the Attorney General (AG) who appears to believe that the private commercial interests of the TI are aligned with the economic interests of the country. He seems to dominate over MoH within the government, which limits the latter in its efforts to elevate health interests in tobacco governance. The TI bears considerable expert and capacity-based authority in tobacco governance (particularly in Fiji), which makes tobacco companies accepted as legitimate actors in the government in both countries.

The dominant causal ideas around tobacco and NCDs undermine the authority of MoH in Fiji and Vanuatu. The idea of individual responsibility suggests that personal choices about the consumption of tobacco (and other harmful commodities) are the reason for high smoking prevalence and the concomitant NCD crisis. This idea neglects the role of wider determinants of health, and while the data shows that the idea of CDOH is present in both countries, the dominance of the former results in the government perceiving MoH as the responsible party to solve the issue of high smoking prevalence and the NCD crisis by educating the public and treating the sick. However, since the prevalence of NCDs has been getting higher in these countries, there is increasing criticism about the performance of MoH. This criticism is detrimental to the expert authority of the agency, which makes the imbalance of authority among the actors in tobacco governance further tip towards the pro-commercial actors.

Figure 12 The interest-based, ideational, and institutional conditions which influence tobacco control in Fiji and Vanuatu



Moreover, tobacco control policies are frequently discussed in economic terms in both countries, which makes it even harder for MoH to ensure that health interests are elevated over commercial interests, as it has no expertise in economic matters. Especially in Fiji, where the AG – who is also the Minister for Economy – already holds most authority within the government, the focus on economic impacts of such policies makes the influence of this actor even stronger.

The institutional conditions in Fiji and Vanuatu are influenced by interests and ideas. The dedicated intersectoral mechanism to forge policy coherence among sectors for tobacco control is multisectoral NCD committees in both countries. However, these committees face challenges to achieve this task, for two main reasons. Firstly, the non-health government actors have a limited understanding of their role in the rise of NCDs as a result of the dominant idea of individual responsibility, which identifies MoH as the only government actor whose engagement is needed. Secondly, the imbalance of authority that tips towards the pro-commercial interests results in MoH having limited influence over the pro-commercial actors. These two issues result in the pro-commercial actors rarely attending the multisectoral NCD committee meetings, or they send delegates who do not have enough authority or capacity to meaningfully contribute to the discussions.

Furthermore, the protection of health interests in tobacco governance is not ensured by the administrative processes of Fiji and Vanuatu. The vulnerabilities characterising SIDS are prevalent in both countries and they have a detrimental impact on how institutions are structured and operate. In Vanuatu clientelism and patronage are consequences of the country being scattered over multiple little islands, and due to the weak regulation of political parties the political landscape rapidly changes in the country. As a result, individuals in executive government positions do not necessarily govern for the sake of public interest, but for their personal, political, or localised interests. Fiji, being a post-authoritarian state, has a centralised government system where the ministries are highly dependent on the AG's discretion, and since he tends to prioritise commercial interests, this constrains MoH from elevating health interests in tobacco governance. These political conditions have a negative impact on the performance management and accountability mechanisms of these countries, which are further burdened by the weak human and financial capacities common in SIDS. The consequences are twofold. Firstly, the rules of policy making – which would ensure the protection of public interests – are often not followed; there are no terms of engagement implemented with the TI; and there are no civil society organisations (CSOs) with capacity to advocate for tobacco control. Because of these issues, the policy making process does not ensure the prioritisation of health interests for tobacco control. Secondly, MoH has limited capacity to make well-

informed policy choices and to be independent from the information received from the TI. Additionally, the weak MoH capacity enables other government actors to challenge the agency's authority in tobacco governance.

In summary, the above presented findings show that the governance of tobacco as commercial determinants of NCDs is particularly challenging for Fiji and Vanuatu. Although the WHO Framework Convention on Tobacco Control (FCTC) requires the establishment of comprehensive, multisectoral tobacco control policies, these countries struggle with implementing such measures. Pro-commercial interests heavily influence tobacco governance by exerting their authority which dominates over pro-health interests. The dominant causal idea of individual responsibility further strengthens their position. The institutional conditions prevalent in Fiji and Vanuatu do not enable the elevation of health interests in tobacco governance; because of the vulnerabilities of SIDS and the political conditions weaken the policy making process, no terms of engagement with the TI are implemented. The dedicated intersectoral mechanisms of multisectoral committees are not efficient enough to forge policy coherence between the opposing mandates and interests of pro-health and pro-commercial actors among such conditions.

The findings indicate that Fiji and Vanuatu struggle to overcome the challenge of conflicting mandates and interests in tobacco governance, despite the tobacco control performance presented in the WHO reports. The interviewee data indicate that gaps exist not only between the rules and reality of policy making, but between the existing tobacco control regulations and their implementation. Such findings underscore the importance of field work in the country of focus and the need for qualitative analysis of the governance of tobacco. There are 38 SIDS signed up to FCTC (89), many of which show lower implementation rates than Fiji and Vanuatu (544,590,591); the findings of this research suggest that these states are likely to struggle with very similar issues in tobacco control, which remain hidden behind the FCTC reports. The recommendations of this dissertation might be useful for these SIDS as well.

2.2. Contribution to academic literature

While some of the findings presented above confirm prior studies in the governance of CDOH in PSIDS, this research has contributed to this scholarship by expanding the available empirical evidence on interests, ideas, and institutions in Fiji and Vanuatu and by providing detailed analysis of the ways such conditions shape government responses to the regulation of tobacco. In the following sections, the key findings are interpreted in relation to the existing academic literature.

2.2.1. The role of SIDS vulnerabilities

This research confirmed that Fiji and Vanuatu face particular challenges in implementing comprehensive, multisectoral tobacco control measures, and it has deepened understanding about how being a SIDS impacts the way governments address CDOH.

Firstly, this research found that SIDS vulnerabilities – the low financial capacity arising from having a middle-income state and needing to distribute resources across several islands, and the low human capacity resulting from being a geographically isolated nation with a small population– make Fiji and Vanuatu susceptible to the influence of vested interests. This makes the careful examination of the costs and benefits of tobacco control difficult. As a result, government agencies are likely to rely on the readily available information provided by the TI – or by development partners. The findings show that development partners have a crucial role in supporting PSIDS in their efforts to control the commercial determinants, but while they often have limited authority to engage certain sectors, the TI has direct access to multiple government agencies. Previous studies on tobacco control in PSIDS showed that capacity constraints make tobacco control policy making and implementation difficult (85,447,455); similar findings were reported in food regulation in Fiji, arguing that human and financial capacity issues limit the robustness of policy development and implementation (115,158,390). This research offered new depth to this understanding by explaining in detail the ways such capacity issues make public health policy development and implementation vulnerable to private commercial interests. Such a connection was previously suggested by a study on Caribbean SIDS; however, this work did not provide detailed analysis on how and why this happens (417).

Secondly, multiple studies aim to explain the legitimacy of the TI (46,54,161,378,668); they found that the pronounced need for economic development in LMICs allows the TI to appear as a useful investor – a legitimate source of development. This research has expanded this understanding by explaining the sources of authority the TI has in Fiji and Vanuatu, revealing that not only does its capacity-based and expert authority increase its legitimacy, but the dominant idea of individual responsibility – embedded in neoliberal ideologies – tips the balance of authority towards pro-commercial actors. As a result, several government agencies do not see the need for the development and implementation of terms of engagement (or even if they do, their reliance on the TI makes such commitment difficult). This explains the findings of other works arguing that Article 5.3 of FCTC on the protection of public health policies from TI interests is poorly implemented in countries where there are already established working relationships between the government and the TI (121–123).

Thirdly, this research found that in Fiji and Vanuatu, the issues of high smoking prevalence and NCDs are discussed in economic terms, not so much in public health terms. This is likely to happen, because in both governments economic and commercial interests are often prioritised over public health, and because of the dominant neoliberal ideologies prevalent in these countries. This corresponds to the findings reported by other studies in food policy making in Fiji (51,115,436,437) and in tobacco control in Caribbean SIDS (417); however, this research showed that this nominates MoE as the chief authority on apprehending the impact of tobacco governance decisions on the country, and MoH remains in a secondary role with its concerns about citizens' health. This partially explains the imbalance of authority between the pro-health and pro-commercial actors, which is a similar finding to the imbalance of power which has been reported in Fiji in food regulation by Thow et al. (436). However, this imbalance is also rooted in the political context of Fiji and Vanuatu, as the next paragraph explains.

Multiple governance and development scholars (481,669–677) describe that LMICs tend to create institutions which resemble those in democratic states to gain legitimacy in the eyes of donors and the public, without actually changing the way the state is run. The structure of government agencies is set up, and on paper all the policy and decision-making processes look like they should in a democratic country. However, in reality the way the country is governed relies on old, informal mechanisms, usually dominated by a political elite. Levitsky and Murillo (675) call this parchment reforms, when "*rules exist on parchment, but in practice, they do little to constrain actors or shape their expectations*". Pritchett et al. (670) describe this as *"isomorphic mimicry, wherein the outward forms (appearances, structures) of functional states and organizations elsewhere are adopted to camouflage a persistent lack of function."* These works could explain why Fiji and Vanuatu appear to be high performers in tobacco control according to the WHO reports and also why there is a gap between the rules and reality of policy making. However, this research has expanded this understanding by explaining how the political conditions characterising SIDS shape institutional structures in Fiji and Vanuatu. The formal political and institutional procedures are set up in a way to ensure public-interested governance; however, the political environment makes the implementation of such rules challenging. High-level government officials often lack the necessary public-interestedness as a result of the heavy politicisation of the government. The weak accountability and performance management mechanisms characterising these states and their limited financial and human capacities result in a gap between the official rules and the actual ways policies are made, and they leave these governments poorly equipped to protect themselves from vested interests. These findings show that mere political calculations are not behind the gap between rules and actual policy

making in Fiji and Vanuatu, but a complex interplay of institutional conditions arising from the SIDS status of these states.

In Fiji, despite the gap between the rules and policy making, the heavily centralised governance could benefit tobacco control if the AG were on board. This indicates that in Fiji the political determinants of health – ideas, actions, and decisions of political actors and their effect on health (396) – play an important role besides CDOH. From this perspective, the Fijian political environment does not support tobacco control only because the dominant ideas are pro-tobacco and the pro-commercial interests are prioritised. In the event the political elite gained interest in tobacco control, the regime could quickly reform these policies. However, as the findings suggest, the dominant ideas around tobacco and NCDs need to change first.

2.2.2. The role of ideas

The findings highlight the particular weight causal ideas carry among the interest-based, ideational, and institutional conditions in Fiji and Vanuatu. The dominance of the idea of individual responsibility bears direct, operational consequences for how tobacco control is implemented in these countries. Even though FCTC requires a set of non-negotiable measures and the commitment of multiple sectors besides health, the non-health government agencies in both countries have the tendency to pursue their pro-commercial interests, because the idea of individual responsibility dissolves their accountability. Thus, this idea creates perfect conditions for the pro-commercial interests to control the regulation of tobacco, and the commitment of MoH and WHO is not enough to implement comprehensive tobacco control, as the findings suggest. These results explain the findings of prior studies by Waqa et al. (115) and Thow et al. (436) on the governance of CDOH in relation to food and nutrition in Fiji. Their work showed that the non-health sectors have weak commitment to multisectoral NCD policies, and that MoH does not have the mandate to fully address CDOH because many of the aspects of industry regulation falls outside of the health sector (436).

These findings also correspond to previous research in Fiji, which showed that the idea of individual responsibility and neoliberal ideologies were dominant in the country and constrained food policy making efforts to address CDOH (49,51,158,436). However, most importantly**,** this research confirms other studies that analysed the ways ideas influence the governance of CDOH. Battams and Townsend (46) suggested that the legitimacy wielded by harmful commodity industries defines the amount of influence they have on governments. Labonté et al. (54) and Lencucha and Thow (43,47) state that ideas shape

institutional structures in tobacco governance, and that it is not enough to merely change the latter but the former needs to be addressed in order to achieve policy coherence for tobacco control (43,47,54). The study by Labonté et al. (54) conducted in Zambia showed that the dominant idea among the government actors responsible for the regulation of tobacco production and sales "*tied tobacco production to wider economic development discourses, particularly in terms of the necessity of tobacco for the country's overall development*" (54). Lencucha and Thow argued that the *"neoliberal paradigm, has conditioned the policy environment in a way that promotes the supply of unhealthy commodities*" (47). This research – by providing a detailed analysis of how causal ideas affect tobacco governance – gives further weight to such arguments and starts to build an empirical base to show how to achieve such results. Suppose that the framing of the problem identified CDOH as a driver of NCDs in these countries, the NCD crisis could be perceived as a failure of MoT, MoA, or MoE, which would raise the authority of MoH over trade, agricultural, and economy matters in relation to harmful commodities. Intersectoral governance for NCD prevention would likely be different. However, without changing the dominant idea it is unlikely that the efforts of the pro-health interests will bring long-term results.

In summary, this research has expanded on earlier studies in SIDS and the governance of harmful commodities. No previously published studies provided a comprehensive analysis of the interaction of interests, ideas, and institutions in tobacco control in PSIDS, and as the findings of this research show, all these three types of conditions have an important role in shaping government responses to the NCD crisis. Therefore, this research provides a significant contribution to the scholarly literature, because the depth and richness of its analysis goes beyond the scope of earlier works.

The tobacco control scholarship emphasises the need for institutional structures; however, as this research shows, such mechanisms are likely to fail if governance actors are guided by ideas opposed to accepting responsibility for the population's smoking habits. The findings of this research confirm that the ideas which dominate the thinking of government officials around tobacco use and NCDs define the way interests are prioritised, policy directions are set, and responsibility is delegated to actors. In Fiji and Vanuatu, the idea of individual responsibility dominates over the idea of CDOH; without wider acceptance of the latter idea, the conflict of mandates will be present in the governments, and pro-health actors will continue to face the reluctance of non-health government agencies to engage in comprehensive, multisectoral tobacco control policies. The public health and CDOH scholarship have discussed the need for such a shift in the dominant ideas around NCDs; this research has started to build the necessary

empirical evidence and academic knowledge, and provided a new methodological approach to help inform the ways such change can be realised.

3. Recommendations

The findings show that interests, ideas, and institutions impact each other and focusing solely on one of them is not enough to ensure the implementation of comprehensive tobacco control policies. Since this study followed an exploratory design, further research would be useful to strengthen the validity of the recommendations derived from its findings. Nevertheless, the following recommendations might be of benefit for public servants or development partners working in Fiji and Vanuatu, or in other PSIDS. Recommendation 1 captures the need for a shift in ideas; recommendation 2, 3, and 4 are focusing on strengthening institutional structures. This dissertation suggests that a change in both ideational and institutional conditions is necessary to tackle the challenge of conflicting mandates and interests in the governance of CDOH.

Recommendation 1: Increased promotion of the idea of commercial determinants of health

The first recommendation of this research is the increased promotion of the idea of CDOH. In order to do so, the pro-health actors have to adopt this causal idea. This recommendation corresponds to the works of other scholars who call for a shift in the dominant ideas from an individual responsibility/biomedical approach towards a wider determinants of health framing to control tobacco (47,54,67) and in the regulation of harmful commodities in general (24,32,43,47,49–55,57,58). As the findings of this dissertation show, development partners, such as WHO, play an important part in introducing global ideas to national government agencies. The idea of CDOH in this sense can be interpreted as a global idea as it is widely recognised by public health experts and scholars worldwide, and FCTC strongly corresponds to it. Kauffman (477) discusses in detail the way global ideas diffuse in domestic settings and offers a step-by-step process on how to ensure that such transfer happens. According to the author, a global idea needs first to diffuse to the "grassroots" domestically (step 1), before it can be applied in national policy making, where a range of activities have to happen, such as agenda setting with local authorities, mobilisation within society, making rules, implementation, and evaluation, adaptation and consolidation (step 2). If the idea has successfully infiltrated the ways domestic agencies think, it has the potential to feed back to the global level of ideas by the advocacy of national actors (step 3). This theory assumes a major role for development partners, especially in steps 1 and 2. The advocacy of domestic actors becomes important

in step 2 and step 3: once the pro-health actors in Fiji and Vanuatu adopt the idea of CDOH, it is their turn to advocate it among other government actors and the public.

However, as this research has shown, the promotion of the idea of CDOH goes against the interests of the pro-commercial actors, who have more authority than the pro-health actors, and particularly in PSIDS (and probably in many LMICs) the capacity constraints of MoH and the civil society have to be taken into consideration as well. In order to overcome such barriers, the following steps are recommended based on the findings of this research.

Recommendation 2: Capacity building

Capacity building could facilitate that the institutional conditions support a level playing field among the actors of tobacco governance with different interests. Capacity strengthening programs are commonly provided by development partners in PSIDS. The collected data revealed that both in Fiji and Vanuatu there are currently multiple initiatives focusing on improving the capacity of units working on tobacco control within MoH. However, as the interviewee data revealed, the control of NCDs are perceived to receive less financial assistance than other areas in health, and such programs do not target civil society, and the lack of funding is a major reason why no CSOs are active in tobacco control or in advocacy in relation to NCD prevention. Funding CSOs to operate in this field in SIDS in the Pacific would be an important step in controlling the commercial determinants of NCDs. The limited financial resources of PSIDS governments imply that such funds would need to be provided by development partners.

Increasing the financial and human capacity of MoH would support well-informed policy choices; it would provide adequate capacity to meaningfully follow the policy process (including proper and timely consultations), and would ensure that more evidence of the impact of tobacco investment is presented. If capacity building were conducted in MoA and MoT as well, these agencies would be less reliant on the expertise and capacity provided by TI. This would likely to decrease the expert and capacity-based authority of TI. Capacity strengthening could facilitate the management of conflicts of interest (COI), as there is an urgent need for the establishment of the terms of engagement with the TI. However, such efforts would need to keep in mind the unique vulnerabilities of SIDS; they would need to be sensitive to economic development needs and limited human and financial resources. Moreover, any capacity building initiatives must consider the cultural context of PSIDS (678).

While further deliberation is needed to determine the ideal source or method of funding, this recommendation is aligned with the suggestion of other scholars to build capacity in PSIDS to strengthen

tobacco control (85,447,455). Furthermore, key informants suggested that in Fiji and Vanuatu, weak performance management and accountability mechanisms do not ensure that resources provided are necessarily used in the most efficient way. This implies that, without governance strengthening on this matter, capacity building is unlikely to bring the desired outcomes.

Recommendation 3: Strengthening performance management and accountability mechanisms

This research suggests that performance management and accountability mechanisms need to be strengthened via governance strengthening programmes such as those often provided by the World Bank or WHO. This would ensure that the carefully planned policy processes are actually followed, and it would improve the implementation of FCTC which could result in the development of terms of engagement with the tobacco industry. Such efforts would also lessen the influence of both commercial and political determinants of health in Fiji and Vanuatu. This recommendation is aligned with the suggestions of CDOH scholars (679,680) who highlight the need for strong accountability mechanisms to regulate harmful commodity industries; moreover, it corresponds to the works of development scholars (481,669–677) who emphasise that government strengthening is essential to address the gap between the rules of policy making and their actual implementation.

Governance strengthening initiatives are frequently provided by development partners to LMICs, and there have been examples of such programmes in Fiji according to the collected data; however, the political elite has been selective on which recommendations of the development partners to follow, which leads to the next recommendation of this research.

Recommendation 4: Strengthening the rules of the political system

While this research mainly focused on governance in Fiji and Vanuatu around tobacco, the results suggest the need to strengthen additionally the political system. The tightening of the regulation of the political parties and strengthening the Parliament is necessary in PSIDS for the institutional conditions to ensure that any of the recommendations described above bring the desired outcome. In both Fiji and Vanuatu, the Parliamentary capacity needs to be improved to enable oversight over the government as a way to ensure public-interested policy making and that the governance strengthening programmes bring the desired results. In Vanuatu, regulation of the political parties must to be strengthened in order to decrease frequent rotation, clientelism and patronage within the government. In Fiji the transition to full democracy should be encouraged: the political elite needs to be persuaded to let go of its control – the data showed that there have been developments already about this, so a full transition to democracy is certainly on the cards for Fiji.

The first recommendation – on shifting dominant ideas – is the primary message of this research; however, for PSIDS to follow such a direction, institutional structures must be strengthened, which need is addressed by the remaining three recommendations – capacity building, governance and political system strengthening. The data has shown that in Fiji there is currently work underway in all these areas; in Vanuatu capacity building and political strengthening are in progress. The experience of the development partners engaged in these programmes is that particularly the latter is a very slow process. Inducing change in the dominant ideas will likely take time as well. However, this research shows that without addressing these ideational and institutional conditions, PSIDS will continue to struggle with the influence of vested commercial interests and the conflicting mandates of government agencies, both which makes tackling the NCD crisis challenging.

