Tobacco control policymaking in Europe

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A tug of war

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A tug of war

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CHAPTER 1

General introduction

The problem

Per year, 700,000 Europeans die from the consequences of tobacco consumption, as smoking causes a wide range of illnesses including various types of cancer, cardiovascular diseases and respiratory diseases (1). Tobacco smoke exposes an individual to more than 7,000 chemicals, of which 70 are known to cause damage to nearly every organ in the human body (2). Smoking remains one of the largest preventable causes of death in the world (3). However, on average 26% of people in the European Union (EU) continue to smoke, with figures ranging from as low as 7% in Sweden, to as high as 37% in Greece (1). This inconsistency between convincing evidence on the adverse health effects of smoking since the 1950s (4–6) and continuing smoking behavior can (in part) be explained by the addictive properties of tobacco.

Nicotine is an addictive substance and it is observed to be at least as addictive as cocaine or heroin, for example with regards to difficulties achieving abstinence (7). In the past, the tobacco industry has made cigarettes more addictive, by genetically modifying tobacco crops to produce higher levels of nicotine and adding chemicals such as ammonia to facilitate nicotine absorption by tobacco users (8). Despite being well-aware of the addictiveness and adverse health effects of smoking, CEOs of large tobacco companies have insisted under oath that they believed smoking was not addictive, nor related to death and disease (9). Moreover, the industry has tried to obscure the issue of addiction by framing tobacco consumption in terms of 'individual choice' or 'freedom of choice' (10), implying that smoking is a voluntary act.

Next to its detrimental effects on population health, tobacco consumption causes significant economic burden to society, for example in terms of high healthcare costs (e.g. chemotherapies, COPD treatment) and absenteeism due to illness (11). It is often argued that smoking financially benefits a society through state revenue from excise taxes or because citizens die prematurely and therefore do not enjoy their pensions, but the opposite turns out to be the case: a society with smokers is more expensive than a society without smokers (12).

In short: tobacco consumption is both a public health and economic problem rooted in addiction and sustained by a deceitful industry.

Available solutions

In many governments around the world, a shift occurred from definitely establishing the magnitude of the policy problem of smoking to the selection of appropriate policy solutions (13). It is currently widely recognized that smoking poses a public health problem, therefore countries now seek which policies can be enacted to address this problem (13,14). Tobacco control policy development in Europe is a functioning example of multilevel governance, as policy is developed at various levels (15).

The European Union provides a supranational layer of governance which imposes hard law (i.e.: legally binding) instruments such as Decisions, Regulations, and Directives, which all supersede national law (15,16). Regulations have general application, are binding in their entirety and are directly applicable to all EU member states (17). Decisions are also binding and directly applicable to Members States, but can be addressed to certain states specifically (17). In the field of tobacco control there have been two important directives: the Tobacco Products Directive of 2001 and its revision in 2015 (18–20). The 2015 directive has resulted, for example, in the graphic images on tobacco product packaging. Furthermore, there has been an important Tobacco Advertising Directive (TAD) in 2003, which regulated tobacco advertising and promotion (21).

Furthermore, the EU can propose Recommendations and Resolutions, which are non-binding instruments (i.e.: soft-law). These typically concern aspects of tobacco control that are the responsibility of the Member States, such as tobacco sales to children, which was part of a council recommendation in 2003 (20).

Moreover, the World Health Organization (WHO) through the Framework Convention on Tobacco Control (FCTC) constitutes an additional supranational layer of governance. Although the FCTC is technically legally binding, there are no sanctioning devices available and can thus be considered a soft-law framework. As a result, countries vary considerably in their interpretation, implementation and enforcement of FCTC mandates (22). The FCTC is the first global public health treaty, which has been signed and ratified by 180 Parties world-wide, including the EU itself and all its member states (23). The purpose of this treaty is to 'protect present and future generations from the devastating […] consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels to reduce […] the prevalence of tobacco use and exposure to tobacco smoke' (24). The FCTC proposes a set of policies called the 'MPOWER package', which is an acronym of the following six groups of policies:

Monitor tobacco use and prevention policies,
Protect people from tobacco smoke,
Offer help to quit tobacco use,
Warn about the dangers of tobacco,
Enforce bans on tobacco advertising, promotion and sponsorship and,
Raise taxes on tobacco (25).

A large-scale study in 126 countries suggested that these MPOWER policy measures are indeed effective, as countries with more enacted MPOWER policies experience larger reductions in smoking prevalence (26).

Beside the European and global level, subnational levels within countries can also enact tobacco control policies. Subnational levels may refer to villages, cities, municipalities, provinces, counties, regions or federal states. Their role in tobacco control strongly depends on whether they are legally authorized to formulate such policies in addition to, or going beyond the policies formulated at the national level. In the United States, for example, states, counties and cities are often allowed to go beyond federal legislation in tobacco control (in other words: local law is often not *pre-empted* by federal law). This is illustrated by several states and US cities which have increased the legal age of sale for tobacco to 21, which is more restrictive than the federal legal age of sale of 18 years (27). In Germany, the federal government devolved the implementation of the smoking ban to the federal states, which resulted in strong variations across states in the way it was implemented (28). In Italy, a similar mechanism was observed as the smoking ban legally allowed Italian regions to go beyond national legislation, which resulted in, for example, a smoke free beach in Bibione (29).

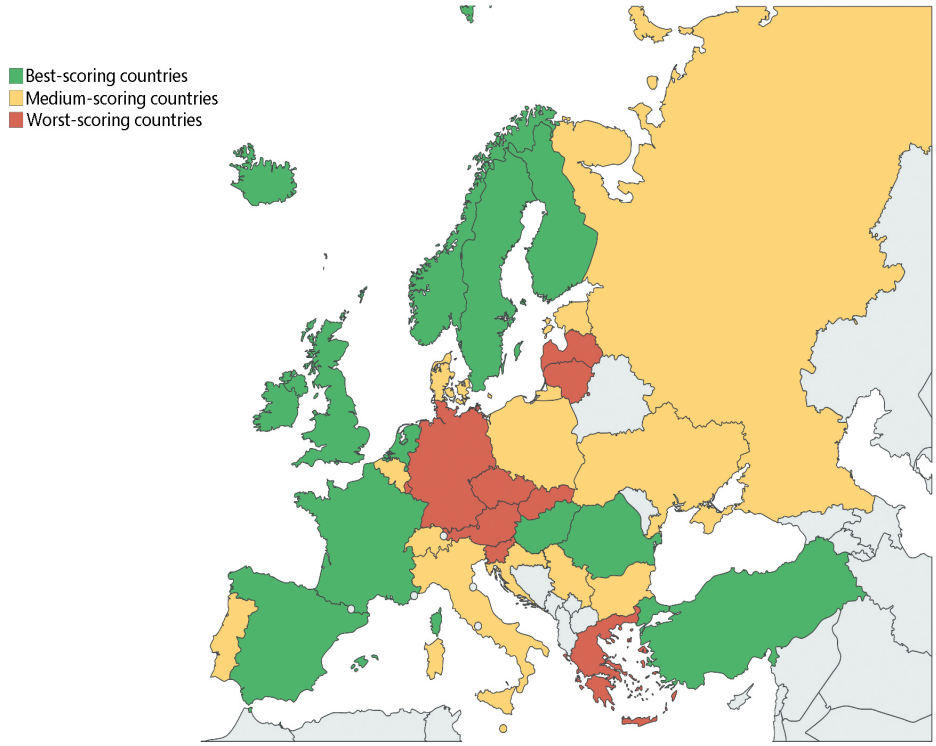
A large part of the responsibility for tobacco control policy, however, still rests at the national level (15). Despite the fact that countries within the EU have been enacting stricter tobacco control measures over time, and despite strong harmonizing influences of the European community on tobacco control policy, there is still substantial variance in tobacco control policy comprehensiveness across European countries (13,30). Countries have typically responded to the problem of tobacco consumption in different, idiosyncratic ways, and there are significant time lags between acknowledgement of the problem and the emergence of effective policy measures to address it (14,31). Some countries have been quicker than others to comprehensively address the issue after the health effects became apparent, for example Finland in 1976 (32).