4. Limitations

While this study shows considerable strengths in the depth of analysis and the rigorous application of the analytical framework, it also has a few limitations. Firstly, contrary to the assumptions of the case selection process, the collected data indicates that Fiji and Vanuatu are not necessarily performing well in tobacco control in regard to the implementation of comprehensive, multisectoral policies. It would had been optimal to study SIDS that had succeeded in overcoming barriers caused by the various interest-based, ideational, and institutional conditions discussed in the findings; however, the results of this research suggest that the tobacco control reports do not necessarily provide a realistic picture of a country's performance in the implementation of FCTC. Based on this, in order to ensure that a high performing state is selected for a similar study, in-country assessment of tobacco control would be necessary. Nevertheless, this research has succeeded in exploring the conditions that play a major role in the governance of CDOH in SIDS, despite Fiji and Vanuatu displaying struggles with some of them.

Secondly, the gap in the scholarly knowledge regarding the issues of the governance of commercial determinants of NCDs in PSIDS does not only cover tobacco but other harmful commodities. The temporal and capacity restrictions of a PhD study allowed a focus on only one of these commodities. While there are many parallels between the conditions important in the regulation of alcohol, ultra-processed foods and drinks and tobacco, the complexity surrounding each of these commodities makes the generalisability of the findings of this research limited. However, an increasing amount of academic literature on CDOH highlights the similarities between the strategies and tactics of these industries (1–4,4–12), which

suggests that findings about tobacco control can benefit work done in the regulation of alcohol and ultra-processed foods and drinks as well.

The third limitation also arises due to the temporal and capacity restrictions of PhD study: only two cases were examined in this research, which reduces the generalisability of the findings. However, given that the purpose of this study was to explore important conditions in multisectoral tobacco control, instead of a limitation the small number of cases could be viewed as a necessary first step, which provides an outline of a longer journey in understanding the governance of CDOH.

5. Future research directions

This study employed an exploratory research design to investigate and map out the important conditions that influence the way the governments of Fiji and Vanuatu address the commercial determinants of NCDs through a focus on tobacco control. The contributions of this work to the scholarly literature are just a first step in understanding the ways interests, ideas, and institutions interact and shape PSIDS governments' approaches to NCD prevention. Further research is necessary to reveal whether the findings discussed above characterise other PSIDS and SIDS in general. Moreover, many of the conditions discussed are likely to influence governments in LMICs as well, and the impact of ideas has been shown to have an important role in the regulation of harmful commodities in high-income countries, too.

Therefore, the expansion of the focus of this research could be the next step, in the form of a postdoctoral research project. Firstly, this could be done by examining the interests, ideas, and institutions influencing the governance of alcohol and ultra-processed foods and drinks. Secondly, a multiple-case design including a larger number of SIDS, possibly not only in the Pacific but in other geographical regions, would deepen understanding about the relevant conditions and strengthen the generalisability of the findings.

Another direction for future research would be to narrow the focus of analysis to the diffusion of ideas. As this research has shown, causal ideas play a crucial role in defining interests and institutional structures, an in-depth examination of the ways ideas around harmful commodities and NCDs formulate and spread among governance actors in SIDS could be warranted. The CDOH literature has placed increasing emphasis on the need to shift from the dominant idea of individual responsibility to the direction of ideas of social, commercial, and political determinants of health, and although this research has started to build the necessary empirical evidence and academic knowledge, to help inform the ways a CDOH can be better governed in PSIDS, more work is required in this area.

A third, longer term research project could examine the correlation between political systems and governance strengthening programmes and the ways commercial determinants of NCDs are addressed in SIDS in regulations in the public interest. Such research would further increase the interdisciplinary nature of this work by expanding to the scholarship of development studies and political science and would provide an important contribution to the political determinants of health literature.

6. Conclusion

This dissertation has contributed to the scholarly literature by expanding the evidence base and knowledge on the interests, ideas, and institutions which influence the way SIDS governments – more specifically those of Fiji and Vanuatu – address the commercial determinants of NCDs, with a focus on tobacco. Furthermore, it has provided a new methodological approach to help understand and inform how countries can better govern harmful commodity industries. Two key insights emerged from the findings of this research.

Firstly, the vulnerabilities of SIDS have to be taken into account and addressed in order to successfully govern the commercial determinants of NCDs in these countries. Smallness, geographic isolation, and a middle-income economy result in human and financial capacity issues; being spread out across multiple small islands contributes to clientelism and patronage; and the weak regulation of the political systems enable the existence of a quickly changing political landscape in Vanuatu and a heavily centralised government in post-authoritarian Fiji. These conditions result in issues of the public-interestedness of high-level government officials, weak accountability and performance management mechanisms, which correlate with the gaps between rules and the actual ways policies are made in these countries. This means that even if procedures are in place which would ensure public-interested policy making in tobacco governance (i.e. tobacco control), such procedures are unlikely to be adequately followed, which gives way to the harmful impact of the commercial and political determinants of health.

Secondly, the dominant causal ideas need to shift to support the governance of commercial determinants of NCDs. Institutional mechanisms and procedures are not enough to ensure the development and implementation of comprehensive, multisectoral policies. In Fiji and Vanuatu the non-health government agencies are effectively excused from contributing to the fight against NCDs, because the dominant idea of individual responsibility relieves them of any responsibility. This research argues that an increased focus is necessary on the causal ideas prevalent in the space of harmful commodities and NCDs in order to

understand how PSIDS can effectively address CDOHs. Ideas can be shifted and changed, and without moving away from the idea of individual responsibility fuelled by neoliberal ideologies, the governance actors needed for the control of harmful commodity industries will not be likely to engage into coherent, multisectoral policies. Furthermore, this research suggests that the governments and political systems of SIDS need to be strengthened for the sake of public-interested regulation. Policy issues where conflicting mandates and interests are contested – such as the governance of harmful commodities – are difficult to solve, but that is why carefully planned administrative procedures are in place in most democratic governments. Governance and political system strengthening would enable these mechanisms to serve their purpose without being captured by vested interests.

The next important step is to examine interests, ideas, and institutions in a wider range of SIDS in order to collect more evidence and deepen the understanding of the role of such conditions and to strengthen the generalisability of the findings. Furthermore, future research would be important to reveal where causal ideas around harmful commodities and NCDs originate from and how they spread – not only in SIDS, but in LMICs in general. Such research could provide useful lessons on how to diffuse the idea of CDOH into the governments of these countries. Shifting dominant ideas will be vital in tackling the NCD crisis.

References

1. Freudenberg N. Lethal But Legal: Corporations, Consumption, and Protecting Public Health. 2014;346.

2. Brownell KD, Warner KE. The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food? Milbank Quarterly. 2009;87(1):259–94.

3. Wiist WH. The Bottom Line or Public Health : Tactics Corporations Use to Influence Health and Health Policy and What We Can Do to Counter Them [Internet]. Oxford University Press; 2010. Available from: https://ebookcentral-proquest-com.virtual.anu.edu.au/lib/anu/detail.action?docID=3053680.

4. Abbott FM, Dukes MNG. Global pharmaceutical policy: ensuring medicines for tomorrow's world. Cheltenham, UK;Northampton, MA; Edward Elgar; 2009.

5. Anaf J, Baum FE, Fisher M, Harris E, Friel S. Assessing the health impact of transnational corporations: a case study on McDonald's Australia. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0230-4

6. Clapp J, Scrinis G. Big Food, Nutritionism, and Corporate Power. Globalizations. 2017 Jun 7;14(4):578–95.

7. Cowling K, Magraw D. Addressing NCDs: Protecting Health From Trade and Investment Law Comment on "Addressing NCDs: Challenges From Industry Market Promotion and Interferences." International Journal of Health Policy and Management. 2019 Jun 2;8(8):508–10.

8. Hastings G. Why corporate power is a public health priority. British Medical Journal. 2012;345(7871):26–9.

9. Kickbusch I, Allen L, Franz C. The commercial determinants of health. The Lancet Global Health. 2016 Dec;4(12):e895–6.

10. Moodie AR. What Public Health Practitioners Need to Know About Unhealthy Industry Tactics. Am J Public Health. 2017 Jul;107(7):1047–9.

11. Stuckler D, McKee M, Ebrahim S, Basu S. Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco. PLoS Medicine. 2012 Jun 26;9(6):e1001235.

12. Stuckler D, Nestle M. Big Food, Food Systems, and Global Health. PLoS Medicine. 2012 Jun 19;9(6):e1001242.

13. Hawkins B, Holden C, Eckhardt J, Lee K. Reassessing policy paradigms: A comparison of the global tobacco and alcohol industries. Global Public Health. 2018 Jan 2;13(1):1–19.

14. Hawkins B, McCambridge J. Can internal tobacco industry documents be useful for studying the UK alcohol industry? Bmc Public Health. 2018 Jun 28;18:808.

15. Greer SL, Wismar M, Figueras J, European Observatory on Health Systems and Policies, editors. Strengthening health system governance: better policies, stronger performance. Maidenhead, Berkshire, England: Open University Press; 2016. 272 p. (European Observatory on Health Systems and Policies series).

16. Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen: World Health Organization, Regional Office for Europe; 2013. 107 p.

17. Institute for Health Metrics and Evaluation. Frequently Asked Questions [Internet]. Institute for Health Metrics and Evaluation. 2019. Available from: http://www.healthdata.org/gbd/faq#What%20is%20a%20YLL?

18. Vos T, Lim SS, Abbafati C, Abbas KM, Abbasi M, Abbasifard M, et al. Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet. 2020 Oct;396(10258):1204–22.

19. Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. The Lancet. 2013 Feb;381(9867):670–9.

20. Peto R, Lopez AD, Boreham J, Thun M, Heath CJ. Mortality from smoking in Developed Countries 1950-2000. Indirect estimates from National Vital Statistics. Oxford : Oxford University Press; 1994.

21. Rosenberg L, Kaufman DW, Helmrich SP, Shapiro S. The risk of myocardial infarction after quitting smoking in men under 55 years of age. Vol. 313. N Engl J Med; 1985.

22. Thakur JS, Garg R, Narain JP, Menabde N. Tobacco use: A major risk factor for non communicable diseases in South-East Asia region. Indian Journal of Public Health. 2011;55(3):155–60.

23. Murray CJL, Aravkin AY, Zheng P, Abbafati C, Abbas KM, Abbasi-Kangevari M, et al. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet. 2020 Oct;396(10258):1223–49.

24. Baum F. Governing for Health. Advancing Health and Equity through Policy and Advocacy. Oxford: Oxford University Press; 2019.

25. Schram A, Labonté R, Sanders D. Urbanization and International Trade and Investment Policies as Determinants of Noncommunicable Diseases in Sub-Saharan Africa. Progress in Cardiovascular Diseases. 2013 Nov;56(3):281–301.

26. Schrecker T, Bambra C. How politics makes us sick. Palgrave Macmillan; 2015.

27. Swinburn B, Kraak V, Allender S, Atkins V, Baker P, Bogard JR, et al. The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report. The Lancet. 2019;393(10173):791–846.

28. Friel S, Baker P, Lee, J, Nisbett N, Buse K, Oenema S. Global Governance for Nutrition and the role of UNSCN. UNSCN; 2017.

29. Adjaye-Gbewonyo K, Vaughan M. Reframing NCDs? An analysis of current debates. Global Health Action. 2019 Jan 1;12(1):1641043.

30. Baum FE, Sanders DM, Fisher M, Anaf J, Freudenberg N, Friel S, et al. Assessing the health impact of transnational corporations: its importance and a framework. Globalization and Health [Internet]. 2016 Dec [cited 2020 May 30];12(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0164-x

31. Bonnitcha J, Poulsen LNS, Waibel M. The political economy of the investment treaty regime. First edition. New York, NY: Oxford University Press; 2017. 325 p.

32. Friel S, Ponnamperuma S, Schram A, Gleeson D, Kay A, Thow A-M, et al. Shaping the discourse: What has the food industry been lobbying for in the Trans Pacific Partnership trade agreement and what are the implications for dietary health? Critical Public Health. 2016 Oct 19;26(5):518–29.

33. Gleeson D, Friel S. Emerging threats to public health from regional trade agreements. The Lancet. 2013 Apr;381(9876):1507–9.

34. Knai C, Petticrew M, Mays N, Capewell S, Cassidy R, Cummins S, et al. Systems Thinking as a Framework for Analyzing Commercial Determinants of Health: Framework for Analyzing Commercial Determinants of Health. The Milbank Quarterly. 2018 Sep;96(3):472–98.

35. Lucyk K, McLaren L. Taking stock of the social determinants of health: A scoping review. Moore S, editor. PLOS ONE. 2017 May 11;12(5):e0177306.

36. Madureira Lima J, Galea S. Corporate practices and health: a framework and mechanisms. Globalization and Health [Internet]. 2018 Dec [cited 2020 May 30];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0336-y

37. McKee M, Stuckler D. Revisiting the Corporate and Commercial Determinants of Health. American Journal of Public Health. 2018 Sep;108(9):1167–70.

38. World Economic Forum and Harvard School of Public Health. The Global Economic Burden of NCDs. Geneva: World Health Organization; 2011.

39. UN. Sustainable Development Goals. 2017.

40. WHO FCTC Secretariat, UNDP. The WHO Framework Convention for Tobacco Control. An Accelerator for Sustainable Development. New York, N.Y.: UNDP; 2017 May.

41. Magnusson RS. Non-communicable diseases and global health governance: enhancing global processes to improve health development. Globalization and Health. 2007;3(1):2.

42. Magnusson RS. Rethinking global health challenges: Towards a 'global compact' for reducing the burden of chronic disease. Public Health. 2009 Mar;123(3):265–74.

43. Lencucha R, Thow AM. Intersectoral policy on industries that produce unhealthy commodities: governing in a new era of the global economy? BMJ Global Health. 2020 Aug;5(8):e002246.

44. Buse K, Hawkes S. Health in the sustainable development goals: ready for a paradigm shift? Globalization and Health [Internet]. 2015 Dec [cited 2018 Mar 15];11(1). Available from: http://www.globalizationandhealth.com/content/11/1/13

45. Buse K, Tanaka S, Hawkes S. Healthy people and healthy profits? Elaborating a conceptual framework for governing the commercial determinants of non-communicable diseases and identifying options for reducing risk exposure. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 23];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0255-3

46. Battams S, Townsend B. Power asymmetries, policy incoherence and noncommunicable disease control - a qualitative study of policy actor views. Critical Public Health. 2019 Oct 20;29(5):596–609.

47. Lencucha R, Thow AM. How Neoliberalism Is Shaping the Supply of Unhealthy Commodities and What This Means for NCD Prevention. Int J Health Policy Manag. 2019 Jul 8;8(9):514–20.

48. Townsend B, Schram A, Labonté R, Baum F, Friel S. How do actors with asymmetrical power assert authority in policy agenda-setting? A study of authority claims by health actors in trade policy. Social Science & Medicine. 2019 Sep;236:112430.

49. Phillips T, McMichael C, O'Keefe M. "We invited the disease to come to us": neoliberal public health discourse and local understanding of non-communicable disease causation in Fiji. Critical Public Health. 2018 Oct 20;28(5):560–72.

50. Ayo N. Understanding health promotion in a neoliberal climate and the making of health conscious citizens. Critical Public Health. 2012 Mar;22(1):99–105.

51. Phillips T, Ravuvu A, McMichael C, Thow AM, Browne J, Waqa G, et al. Nutrition policy-making in Fiji: working in and around neoliberalisation in the Global South. Critical Public Health. 2019 Nov 22;1–11.

52. Glasgow S, Schrecker T. The double burden of neoliberalism? Noncommunicable disease policies and the global political economy of risk. Health and Place. 2015;34(Journal Article):279–86.

53. Rushton S, Williams OD. Frames, Paradigms and Power: Global Health Policy-Making under Neoliberalism. Global Society. 2012;26(2):147–67.

54. Labonte R, Lencucha R, Drope J, Packer C, Goma F, Zulu R. The institutional context of tobacco production in Zambia. Global Health. 2018;14(1):5.

55. Sainsbury E, Magnusson R, Thow A-M, Colagiuri S. Explaining resistance to regulatory interventions to prevent obesity and improve nutrition: A case-study of a sugar-sweetened beverages tax in Australia. Food Policy. 2020 May;93:101904.

56. MacKenzie R, Mathers A, Hawkins B, Eckhardt J, Smith J. The tobacco industry's challenges to standardised packaging: A comparative analysis of issue framing in public relations campaigns in four countries. Health Policy. 2018 Sep;122(9):1001–11.

57. Friel S. Climate Change and the People's Health [Internet]. Oxford University Press; 2019. Available from: http://anu.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwpV2xTsMwED1BJiQGaEFAaeUJpoJrO7W9IFVVK0YGhm5RUhuIhByJ0P_nzk6rwsDS3bkojpT3cs_vHYAUD3z855tgcuGdQzagrV_zShHwv-VaTZGvV1Ucp7I3GwbE1hrzS8638rFpG8qEJQO0soi8E1ISKIMQf4COJaczXauZ2TVZBKmGuUxROukK0aXu7Cpsk0j_rU7YFTZ7yLM8g4zcCOdw5EMPTlOTjSXvUB_u5p81Mk7PkkeAlcExJHTsJR4Lv2-7hRewWC5e589jLF64-j3OCaHAZxqd1aX9fBSkHrQ1ae4FrUMIihHQxuQF5QFOtLyELDTBXwHzpbEl0TqOuzzFp_ear53S2iHYW2Wv4emwe90cWmAAJ0g6bGpj3EL2_bXxw7i9o_jyfgDIep-5

58. Astuti PAS, Assunta M, Freeman B. Why is tobacco control progress in Indonesia stalled? - a qualitative analysis of interviews with tobacco control experts. Bmc Public Health. 2020 Apr 19;20(1).

59. Cambridge Dictionary. A level playing field [Internet]. Cambridge Dictionary. 2020. Available from: https://dictionary.cambridge.org/dictionary/english/a-level-playing-field

60. World Health Organization, Finland, Sosiaali- ja terveysministeriö, Global Conference on Health Promotion. Health in all policies: Helsinki statement, framework for country action : the 8th Global Conference on Health Promotion jointly organized by [Internet]. 2014 [cited 2018 May 4]. Available from: http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf

61. Kickbusch I, McCann W, Sherbon T. Adelaide revisited: from healthy public policy to Health in All Policies. Health Promotion International. 2008;23:1–4.

62. Rudolph L, Caplan J, Ben-Moshe K, Dillion L. Health in All Policies: A Guide for State and Local Governments. Washington, DC/Oakland, CA: American Public Health Association; 2013.

63. Kickbusch I. Health in all policies: where to from here? Health Promotion International. 2010;25.

64. De Alba L. United Nations System-Wide Coherence on Tobacco Control. New York, N.Y.: United Nations Economic and Social Council; 2012. Report No.: Draft Resolution No. E/2012/L.18.

65. Kavanagh D, Richards D. Departmentalism and joined-up government. Parliamentary Affairs. 2001;54(1):1–18.

66. Mialon M, Vandevijvere S, Carriedo-Lutzenkirchen A, Bero L, Gomes F, Petticrew M, et al. Mechanisms for addressing and managing the influence of corporations on public health policy, research and practice: a scoping review. BMJ Open. 2020 Jul;10(7):e034082.

67. Lencucha R, Drope J, Chavez JJ. Whole-of-government approaches to NCDs: the case of the Philippines Interagency Committee—Tobacco: Table 1. Health Policy and Planning. 2015 Sep;30(7):844–52.

68. WHO FCTC, UNDP. National Tobacco Control Strategies. New York, N.Y.: UNDP; 2019.

69. Magnusson RS, Patterson D. The role of law and governance reform in the global response to non-communicable diseases. 2014;18.

70. Fooks GJ, Smith J, Lee K, Holden C. Controlling corporate influence in health policy making? An assessment of the implementation of article 5.3 of the World Health Organization framework convention on tobacco control. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0234-8

71. Assunta M, Dorotheo EU. SEATCA Tobacco Industry Interference Index: a tool for measuring implementation of WHO Framework Convention on Tobacco Control Article 5.3. Tobacco Control. 2016 May;25(3):313–8.

72. Chugh A, Bassi S, Nazar GP, Bhojani U, Alexander C, Lal P, et al. Tobacco Industry Interference Index: Implementation of the World Health Organization's Framework Convention on Tobacco Control Article 5.3 in India. Asia Pacific Journal of Public Health. 2020 May 12;101053952091779.

73. Mialon M, Swinburn B, Sacks G. A proposed approach to systematically identify and monitor the corporate political activity of the food industry with respect to public health using publicly available information: Food industry political activity. Obesity Reviews. 2015 Jul;16(7):519–30.

74. World Health Organization. WHO Framework Convention on Tobacco Control: Guidelines for Implementation of Article 5.3 Articles 8 to 14. 2013;(Generic).

75. Savell E, Gilmore AB, Fooks G. How Does the Tobacco Industry Attempt to Influence Marketing Regulations? A Systematic Review. Derrick GE, editor. PLoS ONE. 2014;9(2):e87389.