Countries vary considerably in terms of their tobacco control policy comprehensiveness (30,31). One of the most widely used benchmarking attempts to make such variations explicit for European countries, is through the Tobacco Control Scale (TCS) (30). The TCS has a maximum score of 100 and quantifies how many tobacco control policies are implemented in a given country. It is based on six cost effective tobacco control interventions prescribed by the World Bank, which are similar to the MPOWER package provided by the FCTC: price increases through taxes, smoke-free venues, consumer information such as through media campaigns, advertising bans, health warnings, and smoking cessation treatment (33). Figure 1 shows a European map with best, medium and worst scoring countries in terms of their score on the TCS in 2016.

In short: tobacco control policy in European countries is a functioning example of multi-level governance as policy is developed at multiple levels including the global, the EU, the national, and subnational level. There are many available effective policy options to address the problems that tobacco consumption poses, though both hard and soft law instruments provided by

supranational organizations. Most responsibility still rests at the national level, however, and countries have responded in varying ways to the problems posed by tobacco consumption.

Figure 1: European map with best, medium and worst scoring countries in terms of their TCS score in 2016



Theories of policymaking

A rudimentary theory of policymaking could be that emergent knowledge (e.g. smoking causes death and disability) automatically provides the necessary pressure for policy to develop: a so-called 'knowledge driven model' (14). As discussed in the previous parts, it is widely recognized that tobacco consumption poses a public health problem and effective policies are available. This could lead a somewhat naïve person - or scientist - to believe that policy enactment will automatically follow. Yet, this is not the case. If this had indeed been so simple, countries would have responded much earlier to the problems posed by tobacco consumption, probably around the 1960s which is roughly a decade after the first evidence on the harms of smoking emerged. However, policymakers rarely use evidence in such a linear, straightforward way (14). Many other possible factors play a role, such as values and ideology of policymakers (10), the continuous pressure of interest groups (34), or the economic benefits of the tobacco industry within a

country (13). Therefore, there is a need to employ more sophisticated theories of policymaking, which can be borrowed from political science (16).

There are various political science theories that try to explain policy change: Kingdon's three streams approach (35), the theory of Punctuated Equilibrium (36), the Advocacy Coalition Framework (37), theories on Multilevel Governance (38), theories on policy transfer (39,40), and others. These theories of policymaking highlight different aspects of the policy process and relate to different stages of the process of policymaking, but can be broken down into five broad core components: societal factors, the role of institutions, agenda setting/framing, interest groups, and the role and transfer of ideas (13). We will discuss these components one-by-one in the following text, with some illustrative examples.

Societal factors

Policy decisions are not made in isolation from the wider environment. Societal factors provide the context for policy decisions and advocacy (16). A few possible factors relevant in explaining differences in tobacco control policies across countries are: level of smoking prevalence, the economic benefits of tobacco to the national economy, and public attitudes towards smoking and towards tobacco control policy measures (13). These factors are typically dynamic: smoking prevalence in Europe generally decreases over time (1), as does the economic presence of the tobacco industry in terms of manufacture and productions (13). Support for future tobacco control policies generally increases over time (41), while public attitudes towards smoking become increasingly negative. These factors are often interlinked, as a decline in smoking prevalence corresponds to a decline in sales and concomitant decline in economic benefits to society (e.g.: associated jobs and income through excise taxes). Smoking prevalence is tightly linked to public support for tobacco control within a society as smokers are found to be less supportive of future tobacco control policies, as opposed to non-smokers and ex-smokers (42,43).

It must be noted that such societal factors are not inherently capable in explaining policy change, but they provide the context for actors to exploit opportunities (44). Tobacco control interest groups may try to influence certain factors, for example public support by means of mass-media campaigns. Tobacco control interest groups may also use high incidences of public support in their communication to policymakers, just like the tobacco industry may use employment figures from tobacco sales as a way to persuade policymakers to refrain from enacting stricter tobacco control policies.

The role of institutions

A common aim of any institutional approach is to link policy outcomes with one or multiple institutions that could influence a policy's progress (13). Institutions may be broadly defined as

"relatively enduring features of political and social life that structure behavior and that cannot be changed easily or instantaneously" (45). Institutions are associated with regular patterns of behavior, and within institutions there are norms, practices and relationships that influence such regular patterns of behavior (13). A comparative focus on institutions may help explain why countries come to demonstrate such variance in tobacco control policies (13).

Institutions can have an effect on which interest groups have more influence on the policy process. When there is a short period of increased attention to a certain policy issue, institutions are created and/or reorganized (36). They remain in place, however, after the attention is directed to other issues, sustaining procedures and biases which favor one type of policy outcomes at the expense of other policy outcomes (36).

An example of an institutional dimension relevant in explaining tobacco control policy development is the centrality of the health ministry (13,46). A country's health ministry usually has a public health focus on policy, as opposed to trade and treasury departments that tend to highlight economic aspects such as government income from excise tax and employment (46). When the health ministry plays a central role in policymaking, resultant policy is likely more comprehensive and health oriented.

Another example of a formalized institutional arrangement, is a government's interpretation of FCTC's Article 5.3, which aims to protect tobacco control policymaking from tobacco industry interests (24). Some countries adopted stricter interpretations of this article after the issue gained public and political attention. Such countries, for example, allow no contacts between policymakers and representatives of the tobacco industry. Other countries may have a weaker interpretation, for example in terms of transparency. In such cases, contacts are allowed, but need to be reported and publicly available.

Agenda setting/Framing

Agenda setting

Getting issues or problems on the policy agenda is the first step in the process of policymaking, a process which is called 'agenda setting' (47). After the agenda is set and the problem acknowledged and defined, appropriate policies need to be identified and chosen to address the problem, which is called the 'policy formulation' stage. Then, a specific policy instrument needs to find sufficient political and public support, which is referred to as the 'legitimation' stage. Then, the policy instrument is implemented, evaluated, and ultimately maintained or terminated (48).

The policy agenda refers to policy issues or problems that policymakers perceive as significant at a certain point in time (49). The number of issues that can be on the policy agenda is limited, as it is impossible for policymakers to consider all issues that confront a society simultaneously (50). Sometimes a crisis can 'catapult' an issue on the policy agenda, such as was the case during the European 'refugee crisis' in 2015 (51). In other cases, the policy agenda may be set by policy participants that have an interest in specific policy outcomes, such as public health or industry interest groups. These groups typically compete to get their policy issues on the agenda, or in the case of the tobacco industry: keep the issue off the agenda (47,52).

Venue shopping

Policy participants can try multiple venues to address a problem or define policy problems, such as government, the media, or the judiciary. This is a phenomenon called 'venue shopping' (53). As an example: in the Netherlands, a public criminal case against the tobacco industry by the Youth Smoking Prevention Foundation (Stichting Rookpreventie Jeugd) triggered a wave of publicity and attention. The tobacco industry was accused of misleading consumers by puncturing holes in cigarette filters in such a way that official measurement machinery indicates lower tar and nicotine levels than smokers actually inhale (54). The judiciary and the media in this case provided alternative venues to focus on the tobacco industry as being unreliable and deceitful, which ultimately also resulted in questions in parliament (55).

Framing

Even when an issue finally does get attention, interest groups continue to compete to ensure that their depiction (i.e.: frame) of the issue remains in the forefront (47). The group that can successfully frame a problem, will be the one to define the solutions and by doing so, prevail in the policy debate (14,56). By framing an issue, groups create a narrative of a policy problem which is both diagnostic and prescriptive: they indicate what is wrong, and how it needs to be fixed (57).

In tobacco control, proponents and opponents persistently struggle to frame tobacco in different ways, focusing on different dimensions of tobacco consumption, which is a multi-dimensional policy problem (58,59). These dimensions allow for numerous possible ways to frame the policy issue. This can be done in terms of adverse health effects, vulnerable groups (such as children or citizens with low socio-economic status), economic burden to society, impacts on associated jobs, state revenue from excise taxes, individual freedom, et cetera. The way an issue is framed can ultimately have an impact on the way resources are allocated (i.e.: on which policy solutions public money is spent).

Interest groups

Advocacy by interest groups is important in explaining tobacco control policy development (58), as more comprehensive regulations are typically attributed to health NGOs, and weaker or avoided regulations are often attributed to the tobacco industry (60–65). Research on tobacco control policy increasingly focuses on interest groups, as is illustrated by the emergence of theories that focus on their role in the policy process, such as the Advocacy Coalition Framework (ACF) and the theory of Punctuated Equilibrium (53,66).

According to the ACF, coalitions are structured around a central belief (e.g. smoking is bad for health) and these incorporate actors from civil society, the media and government (37). Shared beliefs are the 'glue' that bind these actors together in advocacy coalitions, and they engage in coordinated activity over time (37).

The Theory of Punctuated Equilibrium states that long periods of policy stability are alternated by short and important changes in policy, which are called 'punctuated equilibria' (53). Here, groups are assumed to have a 'policy monopoly' which has two elements: a monopoly on political understandings of the policy issue (reflected by the dominant frame) and institutional arrangements that reinforce such policy monopolies (67).

The previous section described that the dominant interest group typically prevails in framing both the policy problem and proposing policy solutions. The tobacco industry may deny or downplay the size of the problem, and propose weaker, non-intrusive policy measures such as education, as opposed to more intrusive legislative measures such as bans which are often proposed by health groups (68).

A shift in the relative power of interest groups is generally apparent over time. In earlier days, the tobacco industry typically had a larger influence on policy agendas (1). This was in times where large proportions of the population smoked and health effects remained largely unknown. When health effects did become apparent, health groups began to advocate for the enactment of stricter tobacco control policies.

The role and transfer of ideas

Scholars that focus on the role of ideas in the process of policymaking use terms such as policy diffusion, lesson drawing, policy borrowing, policy transfer, policy emulation and policy copying. Although distinctions can be made between these terms, they all refer to a "process by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system" (40).

Smith (2015) refers to three levels of ideas commonly identified in political science: policy paradigms, policy frames, and policy solutions (14). Whereas policy paradigms refer to overarching ways of thinking about the world (e.g. left versus right wing political preference), policy frames refer to ideas that help define what is, and what is not considered a policy problem (e.g. increasing differences in smoking status between high and low SES individuals are problematic and should be addressed), and policy solutions refers to particular policy instruments (e.g. a ban on tobacco vending machines) (14). Within the policy transfer literature, 'ideas' are commonly operationalized as policy instruments (69).

Ideas that spread like a virus

Ideas can 'spread like a virus' and in tobacco control this is no exception (31). Tobacco control itself can be seen as a virus-like 'idea whose time has come', as it becomes more and more conventional for governments to act upon the ever-mounting evidence of the problems caused by tobacco consumption and the effectiveness of the various policy solutions (70). Besides tobacco control itself, emerging evidence on the harms of passive smoking since the end of the 1980s has caused a spread in the development and enactment of smoke-free policies over the following decades (70,71). Public health interest groups could make the claim that smoking is not merely an individual choice harming only the health of the smoker, but also a choice that could harm the health of a non-smoker. In a similar vein, the idea of tobacco as an addictive drug spread in the course of the 1990s. Before that, it was more readily considered a dependence or even more euphemistically as 'a bad habit' (72).

This thesis

Added value of this thesis

In the scientific tobacco control literature, most research comes from the medical, public health or behavioral sciences, less from public policy or political science (16,73,75). Publications in tobacco control are dominated by studies on smoking and health (75). When tobacco control policies are examined, studies usually focus on the *impacts* of tobacco control policies, and less on what *determines* tobacco control policy adoption. The tobacco control policy process remains understudied, perhaps because policymaking is considered complex or abstract (76).

When scholars do investigate the policy process, they often conduct single country case studies over time (31). These case studies are informative if a person wants to know more about the situation within a specific country. It may offer limited theoretical insights, however, as results are very much bound to the context of a single country (31). A cross-country comparative approach has the potential to discover variables that are necessarily treated as constants in single country case studies, such as strength of the tobacco industry in terms of manufacture and production (77). However, cross-national comparative research comparing more than two countries is rarely

conducted (31,77). The reason for this may be because it is a substantial challenge to group countries into explanatory clusters, as this sometimes involves (crude) classifications (31). Single country case studies do not need to make such classifications. As such, they can do justice to the complexity and idiosyncrasy of the process of policymaking in a certain country. The potential to reach general conclusions is however far greater with a cross-country comparative approach (31). This thesis will try to fill this knowledge gap by investigating the determinants of tobacco control policymaking, employing when possible a cross-national approach comparing various European countries.

Aims of this thesis

The overall aim of this thesis is to examine what underlies the considerable variations in tobacco control policy comprehensiveness across European countries. In the first part, we will focus on public support, framing, interest groups, institutions, and policy learning.

In the second part of this thesis, we zoom in on one of these determinants: tobacco control partnerships. This approach was chosen after data that emerged from the first part suggested that there is considerable room for improvement of the way the tobacco control community is organized. This is a determinant which can be changed and improved, yet it has been scantly researched (78).

Two specific aims will be addressed:

1. To examine determinants of tobacco control policymaking in European countries
2. To examine which characteristics are related to tobacco control partnership strength and how European partnerships compare with regards to these characteristics.

Outline of this thesis

Part 1: determinants of tobacco control policymaking in European countries

Part 1 consists of four chapters aimed to understand various determinants of tobacco control policymaking in European countries. Chapter 2 reviews what is known about determinants of the policy processes regarding three youth access and exposure policies: raising the age of sale, banning tobacco displays at points of sale, and limiting the number and type of tobacco outlets. Chapter 3 examines the importance of framing, by examining how public support, one of the determinants of policymaking, relates to support for the protection of children against tobacco. Studies in Chapter 4 and 5 compare various European countries and are based on expert interviews conducted across Europe. Chapter 4 examines the relative power balance of pro and anti-tobacco control interest groups by looking at framing and institutional arrangements across 6 European countries. Chapter 5 examines policy learning in 5 European countries by looking at considerations to accept or dismiss foreign examples in tobacco control.

Part 2: characteristics associated with tobacco control partnership strength
Part 2 consists of two chapters presenting the results of our research aimed to discover which characteristics contribute to tobacco control partnership strength, and to develop a tool to measure the prevalence of such characteristics. Chapter 6 draws from an expert panel to identify characteristics associated with tobacco control partnership strength. Chapter 7 is dedicated to the development and application of a tool to systematically assess the prevalence of characteristics associated with partnership strength across European countries.

General discussion
The general discussion of this thesis provides an overview and interpretation of the main findings followed by a discussion on theoretical and methodological considerations including generalizability. Implications for science and practice are discussed as well.

Data sources and methodology
Table 1 provides an overview of the data sources, methods, and setting per chapter.

Table 1. Overview of chapters and study characteristics

Chapter	Data source	Method	Setting
Part 1			
Chapter 2	Literature review	Realist inspired review	-
Chapter 3	Dutch Cancer Society (KWF) survey data	Quantitative, cross-sectional	The Netherlands
Chapter 4	Interview data	Qualitative, framework method	6 European countries
Chapter 5	Interview data	Qualitative, bottom-up thematic analysis	5 European countries
Part 2			
Chapter 6	Expert panel data	Qualitative, bottom-up thematic analysis	10 European countries
Chapter 7	Expert panel data, pilot test data, survey data	Quantitative, descriptive	EU28 + Norway and Switzerland

Methodology
The methodology in this thesis has two main characteristics: it is predominantly qualitative and realist-inspired.