76. WHO. The History of the World Health Organization Framework Convention for Tobacco Control. Geneva, Switzerland: WHO; 2009.

77. Casswell S. Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry?: Alcohol corporate interests compared with tobacco. Addiction. 2013 Apr;108(4):680–5.

78. Collin J. Tobacco control, global health policy and development: towards policy coherence in global governance. Tobacco Control. 2012 Mar;21(2):274–80.

79. WHO FCTC. 2018 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control. WHO; 2018.

80. Assunta M. Global Tobacco Industry Interference Index 2019. Global Center for Good Governance in Tobacco Control; 2019.

81. Clifford D, Hill S, Collin J. Seeking out 'easy targets'? Tobacco companies, health inequalities and public policy. Tobacco Control. 2014 Nov;23(6):479–83.

82. Doku D. The tobacco industry tactics - a challenge for tobacco control in low and middle income countries. African Health Sciences. 2010;2:201–3.

83. Eckhardt J, Holden C, Callard CD. Tobacco control and the World Trade Organization: mapping member states' positions after the framework convention on tobacco control. Tobacco Control. 2016 Nov;25(6):692–8.

84. Tangcharoensathien V, Chandrasiri O, Kunpeuk W, Markchang K, Pangkariya N. Addressing NCDs: Challenges From Industry Market Promotion and Interferences. International Journal of Health Policy and Management. 2019 Jan 20;8(5):256–60.

85. Cussen A, McCool J. Tobacco Promotion in the Pacific: The Current State of Tobacco Promotion Bans and Options for Accelerating Progress. Asia Pacific Journal of Public Health. 2011 Jan;23(1):70–8.

86. University of Bath. Latin America and Caribbean Region [Internet]. Tobacco Tactics. 2020. Available from: https://tobaccotactics.org/wiki/latin-america-and-caribbean-region/

87. Fernandes R, Pinho P. The distinctive nature of spatial development on small islands. Progress in Planning. 2017 Feb;112:1–18.

88. Magnusson RS, Patterson D. How Can We Strengthen Governance of Non-communicable Diseases in Pacific Island Countries and Territories?: Governance of NCDs in Pacific Islands. Asia & the Pacific Policy Studies. 2015 May;2(2):293–309.

89. WHO FCTC Secretariat. WHO FCTC Implementation Database [Internet]. 2020. Available from: https://untobaccocontrol.org/impldb/

90. SPC. Pacific NCD Summit Report. Tonga; 2016.

91. Tolley H, Snowdon W, Wate J, Durand AM, Vivili P, McCool J, et al. Monitoring and accountability for the Pacific response to the non-communicable diseases crisis. BMC Public Health [Internet]. 2016 Dec [cited 2018 Dec 22];16(1). Available from: http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3614-8

92. WHO GHO. Current tobacco smoking, age-standardised [Internet]. 2020. Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/current-tobacco-smoking-age-standardised

93. The Government of Kiribati and WPRO. Kiribati STEPS Survey 2004-2006. WHO; 2006.

94. The Government of Papue New Guinea and WPRO. Papua New Guinea STEPS Survey 2007-2008 Fact Sheet. WHO; 2008.

95. The Government of Solomon Islands and WPRO. Solomon Islands STEPS Survey 2006 Fact Sheet. WHO; 2006.

96. The Government of Nauru and WPRO. Nauru NCD Risk Factors STEPS Report. WHO; 2007.

97. The Government of Samoa and WPRO. Samoa STEPS Survey Fact Sheet. WHO; 2002.

98. The Government of the Federated States of Micronesia and WPRO. FSM (Chuuk) STEPS Survey 2006. WHO; 2006.

99. Snowdon W, Kubuabola I, Tukana I. Fiji NCD Risk Factors STEPS Report 2011. Suva, Fiji: Fiji Ministry of Health and Medical Services, the World Health Organization and the Pacific Research Centre for Prevention of Obesity and NCD; 2011. (NCD STEPS Reports).

100. The Government of Tonga and WPRO. Tonga STEPS Survey 2004 Fact Sheet. WHO; 2004.

101. Vanuatu Ministry of Health, WPRO. Vanuatu NCD Risk Factors STEPS Report 2013. 2013.

102. The Government of Marshall Islands and WPRO. Marshall Islands STEPS Survey Fact Sheet. WHO; 2002.

103. Hall P. The role of interests, institutions, and ideas in the comparative political economy of the industralized nations. In: Comparative Politics. 1997. p. 174–207.

104. WHO. Noncommunicable diseases [Internet]. Fact Sheets. 2018 [cited 2019 Jan 15]. Available from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

105. Tanaka S, Hawkes S, Pegram T, Buse K. Non-communicable Diseases: Global epidemics; global determinants; global solutions? UCL; 2014.

106. Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, et al. Profits and pandemics: Prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. The Lancet. 2013;381(9867):670–9.

107. WHO. Tobacco fact sheet. WHO Western Pacific Region . 2017.

108. WHO. History of the World Health Organization Framework Convention on Tobacco Control. Geneva: World Health Organization; 2009.

109. WHO FCTC. Outcomes of the sixth session of the Conference of Parties. Geneva; 2014.

110. Bilano V, Gilmour S, Moffiet T, d'Espaignet ET, Stevens GA, Commar A, et al. Global trends and projections for tobacco use, 1990–2025: an analysis of smoking indicators from the WHO Comprehensive Information Systems for Tobacco Control. The Lancet. 2015;385(9972):966–76.

111. Genchev D. Pacific islands continue to progress towards Tobacco Free Pacific 2025 [Internet]. News releases. 2018. Available from: https://www.who.int/westernpacific/news/releases/news-from-the-country/-pacific-islands-continue-to-progress-towards-tobacco-free-pacific-2025

112. Corbett J, Connell J. All the world is a stage: global governance, human resources, and the 'problem' of smallness. The Pacific Review. 2015 May 27;28(3):435–59.

113. Plahe JK, Hawkes S, Ponnamperuma S. The Corporate Food Regime and Food Sovereignty in the Pacific Islands. The Contemporary Pacific. 2013;25(2):309–38.

114. Ibell C, Sheridan SA, Hill PS, Tasserei J, Maleb M-F, Rory J-J. The individual, the government and the global community: sharing responsibility for health post-2015 in Vanuatu, a small island developing state. International Journal for Equity in Health [Internet]. 2015 Dec [cited 2018 Dec 22];14(1). Available from: http://www.equityhealthj.com/content/14/1/102

115. Waqa G, Bell C, Snowdon W, Moodie M. Factors affecting evidence-use in food policy-making processes in health and agriculture in Fiji. BMC Public Health [Internet]. 2017 Dec [cited 2018 Mar 15];17(1). Available from: http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3944-6

116. Bryden A, Petticrew M, Mays N, Eastmure E, Knai C. Voluntary agreements between government and business—A scoping review of the literature with specific reference to the Public Health Responsibility Deal. Health Policy. 2013 May;110(2–3):186–97.

117. Panjwani C, Caraher M. The Public Health Responisibility Deal: Brokering a deal for public health, but on whose terms? Health Policy. 2014;114:163–73.

118. Sharma LL, Teret SP, Brownell KD. The Food Industry and Self-Regulation: Standards to Promote Success and to Avoid Public Health Failures. American Journal of Public Health. 2010;100(2):240–6.

119. Schram A. When evidence isn't enough: Ideological, institutional, and interest-based constraints on achieving trade and health policy coherence. Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development. 2017 Dec 4;146801811774415.

120. Barraclough S, Morrow M. The political economy of tobacco and poverty alleviation in Southeast Asia: contradictions in the role of the state. Glob Health Promot. 2010 Mar;17(1 Suppl):40–50.

121. MacKenzie R, Collin J. 'A preferred consultant and partner to the Royal Government, NGOs, and the community': British American Tobacco's access to policy-makers in Cambodia. Global Public Health. 2017 Apr 3;12(4):432–48.

122. Lee S. What hinders implementation of the WHO FCTC Article 5.3? – The case of South Korea. Global Public Health. 2016 Oct 20;11(9):1109–20.

123. Kuijpers TG, Kunst AE, Willemsen MC. Who calls the shots in tobacco control policy? Policy monopolies of pro and anti-tobacco interest groups across six European countries. BMC Public Health [Internet]. 2019 Dec [cited 2020 Jun 7];19(1). Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7158-6

124. Collin J. Tobacco control, global health policy and development: towards policy coherence in global governance. Tobacco Control. 2011;21:274-280.

125. Avant DD, Finnemore M, Sell SK, editors. Who Governs the Globe? [Internet]. Cambridge: Cambridge University Press; 2010. (Cambridge Studies in International Relations). Available from:

https://www.cambridge.org/core/books/who-governs-the-globe/6B6B62E4C2E00E560DF3B2B35E79C839

126. Stone DA. Causal Stories and the Formation of Policy Agendas. Political Science Quarterly. 1989;104(2).

127. Feiock RC. The Institutional Collective Action Framework. Policy Studies Journal. 2013;41(3).

128. Croley SP. Regulation and Public Interests: The Possibility of Good Regulatory Government [Internet]. Princeton: Princeton University Press; 2008 [cited 2018 May 3]. Available from: http://www.degruyter.com/view/books/9781400828142/9781400828142/9781400828142.xml

129. Davies SC MBChB, Winpenny E PhD, Ball S PhD, Fowler T PhD, Rubin J PhD, Nolte E Dr. For debate: a new wave in public health improvement. Lancet, The. 2014;384(9957):1889–95.

130. de Leeuw E. Engagement of Sectors Other than Health in Integrated Health Governance, Policy, and Action. Annu Rev Public Health. 2017 Mar 20;38(1):329–49.

131. Ottersen OP, Dasgupta J, Blouin C, Buss P, Chongsuvivatwong V, Frenk J, et al. The political origins of health inequity: prospects for change. The Lancet. 2014;383:630–66.

132. Porter R. The greatest benefit to mankind: medical history of humanity from antiquity to the present. London: Harper Collins; 1997.

133. Watt RG. From victim blaming to upstream action: tackling the social determinants of oral health inequalities. Community Dentist Oral Epidemiol. 2007 Feb;35(1):1–11.

134. Davies E. How much freedom is healthy? BMJ : British Medical Journal. 2013;346(jan25 2):f514–f514.

135. Kenworthy N, MacKenzie R, Lee K. Case studies on Corporations and Global Health Governance: Impacts, Influence and Accountability. Rowman & Littlefield International; 2016.

136. Whitehead M, Loring B, Povall S, Organisation mondiale de la santé, Bureau régional de l'Europe. The equity action spectrum: taking a comprehensive approach : guidance for addressing inequities in health. Copenhagen, Denmark: World Health Organization, Regional office for Europe; 2014.

137. WHO Commission on Social Determinants of Health, World Health Organization, editors. Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report. Geneva, Switzerland: World Health Organization, Commission on Social Determinants of Health; 2008. 246 p.

138. Bambra C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. Journal of Epidemiology & Community Health. 2010;64(4):284–91.

139. Bukhman G, Mocumbi AO, Horton R. Reframing NCDs and injuries for the poorest billion: a Lancet Commission. Lancet, The. 2015;386(10000):1221–2.

140. Graham H. Uniqueal lives: Health and Socioeconomic Inequalities. Buckingham: Open University Press; 2007.

141. Marmot M, Bell R. Fair society, healthy lives. Public Health. 2012;126(SUPPL.1):S4–10.

142. Mendenhall E, Kohrt B, Norris S, Ndetei D, Prabhakaran D. Non-communicable disease syndemics: poverty, depression, and diabetes among low-income populations. Lancet, The. 2017;389(10072):951–63.

143. Pennington A, Orton A, Whitehead M, Ring A, Fox D, Pettircrew M, et al. Missing women? The health inequalities impact of low control and gender discrimination: a theory-led systematic review of observational studies. European Journal of Public Health. 2013;23(Supplement 1):89–90.

144. Phelan JC, Link BG, Diez-Roux A, Kawachi I, Levin B. "Fundamental Causes" of Social Inequalities in Mortality: A Test of the Theory. Journal of Health and Social Behaviour. 2004;265–85.

145. Phelan JC, Link B, Tehranifar P. Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications. Journal of Health and Social Behaviour. 2010;51(S):S28-40.

146. Pickett KE, Wilkinson RG. Income inequality and health: A causal review. Social Science and Medicine. 2015;128:316–26.

147. Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: :45.

148. Maani N, Collin J, Friel S, Gilmore AB, McCambridge J, Robertson L, et al. Bringing the commercial determinants of health out of the shadows: a review of how the commercial determinants are represented in conceptual frameworks. European Journal of Public Health [Internet]. 2020 Jan 18 [cited 2020 May 30]; Available from: https://academic.oup.com/eurpub/advance-article/doi/10.1093/eurpub/ckz197/5709506

149. Canadian Council on Social Determinants of Health, Social Determinants of Health Framework Task Group, Canadian Council on Social Determinants of Health. A review of frameworks on the determinants of health [Internet]. 2015 [cited 2020 May 30]. Available from: https://www.deslibris.ca/ID/247862

150. Hiscock R, Bauld L, Fidler JA, Munafo M. Socioeconomic status and smoking: a review. Ann N Y Acad Sci. 2012;107–23.

151. Clare P, Bradford D, Courtney RJ, Martire K, Mattick RP. The relationship between socioeconomic status and 'hardcore' smoking over time – greater accumulation of hardened smokers in low-SES than high-SES smokers. Tobacco Control. 2014;1–6.

152. Greenhalgh Bayly, M, & Winstanley, MH EM, Scollo MH [editors] MM and W. 1.7 Trends in the prevalence of smoking by socio-economic status. In: Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2015.

153. Laaksonen M, Rahkonen O, Karvonen S, Lahelma E. Socioeconomic status and smoking: Analysing inequalities with multiple indicators. European Journal of Public Health. 2005;15(3):262–9.

154. Graham H PhD. Why Social Disparities Matter for Tobacco-Control Policy. American Journal of Preventive Medicine. 2009;37(2):S183–4.

155. GRAHAM H. Smoking, Stigma and Social Class. Journal of social policy. 2012;41(1):83–99.

156. Graham H. Women and smoking: Understanding socioeconomic influences. Drug and Alcohol Dependence. 2009;104(Journal Article):S11–6.

157. Health in All Policies (HiAP) Framework for Country Action. Health Promotion International. 2014 Jun 1;29(suppl 1):i19–28.

158. Friel S, Harris P, Simpson S, Bhushan A, Baer B. Health in All Policies Approaches: Pearls from the Western Pacific Region: Health in All Policies in the Pacific. Asia & the Pacific Policy Studies. 2015 May;2(2):324–37.

159. Balarajan Y, Reich MR. Political economy challenges in nutrition. Globalization and Health [Internet]. 2016 Dec [cited 2018 Mar 15];12(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0204-6

160. Gill SR, Benatar SR. Reflections on the political economy of planetary health. Review of International Political Economy. 2019 Aug 7;1–24.

161. Holden C, Lee K. Corporate Power and Social Policy. The Political Economy of the Transnational Tobacco Companies. Global Social Policy. 2009;9(3):328–54.

162. Kay A, Williams OD. Global Health Governance: Crisis, Institutions and Political Economy. Basingstoke, United Kingdom: Palgrave Macmillan; 2009.

163. MacLean SJ, Brown SA, Fourie P. Health for some: the political economy of global health governance [Internet]. New York;Basingstoke, UK; Palgrave Macmillan; 2009. Available from: http://anu.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwdV1NT8MwDLUYXJCmCcYQY2XKidvQmqRbch1iQpyROFZp4lyATtrG_8dJ1ggNOLbqV6zEfn7pswEEf5jPjnxCRRgOneGy8s5JW6ql8-XSOo-VlRhbH_7oDZNrR-eKiVmFm7kLCksB6_cIEnEeUzKRuZW5pNSclyEJI4TNgwKiOhTb6Y5jNGq_fnngGFbWF3AapAaXcILtEPqJQWNJGDSEIiln2Rt-eLNFds-6E5vt-xUM0nWMQCfbbT5xBMX66fXxeUbvqw-kTN19v-LX0DfhZ_Z2H0Vv7gaYolSxsVoYKxZSaae91sYq31A8RlpEYxj9-awxTLrR1KYJVInd72pBEEVxvbj9564JnKctksArFHDmad7jXTTPFHpq9TKN1v0Gq7J8sA

164. Sell SK, Williams OD. Health under Capitalism: A Global Political Economy of Structural Pathogenesis. 2018;

165. de Leeuw E, Clavier C, Breton E. Health policy--why research it and how: health political science. Health research policy and systems. 2014;12(1):55.

166. Franco Á, Álvarez-Dardet C, Ruiz MT. Effect of democracy on health: ecological study. BMJ. 2004;329(7480):1421–3.

167. Mackenbach JP. Political determinants of health. The European Journal of Public Health. 2014;24(1):2–2.

168. Kickbusch I. The political determinants of health--10 years on. BMJ. 2015 Jan 8;350(jan08 2):h81–h81.

169. Cluzeau F. Governance for Health: Special Issue Commentary. Public Health. 2015;129(7):864–5.

170. Engebretsen E, Heggen K. Global Governance for Health: what about liberal power? The Lancet. 2014;384:384.

171. Goldblatt P. Governance for Health: Special Issue Commentary. Public Health. 2015;129:866–7.

172. Jooma R. Political Determinants of Health: Lessons for Pakistan. Pakistan Journal of Medical Sciences [Internet]. 2014 Apr 1 [cited 2018 Mar 15];30(3). Available from: http://pjms.com.pk/index.php/pjms/article/view/5487

173. Kickbusch I. Addressing the interface of the political and commercial determinants of health. Health Promotion International. 2012 Dec 1;27(4):427–8.

174. Kickbusch I, Reddy KS. Global health governance - the next political revolution. Public Health. 2015;129(7):838–42.

175. McKee M. Grenfell Tower fire: why we cannot ignore the political determinants of health. BMJ. 2017 Jun 20;j2966.

176. McNeill D, Ottersen OP. Global Governance for Health: How to motivate political change? Public Health. 2015;129(7):833–7.

177. O'Sullivan D. Justice, culture and the political determinants of indigenous Australian health. Ethnicities. 2012 Dec;12(6):687–705.

178. Rochford C, Tenneti N, Moodie R. Reframing the impact of business on health: the interface of corporate, commercial, political and social determinants of health. BMJ Global Health. 2019 Aug;4(4):e001510.

179. Schrecker T. Bringing (domestic) politics back in: global and local influences on health equity. Public Health. 2015 Jul;129(7):843–8.

180. Collin J, Hill SE, Eltanani MK, Plotnikova E, Ralston R, Smith KE. Can public health reconcile profits and pandemics ? An analysis of attitudes to commercial sector engagement in health policy and research. 2017;1–14.

181. Kickbusch I. Addressing the commercial determinants is critical to emerging economies. Ciencsia & Saude Coletiva. 2015;20(4):669.

182. WHO. Noncommunicable Diseases Progress monitor 2017. 2017.

183. Jahiel RI, Babor TF. Industrial epidemics, public health advocacy and the alcohol industry: lessons from other fields. Addiction. 2007;102(9):1335–9.

184. Buse K, Tanaka S, Hawkes S. Healthy people and healthy profits? Elaborating a conceptual framework for governing the commercial determinants of non-communicable diseases and indentifying options for reducing risk exposure. Globalization and Health. 2017;13:34.

185. West R, Marteau T. Commentary on Casswell (2013): The commercial determinants of health. Addiction. 2013 Apr;108(4):686–7.

186. Kickbusch I, Allen L, Franz C. The commercial determinants of health. The Lancet Global Health. 2016;4(12):e895–6.

187. Doyle L. The political economy of health. Pluto Press; 1979.

188. Smith KE, Savell E, Gilmore AB. What is known about tobacco industry efforts to influence tobacco tax? A systematic review of empirical studies. Tobacco Control. 2013 Mar;22(2):e1–e1.

189. Fooks GJ, Gilmore AB, Smith KE, Collin J, Holden C, Lee K. Corporate Social Responsibility and Access to Policy Élites: An Analysis of Tobacco Industry Documents. Hall WD, editor. PLoS Medicine. 2011 Aug 23;8(8):e1001076.

190. Hastings G. Why corporate power is a public health priority. BMJ: British Medical Journal. 2012;345(7871):26–9.

191. Moodie C, MacKintosh AM, Brown A, Hastings GB. Tobacco marketing awareness on youth smoking susceptibility and perceived prevalence before and after an advertising ban. Eur J Public Health. 2008 Oct;18(5):484–90.

192. Hastings G, MacFadyen L. A day in the life of an advertising man: review of internal documents from the UK tobacco industry's principal advertising agencies. British Medical Journal. 2000 Aug 5;321(7257):366–71.

193. Drope J, Chapman S. Tobacco industry efforts at discrediting scientific knowledge of environmental tobacco smoke: a review of internal industry documents. Journal of Epidemiology and Community Health. 2001 Aug;55(8):588–94.