First, a qualitative approach was needed, as we tried to answer the question *why* tobacco control policy development differs from country to country. Qualitative research is best suited to understand social phenomena from the perspectives of the (policy) actors themselves (79).

As we study policy processes, the policy actors within policy domains have most detailed knowledge about these processes, as they concern them in their daily lives. There are quantitative studies investigating variations in tobacco control across countries, yet such studies can only establish a correlation between variables, and not *how* or *why* such variables are related (80). Establishing a significant correlation between Y and Z does not offer an explanatory model of how Z is influenced by Y. Qualitative research has the potential to identify such explanatory models.

A 'realist inspired' approach as adopted in this thesis, refers to an approach which focuses precisely on such 'inner workings' or 'mechanisms' of phenomena such as tobacco control policymaking (81). The realist methodology aims to explain *how* things work: taking a look into the 'black box' of policymaking (81). Realist approaches take into account the context, which is needed for a cross-country study on policymaking. It aims to explain how the context (the country), the mechanism (how policymaking works), and the outcome (comprehensive tobacco control policy) interrelate (81).

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PART 1

Determinants of tobacco control policymaking

CHAPTER 2

What is known from the literature about the process of policymaking?

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ABSTRACT

Background: Policymakers can adopt and implement various supply-side policies to limit youth access and exposure to tobacco, such as increasing the minimum age of sale, limiting the number or type of tobacco outlets, or banning the display of tobacco products. Many studies have assessed the impact of these policies, while less is known about the preceding policy process. The aim of our review was to assess the available evidence on the preceding process of agenda setting, policy formulation, and policy legitimation.

Methods: A systematic literature search was conducted using the PubMed and the Social Sciences Citation Index databases. After selection, 200 international peer-reviewed articles were identified and analyzed. Through a process of close reading, evidence based on scientific enquiry and anecdotal evidence on agenda setting, policy formulation and policy legitimation was abstracted from each article.

Results: Scientific evidence on the policy process is scarce for these policies, as most of the evidence found was anecdotal. Only one study provided evidence based on a scientific analysis of data on the agenda setting and legitimation phases of policy processes that led to the adoption of display bans in two Australian jurisdictions.

Conclusion: The processes influencing the adoption of youth access and exposure policies have been grossly understudied. A better understanding of the policy process is essential to understand country variations in tobacco control policy.

INTRODUCTION

Youth smoking continues to be a widespread public health problem. Globally, an estimated 7.0% of children aged 13-15 smoke; the Americas (13.0%) and the European region (9.8%) demonstrate the highest prevalence of smoking among children (1). Youth smoking can be prevented in various ways. One of the strategies is to reduce youth access to tobacco products. The policy most often used to achieve this reduction of access is raising the minimum age-of-sale for the purchase of tobacco. Most countries have implemented this policy, in line with the recommendations of Article 16 of the Framework Convention on Tobacco Control (FCTC), which aims to reduce sales to and by minors (2). Reviews examining the effectiveness of age-of-sale policies report mixed and inconclusive findings and urge the consideration of enforcement conditions and personal characteristics (3–7). A reduction in illegal sales to minors does not necessarily mean that youth tobacco consumption is also decreased, because minors can often still access tobacco through social sources (8). This is one of the reasons some authors have concluded that age-of-sale policies are ineffective (9). Others conclude that such policies may be effective, as long as they are well enforced (10).

Youth access to tobacco may also be reduced by limiting the number or type of tobacco outlets. Tobacco retailing throughout the world is completely normalized, and "tobacco can be sold openly, from virtually any business" (11). Policy measures directly limiting the number of tobacco outlets, for example, specialized shops, have rarely been adopted. Thus far, only the Hungarian government has done so, substantially reducing the number of outlets from 42,000 to 7,000, with the explicit aim to decrease smoking prevalence (12). It can be argued from the perspective of economic theory that a higher tobacco retail density leads to increased tobacco consumption due to increased availability and reduced retrieval costs (13). However, because policies that reduce the number of sale outlets are rarely adopted, there is limited data on their effectiveness. Some, but not all, studies on this subject have reported positive associations between tobacco outlet density and smoking behavior (14–16). However, because the studies all used observational research designs, causality cannot be inferred (17).

Next to increasing the age of sale and limiting the absolute number of outlets, policymakers may choose to ban the sale of tobacco from certain types of retail outlets. Sale restrictions may be related to the primary function of the sale outlet, which can be in conflict with tobacco sales, such as in the case of pharmacies (18). Another option is a ban on tobacco vending machines, which may offer easy access of tobacco to minors. To address this issue, Article 16 of the FCTC recommends putting into place a ban on vending machines, or at least some restrictions on accessibility (2). Many countries have addressed this issue; a total of 89 countries worldwide now have a ban on tobacco vending machines (19).

Directly limiting the number of tobacco retailers may be a step too far for policymakers, which is perhaps indicated by the small number of countries that have adopted this policy measure thus far. An alternative option for policymakers may be to consider banning tobacco displays at points of sale, which will not reduce physical access but aims to reduce exposure to pro-smoking messages at points of sale. Studies and reviews have demonstrated positive associations between exposure to tobacco displays and youth smoking behavior and susceptibility (20–24). A growing number of countries have adopted a display ban (22,25,26), and evaluations of the countries that have implemented this ban suggest that it helps to denormalize smoking (27–29).

While there is an emerging body of literature on the effectiveness of the various policies that limit youth access and exposure to tobacco, less is known about the preceding policy process that leads to their adoption by policymakers. In fact, most public health research is carried out without considering the policy process at all (30). Public health advocates and professionals who want to effectively use the political arena need to have at least a basic understanding of how policymaking works (31). The more thoroughly this process is examined, the better these individuals can anticipate constraints and opportunities for policy change (32).

There are several theories that may be used to study the preceding process of policymaking up until policy adoption, such as Kingdon's three streams (33), the punctuated equilibrium theory (34), the advocacy coalition framework (35), theories on multilevel governance (36), theories on policy transfer (37,38) and others. These theories focus on different aspects of the policymaking process, which are relevant to different stages of the policymaking process. Cairney (39) breaks down the policy process into the following six stages: agenda setting, policy formulation, legitimation, implementation, evaluation, and policy maintenance, succession or termination. In the current paper, we are interested in the first three stages, as these are relevant to the adoption of policies. Agenda setting refers to the identification of policy problems (e.g., a high level of youth smoking). Formulation refers to the selection of appropriate solutions for the policy problem (e.g., an age-of-sale policy). Legitimation refers to ensuring that the chosen policy has enough political and public support. While much is known about the impacts of policy, considerably less is known about its antecedents (40). A better insight into the stages up until policy adoption is of vital importance for advocates that wish to foster tobacco control policy.

The aim of this paper is to assess the scientific evidence on the first three stages of the policymaking process of raising the legal age for the purchase of tobacco, limiting the number or type of tobacco outlets, and banning tobacco displays at points of retail. We will assess the quantity and quality of the evidence that can be found in the international scientific literature.

METHODS

We conducted a literature search to find evidence on the agenda setting, policy formulation and policy legitimation stages of the policy cycle for the three policies under study. The search strategy was informed by a quick scan of the literature and by *a priori* inspection of the case of the Netherlands. In this preparatory step, we examined Dutch parliamentary documents about the emergence of tobacco control legislation from 1995 onwards. In addition, we interviewed a member of parliament, a civil servant, and an academic expert, and questions were sent by e-mail to international tobacco control experts. These sources provided us with relevant insights into the policymaking process of the three policies. We translated this knowledge into keywords for our search strategy.