194. Rosenberg NJ, Siegel M. Use of corporate sponsorship as a tobacco marketing tool: a review of tobacco industry sponsorship in the USA, 1995-99. Tobacco Control. 2001 Sep;10(3):239–46.

195. Tong EK, England L, Glantz SA. Changing conclusions on secondhand smoke in a sudden infant death syndrome review funded by the tobacco industry. Pediatrics. 2005 Mar;115(3):E356–66.

196. Anderson SJ. Marketing of menthol cigarettes and consumer perceptions: a review of tobacco industry documents. Tobacco Control. 2011 May;20:II20–8.

197. Ulucanlar S, Fooks GJ, Hatchard JL, Gilmore AB. Representation and Misrepresentation of Scientific Evidence in Contemporary Tobacco Regulation: A Review of Tobacco Industry Submissions to the UK Government Consultation on Standardised Packaging. Hall WD, editor. PLoS Medicine. 2014 Mar 25;11(3):e1001629.

198. Halas G, Schultz ASH, Rothney J, Wener P, Holmqvist M, Cohen B, et al. A Scoping Review of Foci, Trends, and Gaps in Reviews of Tobacco Control Research. Nicotine & Tobacco Research. 2020 May;22(5):599–612.

199. Savell E, Fooks G, Gilmore AB. How does the alcohol industry attempt to influence marketing regulations? A systematic review. Addiction. 2016 Jan;111(1):18–32.

200. McCambridge J, Mialon M. Alcohol industry involvement in science: A systematic review of the perspectives of the alcohol research community. Drug and Alcohol Review. 2018 Jul;37(5):565–79.

201. McCambridge J, Mialon M, Hawkins B. Alcohol industry involvement in policymaking: a systematic review. Addiction. 2018 Sep;113(9):1571–84.

202. Mialon M, McCambridge J. Alcohol industry corporate social responsibility initiatives and harmful drinking: a systematic review. European Journal of Public Health. 2018 Aug;28(4):664–73.

203. Office of the High Commissioner for Human Rights (OHCHR). Five ways to tackle the public health disaster of bad diets - UN Expert on the right to food [Internet]. Available from: http://www.ohchr.org/EN/NewsEvents/Pages/ DisplayNews.aspx?NewsID=11913&LangID=E.

204. Magnusson RS, Patterson D. The role of law and governance reform in the global response to non-communicable diseases. Global Health. 2014;10(44).

205. Buffinton LM. Corporate political activity agents: Understanding how firms use expert consultants to transmit information to regulators of risky products [Internet]. [Canberra]: Australian National University; 2019. Available from: https://openresearch-repository.anu.edu.au/handle/1885/186082

206. Mellahi K, Frynas JG, Sun P, Siegel D. A Review of the Nonmarket Strategy Literature: Toward a Multi-Theoretical Integration. Journal of Management. 2016 Jan;42(1):143–73.

207. Eckhardt J, Lee K. Global Value Chains, Firm Preferences and the Design of Preferential Trade Agreements. Global Policy. 2018 Oct;9:58–66.

208. Lee K, Eckhardt J, Holden C. Tobacco industry globalization and global health governance: towards an interdisciplinary research agenda. Palgrave Communications [Internet]. 2016 Dec [cited 2020 Nov 26];2(1). Available from: http://www.nature.com/articles/palcomms201637

209. Baker P, Kay A, Walls H. Trade and investment liberalization and Asia¿s noncommunicable disease epidemic: a synthesis of data and existing literature. Globalization and Health. 2014;10(1):66.

210. Schram A, Townsend B, Youde J, Friel S. Public health over private wealth: rebalancing public and private interests in international trade and investment agreements. Public Health Research & Practice [Internet]. 2019 Sep 25 [cited 2019 Oct 4];29(3). Available from: http://www.phrp.com.au/?p=38459

211. Thow AM, McGrady B. Protecting policy space for public health nutrition in an era of international investment agreements. Bulletin of the World Health Organization. 2014 Feb 1;92(2):139–45.

212. McGrady B. Trade and Public Health. Cambridge University Press; 2011.

213. McGrady B, Jones A. Tobacco Control and Beyond: The Broader Implications of United States—Clove Cigarettes for Non-Communicable Diseases. American Journal of Law & Medicine. 2013 Jun 1;39(2–3):265–89.

214. Hawkins B, Holden C. A Corporate Veto on Health Policy? Global Constitutionalism and Investor–State Dispute Settlement. Journal of Health Politics, Policy and Law. 2016 Oct;41(5):969–95.

215. Labonte R, Blouin C, Forman L. Trade and Health. In: Global Health Governance Crisis, Institutions and Political Economy. Palgrave Macmillian; 2009. (International Political Economy Series).

216. Ruckert A, Schram A, Labonté R, Friel S, Gleeson D, Thow A-M. Policy coherence, health and the sustainable development goals: a health impact assessment of the Trans-Pacific Partnership. Critical Public Health. 2017 Jan;27(1):86–96.

217. Shaffer ER, Brenner JE, Houston TP. International trade agreements: a threat to tobacco control policy. Tob Control. 2005 Aug 1;14(suppl 2):ii19.

218. WHO WPRO, SPC, UNDP, C-POND. Trade, trade agreements and non-communicable diseases in the Pacific Islands. Intersections, Lessons Learned, Challenges and Way Forward. 2013.

219. Iglesias RM, Gomis B, Carrillo Botero N, Shepherd P, Lee K. From transit hub to major supplier of illicit cigarettes to Argentina and Brazil: the changing role of domestic production and transnational tobacco companies in Paraguay between 1960 and 2003. Globalization and Health [Internet]. 2018 Dec [cited 2020 Jan 25];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0413-2

220. Lee S, Holden C, Lee K. Are transnational tobacco companies' market access strategies linked to economic development models? A case study of South Korea. Global Public Health. 2013;8(4):435–48.

221. Peeters S, Costa H, Stuckler D, McKee M, Gilmore AB. The revision of the 2014 European tobacco products directive: an analysis of the tobacco industry's attempts to 'break the health silo.' Tobacco Control. 2015 Feb 24;tobaccocontrol-2014-051919.

222. Hogg SL, Hill SE, Collin J. State-ownership of tobacco industry: a 'fundamental conflict of interest' or a 'tremendous opportunity' for tobacco control? Tobacco Control. 2016 Jul;25(4):367–72.

223. Lencucha R, Drope J, Labonte R. Rhetoric and the law, or the law of rhetoric: How countries oppose novel tobacco control measures at the World Trade Organization. Social Science & Medicine. 2016 Sep;164:100–7.

224. Appau A, Drope J, Labonté R, Stoklosa M, Lencucha R. Disentangling regional trade agreements, trade flows and tobacco affordability in sub-Saharan Africa. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 23];13(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0305-x

225. Chaloupka FJ, Laixuthai A. US Trade policy and cigarette smoking in Asia. 1996.

226. Hsieh C-R, Hu T-W, Lin C-FJ. The Demand for Cigarettes in Taiwan: Domestic Versus Imported Cigarettes. Contemporary Economic Policy. 1999 Apr;17(2):223–34.

227. Lee K, Carpenter C, Challa C, Lee S, Connolly GN, Koh HK. The strategic targeting of females by transnational tobacco companies in South Korea following trade liberalisation. Globalization and Health. 2009 Jan 30;5(1):2.

228. Lee S, Lee K, Holden C. Creating demand for foreign brands in a 'home run' market: tobacco company tactics in South Korea following market liberalisation. Tobacco Control. 2014 May;23(3):e8–e8.

229. Taylor A, Chaloupka FJ, Guindon E, Corbett M. The impact of trade liberalization on tobacco consumption. In: Tobacco Control in Developing Countries. 2000.

230. Wen CP, Cheng TY, Eriksen MP, Tsai SP, Hsu CC. The impact of the cigarette market opening in Taiwan. Tobacco Control. 2005;14(suppl_1):i4–9.

231. Wipfli H, Bettcher DW, Subramaniam C, Taylor AL. Confronting the tobacco epidemic: Emerging mechanisms of global governance. In 2009. Available from: http://anu.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwtV3PSxwxFA6KIKUe1LZoq5CTIMtoZpL5EcFDEUXUW7dnyeRHEdyZhd09-N_73iST6LY99NDLsJMwyybfS-a9t_m-RwgvzIi2ticorRSTppTM5twUppZSV3muRF2IttTqfW2YWHwztf1X4KENoEci7T-AH78UGuAzmABcwQjguuYfv8vEDpmUufPc51vv5sXI2y4jVMF_nqRMywrCZ9TE8IZyhayMuHOn8P778_NLFxgLweCQO4hqCCP_CncKrfuJ9TVocUommAIbqiLNLDKOnxaz4SRJUCX5NdT9jWY45iLSYatRhwv8xQoWta_C89vu7JWrlMZy5Dh9i96fz0iPnbFBcZY16fU0_iW_9taKZwkhHgMvEzaqExRLn5knvby0XfbzxybZhM0I4_T7h5h2Y7xG1TMvrgTOGwcHzN-EXxBEmcbOIt6H_m1yGoZy7gdyAcM4__MgUH5W9_PV4o3LMt0lH5HGQpFfAuPYIxu22yc7PktLPfnsE7l7AxoF0GgAjY6gXdARMpogo72jHjKaIPtMpjfX06vbLFTXyHqYr4xbaYpGMVvBKmQm16puZSuYbXTNNBPCVo1orHLDKm8ca1klGw3ufVswDs9-ITsKSRjdciBrmgNCW-NK1vIaonAppCiVUcqVed1yJZzj5pAc-Pl4nHsplccI3te_d30jH5KtHZEtB0vTHoMz2a1eAZTtVMk

232. Linhart C, Tukana I, Lin S, Taylor R, Morrell S, Vatucawaqa P, et al. Declines and plateaux in smoking prevalence over three decades in Fiji. Nicotine & Tobacco Research. 2016 Nov 2;ntw292.

233. University of Bath. Tobacco Farming [Internet]. Tobacco Tactics. 2020. Available from: https://tobaccotactics.org/wiki/tobacco-farming/

234. Lencucha R, Pal NE, Appau A, Thow A-M, Drope J. Government policy and agricultural production: a scoping review to inform research and policy on healthy agricultural commodities. Globalization and Health [Internet]. 2020 Dec [cited 2020 Mar 10];16(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-0542-2

235. Magati P, Drope J, Lencucha R, Labonté R. The Economics of Tobacco Farming in Kenya. Nairobi: International Institute for Legislative Affairs and American Cancer Society; 2016.

236. Makoka D, Drope J, Appau A, Labonte R, Li Q, Goma F, et al. Costs, revenues and profits: an economic analysis of smallholder tobacco farmer livelihoods in Malawi. Tobacco Control. 2017;26(6):634–40.

237. Moyer-Lee J, Prowse M. How traceability is restructuring Malawi's tobacco industry. Development Policy Review. 2015;33(2):159–74.

238. Nino HP. Class dynamics in contract farming: the case of tobacco production in Mozambique. Third World Quarterly. 2016;37(10):1787–808.

239. Appau A, Drope J, Witoelar F, Chavez JJ, Lencucha R. Why Do Farmers Grow Tobacco? A Qualitative Exploration of Farmers Perspectives in Indonesia and Philippines. International Journal of Environmental Research and Public Health. 2019 Jul 2;16(13):2330.

240. Baker P, Friel S, Gleeson D, Thow A-M, Labonte R. Trade and nutrition policy coherence: a framing analysis and Australian case study. Public Health Nutr. 2019 Aug;22(12):2329–37.

241. Drope J, Makoka D, Lencucha R, Appau A. Farm-level economics of tobacco production in Malawi. Centre for Agricultural Research and Development and Lilongwe University of Agriculture and Natural Resources; 2016.

242. Goma F, Drope J, Zulu R, Li Q, Chelwa G, Labonte R, et al. The Economics of Tobacco Farming in Zambia. 2017 p. 32.

243. Labonté R. Supply vs Demand: Trade, Tobacco and Tobacco Control in 3 Sub-Saharan African Countries. Seminar presented at; 2017; School of Regulation and Global Governance, Australian National University.

244. Leppan W, Lecours N, Buckles D. Tobacco control and tobacco farming: separating myth from reality. 2014;(Generic).

245. Tobacco Free Portfolios. The toolkit. 12th ed. 2019.

246. Akhter F, Buckles D, Tito R. Breaking the dependency on tobacco production: transition strategies for Bangladesh. In: Tobacco control and tobacco farming: separating myth from reality [Internet]. London; New York, NY; Ottawa: Anthem Press; International Development Research Centre; 2014. p. 141–87. Available from: http://idl-bnc.idrc.ca/dspace/bitstream/10625/53191/1/IDL-53191.pdf

247. Chand C. Sabeto Farmers Turn To Tobacco Farming. FijiSun. 2009 Dec 7;

248. Eidt Goncalves de Almeida G. Diversification Strategies for Tobacco Farmers: Lessons from Brazil. In: Tobacco control and tobacco farming: separating myth from reality [Internet]. London; New York, NY; Ottawa: Anthem Press, International Development Research Centre.; 2011. p. 211–45. Available from: http://idl-bnc.idrc.ca/dspace/bitstream/10625/53191/1/IDL-53191.pdf

249. Otañez M, Graen L. "Gentlemen, Why Not Suppress the Prices?": Global Leaf Demand and Rural Livelihoods in Malawi. In: Tobacco control and tobacco farming: separating myth from reality [Internet]. London; New York, NY; Ottawa: Anthem Press; International Development Research Centre; 2014. p. 61–95. Available from: http://idl-bnc.idrc.ca/dspace/bitstream/10625/53191/1/IDL-53191.pdf

250. WHO Regional Office for Europe. Tobacco Control Playbook. Copenhagen, Denmark: WHO; 2019.

251. Michael D. Basil DZB Caroline Schooler. Cigarette Advertising to Counter New Years Resolutions. Journal of Health Communication. 2000;5(2):161–74.

252. Carroll DM, Soto C, Baezconde-Garbanati L, Huang L-L, Lienemann BA, Meissner HI, et al. Tobacco Industry Marketing Exposure and Commercial Tobacco Product Use Disparities among American Indians and Alaska Natives. Substance Use & Misuse. 2020 Jan 1;55(2):261–70.

253. Cruz TB, McConnell R, Low BW, Unger JB, Pentz MA, Urman R, et al. Tobacco Marketing and Subsequent Use of Cigarettes, E-Cigarettes, and Hookah in Adolescents. Nicotine & Tobacco Research. 2019 Jul;21(7):926–32.

254. Donovan RJ, Jancey J, Jones S. Tobacco point of sale advertising increases positive brand user imagery. Tob Control. 2002 Sep;11(3):191–4.

255. Gardiner PS. The African Americanization of menthol cigarette use in the United States. Nicotine Tob Res. 2004 Feb;6 Suppl 1:S55-65.

256. Giovenco DP, Spillane TE, Merizier JM. Neighborhood Differences in Alternative Tobacco Product Availability and Advertising in New York City: Implications for Health Disparities. Nicotine & Tobacco Research. 2019 Jul;21(7):896–902.

257. Hrywna M, Grafova IB, Delnevo CD. The Role of Marketing Practices and Tobacco Control Initiatives on Smokeless Tobacco Sales, 2005-2010. International Journal of Environmental Research and Public Health. 2019 Oct;16(19):3650.

258. Isip U, Calvert J. Analyzing big tobacco's global youth marketing strategies and factors influencing smoking initiation by Nigeria youths using the theory of triadic influence. BMC Public Health. 2020 Mar 20;20(1):377.

259. Katz JE. Individual rights advocacy in tobacco control policies: an assessment and recommendation. Tobacco Control. 2005 Aug 1;14(suppl_2):ii31–7.

260. Kreitzberg DS, Herrera AL, Loukas A, Pasch KE. Exposure to tobacco and nicotine product advertising: Associations with perceived prevalence of use among college students. Journal of American College Health. 2018 Nov 17;66(8):790–8.

261. Ling PM, Glantz SA. Tobacco industry research on smoking cessation. Recapturing young adults and other recent quitters. J Gen Intern Med. 2004 May;19(5 Pt 1):419–26.

262. Mantey DS, Clendennen SL, Pasch KE, Loukas A, Perry CL. Marketing exposure and smokeless tobacco use initiation among young adults: A longitudinal analysis. Addictive Behaviors. 2019 Dec;99:106014.

263. McDaniel PA, Forsyth SR. Exploiting the "video game craze": A case study of the tobacco industry's use of video games as a marketing tool. Plos One. 2019 Jul 25;14(7):e0220407.

264. Moran MB, Heley K, Pierce JP, Niaura R, Strong D, Abrams D. Ethnic and Socioeconomic Disparities in Recalled Exposure to and Self-Reported Impact of Tobacco Marketing and Promotions. Health Communication. 2019 Feb 23;34(3):280–9.

265. Oliveira da Silva AL, Bialous SA, Albertassi PGD, Arquete DA dos R, Fernandes AMMS, Moreira JC. The taste of smoke: tobacco industry strategies to prevent the prohibition of additives in tobacco products in Brazil. Tobacco Control. 2019 Dec;28(e2):e92–101.

266. Roberts ME, Keller-Hamilton B, Hinton A, Browning CR, Slater MD, Xi W, et al. The magnitude and impact of tobacco marketing exposure in adolescents' day-to-day lives: An ecological momentary assessment (EMA) study. Addictive Behaviors. 2019 Jan;88:144–9.

267. Shafey O, Fernandez E, Thun M, Schiaffino A, Dolwick S, Cokkinides V. Cigarette advertising and female smoking prevalence in Spain, 1982-1997: case studies in International Tobacco Surveillance. Cancer. 2004 Apr 15;100(8):1744–9.

268. Soneji S, Knutzen KE, Tan ASL, Moran MB, Yang J, Sargent J, et al. Online tobacco marketing among US adolescent sexual, gender, racial, and ethnic minorities. Addictive Behaviors. 2019 Aug;95:189–96.

269. Soneji S, Yang J, Moran MB, Tan ASL, Sargent J, Knutzen KE, et al. Engagement With Online Tobacco Marketing Among Adolescents in the United States: 2013-2014 to 2014-2015. Nicotine & Tobacco Research. 2019 Jul;21(7):918–25.

270. Stevens P, Carlson LM, Hinman JM. An analysis of tobacco industry marketing to lesbian, gay, bisexual, and transgender (LGBT) populations: strategies for mainstream tobacco control and prevention. Health Promot Pract. 2004 Jul;5(3 Suppl):129S-134S.

271. Wadsworth E, McNeill A, Li L, Hammond D, Thrasher JF, Yong H-H, et al. Reported exposure to E-cigarette advertising and promotion in different regulatory environments: Findings from the International Tobacco Control Four Country (ITC-4C) Survey. Preventive Medicine. 2018 Jul;112:130–7.

272. Watson KA, Gammon DG, Loomis BR, Juster HR, Anker E. Trends in Cigarette Advertising, Price-Reducing Promotions, and Policy Compliance in New York State Licensed Tobacco Retailers, 2004 to 2015. American Journal of Health Promotion. 2018 Nov;32(8):1679–87.

273. Astuti PAS, Assunta M, Freeman B. Raising generation "A": a case study of millennial tobacco company marketing in Indonesia. Tobacco Control. 2018 Jul;27(E1):E41–9.

274. MacKenzie R, Eckhardt J, Widyati Prastyani A. Japan Tobacco International: To 'be the most successful and respected tobacco company in the world.' Global Public Health. 2017 Mar 4;12(3):281–99.

275. ASH. Tobacco and the Developing World. Action on Smoking and Health; 2019 Jul. (ASH Fact sheet).

276. Gilmore AB, Fooks G, Drope J, Bialous SA, Jackson RR. Exposing and addressing tobacco industry conduct in low-income and middle-income countries. The Lancet. 2015 Mar;385(9972):1029–43.

277. Krishnamoorthy Y, Majella MG, Murali S. Impact of tobacco industry pricing and marketing strategy on brand choice, loyalty and cessation in global south countries: a systematic review. International Journal of Public Health. 2020 Sep;65(7):1057–66.

278. Dagli E, Guner M, Sonmez U, Yildiz F, Ay P, Elbek O, et al. Heated tobacco product marketing: internet platforms undermine regulations. European Respiratory Journal. 2019 Sep 28;54.

279. Dunlop S, Freeman B, Perez D. Exposure to Internet-Based Tobacco Advertising and Branding: Results From Population Surveys of Australian Youth 2010-2013. Journal of medical Internet research. 2016;18(6):e104.

280. Escobedo P, Cruz TB, Tsai K-Y, Allem J-P, Soto DW, Kirkpatrick MG, et al. Monitoring Tobacco Brand Websites to Understand Marketing Strategies Aimed at Tobacco Product Users and Potential Users. Nicotine & Tobacco Research. 2018 Nov;20(11):1393–400.