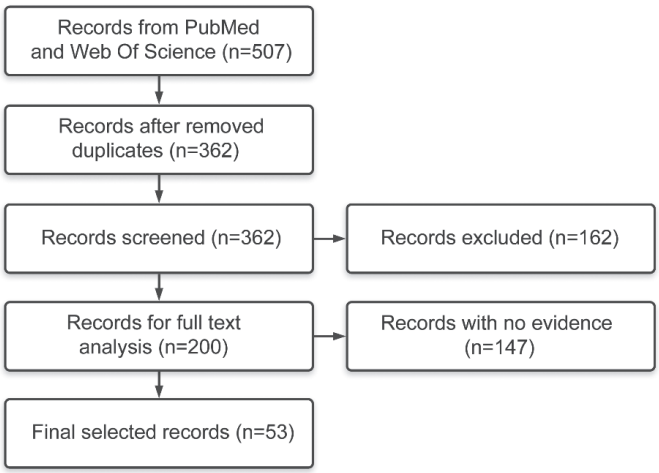
We conducted a literature search using the PubMed and Social Sciences Citation Index (SSCI) databases. Whereas the first database predominantly covers biomedical journals, the SSCI covers a wide range of 176 political science journals. We searched for articles published in peer-reviewed journals up to March 2016. We set no publication date requirement for the articles to be included because countries differed in the timing of policy adoption.

Screening

The search yielded 507 references to international peer-reviewed articles. After removing 145 duplicates, 362 articles remained for title and abstract screening. The selection of studies was performed in two stages by two reviewers: TGK and Paulien Nuyts (a project member). During the first selection stage, the titles and abstracts of the selected studies were screened by both reviewers to select appropriate studies for full text screening. During the second stage, the full texts were assessed to abstract relevant evidence about the first three stages of the policy process. Because of limited time, the full-text screening was completed by TGK after a random sample of 20 articles (10%) had been screened by both reviewers to test and fine tune the eligibility criteria, as well as to ensure consensus.

The title and abstract screening criteria were as follows: an article should 1) be written in English, 2) have a full text available and 3) concern one of the three policies of interest (i.e., raising the age of sale, limiting the number or type of sale outlets and banning tobacco displays) or broader topics such as youth access/availability. A total of 138 articles were not related to any of the three selected policies, 15 articles had no full text available, and 9 articles were not written in English. We checked whether the non-English articles mainly focused on the first three stages of the policymaking process by reading the English abstracts, and concluded this was not the case. The remaining 200 articles were analyzed to determine whether they presented evidence on any of the first three stages of the policymaking process (see data extraction below).

Figure 1: PRISM flowchart diagram of included articles



Data extraction

Because this review is realist inspired, we followed the Realist And Meta-narrative Evidence Synthesis: Evolving Standards (RAMESES) guidelines for data extraction and appraisal (41). Both reviewers appraised the contribution of evidence in terms of both rigor and relevance. In terms of rigor (i.e., judging the credibility and trustworthiness of evidence), a dichotomy was made between "anecdotal evidence," such as author accounts in the introduction and discussion sections (which could be considered "thin" evidence), and evidence resulting from scientific analyses employing a scientific method (which could be considered "thick" evidence). Evidence was considered relevant if it explicitly described a causal link between a certain determinant and the adoption one of the three selected policies (e.g., the enactment of a ban on vending machines in response to the federal Synar Amendment of the United States).

Subsequently, the 200 articles were assessed by the first author alone. Evidence was deemed relevant if it met the following eligibility criteria referring to the first three stages of the policy process: 1) agenda setting: the paper provides information on the process of acknowledging an issue as a policy problem 2) policy formulation: the paper provides information on the process of formulating a policy in response to a problem, and 3) policy legitimation: the paper provides information on the process of legitimating the choice for a specific type of policy. We further extracted the title of the article, the full names of the authors, the year of publication, the main focus of the article *("Agenda setting/policy formulation/legitimation", "Enforcement/compliance", "Effectiveness of policy", "Industry misconduct"* or *"Other")* and the policy measure the evidence was related to (*"Raising the age of Sale", "Limiting number or type of tobacco outlets"* or *"Banning tobacco displays"*).

RESULTS

We found 74 pieces of evidence in 53 articles that were related to one or more of the three policy stages of interest. Fifty-two pieces of evidence were related to raising the age of sale, 15 were related to limiting the number or type of tobacco outlets, and 7 were related to banning tobacco displays. One article offered a systematic analysis of data, whereas the other 52 articles gave anecdotal author accounts. A summary of the findings for each policy can be found in Table 1.

Raising the age of sale

All evidence about the age-of-sale policies was anecdotal and found in articles that focused on a different topic than agenda setting, policy formulation and/or legitimation (Table 1). Thirty pieces of evidence were found in articles that had enforcement/compliance (*n* = 13) or effectiveness of the policy (*n* = 17) as the main focus. Much of this evidence was from papers on the implementation of the federal Synar Amendment of the United States, in which the authors commented on the adoption of age-of-sale policies by individual states in response to this amendment. Seventeen pieces of evidence about age-of-sale policies were found in articles with a main focus on industry misconduct, in which the authors commented on how the industry promoted voluntary agreements as alternative policy solutions. The authors referred to these agreements as ineffective by design and noted that they were intended to ward off more comprehensive and effective legislation.

Limiting the number or type of tobacco outlets

Fifteen pieces of evidence were found that concerned limiting the number or type of tobacco outlets. Again, no evidence was found in articles that had agenda setting, policy formulation and/or legitimation as the main focus. Most pieces of evidence focused on the enforcement of and compliance with the policy (*n* = 4) or the effectiveness of the policy (*n* = 5). The pieces of evidence were all anecdotal, meaning that they were not found in the results section of the article and were not based on a systematic analysis of data.

Banning tobacco displays

We found seven pieces of evidence related to banning tobacco displays. Five of these came from one paper (42). This was the only article in our database that focused on the first stages of the policy cycle and that offered a systematic analysis of data concerning the policymaking process. These authors examined the adoption of display bans in two Australian jurisdictions. The empirical analysis showed how the ban was legitimized by framing it in terms of youth prevention and combining the ban with other policy measures, thus generating strong public support for these measures. Furthermore, presenting the ban as a natural extension of existing advertising bans increased its attractiveness to policymakers. Evidence was also presented regarding the

agenda setting phase, which described how a widely accepted and highly compelling evidence base about tobacco control interventions in general created a favorable political environment. This environment enabled the passage of a tobacco display ban without an explicit prior analysis of scientific evidence in support of the ban (42). The remaining two pieces of evidence were anecdotal and described the FCTC, endgame strategies and their agenda setting functions.

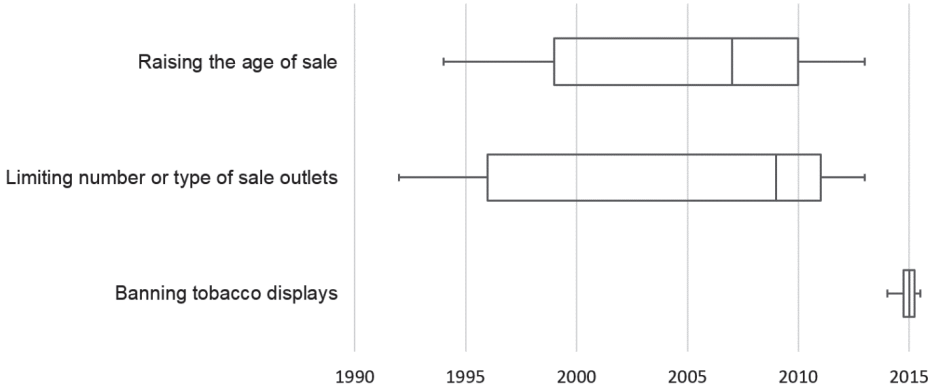
Table 1: Pieces of evidence by policy and main focus of article

	Raising age of sale	Limiting number or type of tobacco outlets	Banning tobacco displays	Total
Main research focus of article				
Agenda setting /formulation/ legitimation	0	0	5(42)	5
Enforcement/compliance	13(43–55)	4(51,84,85)	0	17
Effectiveness of policy	17(9,56–70)	5(64,86–88)	1(22)	23
Industry misconduct	17(71–79)	2(76,89)	0	19
Other	5(80–83)	4(81,90,91)	1(92)	10
Total pieces of evidence	52	15	7	74

Distribution across time

Figure 2 presents boxplots of the distribution across time of the publication of the identified pieces of evidence regarding the three policy measures. The evidence on the policy process of the two youth access policies was published prior to evidence on the policy process of the display bans.

Figure 2: Dispersion of published evidence across time



DISCUSSION

Our study showed that scientific, systematic evidence on the first stages of the policy process is scarce for the three policies under study. Most evidence was anecdotal, i.e., restricted to incidental observations presented as accounts of the authors. We were able to identify only one study that presented systematic scientific evidence on the policy process (42). This study provided evidence on the agenda setting and legitimation phases of policy processes that ultimately resulted in the adoption of display bans in two Australian jurisdictions (42).

These findings support the general claim of Clavier et al. (30) that the policymaking process is understudied in the health promotion field, at least as far as youth prevention policies in the field of tobacco control are concerned. Scholars often study what happens after a policy has been adopted (e.g., the implementation, evaluation and policy maintenance stages). The predominance of this late-stage focus is illustrated by our finding that most pieces of anecdotal evidence that we found regarding the early phases of the policy process were identified in papers that mainly focused on later stages of the process (e.g., evaluation and policy maintenance).

Why are the initial phases of the policy process understudied in research on policies to limit youth access and exposure to tobacco? The answer might be that public health scientists consider policymaking to be an abstract construct that is best left to the domain of politics (93). De Leeuw et al. (93) remark that only a few health promotion scholars are trained in the political sciences. The interest of researchers trained in health promotion or public health may not lie in the 'obscure' and hard-to-grasp process of policymaking. Moreover, researchers who are trained in the behavioral or psychological sciences may be more inclined to study the behavior of individuals in response to a certain tobacco control policy. Tobacco control policies may then be merely considered distal determinants of health (93).

In describing the relationship between science and policymaking, Larsen (94) argues that the tobacco control research literature can be classified into two broad categories: a science-driven body and a policy-driven one. Research in the science-driven category often concludes that policymakers should base their policies on scientific findings, which are considered to be immediate and sufficient causes for the formulation of policies. Smith (95) makes a similar claim in the wider domain of public health policy by describing a "knowledge-driven model" in which research findings are assumed to provide the necessary pressure for policy to develop. Politics are then merely seen as a "barrier", which science must overcome. The second body of tobacco control research, Larsen (94) claims, is smaller in size and regards scientific findings as one among many factors that influence policymakers' decisions. This category typically focuses on the dynamics and institutional surroundings of public policy.

It seems that most literature that we found could be grouped into the first category (i.e., the science- or knowledge-driven body of literature), which is often reflected by normative comments in the discussion sections in which authors conclude that policymakers should consider scientific evidence about effectiveness to base policymaking decisions on. However, without rigorous scientific assessment of the first stages, it remains uncertain how the outcomes of studies on effectiveness, enforcement or compliance could be relevant to policymaking in these initial phases. Whereas advocates stress the importance of evidence in their work and define it as being central to their advocacy, politicians and political advisors may be more inclined to listen to economic and ideological arguments in governmental debates (96).

A possible limitation of this study was that, due to time and resource constraints, the full-text screening of the 200 articles was performed by one individual. Full-text screening by two individuals may have resulted in slightly more or fewer abstracted anecdotal pieces of evidence. However, the main conclusion of our study remains valid: there is only one article that focuses on the first three stages of the policy process.

If we want to understand the substantial variation in tobacco control policy adoption across different countries (97), we need to gain more insight into the first phases of the policy process. Many ideas circulate about what causes this variation in policy adoption; however, there is barely any scientific evidence on why policy processes have led to such different outcomes in different countries. Moreover, a better understanding of such processes may be of crucial importance for tobacco control advocates to work more effectively.

CONCLUSION

The processes influencing the adoption of youth access and exposure policies have been grossly understudied. We identified only one study that systematically examined the first stages of the policy process of tobacco display bans in two Australian jurisdictions. Aside from the evidence resulting from this study, which was based on a scientific analysis of data, all other evidence we found was merely anecdotal and restricted to author accounts. We therefore call on researchers to devote more attention to the initial phases of the policy process of youth prevention policies in tobacco control. Specifically, this means systematic empirical research that employs existing theories on the process of policymaking (33–38) and that utilizes, when possible, a comparative approach. A better understanding of these three first phases as they are relevant to policy adoption is essential to understand country variations in tobacco control policy and to help tobacco control advocates use the political arena more effectively.

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CHAPTER 3

Public support for tobacco control, the role of a child-frame

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ABSTRACT

Introduction: In many countries, health advocates aim to increase public support for tobacco control policies by framing these policies in terms of child protection. We examined whether support for the protection of children is indeed associated with support for tobacco control policies, even among smokers, opponents of state intervention and opponents of a governmental role in tobacco control.

Methods: We used a survey on a representative sample of Dutch adults of 18 years and older (n=1,631). The survey measured respondents' support for banning tobacco displays, raising the age of sale for tobacco to 21 years and limiting tobacco sales to specialized shops. Regression analyses were done to assess the association with respondents' support for the protection of children against tobacco. In further analyses, subgroup interactions were added.

Results: Respondents' support for the protection of children against tobacco with legislation was positively related to support for all three policies. Associations were weaker for smokers (except for raising the age) but similar for opponents of state intervention and opponents of a governmental role in tobacco control.

Conclusion: This is the first paper to empirically support the idea that emphasizing the need to protect children against tobacco enhances support for tobacco control policies. This 'child effect' is effective in all segments of the population, albeit somewhat weaker among smokers.

INTRODUCTION

Most social scientists acknowledge the association between public opinion and public policy (1). This so called 'policy responsiveness' has been established in the domain of tobacco control in a variety of European countries and US states, where smoke-free legislation was found to follow public preferences (2–4). Public policies are a major determinant of public health (5) and are therefore crucial in addressing smoking induced diseases and morbidity. According to the WHO's Framework Convention for Tobacco Control (FCTC) public policies that are unpopular may 'need to be altered or reframed with better advocacy and communication strategies' (6). How a policy is described or *'framed'* can 'determine the extent to which it has popular or political support' and the language used shapes the way people come to think about it (7). Framing can be understood as narratives that are both diagnostic and prescriptive: per policy these narratives tell what needs to be changed or improved, and how this may be addressed (8).

A frame used by many tobacco control organizations, is the protection of children against tobacco (9,10). There are some indications from the literature that a child-frame is related to support for prospective tobacco control policies. Scholars have observed that tobacco control policy support is higher for policies that explicitly target children (11), that policymakers purposefully use a child-frame in opinion polls to yield high public support for a tobacco display ban (12,13) and that reducing youth opportunities to smoke and establishing positive role models for children are reasons to support smoke-free parks (14). However, scholars have not yet empirically tested this 'child-effect' and how it relates to tobacco control policy support among the general public. In order to better understand how these two concepts are related, we examine how people's support for the protection of children is related to their support for three prospective tobacco control retail policies: banning tobacco displays at point of sale, raising the age of sale to 21 and limiting sales to specialized shops. These supply-side policies are regarded as logical next steps in tobacco control efforts and are thus far only adopted by a few progressive countries and US states and cities (15–17). Moreover, these policies can readily be framed with the aim to prevent youth access and exposure to tobacco products.