281. Marion H, Garner W, Estrada A, Moorer C, Acosta-Velazquez I. Online Pro-Tobacco Marketing Exposure Is Associated With Dual Tobacco Product Use Among Underage US Students. American Journal of Health Promotion. :0890117120905231.

282. Richardson A, Ganz O, Vallone D. Tobacco on the web: surveillance and characterisation of online tobacco and e-cigarette advertising. Tobacco Control. 2015;24(4):341–7.

283. Astuti PAS, Kurniasari NMD, Mulyawan KH, Sebayang SK, Freeman B. From glass boxes to social media engagement: an audit of tobacco retail marketing in Indonesia. Tobacco Control. 2019 Dec;28(e2):e133–40.

284. Freeman B, Hefler M, Hunt D. Philip Morris International's use of Facebook to undermine Australian tobacco control laws. Public Health Research & Practice [Internet]. 2019 Sep 25 [cited 2019 Oct 4];29(3). Available from: http://www.phrp.com.au/?p=38505

285. Freeman B, Chapman S. British American Tobacco on Facebook: undermining article 13 of the global World Health Organization Framework Convention on Tobacco Control. Tobacco Control. 2010;19(3):e1–9.

286. Freeman B, Chapman S. Is "YouTube" telling or selling you something? Tobacco content on the YouTube video-sharing website. Tobacco Control. 2007 Jun;16(3):207–10.

287. Watts C, Hefler M, Freeman B. 'We have a rich heritage and, we believe, a bright future': how transnational tobacco companies are using Twitter to oppose policy and shape their public identity. Tobacco Control. 2019;28(2):227–32.

288. Azagba S, Manzione L. Retail Outlets and Point-of-Sale Marketing of Alternative Tobacco Products: Another Threat to Tobacco Control. J Adolesc Health. 2020 Apr;66(4):385–6.

289. Halpern-Felsher B. Point-of-sale marketing of heated tobacco products in Israel: cause for concern. Israel Journal of Health Policy Research. 2019 May 27;8:47.

290. Scollo M, Bayly M, White S, Lindorff K, Wakefield M. Tobacco product developments in the Australian market in the 4 years following plain packaging. Tobacco Control. 2018 Sep;27(5):580–4.

291. White C, Oliffe JL, Bottorff JL. From the Physician to the Marlboro Man: Masculinity, Health, and Cigarette Advertising in America, 1946–1964. Men and Masculinities. 2012;15(5):526–47.

292. Assunta M, Chapman S. The lightest market in the world: Light and mild cigarettes in Japan. Nicotine & Tobacco Research. 2008 May;10(5):803–10.

293. Staal YC, van de Nobelen S, Havermans A, Talhout R. New Tobacco and Tobacco-Related Products: Early Detection of Product Development, Marketing Strategies, and Consumer Interest. JMIR Public Health Surveill. 2018 May 28;4(2):e55–e55.

294. Chapman S. E-cigarettes: the best and the worst case scenarios for public health-an essay by Simon Chapman. Bmj-British Medical Journal. 2014 Sep 9;349:g5512.

295. Chapman S, Bareham D, Maziak W. The Gateway Effect of E-cigarettes: Reflections on Main Criticisms. Nicotine & Tobacco Research. 2019 May;21(5):695–8.

296. McKee M, Daube M, Chapman S. E-cigarettes should be regulated. Medical Journal of Australia. 2016 May 16;204(9):331-+.

297. Chapman S. E-cigarettes: does the new emperor of tobacco harm reduction have any clothes? European Journal of Public Health. 2014 Aug;24(4):535–6.

298. Hawkins B, Lee K. UK: Tobacco industry and e-cigarettes ; New issue, familiar tactics. Tobacco Control. 2013 Nov;22(6):365–6.

299. Chapman S. The future of electronic cigarette growth depends on youth uptake. Med J Aust. 2015 May 18;202(9):467–8.

300. Balwicki Ł, Stokłosa M, Balwicka-Szczyrba M, Tomczak W. Tobacco industry interference with tobacco control policies in Poland: legal aspects and industry practices: Table 1. Tobacco Control. 2016 Sep;25(5):521–6.

301. Collin J, Hill SE, Kandlik Eltanani M, Plotnikova E, Ralston R, Smith KE. Can public health reconcile profits and pandemics? An analysis of attitudes to commercial sector engagement in health policy and research. Weishaar H, editor. PLOS ONE. 2017 Sep 8;12(9):e0182612.

302. Costa H, Gilmore AB, Peeters S, McKee M, Stuckler D. Quantifying the influence of the tobacco industry on EU governance: automated content analysis of the EU Tobacco Products Directive. Tobacco Control. 2014 Nov;23(6):473–8.

303. Gilmore AB, Savell E, Collin J. Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease? Journal of Public Health. 2011 Mar 1;33(1):2–4.

304. Stuckler D, Basu S, McKee M. Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed? PLoS Medicine. 2011 Apr 12;8(4):e1001020.

305. Trochim WMK. Development of a model of the tobacco industry's interference with tobacco control programmes. Tobacco Control. 2003 Jun 1;12(2):140–7.

306. Holden C, Lee K, Gilmore A, Fooks G, Wander N. Trade policy, health, and corporate influence: British American Tobacco and China's Accession to the World Trade Organization. International Journal of Health Services. 2010;40(3):421–41.

307. Assunta M, Chapman S. A mire of highly subjective and ineffective voluntary guidelines: tobacco industry efforts to thwart tobacco control in Malaysia. Tobacco Control. 2004 Dec;13(Suppl 2):ii43–50.

308. Assunta M, Chapman S. Health treaty dilution: a case study of Japan's influence on the language of the WHO Framework Convention on Tobacco Control. Journal of Epidemiology and Community Health. 2006 Sep;60(9):751–6.

309. Assunta M, Ritthiphakdee B, Soerojo W, Cho MM, Jirathanapiwat W. Tobacco industry interference: A review of three South East Asian countries. Indian J Public Health. 2017 Sep;61(Suppl 1):S35–9.

310. Cunningham K, Kamonpatana K, Bao J, Ramos-Buenviaje J, Wagianto A, Yeap P. Unilever Nutrition Strategy and Examples in Asia. Journal of Nutritional Science and Vitaminology. 2015;61(Supplement):S39–40.

311. Green H. Global Obesity: Nestle Initiatives in Nutrition, Health, and Wellness. Nutrition Reviews. 2006 Feb;64:S62–4.

312. Chapman S. International tobacco control should repudiate Jekyll and Hyde health philanthropy. Tobacco Control. 2008 Jan;17(1):1–1.

313. Rimmer L. BAT in Its Own Words:The Alternative British American Tobacco Report. London (UK): Action on Smoking andHealth/Christian Aid/Friends of the Earth; 2005.

314. Foundation for a Smoke-Free World. Our Mission [Internet]. 2020. Available from: https://www.smokefreeworld.org/our-vision/

315. Daube M, Moodie R, McKee M. Towards a smoke-free world? Philip Morris International's new Foundation is not credible. The Lancet. 2017 Oct;390(10104):1722–4.

316. Fang J, Lee K. World: PMI-funded Foundation for a Smoke-Free World adding insult to injury [Internet]. Tobacco Control. 2019 [cited 2020 Sep 3]. Available from: https://blogs.bmj.com/tc/2019/09/26/world-pmi-funded-foundation-for-a-smoke-free-world-adding-insult-to-injury/

317. Legg T, Peeters S, Chamberlain P, Gilmore AB. The Philip Morris-funded Foundation for a Smoke-Free World: tax return sheds light on funding activities. The Lancet. 2019 Jun;393(10190):2487–8.

318. van der Eijk Y, Bero LA, Malone RE. Philip Morris International-funded 'Foundation for a Smoke-Free World': analysing its claims of independence. Tobacco Control. 2019 Nov;28(6):712–8.

319. Thomas DP, Hefler M, Bonevski B, Calma T, Carapetis J, Chamberlain C, et al. Australian researchers oppose funding from the Foundation for a Smoke-Free World. Aust N Z J Public Health. 2018 Dec;42(6):506–7.

320. McDaniel PA, Malone RE. Creating the '"Desired Mindset"': Philip Morris's Efforts to Improve Its Corporate Image Among Women. Women and Health. 2009;49:441–74.

321. Ulucanlar S, Fooks GJ, Gilmore AB. The Policy Dystopia Model: An Interpretive Analysis of Tobacco Industry Political Activity. Novotny TE, editor. PLOS Medicine. 2016 Sep 20;13(9):e1002125.

322. Bryan-Jones K, Chapman S. Political dynamics promoting the incremental regulation of secondhand smoke: a case study of New South Wales, Australia. Bmc Public Health. 2006 Jul 21;6:192.

323. Hawkins B, Holden C, Mackinder S. The Battle for Standardised Cigarette Packaging in Europe Multi-Level Governance, Policy Transfer and the Integrated Strategy of the Global Tobacco Industry. Palgrave Macmillan UK; 2020. (Palgrave Studies in Public Health Policy Research).

324. Goodchild M, Nargis N, Tursan d'Espaignet E. Global economic cost of smoking-attributable diseases. Tobacco Control. 2018;27(1):58–64.

325. David P. Basic economic gap related to smoking: reconciling tobacco tax receipts and economic costs of smoking-attributable diseases. Tobacco Control. 2019 Sep;28(5):558–61.

326. Chaloupka FJ, Yurekli A, Fong GT. Tobacco taxes as a tobacco control strategy. Tob Control. 2012 Mar;21(2):172–80.

327. Jha P, Asian Development Bank, editors. Tobacco taxes: a win-win measure for fiscal space and health. Mandaluyong City; 2012. 28 p.

328. Koch SF. Quasi-experimental evidence on tobacco tax regressivity. Social Science & Medicine. 2018;196(Journal Article):19–28.

329. Chaloupka FJ, Straif K, Leon ME. Effectiveness of tax and price policies in tobacco control. Tob Control. 2011 May;20(3):235–8.

330. Emery S, White MM, Gilpin EA, Pierce JP. Was there significant tax evasion after the 1999 50 cent per pack cigarette tax increase in California? Tob Control. 2002 Jun 1;11(2):130.

331. Schwartz R, Zhang B. Debunking the taxation-contraband tobacco myth. CMAJ [Internet]. 2016 Jan 1; Available from: http://www.cmaj.ca/content/early/2016/01/18/cmaj.150492.abstract

332. U.S. National Cancer Institute, World Health Organization. The Economics of Tobacco and Tobacco Control. Bethesda, MD; Geneva, Switzerland: U. S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; World Health Organization; 2016.

333. World Bank. Economics of Tobacco Taxation Toolkit. Washington, D.C: World Bank; 2018.

334. Zhang B, Schwartz R. What Effect Does Tobacco Taxation Have on Contraband? Debunking the Taxation - Contraband Tobacco Myth. Toronto: Ontario Tobacco Research Unit; 2015 p. 32.

335. Rowell A, Evans-Reeves K, Gilmore AB. Tobacco industry manipulation of data on and press coverage of the illicit tobacco trade in the UK. Tobacco Control. 2014 May;23(e1):e35–43.

336. Smith J, Thompson S, Lee K. Death and taxes: The framing of the causes and policy responses to the illicit tobacco trade in Canadian newspapers. Alvares C, editor. Cogent Social Sciences

[Internet]. 2017 May 18 [cited 2020 Mar 9];3(1). Available from: https://www.cogentoa.com/article/10.1080/23311886.2017.1325054

337. Stoklosa M, Ross H. Contrasting academic and tobacco industry estimates of illicit cigarette trade: evidence from Warsaw, Poland: Table 1. Tobacco Control. 2014 May;23(e1):e30–4.

338. Magnusson RS. Case studies in nanny state name-calling: what can we learn? Public Health. 2015 Aug;129(8):1074–82.

339. Chau J, Kite J, Ronto R, Bhatti A, Bonfiglioli C. Talking about a nanny nation: investigating the rhetoric framing public health debates in Australian news media. Public Health Research & Practice [Internet]. 2019 Sep 25 [cited 2019 Oct 4];29(3). Available from: http://www.phrp.com.au/?p=38504

340. Baum F, Fisher M. Why behavioural health promotion endures despite its failure to reduce health inequities. Sociology of Health & Illness. 2014 Feb;36(2):213–25.

341. Hoek J. Informed choice and the nanny state: learning from the tobacco industry. Public Health. 2015 Aug;129(8):1038–45.

342. Iida K, Proctor RN. 'The industry must be inconspicuous': Japan Tobacco's corruption of science and health policy via the Smoking Research Foundation. Tobacco Control. 2018 Jul;27(e1):e3–11.

343. Imperial Tobacco. Imperial Tobacco Group PLC and Imperial Tobacco UK Joint Response to the Department of Health Consultation on the Future of Tobacco Control. 2008.

344. Mamudu HM, Hammond R, Glantz SA. Project Cerberus: Tobacco Industry Strategy to Create an Alternative to the Framework Convention on Tobacco Control. American Journal of Public Health. 2008 Sep;98(9):1630–42.

345. Hawkins B, Holden C, Mackinder S. A multi-level, multi-jurisdictional strategy: Transnational tobacco companies' attempts to obstruct tobacco packaging restrictions. Global Public Health. 2019 Apr 3;14(4):570–83.

346. Assunta M. Tobacco industry's ITGA fights FCTC implementation in the Uruguay negotiations. Tob Control. 2012 Nov;21(6):563–8.

347. Assunta M. USA/Asia: US-based Think-Tank Tries to Intimidate Regional Tobacco Control Group. Tobacco Control. 2016 Jul;25(4):373–4.

348. Chapman S. "Avoid health warnings on all tobacco products for just as long as we can": a history of Australian tobacco industry efforts to avoid, delay and dilute health warnings on cigarettes. Tobacco Control. 2003 Dec 1;12(90003):13iii–22.

349. Brandt AM. The cigarette century: the rise, fall, and deadly persistence of the product that defined America. New York: Basic Books; 2007.

350. Robertson N, Sacks G, Miller P. The revolving door between government and the alcohol, food and gambling industries in Australia. Public Health Research & Practice [Internet]. 2019 Sep 25 [cited 2019 Oct 4];29(3). Available from: http://www.phrp.com.au/?p=38553

351. Smith J, Thompson S, Lee K. The atlas network: a "strategic ally" of the tobacco industry: The Atlas Network: A "Strategic Ally" of the Tobacco Industry. The International Journal of Health Planning and Management. 2017 Oct;32(4):433–48.

352. Brezis ES. Legal conflicts of interest of the revolving door. Journal of Macroeconomics. 2017 Jun;52:175–88.

353. Apollonio DE, Malone RE. The "We Card" Program: Tobacco Industry "Youth Smoking Prevention" as Industry Self-Preservation. American journal of public health. 2010 Jul;100(7):1188–201.

354. Henriksen L, Schleicher NC, Johnson TO, Lee JGL. Assurances of Voluntary Compliance: A Regulatory Mechanism to Reduce Youth Access to E-Cigarettes and Limit Retail Tobacco Marketing. American Journal of Public Health. 2020 Feb;110(2):209–15.

355. Magnusson RS. Framework legislation for non-communicable diseases: and for the Sustainable Development Goals? BMJ Global Health. 2017 Aug;2(3):e000385.

356. Curran L, Eckhardt J. Smoke screen? The globalization of production, transnational lobbying and the international political economy of plain tobacco packaging. Review of International Political Economy. 2017;24(1):87–118.

357. Hepburn J, Nottage L. A Procedural Win for Public Health Measures Philip Morris Asia Ltd v. Commonwealth of Australia, PCA Case No. 2012-12, Award on Jurisdiction and Admissibility, 17 December 2015 (Karl-Heinz Bockstiegel, Gabrielle Kaufmann-Kohler, Donald M. McRae). J World Invest Trade. 2017;18(2):307–19.

358. Corben R. Tobacco industry challenges Thai government [Internet]. DW. 2013. Available from: https://www.dw.com/en/tobacco-industry-challenges-thai-government/a-17156836

359. Blouin C. Trade Policy and Health: Adding Retrospective Studies to the Research Agenda Comment on "The Trans-Pacific Partnership: Is It Everything We Feared for Health?" International Journal of Health Policy and Management. 2016 Sep 10;6(4):243–4.

360. Friel S, Hattersley L, Townsend R. Trade Policy and Public Health. Annual Review of Public Health. 2015 Mar 18;36(1):325–44.

361. Turia T. Government moves forward with plain packaging of tobacco products. New Zealand Government [Internet]. 2013; Available from: http://www.beehive.govt.nz/release/government-moves-forward-plain-packag...

362. Collin J. Complicity in contraband: British American Tobacco and cigarette smuggling in Asia. Tobacco Control. 2004 Dec 1;13(suppl_2):ii104–11.

363. Gomis B, Lee K, Carrillo Botero N, Shepherd P, Iglesias RM. "We think globally": the rise of Paraguay's Tabacalera del Este as a threat to global tobacco control. Globalization and Health

[Internet]. 2018 Dec [cited 2020 Mar 9];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0412-3

364. Joossens L, Raw M. Cigarette smuggling in Europe: who really benefits? Tobacco Control. 1998 Mar 1;7(1):66–71.

365. Joossens L, Raw M. Progress in combating cigarette smuggling: controlling the supply chain. Tobacco Control. 2008 Nov 20;17(6):399–404.

366. Joossens L, Gilmore AB, Stoklosa M, Ross H. Assessment of the European Union's illicit trade agreements with the four major Transnational Tobacco Companies. Tobacco Control. 2016 May;25(3):254–60.

367. Lee K, Collin J. "Key to the Future": British American Tobacco and Cigarette Smuggling in China. Novotny TE, editor. PLoS Medicine. 2006 Jul 18;3(7):e228.

368. LeGresley E, Lee K, Muggli ME, Patel P, Collin J, Hurt RD. British American Tobacco and the "insidious impact of illicit trade" in cigarettes across Africa. Tobacco Control. 2008 Oct 1;17(5):339–46.

369. Nakkash R, Lee K. Smuggling as the "key to a combined market": British American Tobacco in Lebanon. Tobacco Control. 2008 Oct 1;17(5):324–31.

370. Collin J, Gilmore A. Corporate (anti)social (ir)responsibility: Transnational tobacco companies and the attempted subversion of global health policy. Global Social Policy. 2012;2(3).

371. Gilmore AB, Gallagher AWA, Rowell A. Tobacco industry's elaborate attempts to control a global track and trace system and fundamentally undermine the Illicit Trade Protocol. Tobacco control. 2018;(Journal Article).

372. Gilmore AB, Gallagher AWA, Rowell A. Tobacco industry's elaborate attempts to control a global track and trace system and fundamentally undermine the Illicit Trade Protocol. Tobacco Control. 2019 Mar;28(2):127–40.

373. Gonzalez M, Green LW, Glantz SA. Through tobacco industry eyes: civil society and the FCTC process from Philip Morris and British American Tobacco's perspectives. Tobacco Control. 2012 Jul;21(4):e1–e1.

374. Liberman J, Blecher E, Carbajales AR, Burke F. Opportunities and risks of the proposed FCTC protocol on illicit trade. Tobacco Control. 2011 Nov 1;20(6):436–8.

375. Tobacco Tactics. Illicit Trade Protocol [Internet]. Tobacco Tactics. 2019. Available from: https://www.tobaccotactics.org/index.php?title=Illicit_Trade_Protocol_(ITP)#cite_note-study-13

376. WHO FCTC. WHO Framework Convention on Tobacco Control. Geneva, Switzerland: WHO FCTC; 2003.

377. Cejudo GM, Michel CL. Addressing fragmented government action: coordination, coherence, and integration. Policy Sciences. 2017 Dec;50(4):745–67.

378. Lencucha R, Drope J, Labonte R, Zulu R, Goma F. Investment incentives and the implementation of the Framework Convention on Tobacco Control: evidence from Zambia. Tobacco Control. 2016 Jul;25(4):483–7.

379. Ashoff G. Enhancing Policy Coherence for Development: Justification, Recognition and Approaches to Achievement. German Development Institute; 2005.

380. Christensen T, Laegreid P. The Whole-of-Government Approach – Regulation, Performance, and Public-Sector Reform. 2006;29.

381. Boston J, Gill D. Joint or Shared Accountability: Issues and Options. 2011;38.

382. Magnusson RS, Patterson D. The role of law and governance reform in the global response to non-communicable diseases. Globalization and Health. 2014 Jun 5;10:44.

383. Beaglehole R, Bonita R, Horton R, Adams C, Alleyne G, Asaria P, et al. Priority actions for the non-communicable disease crisis. The Lancet. 2011 Apr;377(9775):1438–47.

384. UN. Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. New York, NY: United Nations; 2011.

385. Baur LA, Twigg SM, Magnusson RS, editors. A modern epidemic: expert perspectives on obesity and diabetes. Sydney: Sydney University Press; 2012. 432 p.

386. Dubé L, Pingali P, Webb P. Paths of convergence for agriculture, health, and wealth. Proceedings of the National Academy of Sciences. 2012 Jul 31;109(31):12294–301.

387. Dubé L, Addy NA, Blouin C, Drager N. From policy coherence to 21st century convergence: a whole-of-society paradigm of human and economic development: A whole-of-society paradigm of human and economic development. Annals of the New York Academy of Sciences. 2014 Dec;1331(1):201–15.

388. Binderkrantz AS, Christiansen PM, Pedersen HH. A Privileged Position? The Influence of Business Interests in Government Consultations. Journal of Public Administration Research and Theory. 2014 Oct 1;24(4):879–96.

389. Rose-Ackerman S. From elections to democracy: building accountable government in Hungary and Poland. Cambridge, UK;N.Y., NY; Cambridge University Press; 2005.

390. Christoforou A, Snowdon W, Laesango N, Vatucawaqa S, Lamar D, Alam L, et al. Progress on Salt Reduction in the Pacific Islands: From Strategies to Action. Heart, Lung and Circulation. 2015 May;24(5):503–9.

391. Coriakula J, Moodie M, Waqa G, Latu C, Snowdon W, Bell C. The development and implementation of a new import duty on palm oil to reduce non-communicable disease in Fiji. Globalization and Health [Internet]. 2018 Dec [cited 2018 Dec 22];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0407-0

392. Ayres I, Braithwaite J. Tripartism: Regulatory Capture and Empowerment. Law & Social Inquiry. 1991;16(3):435.

393. Valente F, Michéle L. A Role for the Private Sector in Tackling Malnutrition? FIAN International, Right to Food Journal. 2015;10:6.

394. Panjwani C, Caraher M. The Public Health Responsibility Deal: Brokering a deal for public health, but on whose terms? Health Policy. 2014 Feb;114(2–3):163–73.

395. Lencucha R, Dube L, Blouin C, Hennis A, Pardon M, Drager N. Fostering the Catalyst Role of Government in Advancing Healthy Food Environments. International Journal of Health Policy and Management. 2018;7(6):485–90.

396. Ottersen OP Prof, Dasgupta J MA, Blouin C PhD, Buss P MD, Chongsuvivatwong V Prof, Frenk J Prof, et al. The political origins of health inequity: prospects for change. Lancet, The. 2014;383(9917):630–67.

397. Petticrew M, Eastmure E, Mays N, Knai C, Durand MA, Nolte E. The Public Health Responsibility Deal: how should such a complex public health policy be evaluated? Journal of Public Health. 2013 Dec;35(4):495–501.

398. Tanaka S, Hawkes S, Pegram T, Buse K. Non--communicable Diseases: Global epidemics; global determinants; global solutions? Towards a healthy role for transnational food, beverage and alcohol industries in the global governance of noncommunicable disease risk. UCL; 2014.

399. West R, Marteau T. Commentary on Casswell (2013): The commercial determinants of health: Commentary. Addiction. 2013 Apr;108(4):686–7.

400. Collin J, Casswell S. Alcohol and the Sustainable Development Goals. 2016;387:2582–4.

401. WHO. Framework of engagement with non-State actors. Sixty-Ninth World Health Assembly. Agenda item 11.3. 2016.

402. World Health Organization, editor. Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010. 38 p.

403. Moscetti CW, Taylor AL. Take me to our liter: Politics, power and public-private partnerships with the sugarsweetened beverage industry in the post-2015 Development Agenda. Washington International Law Journal. 2015;24(3):635.

404. Crosbie E, Thomson G, Freeman B, Bialous S. Advancing progressive health policy to reduce NCDs amidst international commercial opposition: Tobacco standardised packaging in Australia. Global Public Health. 2018 Dec 2;13(12):1753–66.

405. Stigler G. The Theory of Economic Regulation. The Bell Journal of Economics and Management Science. 1971;2(1):3–21.

406. Pacific Data Hub. MANA Dashboard [Internet]. Tobacco. 2019 [cited 2019 Jul 10]. Available from: https://pacificdata.org/health-dashboard/tobacco

407. Win Tin ST, Kubuabola I, Ravuvu A, Snowdon W, Durand AM, Vivili P, et al. Baseline status of policy and legislation actions to address non communicable diseases crisis in the Pacific. BMC Public Health. 2020 May 12;20(1):660.

408. Hawkins B, Holden C. European Union implementation of Article 5.3 of the Framework Convention on Tobacco Control. Globalization and Health [Internet]. 2018 Dec [cited 2020 Jun 7];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0386-1

409. UN-OHRLLS. Small Island Developing States. Small Islands Big(ger) Stakes. UN Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States; 2011.

410. Veenendaal W. When Things Get Personal: How Informal and Personalized Politics Produce Regime Stability in Small States. Government and Opposition. 2018 Oct 10;1–20.

411. Veenendaal W, Corbett J. Clientelism in small states: how smallness influences patron–client networks in the Caribbean and the Pacific. Democratization. 2020 Jan 2;27(1):61–80.

412. Connell J. Towards Free Trade in the Pacific? The Genesis of the "Kava-Biscuit War" between Fiji and Vanuatu. Geographical Research. 2007 Mar;45(1):1–12.

413. Kelsey J. Acceding countries as pawns in a power play: a case study of the Pacific Islands. In: Multilateralism at the Crossroads. Geneva, Switzerland; 2004.

414. Snowdon W, Thow AM. Trade policy and obesity prevention: challenges and innovation in the Pacific Islands: Trade and obesity in the Pacific Islands. Obesity Reviews. 2013 Nov;14:150–8.

415. Larmour P, Barcham M. National integrity systems in small Pacific Island states. Public Administration and Development. 2006 May;26(2):173–84.

416. Prasad S. Statement of the Pacific Small Island Developing States At the G77 and China Ambassadorial Meeting [Internet]. 2019 Jan 18; New York, N.Y. Available from: https://www.un.int/fiji/statements_speeches/statement-pacific-small-island-developing-states-g77-and-china-ambassadorial

417. Healthy Caribbean Coalition. Managing Conflict of Interest for NCD Prevention and Control in the Caribbean: Challenges for Small Island Developing States. 2020.

418. UN. Resolution adopted by the General Assembly on 14 November 2014. Geneva, Switzerland; 2014 Dec. (Resolutions). Report No.: A/RES/69/15.

419. UN. Small Island Developing States Partnership Framework [Internet]. Sustainable Development Goals Knowledge Platform. 2019 [cited 2019 Jul 10]. Available from: https://sustainabledevelopment.un.org/sids/partnershipframework

420. Linhart C, Naseri T, Lin S, Taylor R, Morrell S, McGarvey ST, et al. Tobacco smoking trends in Samoa over four decades: can continued globalization rectify that which it has wrought? Globalization and

Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0256-2

421. Howard J, Ali H, Robins L. Alcohol, cannabis and amphetamine-type stimulants use among young Pacific Islanders. Drug and Alcohol Review. 2011;30(1):104–10.

422. Kessaram T, McKenzie J, Girin N, Roth A, Vivili P, Williams G, et al. Alcohol use in the Pacific region: Results from the STEPwise approach to surveillance, Global School-Based Student Health Survey and Youth Risk Behavior Surveillance System. Drug and Alcohol Review. 2016;35(4):412–23.

423. McDonald D, Elvy G, Mielke J. Alcohol in the South Pacific: The mid-1990s. Drug and Alcohol Review. 1997;16(4):383–90.

424. Nosa V, Duffy S, Singh D, Lavelio S, Amber U, Homasi-Paelate A, et al. The use of home brew in Pacific Islands countries and territories. Journal of Ethnicity in Substance Abuse: Ethnography in Substance Abuse Research. 2018;17(1):7–15.

425. Odden HL. Alcohol, tobacco, marijuana and hallucinogen use in Samoan adolescents: Substance use in Samoan adolescents. Drug and Alcohol Review. 2012;31(1):47–55.

426. Quinn B, Peach E, Wright CJC, Lim MSC, Davidson L, Dietze P. Alcohol and other substance use among a sample of young people in the Solomon Islands. Australian and New Zealand Journal of Public Health. 2017;41(4):358–64.

427. Smith BJ, Phongsavan P, Bauman AE, Havea D, Chey T. Comparison of tobacco, alcohol and illegal drug usage among school students in three Pacific Island societies. Drug and Alcohol Dependence. 2007 Apr;88(1):9–18.

428. Anderson IPS. The Economic Costs of Noncommunicable Diseases in the Pacific Islands: A Rapid Stocktake of the Situation in Samoa, Tonga, and Vanuatu [Internet]. World Bank; 2012 [cited 2018 Mar 15]. Available from: http://elibrary.worldbank.org/doi/book/10.1596/27219

429. Cassels S. Overweight in the Pacific: links between foreign dependence, global food trade, and obesity in the Federated States of Micronesia. Globalization and Health. 2006 Jul 11;2(1):10.

430. Dancause KN, Vilar M, Wilson M, Soloway LE, DeHuff C, Chan C, et al. Behavioral risk factors for obesity during health transition in Vanuatu, South Pacific: Obesity Risk During Transition, Vanuatu. Obesity. 2013 Jan;21(1):E98–104.

431. Estime SM, Lutz B, Strobel F. Trade as a structural driver of dietary risk factors for noncommunicable diseases in the Pacific: an analysis of household income and expenditure survey data. Globalization and health. 2014;10(1):48–48.

432. Lin TK, Teymourian Y, Tursini MS. The effect of sugar and processed food imports on the prevalence of overweight and obesity in 172 countries. Globalization and Health [Internet]. 2018 Dec [cited 2020 Feb 13];14(1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0344-y

433. Ravuvu A, Friel S, Thow A-M, Snowdon W, Wate J. Monitoring the impact of trade agreements on national food environments: trade imports and population nutrition risks in Fiji. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0257-1

434. Savage A, McIver L, Schubert L. Review: the nexus of climate change, food and nutrition security and diet-related non-communicable diseases in Pacific Island Countries and Territories. Climate and Development. 2020 Feb 7;12(2):120–33.

435. Veatupu L, Puloka V, Smith M, McKerchar C, Signal L. Me'akai in Tonga: Exploring the Nature and Context of the Food Tongan Children Eat in Ha'apai Using Wearable Cameras. International Journal of Environmental Research and Public Health. 2019 May 14;16(10):1681.

436. Thow AM, Waqa G, Browne J, Phillips T, McMichael C, Ravuvu A, et al. The political economy of restricting marketing to address the double burden of malnutrition: two case studies from Fiji. Public Health Nutrition. 2020 Jun 17;1–10.

437. Latu C, Moodie M, Coriakula J, Waqa G, Snowdon W, Bell C. Barriers and Facilitators to Food Policy Development in Fiji. Food and Nutrition Bulletin. 2018 Dec;39(4):621–31.

438. Mialon M, Swinburn B, Wate J, Tukana I, Sacks G. Analysis of the corporate political activity of major food industry actors in Fiji. Globalization and Health [Internet]. 2016 Dec [cited 2020 Feb 13];12(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-016-0158-8

439. Thow AM, Swinburn B, Colagiuri S, Diligolevu M, Quested C, Vivili P, et al. Trade and food policy: Case studies from three Pacific Island countries. Food Policy. 2010 Dec;35(6):556–64.

440. Murphy MM, Unwin N, Samuels TA, Hassel TA, Bishop L, Guell C. Evaluating policy responses to noncommunicable diseases in seven Caribbean countries: challenges to addressing unhealthy diets and physical inactivity. Revista Panamericana de Salud Pública. 2018 Dec 17;42:1–8.

441. Paterson K, Glover M, Centre of Research Excellence: Indigenous Sovereignty & Smoking. Suki and tobacco use among the iTaukei people of Fiji. 2019.

442. Marshall M. The second fatal impact: Cigarette smoking, chronic disease, and the epidemiological transition in Oceania. Social Science & Medicine. 1991 Jan;33(12):1327–42.

443. Marshall M. Drinking Smoke: The Tobacco Syndemic in Oceania. 1st ed. Honolulu: University Of Hawaii Press; 2013.

444. Martiniuk ALC, Lee CMY, Lam TH, Huxley R, Suh I, Jamrozik K, et al. The fraction of ischaemic heart disease and stroke attributable to smoking in the WHO Western Pacific and South-East Asian regions. Tobacco Control. 2006 2008;15(3):181–8.

445. Martiniuk ALC, Lee CMY, Woodward M, Huxley R. Burden of Lung Cancer Deaths due to Smoking for Men and Women in the WHO Western Pacific and South East Asian Regions. 2010;10:67–72.

446. Kessaram T, McKenzie J, Girin N, Roth A, Vivili P, Williams G, et al. Noncommunicable diseases and risk factors in adult populations of several Pacific Islands: results from the WHO STEPwise approach to surveillance. Australian and New Zealand Journal of Public Health. 2015 Aug;39(4):336–43.

447. Sugden C, Phongsavan P, Gloede S, Filiai S, Tongamana VO. Developing antitobacco mass media campaign messages in a low-resource setting: experience from the Kingdom of Tonga. Tobacco Control. 2017 May;26(3):344–8.

448. Tareg ARC, Modeste NN, Lee JW, Santos HD. Health Beliefs About Tobacco With Betel Nut Use Among Adults in Yap, Micronesia. International Quarterly of Community Health Education. 2015 Apr;35(3):245–57.

449. Tanielu H, McCool J, Umali E, Whittaker R. Samoan Smokers Talk About Smoking and Quitting: A Focus Group Study. Nicotine & Tobacco Research. 2018 Aug 14;20(9):1132–7.

450. Waqa G, McCool J, Snowdon W, Freeman B. Adolescents Perceptions of Pro- and Antitobacco Imagery and Marketing: Qualitative Study of Students from Suva, Fiji. BioMed Research International. 2015;2015:1–7.

451. Weitz CA, Olszowy KM, Dancause KN, Sun C, Pomer A, Silverman H, et al. Rolling Tobacco in Banana Leaves, Newspaper, or Copybook Paper Associated With Significant Reduction in Lung Function in Vanuatu. Asia Pacific Journal of Public Health. 2017 Apr;29(3):180–8.

452. WHO. Tobacco Free Initiative (TFI) [Internet]. 2020. Available from: https://www.who.int/tobacco/mpower/en/

453. World Bank. NCD Roadmap Report. 2014 Jun.

454. Groth-Marnat G, Leslie S, Renneker M. Tobacco control in a traditional Fijian village: Indigenous methods of smoking cessation and relapse prevention. Social Science & Medicine. 1996 Aug;43(4):473–7.

455. Martin E, de Leeuw E. Exploring the implementation of the framework convention on tobacco control in four small island developing states of the Pacific: a qualitative study. BMJ Open. 2013 Dec;3(12):e003982.

456. McCool J, McKenzie J, Lyman A, Allen M. Supporting Pacific Island Countries to Strengthen Their Resistance to Tobacco Industry Interference in Tobacco Control: A Case Study of Papua New Guinea and Solomon Islands. International Journal of Environmental Research and Public Health. 2013 Aug 6;10(12):3424–34.

457. Healthy Carbbean Coalition. Civil Society Led in the Caribbean Experiences from The Jamaica Coalition for Tobacco Control. 2016 Dec.

458. Carreras, Food for the Poor rescue farmer from eviction. Jamaica Observer [Internet]. 2016 Oct 1; Available from: www.jamaicaobserver.com/news/Carreras--Food-for-the-Poor-rescue-farmer-from-eviction_75667?profile=&template=PrinterVersion

459. Pomey M-P, Morgan S, Church J, Forest P-G, Lavis JN, McIntosh T, et al. Do Provincial Drug Benefit Initiatives Create an Effective Policy Lab? The Evidence from Canada. Journal of Health Politics, Policy and Law. 2010 Oct;35(5):705–42.

460. Birkland TA. An Introduction to the Policy Process: Theories, Concepts and Models of Public Policy Making. Abingdon, UK: Routledge; 2016.

461. Dahl RA. Who governs?: democracy and power in an American city. 2nd ed. London;New Haven, Conn; Yale University Press; 2005.

462. Bourdieu P. The forms of capital. In: The Sociology of Economic Life. Westview Press; 1992.

463. Barnett M, Duvall R. Power in Global Governance. Cambridge University Press;

464. Sriram V, Topp SM, Schaaf M, Mishra A, Flores W, Rajasoluchana SR, et al. 10 best resources on power in health policy and systems in low- and middle-income countries. Health Policy and Planning. 2018;611–21.

465. Moon S. Power in global governance: an expanded typology from global health. Globalization and Health [Internet]. 2019 Nov [cited 2020 Mar 4];15(S1). Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-019-0515-5

466. Alesina A, Spolaore E. On the Number and Size of Nations. The Quarterly journal of economics. 1997;112(4):1027–56.

467. Bolton P, Roland G. The Breakup of Nations: A Political Economy Analysis. The Quarterly journal of economics. 1997;112(4):1057–90.

468. Marks G, Hooghe L. Optimality and Authority: A Critique of Neoclassical Theory. JCMS: Journal of Common Market Studies. 2000 Dec;38(5):795–816.

469. Raz J. Authority. NYU Press; 1990.

470. Waldron J. Hart and the Principles of Legality. In: The legacy of HLA Hart: legal, political, and moral philosophy. New York;Oxford; Oxford University Press; 2008. p. 84.

471. Karp DJ. Transnational corporations in 'bad states': human rights duties, legitimate authority and the rule of law in international political theory. International Theory. 2009 Mar;1(1):87–118.

472. Schmidt VA. Discursive Institutionalism: The Explanatory Power of Ideas and Discourse. Annual Review of Political Science. 2008 Jun;11(1):303–26.

473. Cartensen MB. Bringing Ideational Power into the Paradigm Approach: Critical Perspectives on Policy Paradigms in Theory and Practice. In: Policy Paradigms in Theory and Practice. Palgrave Macmillan UK; 2015. (Studies in the Political Economy of Public Policy.).

474. Carstensen MB, Schmidt VA. Power through, over and in ideas: conceptualizing ideational power in discursive institutionalism. Journal of European Public Policy. 2016;23(3):318–37.

475. Finnemore M. International organizations as teachers of norms: the United Nations educational, scientific, and cultural organization and science policy. International Organization. 1993;47:565–97.

476. Finnemore M, Sikkink K. International Norm Dynamics and Political Change. International Organization. 1998 Oct 1;52(4):887–917.

477. Kauffman CM. Grassroots global governance: local watershed management experiments and the evolution of sustainable development. New York, NY: Oxford University Press; 2017. 252 p.

478. Sabatier PA. Theories of the Policy Process. 2nd ed. Westview Press; 2007.

479. Stigler GJ. The citizen and the State: essays on regulation. Chicago: University Of Chicago Press; 1975.

480. Carpenter DP. The forging of bureaucratic autonomy: reputations, networks, and policy innovation in executive agencies, 1862-1928. Princeton, N.J;Oxford; Princeton University Press; 2001.

481. Levitsky S, Murillo MV. Building Institutions on Weak Foundations: Lessons from Latin America. 2013;49.

482. Steven Levitsky, Maria Victoria Murillo - Argentine Democracy_ The Politics of Institutional Weakness (2006).pdf.

483. Levitsky S, Way LA. Competitive Authoritarianism_ Hybrid Regimes After the Cold War (2010, Cambridge University Press).pdf. Cambridge University Press; 2010.

484. Smith J, Lee K. From colonisation to globalisation: a history of state capture by the tobacco industry in Malawi. Review of African Political Economy. 2018 Apr 3;45(156):186–202.

485. Kingdon JW. Agendas, Alternatives, and Public Policies. 2nd ed. Harper Collins College Publishers; 1995.

486. Loveridge RO. Participation in American Politics: The Dynamics of Agenda-Building. By Roger Cobb and Charles Elder. (Boston: Allyn and Bacon, Inc., 1972. Pp. 182. $3.50.). The American political science review. 1973;67(3):1009–10.

487. Edelman MJ. Constructing the political spectacle. Chicago: University of Chicago Press; 1988.

488. Scott WR. Reflections: The Past and Future of Research on Institutions and Institutional Change. Journal of Change Management. 2010 Mar;10(1):5–21.

489. Nadelmann E. Challenging the global prohibition regime. International Journal of Drug Policy. 1998;9(2):85–93.

490. Davies SE, True J. Norm Entrepreneurship in Foreign Policy: William Hague and the Prevention of Sexual Violence in Conflict. Foreign Policy Analysis. 2017;13(3):701–21.

491. Carrigan C, Coglianese C. The Politics of Regulation: From New Institutionalism to New Governance. Annu Rev Polit Sci. 2011 May 9;14(1):107–29.

492. Schmidt VA. Taking ideas and discourse seriously: explaining change through discursive institutionalism as the fourth 'new institutionalism.' European Political Science Review. 2010;2(1):1–25.

493. Pierson P. Increasing returns, path dependence, and the study of politics. American Political Science Review. 2000 Jun;94(2):251–67.

494. Capoccia G, Kelemen RD. The study of critical junctures - Theory, narrative, and counterfactuals in historical institutionalism. World Politics. 2007 Apr;59(3):341-+.