The degree of policy support differs for different segments of the population. Smoking status is found to be related to tobacco control policy support, as smokers generally demonstrate less support for tobacco control policies than non-smokers (18–22). Even though support for tobacco control policies has been found to be much lower among smokers, smokers may support policies more if they think children should be protected against tobacco.

Next to smoking status, having certain ideological views may be of influence on support for tobacco control policies. It has been demonstrated that such views are of influence on the level

of support for tobacco control policies, but it was also noted that using a simplified left-right wing preference scale may not reflect more nuanced ideological beliefs (23). In this paper we use ideological dimensions that go beyond the left-right wing divide and measure beliefs about state intervention and beliefs about the proper role of government in relation to tobacco control. We expect less support from individuals that oppose state intervention since opponents of tobacco control policies typically argue that the government should not interfere with the private lives of citizens and that citizens are themselves responsible for their choices and actions (24). However, possibly, opponents of state intervention might as well support tobacco control policies when they think children should be protected against tobacco.

Some scholars argue that a distinction can be made between symbolic and operational political ideology (25). Whereas the former aspect of ideology is largely understood in terms of self-identification in which respondents identify themselves as being liberal or right-wing, the latter aspect of ideology is more specific and issue-based (25). There have been cases where individuals were identified as being conservative, yet were in favor of specific 'big government' policies, which was incongruent (26). Since tobacco has unique product features, such as its addictiveness and severe health consequences (27), it may well be the case that individuals who oppose general state intervention, may still support governmental intervention with regard to tobacco control. Therefore, we also assess specific, issue-based ideological beliefs: opposition to a governmental role in tobacco control. Furthermore, we assess whether individuals having such beliefs will be more supportive of tobacco control policies when they think children should be protected.

The aim of this study is two-fold: first, we test whether support for the protection of children is positively associated with support for three prospective tobacco control policies. Second, we assess whether this association works as well within groups that are expected to have less policy support: smokers, opponents of state intervention in general and opponents of a governmental role in tobacco control.

METHODS

Data

The data were derived from a Dutch public opinion poll, commissioned by the Dutch Cancer Society and collected by Kantar Public. The sample was drawn from an online panel which consists of more than 120,000 respondents who participate in survey research on a regular basis. Panel members are actively recruited by Kantar Public in case a certain group is underrepresented. A total number of 2,535 stratified invitations were sent and 1,631 respondents participated, which resulted in a response rate of 64%. After the final sample was obtained, a small correction was applied by means of regression weights based on population characteristics (gender, age,

education, family size, social class, wealth, region, and smoking status) derived from a national calibration instrument developed in collaboration with Statistics Netherlands. This instrument is used by market agencies and research departments in order to obtain representative regional and national samples (28). Respondents filled in the online questionnaire between March 28 and April 6 2014 in exchange for saving points worth €2,55 which could later be exchanged for gift certificates. Only fully completed questionnaires were used to compile the database so there were no missing values.

Measures

The dependent variables were support for three prospective tobacco control policies. Support for banning tobacco displays at point of sale was measured with the item *"In order to minimize the advertising of tobacco products, these items should not be displayed visually in the store"*, support for raising the age of sale to 21 was measured by asking *"To what extent would you agree if tobacco products in the Netherlands can only be sold to people aged 21 and over?"* and support for limiting sales to specialized shops with *"Tobacco items should only be sold at tobacco retail stores".* 5-point Likert scales were used ranging from 1 *"Completely disagree"* to 5 *"Completely agree"*.

As predictor for policy support, we used a variable measuring support for the protection of children against tobacco: *"Suppose legislation is possible to ensure that (your) children never start smoking. To what extent would you agree?"* This item was measured with a 5 point Likert scale ranging from 1 *"Completely disagree"* to 5 *"Completely agree"*. Because this variable is ordinal, the answer categories were converted into five dichotomous variables with a 0/1 coding (dummy variables) and added to the model with the first answer category as reference.

Smoking status was operationalized using a dichotomous variable: *"Do you (ever) smoke, or do you not smoke at all?"* (Non-smoker=0, Smoker=1).

Opposition to state intervention in general was operationalized with an item adopted from the European Values Study (29) and added to the 2014 public opinion poll. This item ranged from the proposition *"Individuals should take more responsibility for providing for themselves"* to the proposition *"The state should take more responsibility to ensure that everyone is provided for"* on a 10-point scale. It was reversed so that a higher score indicates more opposition to state intervention.

Opposition to a governmental role in tobacco control was operationalized as a mean score out of three items (α=.74): *"The government should not take any action at all in the field of smoking "; "The government must inform the public about the effects of smoking (reversed)" "The*

government must take measures to reduce smoking (reversed)". These items were all measured on a 5-point Likert scale ranging from 1 *"Completely disagree"* to 5 *"Completely agree"*. A mean score was computed and a higher score indicates more opposition to a governmental role in tobacco control.

The correlation of opposition to state intervention in general and opposition to a governmental role in tobacco control was reasonably low (*r=.04)*, suggesting discriminant validity of the concepts.

The *"I don't know"* answer categories (6) were recoded as *"Not agree, not disagree" (3).* This was done because we wanted to keep the sample representative of the Dutch population. The item with highest percentage of *"I don't know"* was support for the protection of children against tobacco (5.2%).

Demographic covariates included were gender (Male=0, Female=1), socio-economic status (based on education and income on a five point scale with higher scores indicating a higher socio-economic status), having children under 16 years of age (No children under the age of 16 in the household=0, any number of children under the age of 16 in the household=1) and age (18-87). Attitudinal covariates were also included, such as knowledge of the addictiveness of smoking; *"Smoking is a real addiction"* on a five-point Likert scale ranging from 1 *"Completely disagree"* to 5 *"Completely agree"*. Knowledge of the harms of (passive) smoking was computed as a mean score from a scale with 7 items (α=.90); *"Smoking causes 1) heart disease, 2) lung cancer, 3) mouth- and throat cancer, 4) stroke"* and *"Passive smoking causes 5) asthma in children 6) lung cancer 7) heart diseases"* all on a five point Likert scale ranging from 1 *"Completely disagree"* to 5 *"Completely agree".*

Statistical analyses

Linear regression models were built using SPSS statistics version 23. In the first model, which can be seen in Table 2, all variables were regressed on support for one of the three policies. In a second step, interaction effects (child protection × smoking status, child protection × opposition to state intervention, child-protection × opposition to a governmental role in tobacco control) were determined by comparing models with and without the interaction of interest using F change model fit statistics. In a third step, significant interactions (Figure 3a-3e) were added one by one and examined further.

RESULTS

Descriptive statistics

Table 1 gives an overview of descriptive statistics. Figure 1 shows policy support for the three prospective policies on a five-point Likert scale as a function of support for the protection of children. Figure 2 shows a chart of the support per policy measure of all investigated subgroups (the percentage of respondents per group that indicated *'Agree'* and *'Completely agree'* to the policy support questions). Groups in this figure were based on smoking status (0=non-smoker, 1=smoker) and a median split of opposition to state intervention (0=low, 1=high) and opposition to a governmental role in tobacco control (0=low, 1=high).