495. Greif A, Laitin DD. A theory of endogenous institutional change. American Political Science Review. 2004 Nov;98(4):633–52.

496. Peters BG. Institutional Theory. In: The SAGE Handbook of Governance [Internet]. 1 Oliver's Yard, 55 City Road, London EC1Y 1SP United Kingdom: SAGE Publications Ltd; 2011 [cited 2018 Mar 15]. p. 78–90. Available from: http://sk.sagepub.com/reference/hdbk_governance/n6.xml

497. Peters BG, Pierre J, King DS. The politics of path dependency: Political conflict in historical institutionalism. Journal of Politics. 2005 Nov;67(4):1275–300.

498. Bicchi F. "Our size fits all": normative power Europe and the Mediterranean. Journal of European Public Policy. 2006 Mar;13(2):286–303.

499. Bell S. Do We Really Need a New "Constructivist Institutionalism" to Explain Institutional Change? British Journal of Political Science. 2011 Oct;41:883–906.

500. Beckert J. Institutional Isomorphism Revisited: Convergence and Divergence in Institutional Change. Sociological Theory. 2010 Jun;28(2):150–66.

501. Lewis J. The methods of community in EU decision-making and administrative rivalry in the Council's infrastructure. Journal of European Public Policy. 2000;7(2):261–89.

502. den Besten JW, Arts B, Verkooijen P. The evolution of REDD plus : An analysis of discursive-institutional dynamics. Environmental Science & Policy. 2014 Jan;35:40–8.

503. Schmidt VA. Speaking to the Markets or to the People? A Discursive Institutionalist Analysis of the EU's Sovereign Debt Crisis. British Journal of Politics & International Relations. 2014 Jan;16(1):188–209.

504. Kim SY, Swann WL, Weible CM, Bolognesi T, Krause RM, Park AYS, et al. Updating the Institutional Collective Action Framework: Updating the Institutional Collective Action Framework. Policy Studies Journal [Internet]. 2020 May 16 [cited 2020 Jul 15]; Available from: http://doi.wiley.com/10.1111/psj.12392

505. Ansell C, Gash A. Collaborative Governance in Theory and Practice. Journal of public administration research and theory. 2007 2008;18(4):543–71.

506. Bryson JM, Crosby BC, Stone MM. The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature. Public administration review. 2006;66(s1):44–55.

507. Emerson K, Nabatchi T. Collaborative Governance Regimes. Washington: Georgetown University Press; 2015.

508. Koppenjan JFM, Klijn E-H. Managing uncertainties in networks: a network approach to problem solving and decision making. London;New York, NY; Routledge; 2004.

509. Lubell M. Governing Institutional Complexity: The Ecology of Games Framework. Policy studies journal. 2013;41(3):537–59.

510. Ostrom E. Understanding Institutional Diversity. Princeton, N.J: Princeton University Press; 2005.

511. PROVAN KG, MILWARD HB. DO NETWORKS REALLY WORK?: A FRAMEWORK FOR EVALUATING PUBLIC-SECTOR ORGANIZATIONAL NETWORKS. Proceedings and membership directory - Academy of Management. 1999;8(1):A1–6.

512. Swann WL, Kim SY. Practical prescriptions for governing fragmented governments. Policy & Politics. 2018 Apr 30;46(2):273–92.

513. Greer R, Hannibal B, Portney K. The Role of Communication in Managing Complex Water–Energy–Food Governance Systems. Water. 2020 Apr 20;12(4):1183.

514. Becker GS. A Theory of Competition Among Pressure Groups for Political Influence. The Quarterly journal of economics. 1983;98(3):371–400.

515. Levine ME, Forrence JL. Regulatory Capture, Public Interest, and the Public Agenda: Toward a Synthesis. Journal of law, economics, & organization. 1990;6(special):167–98.

516. Kelman S. “Public choice” and public spirit. The Public interest. 1987;(Journal Article):80.

517. Freeman B, Sindall C. Countering the commercial determinants of health: strategic challenges for public health. Public Health Research & Practice [Internet]. 2019 Sep 25 [cited 2019 Oct 4];29(3). Available from: http://www.phrp.com.au/?p=38542

518. Freudenberg N. The Commercial Determinants of NCDs: Public Health Strategies to Reduce Harmful Influences. Prince Mahidol Award Conference: Conference ‘The Political Economy of NCDs: a Whole of Society Approach’; 2019 Feb 1; Bangkok, Thailand.

519. The Fijian Government. Constitution of the Republic of Fiji. The Fijian Government; 2013.

520. Comparative Constitutions Project. Vanuatu’s Constitution of 1980 with Amendments through 2013. Comparative Constitutions Project; 2020.

521. Constitutional history of Fiji [Internet]. Constitutionnet. 2016 [cited 2019 May 31]. Available from: http://constitutionnet.org/country/fiji

522. The Editors of Encyclopaedia Britannica. Checks and balances [Internet]. Encyclopædia Britannica. 2019. Available from: https://www.britannica.com/topic/checks-and-balances

523. Constitution of the Republic of Vanuatu. Act 20 of 1983.

524. Cambridge Dictionary. Government [Internet]. Cambridge Dictionary. 2020. Available from: https://dictionary.cambridge.org/dictionary/english/government

525. George AL, Bennett A. Case studies and theory development in the social sciences. Cambridge, Massachusetts: MIT Press; 2004.

526. Gerring J. What Is a Case Study and What Is It Good for? American Political Science Review. 2004 May;98(2):341–54.

527. Baxter P, Jack S. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. 2008;17.

528. Mills AJ, Durepos G, Wiebe E, editors. Encyclopedia of Case Study Research. SAGE Publications, Inc; 2010.

529. Yin RK. Case study research and applications: design and methods. Sixth edition. Los Angeles: SAGE; 2018. 319 p.

530. Bengtsson P. Multiple Case Studies - not just more data points?! 1999;9.

531. Yin RK. Case study research: design and methods. 3rd ed. Vol. 5. Thousand Oaks, Calif: Sage Publications; 2003.

532. Becker B, Dawson P, Devine K, Hannum C, Hill S, Leydens J, et al. Case Studies. Writing@CSU. [Internet]. Colorado State University; 1994. Available from: https://writing.colostate.edu/guides/guide.cfm?guideid=60.

533. Brady HE, Collier D. Rethinking Social Inquiry: Diverse Tools, Shared Standards. 2nd ed. US: Rowman & Littlefield Publishers; 2010.

534. Cruzes DS, Dybå T, Runeson P, Höst M. Case studies synthesis: a thematic, cross-case, and narrative synthesis worked example. Empirical Software Engineering. 2015 Dec;20(6):1634–65.

535. WHO FCTC. 2016 Global Progress Report of the implementation of the WHO Framework Convention on Tobacco Control. WHO; 2016.

536. FCTC Secretariat. 2010 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO FCTC; 2010.

537. FCTC Secretariat. 2009 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO FCTC; 2009.

538. FCTC Secretariat. 2008 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO FCTC; 2008.

539. FCTC Secretariat. 2007 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO FCTC; 2007.

540. Secretariat F. Global Progress Report. Geneva: WHO FCTC; 2014.

541. WHO. Tobacco Free Initiative (TFI) [Internet]. World Health Organization. 2020. Available from: https://www.who.int/tobacco/mpower/en/

542. Pacific Data Hub. Status of NCD policy and legislation in Pacific Island countries and territories [Internet]. Pacific Monitoring Alliance for NCD Action. 2020. Available from: https://www.pacificdata.org/dashboard/health-dashboard

543. World Health Organization. WHO Report on the Global Tobacco Epidemic: Warning about the dangers of Tobacco. Geneva: World Health Organization; 2011.

544. WHO. WHO report on the global tobacco epidemic 2017. Geneva: WHO; 2017.

545. International Trade Centre. Trade map - International Trade Statistics [Internet]. Market Analysis Tool. 2019. Available from: https://www.trademap.org/tradestat/Country_SelProductCountry_TS.aspx?nvpm=1%7c242%7c%7c%7c%7c24%7c%7c%7c2%7c1%7c1%7c2%7c2%7c1%7c2%7c1%7c1%7c1

546. World Bank. World Development Indicators. 2019.

547. Concerns over Vanuatu tobacco investment. ABC Australia Network News [Internet]. 2012 Dec 10; Available from: https://www.abc.net.au/news/2012-10-12/an-health-advocates-worried-re-vanuatu-tobacco/4310826

548. Fiji Bureau of Statistics. 2017 Population and Housing Census. Suva, Fiji: Fiji Bureau of Statistics; 2018 Jan. (Statistical News).

549. Central Intelligence Agency. The World Factbook. Washington, D.C; 2019.

550. Gravelle K. Fiji's Heritage: History of Fiji. Nadi; 2000.

551. UNDP. Human Development Indicators [Internet]. Fiji. 2019 [cited 2019 May 31]. Available from: http://hdr.undp.org/en/countries/profiles/FJI

552. Aroney N, Corrin J. Endemic revolution: HLA Hart, custom and the constitution of the Fiji Islands. The Journal of Legal Pluralism and Unofficial Law. 2013 Nov;45(3):314–39.

553. Mohammed J, Ashton T, North N. Wave Upon Wave: Fiji's Experiments in Decentralizing Its Health Care System. Asia Pacific Journal of Public Health. 2016 Apr;28(3):232–43.

554. Economist Intelligence Unit. Democracy Index 2018: Me too? Political participation, protest and democracy. Economist Intelligence Unit Limited; 2019. (Democracy Index report series).

555. On The World Map. Large detailed map of Fiji [Internet]. On The World Map. 2020. Available from: http://ontheworldmap.com/fiji/large-detailed-map-of-fiji.html

556. American Cancer Society. Fiji Country Fact Sheet [Internet]. 2019. (The Tobacco Atlas). Available from: https://tobaccoatlas.org/country/fiji/

557. Institute for Health Metrics and Evaluation. Vanuatu [Internet]. Global Burden of Disease Database. 2019 [cited 2019 Aug 7]. Available from: http://www.healthdata.org/vanuatu

558. WHO. Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2016. Geneva, Switzerland; 2018.

559. WHO. Premature deaths due to noncommunicable diseases (NCD) as a proportion of all NCD deaths (%) [Internet]. Global Health Observatory data repository. 2018 [cited 2018 Dec 28]. Available from: http://apps.who.int/gho/

560. Ministry of Health and Medical Services of Fiji. Health Status Report 2016. Ministry of Health and Medical Services of Fiji; 2016.

561. WHO GHO. Life expectancy at birth. Data by country. Global Health Observatory data repository. 2019.

562. Farm Consultancy. Child Labour in the Fiji Tobacco Industry. Suva, Fiji: Farm Consultancy Service; 2003.

563. Statista. Largest tobacco companies worldwide in 2018, based on net sales (in billion U.S. dollars) [Internet]. Statista. 2019. Available from: https://www.statista.com/statistics/259204/leading-10-tobacco-companies-worldwide-based-on-net-sales/

564. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Monday, 1st April, 2019. Suva, Fiji; 2019 Jan. (Daily Hansard).

565. Cancer Council Australia. The manufacturing and wholesaling industry in Australia - major international companies [Internet]. Tobacco in Australia. Facts and Issues. 2019. Available from: https://www.tobaccoinaustralia.org.au/chapter-10-tobacco-industry/10-3-the-manufacturing-and-wholesaling-industry-in-australia

566. Ministry of Agriculture. Ministry of Agriculture Costed Operation Plan 2018/2019. Ministry of Agriculture; 2018.

567. Ministry of Agriculture. Fiji 2020 Agriculture Sector Policy Agenda. Ministry of Agriculture of Fiji; 2020.

568. Ministry of Agriculture of Fiji. Ministry of Agriculture Costed Annual Corporate Plan 2015. Ministry of Agriculture of Fiji; 2015.

569. Ministry of Agriculture of Fiji. Crop and Livestock Production Performance. Ministry of Agriculture of Fiji; 2015.

570. Ministry of Agriculture of Fiji. Agriculture Trade Statistics. Crop and Livestock Sub-Sector. Ministry of Agriculture of Fiji; 2016.

571. Ministry of Industry, Trade and Tourism of Fiji. Ministry of Industry, Trade and Tourism Operation Plan 2018-2019. Ministry of Industry, Trade and Tourism of Fiji; 2018.

572. Ministry of Industry, Trade and Tourism of Fiji. Ministry of Industry, Trade and Tourism Strategic Plan 2018-2023. Ministry of Industry, Trade and Tourism of Fiji; 2018.

573. Tilasto. Fiji: Products of tobacco, substitute, other, extract, essences, import value (US $) [Internet]. Tilasto. 2018. Available from: http://www.factfish.com/statistic-country/fiji/products+of+tobacco,+substitute,+other,+extract,+essences,+import+value

574. The Fiji Government. Foreign Investment Regulations 2009. Jan 21, 2009.

575. The Fiji Government. Tobacco Control Act 1998. Oct 27, 1998 p. 22.

576. The Fiji Government. Tobacco Control Regulations 2000. Sep 11, 2000.

577. WHO FCTC Secretariat. Fiji [Internet]. Implementation Database. 2016 [cited 2019 Aug 7]. Available from: https://untobaccocontrol.org/impldb/fiji/

578. The Fiji Government. Tobacco Control Decree 2010. Decree No. 63 of 2010 Dec 13, 2010.

579. Bastiani D. Protocol to Eliminate Illicit Trade in Tobacco Products [Internet]. WHO FCTC; 2018. Available from: https://www.who.int/fctc/Protocol_summary_3Jul18-en.pdf?ua=1&ua=1

580. WHO. Vanuatu statistics summary (2002 - present). Global Health Observatory. 2020.

581. One World - Nations Online. Administrative map of Vanuatu [Internet]. Nations Online. 2019. Available from: https://www.nationsonline.org/oneworld/map/vanuatu-map.htm

582. American Cancer Society. Vanuatu Country Fact Sheet [Internet]. The Tobacco Atlas. 2019. Available from: https://tobaccoatlas.org/country/vanuatu/

583. McGarry D. Tobacco factory shut down - for now. Vanuatu Daily Post [Internet]. 2019 Jul 8; Available from: https://dailypost.vu/news/tobacco-factory-shut-down-for-now/article_5dfd36a8-ba73-5ed7-a871-850ab6898654.html

584. Roberts A. Health Minister Approves Manufacture of Tobacco. Vanuatu Daily Post. 2020 Feb 17;

585. Tilasto. Vanuatu: Products of tobacco, substitute, other, extract, essences, import value (US $) [Internet]. Tilasto. 2018. Available from: http://www.factfish.com/statistic-country/vanuatu/cigarette%20or%20pipe%20tobacco%20and%20tobacco%20substitute%20mixes%2C%20import%20value

586. Department of Foreign Affairs and Trade, Australian Government. PACER Plus schedule of commitments on tariffs for Vanuatu (HS2012) Part I [Internet]. Department of Foreign Affairs and Trade, Australian Government; 2012. Available from: https://dfat.gov.au/trade/agreements/not-yet-in-force/pacer/Documents/schedule-of-commitments-on-tariffs-for-vanuatu-hs2012-part-i.pdf

587. Parliament of the Republic of Fiji. Official Report of Proceedings (Hansard) [Internet]. Hansard. 2020. Available from: http://www.parliament.gov.fj/hansard/

588. Parliament of the Republic of Vanuatu. Hansard [Internet]. Parliament of the Republic of Vanuatu. 2020. Available from: https://parliament.gov.vu/index.php/hnzard

589. University of the South Pacific School of Law. Pacific Islands Legal Information Institute [Internet]. Pacific Islands Legal Information Institute. 2020. Available from: http://www.paclii.org/

590. WHO Tobacco Free Initative. WHO Report on the Global Tobacco Epidemic, 2019. Geneva, Switzerland: WHO; 2019. (WHO Report on the Global Tobacco Epidemic).

591. Weltgesundheitsorganisation. WHO report on the global tobacco epidemic. 2015, 2015,. Geneva: World Health Organization; 2015.

592. Chadwick B, Gill P, Stewart K, Treasure E. Methods of data collection in qualitative research: interviews and focus groups. BDJ. 2008;204(6):291–5.

593. Young JC, Rose DC, Mumby HS, Benitez-Capistros F, Derrick CJ, Finch T, et al. A methodological guide to using and reporting on interviews in conservation science research. Methods in Ecology and Evolution. 2018;9(1):10–9.

594. Korstjens I, Moser A. Part 4: Trustworthiness and publishing. European Journal of General Practice. 2018;24(1):120–4.

595. UNDP. Annex 1. NGOs andCSOs: A note on terminology [Internet]. 2013. Available from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjVzu390cvqAhXkyjgGHfpXAaUQFjAAegQIAxAB&url=http%3A%2F%2Fwww.asia-pacific.undp.org%2Fcontent%2Fdam%2Fchina%2Fdocs%2FPublications%2FUNDP-CH03%2520Annexes.pdf&usg=AOvVaw3Z6tb1eUnWUQZ0tfIFw_Ro

596. Naderifar M, Goli H, Ghaljaie F. Snowball Sampling: A Purposeful Method of Sampling in Qualitative Research. Strides in Development of Medical Education [Internet]. 2017 Sep 30 [cited 2020 Jul 6];14(3). Available from: http://sdmejournal.com/en/articles/67670.html

597. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2017/09/14 ed. 2018;52(4):1893–907.

598. Beck R, Weber S, Gregory RW. Theory-generating design science research. Information systems frontiers. 2012 2013;15(4):637–51.

599. Bazeley P. Qualitative data analysis with NVivo. 2nd ed. London;Los Angeles; SAGE; 2007.

600. Bergin M. NVivo 8 and consistency in data analysis: reflecting on the use of a qualitative data analysis program. Nurse researcher. 2011;18(3):6–12.

601. Hutchison AJ, Johnston LH, Breckon JD. Using QSR-NVivo to facilitate the development of a grounded theory project: an account of a worked example. International Journal of Social Research Methodology. 2010;13(4):283–302.

602. Leech NL, Onwuegbuzie AJ. Beyond Constant Comparison Qualitative Data Analysis: Using NVivo. School Psychology Quarterly. 2011;26(1):70–84.

603. Sotiriadou P, Brouwers J, Le T-A. Choosing a qualitative data analysis tool: a comparison of NVivo and Leximancer. Annals of Leisure Research. 2014;17(2):218–34.

604. Woods M, Paulus T, Atkins DP, Macklin R. Advancing Qualitative Research Using Qualitative Data Analysis Software (QDAS)? Reviewing Potential Versus Practice in Published Studies using ATLAS.ti and NVivo, 1994–2013. Social Science Computer Review. 2016;34(5):597–617.

605. Tuinstra T. Benefits of growing tobacco in Fiji "immense." TobaccoReporter [Internet]. 2015 May 18; Available from: https://www.tobaccoreporter.com/2015/05/benefits-of-growing-tobacco-in-fiji-immense/

606. Nasiko R. More farmers take up tobacco farming. The Fiji Times [Internet]. 2015 May 15; Available from: https://www.fijitimes.com/more-farmers-take-up-tobacco-farming/

607. Pacific Islands Report. Fiji Farmers Turn to Tobacco Crops. Pacific Islands Report [Internet]. 2008 Jul 22; Available from: http://www.pireport.org/articles/2008/07/22/fiji-farmers-turn-tobacco-crops

608. Roberts A. Vanuatu and China to expand cooperation. Vanuatu Daily Post [Internet]. 2019 Mar 28; Available from: https://dailypost.vu/news/vanuatu-and-china-to-expand-cooperation-in-agriculture-fisheries-livestock/article_cb6ca9d5-d82c-5c33-b674-3fd6cec1a979.html

609. Fiji Department of Information. 3 New Permanent Secretaries Appointed, Former British American Tobacco CEO Is New PS Agriculture. 2019 Aug 14;4.

610. Kate T. Dass appointed as the new Permanent Secretary for Agriculture. The Fiji Times [Internet]. 2019 Aug 14; Available from: https://www.fijitimes.com/dass-appointed-as-the-new-permanent-secretar

611. Nasiko R. $9 million tobacco factory. The Fiji Times. 2019 Mar 16;

612. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday, 23rd March 2017. Suva, Fiji; 2017. (Daily Hansard).

613. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Wednesday, 3rd April, 2019. Suva, Fiji: Parliament of the Republic of Fiji; 2019 Mar. (Daily Hansard).

614. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday 9th July, 2015. Suva, Fiji: Parliament of the Republic of Fiji; 2015 Sep. (Daily Hansard).

615. Fiji Revenue and Customs Service. Summary of revenue policies 2019-2020 budget. Fiij Revenue and Customs Service; 2019.

616. Ministry of Economy of Fiji. Economic and Fiscal Update: Supplement to the 2018-2019 Budget Address. Ministry of Economy of Fiji; 2018.

617. WHO FCTC. Protocol to Eliminate Illicit Trade in Tobacco Products [Internet]. WHO Framework Convention on Tobacco Control. 2019 [cited 2019 Nov 10]. Available from: https://www.who.int/fctc/protocol/illicit_trade/protocol-publication/en/

618. Aru H. Which Ministerial 'Power' under the Tobacco Control Act? Vanuatu Daily Post. 2020 Feb 21;3.

619. Vanuatu says no to tobacco.pdf [Internet]. RNZ News Pacific. 2012. Available from: https://www.rnz.co.nz/international/pacific-news/207779/vanuatu-agency-says-no-to-manufacturing-tobacco

620. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Wednesday 14th March, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Mar. (Daily Hansard).

621. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday,15th March, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Mar. (Daily Hansard).

622. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday, 4th April, 2019. Suva, Fiji; 2019 Apr. (Daily Hansard).

623. Wipfli HL. The Global War on Tobacco. John Hopkins University Press; 2015.

624. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Monday, 10th July, 2017. Suva, Fiji: Parliament of the Republic of Fiji; 2017 Oct. (Daily Hansard).

625. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Tuesday, 10th July, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Oct. (Daily Hansard).

626. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Monday, 13th October, 2014. Suva, Fiji: Parliament of the Republic of Fiji; 2014 Oct. (Daily Hansard).

627. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Monday, 26th September, 2016. Suva, Fiji: Parliament of the Republic of Fiji; 2016 Sep. (Daily Hansard).

628. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday, 19th April, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Apr. (Daily Hansard).

629. Ministry of Health Vanuatu. Vanuatu Health Sector Strategy-2017-2020. 2017.

630. Ministry of Health and Medical Services of Fiji RS. Non-communicable diseases Strategic Plan 2015-2019. Suva: C-POND; 2014. (Fiji Health Sector Support Program).

631. Ministry of Health and Medical Services of Fiji. Non-Communicable Diseases Prevention and Control National Strategic Plan 2010-2014. "From Womb to Tomb with a Double Edged Sword" Everyone's Business. Ministry of Health and Medical Services of Fiji; 2010.

632. Vanuatu NCD Policy & Strategic Plan 2016-2020. :83.

633. WHO. Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions) [Internet]. Noncommunicable diseases and their risk factors. 2020. Available from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjWu4i-_-nqAhXLb30KHZ3AD7gQFjAAegQIAxAB&url=https%3A%2F%2Fwww.who.int%2Fncds%2Fmanagement%2Fpen_tools%2Fen%2F&usg=AOvVaw1XekX6JdAXLgDHwfhR8vaC

634. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Friday, 30th November, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Nov.

635. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Thursday, 12th July, 2018. Suva, Fiji: Parliament of the Republic of Fiji; 2018 Dec. (Daily Hansard).

636. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Friday, 14th July, 2017. Suva, Fiji: Parliament of the Republic of Fiji; 2017 Jul. (Daily Hansard).

637. Parliament of the Republic of Fiji. Parliamentary Debates. Daily Hansard. Tuesday, 5th July, 2016. Suva, Fiji: Parliament of the Republic of Fiji; 2016 May. (Daily Hansard).

638. Nasiko R. Tobacco control requires community efforts. The Fiji Times [Internet]. 2015 Jul 29; Available from: https://www.fijitimes.com/tobacco-control-requires-community-efforts/

639. Vakasukawaqa A. NCDs Linked To Parents' Negligence. Fiji Sun [Internet]. 2017 Jul 1; Available from: https://fijisun.com.fj/2017/07/01/ncds-linked-to-parents-negligence/

640. Fijian Government. Project Aqua Provides Clean Drinking Water to Ten Villages [Internet]. FijiFirst. 2018 [cited 2019 Oct 7]. Available from: https://fijifirst.com/project-aqua-provides-clean-drinking-water-to-ten-villages/

641. The Fiji Government. Tobacco Control Regulations 2012. Aug 2, 2013.

642. Ministry of Finance of Vanuatu. Excise Consolidated Edition 2015. Oct 21, 2015.

643. The Fiji Government. Tobacco Control (Amendment) Decree 2014. Decree No. 25 of 2014 Aug 7, 2014.

644. The Fiji Government. Tobacco Control (Amendment) Decree 2012. Decree No. 72 of 2012 Mar 12, 2012.

645. Republic of Vanuatu. Tobacco Control Act No. 19 of 2008 - Tobacco Control Regulation Order No 86 of 2013. 2013.

646. Republic of Vanuatu. Tobacco Control Act 2008. 2008.

647. United Nations Development Programme (UNDP). New Zealand and UNDP Strengthen Partnership in support of Pacific Parliaments [Internet]. 2020. Available from:

https://www.pacific.undp.org/content/pacific/en/home/presscenter/pressreleases/2018/02/01/new-zealand-and-undp-strengthen-partnership-in-support-of-pacific-parliaments2.html

648. Asian Development Bank. Institutional Strengthening of the Parliament of the Republic of Vanuatu [Internet]. Asian Development Bank. 2003. Available from: https://www.adb.org/projects/documents/institutional-strengthening-parliament-republic-vanuatu

649. Parliament of Australia. Parliamentary Strengthening [Internet]. 2020. Available from: https://www.aph.gov.au/About_Parliament/International_Program/Parliamentary_Strengthening

650. Forsyth M. Understanding Judicial Independence in Vanuatu. 2015;19.

651. Forsyth M, Batley J. What the Political Corruption Scandal of 2015 Reveals about Checks and Balances in Vanuatu Governance. The Journal of Pacific History. 2016 Jul 2;51(3):255–77.

652. Ministry of Economy of Fiji. Fiji Budget Estimates 2016. Ministry of Economy of Fiji; 2015.

653. Ministry of Economy of Fiji. Fiji Budget Estimates 2016-2017. Ministry of Economy of Fiji; 2016.

654. Ministry of Economy of Fiji. Fiji Budget Estimates 2017-2018. Ministry of Economy of Fiji; 2017.

655. Ministry of Economy of Fiji. Budget Estimates 2019-2020. Ministry of Economy of Fiji; 2019.

656. Ministry of Finance of Fiji. Fiji Budget Estimates 2012. Ministry of Finance of Fiji; 2012.

657. Ministry of Finance of Fiji. Fiji Budget Estimates 2014. 2013.

658. Pacific Health Ministers. Joint Forum Economic and Pacific Health Ministers Meeting. Honiara; 2014.

659. GBD 2015 Risk Factors Collaborators. Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. The Lancet. 2016;388(10053):1659–724.

660. United Nations. Sustainable Development Goals [Internet]. Sustainable Development Goals. [cited 2018 Mar 28]. Available from: http://www.un.org/sustainabledevelopment/sustainable-development-goals/

661. McNamara C. Is trade policy a missing piece to a public health puzzle? Global Social Policy. 2018 Apr;18(1):81–7.

662. Friel S, Baker P, Thow A-M, Gleeson D, Townsend B, Schram A. An exposé of the realpolitik of trade negotiations: implications for population nutrition. Public Health Nutrition. 2019 Nov;22(16):3083–91.

663. Fidler DP, Drager N, Lee K. Managing the pursuit of health and wealth: the key challenges. The Lancet. 2009 Jan;373(9660):325–31.

664. Drager N. Foreign policy, trade and health: at the cutting edge of global health diplomacy. Bulletin of the World Health Organization. 2007 Mar 1;85(3):162–162.

665. Collin J. Tobacco, trade and global health: The challenge of policy coherence. :54.

666. Blouin C. Trade policy and health: from conflicting interests to policy coherence. Bulletin of the World Health Organization. 2007 Mar 1;85(3):169–73.

667. Labonte R. Health in All (Foreign) Policy: challenges in achieving coherence. Health Promotion International. 2014 Jun 1;29(suppl 1):i48–58.

668. Lencucha R, Reddy SK, Labonte R, Drope J, Magati P, Goma F, et al. Global tobacco control and economic norms: an analysis of normative commitments in Kenya, Malawi and Zambia. Health Policy and Planning. 2018 Apr 1;33(3):420–8.

669. Braithwaite J, D'Costa B. Cascades of Violence. War, Crime and Peacbuilding Across South Asia. Canberra: ANU Press; 2018.

670. Pritchett L, Woolcock M, Andrews M. Looking like a state: Techniques of Persistent Failure in State Capability for Implementation. Jounral of Development Studies. 2012;

671. Andrews M, Pritchett L, Woolcock M. Escaping Capability Traps Through Problem Driven Iterative Adaptation. World Development. 2013;

672. Pritchett L, Woolcock M. Solutions When the Solution is the Problem: Arraying the Disarray in Development. World Development. 2004 Feb;32(2):191–212.

673. Haque TA. A 'good governance' paradox? Re- examining reform of economic institutions in post-conflict contexts. 2018;27.

674. Howes S, Betteridge A, Sause L, Ugyel L. Evidence-Based Policy Making in the Tropics. Are Developing Countries Different? In: Hybrid Public Policy Innovations Contemporary Policy Beyond Ideology. Taylor & Francis; 2018. (Routledge Studies in Governance and Public Policy).

675. Levitsky S, Murillo MV. Variation in Institutional Strength. Annual Review of Political Science. 2009 Jun;12(1):115–33.

676. Levitsky S, Murillo MV. Argentine Democracy: The Politics of Institutional Weakness. 2006.

677. Albertus M, Menaldo V. Gaming Democracy: Elite Dominance during Transition and the Prospects for Redistribution. British Journal of Political Science. 2014;44(3):575–603.

678. Rhodes D. Capacity across cultures: global lessons from Pacific experiences [Internet]. Fairfield, Vic: Inkshed Press Pty Ltd; 2014. Available from: http://anu.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwdV3LDoIwENwoHvTmA4OKhh_A9CXImUj8AO-

k0Pbohf9P3BZoiNFje9i0yaazu83MAHB2JenXmyAM1SprtP0nwwqpUZhIbWG4pJm6cef-NvGG8drRXjHRs3D97AKRRuQ8m8Mcs861ZNaygRTWYo7cBR_Edca1JbBhlAl2VGsILJ9gAzP93sJyJAJ3O4hKBKoWq-BEOqxKehUM3YUQV49X-UwxVD3MV-rxKJTtIcCeXUeQMG4sw5XxXGlhVbAo4aZh0pi2EFLSA4Q_Qxz_7J9ghUgt-t4_hoXB3NRnd6WLu_sHZ6RfOw

679. Magnusson R, Patterson D. Global action, but national results: strengthening pathways towards better health outcomes for non-communicable diseases. Critical Public Health. 2019 Nov 29;1–13.

680. Swinburn B Prof, Kraak V PhD, Rutter H MBBChir, Vandevijvere S PhD, Lobstein T PhD, Sacks G PhD, et al. Strengthening of accountability systems to create healthy food environments and reduce global obesity. Lancet, The. 2015;385(9986):2534–45.

681. World Health Organization. WHO Report on the Global Tobacco Epidemic: Enforcing Bans on Tobacco Advertising, Promotion and Sponsorship. Geneva: World Health Organization; 2013.

Appendix 1. The calculation of progress in tobacco control in PSIDS

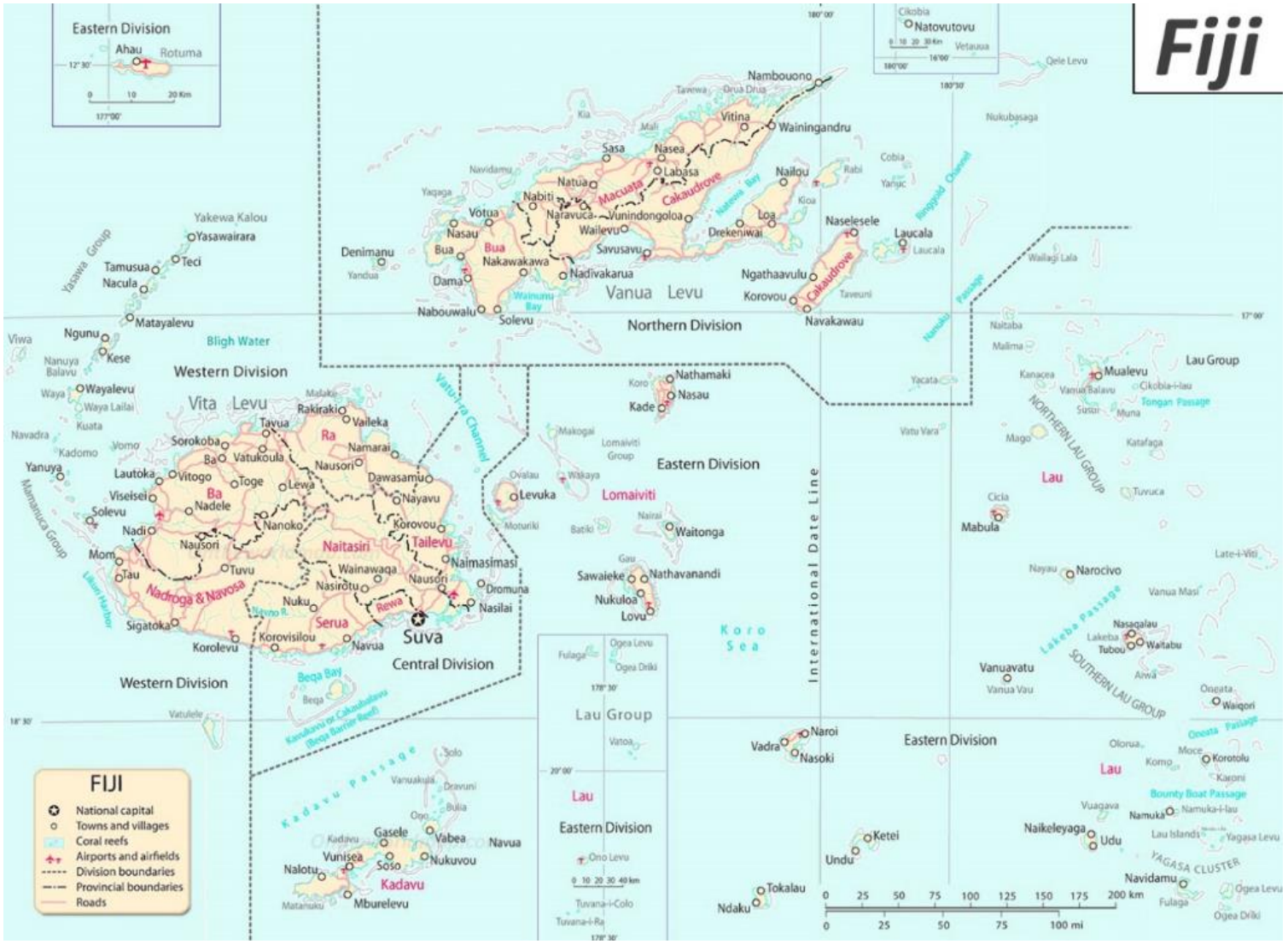
	M (Monitoring)					W1 (Health warnings on packaging)					E (Advertising bans)					R1 (Taxation)					Total change
PSIDS	2016	2014	2012	2010	Change (2010 - 2016)	2016	2014	2012	2010	Change (2010 - 2016)	2016	2014	2012	2010	Change (2010 - 2016)	2016	2014	2012	2010	Change (2010 - 2016)	
Kiribati	2	1	1	2	0	2	1	0		2	3	3	0	0	3	1	3	1	1	0	**5**
Fiji	2	2	2	1	1	3	3	1	0	3	2	2	2	2	0	1	1	1	n/a	0	**4**
Vanuatu	2	2	2	1	1	3	3	1	1	2	3	3	3	2	1	2	2	2	2	0	**4**
Nauru	1	1	1	n/a	0	1	1	1	0	1	2	2	2	2	0	2	n/a	n/a	1	1	**2**
Samoa	2	2	1	1	1	3	3	1	1	2	2	2	2	2	0	2	2	2	2	0	**3**
Solomon Islands	1	1	1	1	0	3	3	1	1	2	2	2	2	3	-1	1	1	1	n/a	0	**1**
Federated States of Micronesia	2	2	1	1	1	0	0	0	0	0	0	0	0	0	0	2	2	2	2	0	**1**
Tonga	1	2	1	1	0	1	1	1	1	0	2	2	2	2	0	2	2	2	2	0	**0**
Marshall Islands	0	1	1	1	-1	0	0	0	0	0	0	0	0	0	0	2	2	1	1	1	**0**
Papua New Guinea	0	n/a	2	2	-2	0	0	0	0	0	2	2	2	2	0	1	1	1	n/a	0	**-2**

Source of data: (543,544,591,681)

Appendix 2. The calculations of tobacco related export in proportion to GDP

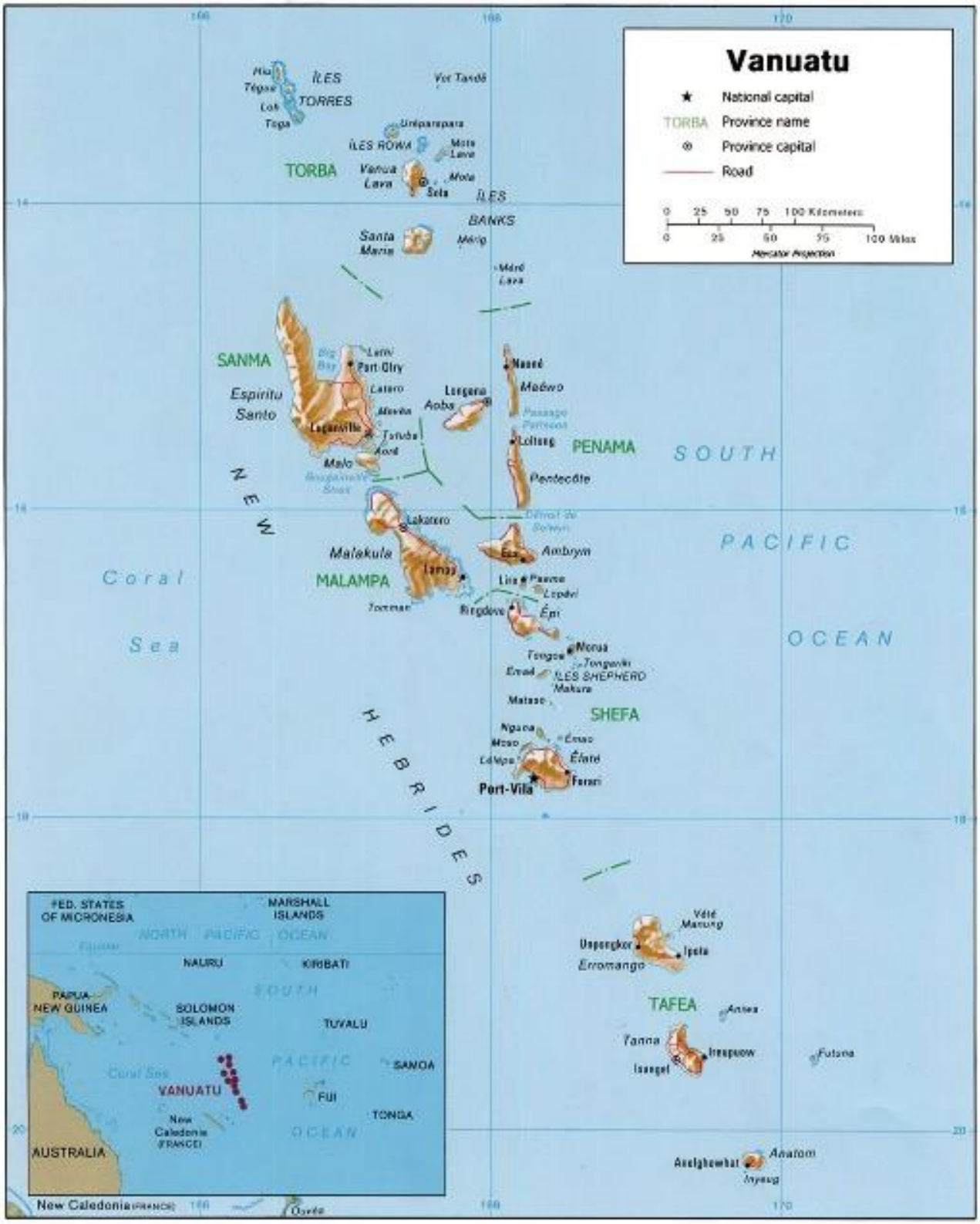
PSIDS	**Total GDP in 2016 (US$, thousands)** Source: (546)	**Tobacco related export, value exported in 2016 (US$, thousands)** Source: (545)	**Calculated tobacco related export in 2016 (% in GDP)**
Kiribati	165765016	0	0.000%
Fiji	4631626234	1726000	0.037%
Vanuatu	773502896	0	0.000%
Nauru	102060130	0	0.000%
Samoa	785916937	231000	0.029%
Solomon Islands	1202125000	766000	0.064%
Federated States of Micronesia	322000000	0	0.000%
Tonga	395159629	257000	0.065%
Marshall Islands	183000000	159000	0.087%
Papua New Guinea	16928680397	724000	0.004%

Appendix 3. The map of Fiji



Source: (555)

Appendix 4. The map of Vanuatu



Source: (581)