Table 1: Descriptive statistics (with regression weights, n=1,631)

	Range	% / Mean	N	SD
Children should be protected against tobacco with legislation (Completely disagree)	0-1	6%	98	-
Children should be protected against tobacco with legislation (Disagree)	0-1	13%	219	-
Children should be protected against tobacco with legislation (Not agree, not disagree)	0-1	25%	412	-
Children should be protected against tobacco with legislation (Agree)	0-1	26%	418	-
Children should be protected against tobacco with legislation (Completely Agree)	0-1	30%	483	-
Female	0-1	52%	832	-
Having any number of children under age 16 in household	0-1	25%	401	-
Smoker	0-1	26%	416	-
Socio-economic status	1-5	3.11	-	1.27
Addiction knowledge	0-5	4.31	-	0.94
Health effects knowledge	0-5	3.86	-	0.81
Age	18-87	44.11	-	18.44
Opposition to state intervention	1-10	6.70	-	2.56
Opposition to a governmental role in tobacco control	1-5	2.37	-	0.98
Support for banning tobacco displays	1-5	3.20	-	1.30
Support for raising the age of sale to 21	1-5	3.36	-	1.47
Support for limiting sales to specialized shops	1-5	3.11	-	1.54

Figure 1: Policy support per policy measure on a 5 point Likert scale as a function of the item: 'Suppose legislation is possible to ensure that (your) children never start smoking. To what extent would you agree?'

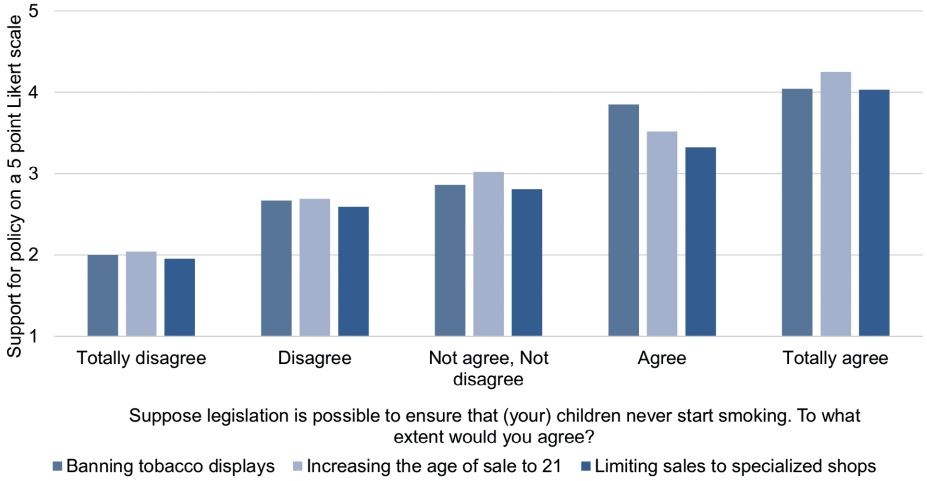
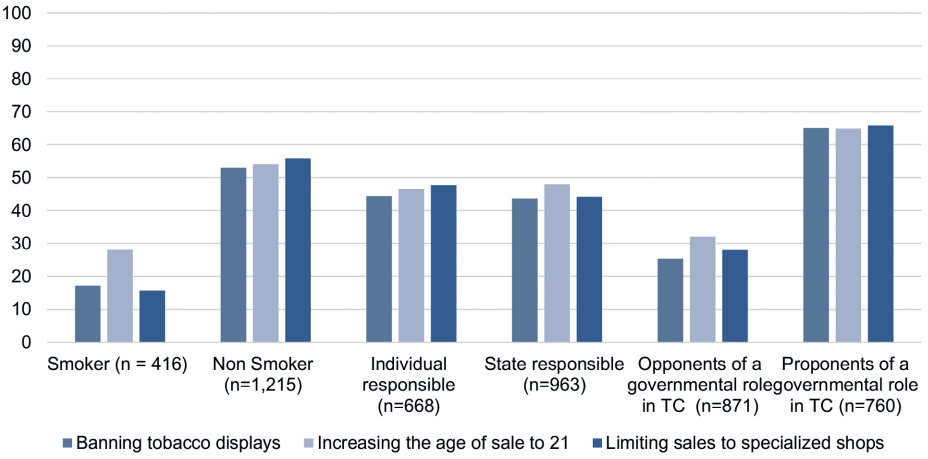


Figure 2: Percentage policy support per policy measure (the sum of 'Agree' and 'Totally agree'), according to smoking status, state interventionism (median-split) and ideas about the proper role of government in tobacco control (median-split)



Main effects

The model with main effects per policy measure can be found in Table 2. Results are reported with the first dichotomized answer category of the independent variable as a reference. Support for the protection of children against tobacco with legislation is positively associated with policy support for all policies. Each answer category of support for the protection of children against tobacco was tested as a reference category and compared to the subsequent category. In general, support for policies increased as a function of support for the protection of children against tobacco.

Table 2: Multiple linear regression analyses per prospective policy (interactions discussed in text)

	Banning tobacco displays		Raising the age of sale to 21		Limiting sales to specialized shops	
	B	**SE**	**B**	**SE**	**B**	**SE**
Main effects						
Children should be protected against tobacco with legislation (Completely disagree)[1]						
Children should be protected against tobacco with legislation (Disagree)	0.08*	0.11	0.12**	0.13	0.08*	0.13
Children should be protected against tobacco with legislation (Not agree, not disagree)	0.18***	0.10	0.24***	0.12	0.17***	0.12
Children should be protected against tobacco with legislation (Agree)	0.24***	0.11	0.29***	0.13	0.22***	0.13
Children should be protected against tobacco with legislation (Completely agree)	0.42***	0.11	0.49***	0.14	0.39***	0.13
Covariates						
Female	0.11***	0.05	0.04*	0.05	0.02	0.05
Age	0.02	0.00	-0.02	0.00	0.15***	0.00
Having any number of children under age 16 in household	0.02	0.05	0.05*	0.06	0.02	0.06
SES	-0.07**	0.02	-0.07**	0.03	-0.03	0.03
Addiction knowledge	0.04*	0.03	-0.02	0.04	-0.05*	0.04
Health effects knowledge	0.10***	0.04	0.08**	0.05	0.09***	0.05
Smoking, state intervention, preferred governmental role in TC						
Smoker	-0.17***	0.06	-0.12***	0.07	-0.23***	0.07
Opposition to state intervention in general	-0.03	0.01	-0.03	0.01	-0.00	0.01
Opposition to a governmental role in tobacco control	-0.27***	0.03	-0.26***	0.04	-0.26***	0.04
R^2	0.41		0.34		0.41	
Adjusted R^2	0.40		0.33		0.41	

[1] reference category, * = $p \leq 0.05$, ** = $p \leq 0.01$, *** = $p \leq 0.001$

Interaction effects

Smoking status

Adding interactions terms of smoking status improved model fit for all three policies (banning tobacco displays: *F change*=11.90, *p*=.000, raising the age of sale to 21: *F change*=7.24, *p*=.000, limiting sales to specialized shops: *F change*=10.40, *p*=.000). These interactions can be seen in figure 3a, 3b and 3c. Interactions with smoking status and support for the protection of children against tobacco is similar for support for banning tobacco displays and support for limiting sales to specialized shops: there is no interaction of smoking status between answer categories 1 (Completely disagree), 2 (Disagree), 3 (Not agree, not disagree) and 4 (Agree). The only interaction observed is between points 4 (Agree) and 5 (Completely agree) for both policies. When four is the reference category and compared to the fifth category: banning tobacco displays: *β*=-0.17, *p*=.000, limiting sales to specialized shops: *β*=-0.14, *p*=.000 (Figure 3a and 3c). Interaction of smoking status was observed concerning support for raising the age of sale to 21 (Figure 3b), but these interactions concerned the first three categories (between the first and second (*β*=-0.23, *p*=.000) and second and third answer category (*β*=-0.91, *p*=.000)).

Opposition to state intervention in general

Opposition to state intervention in general was interacting with support for the protection of children in relation to support for banning tobacco displays (*F change*=4.93, *p*=.001). This interaction is plotted and can be seen in Figure 3d. The overall interaction effect is weak and with regard to the first answer category, reversed: more policy support is observed for respondents that think that individuals should take more responsibility in providing for themselves, and less policy support is observed for respondents that think the state should take more responsibility to ensure that everyone is provided for. With the exception of this interaction, support for banning tobacco displays across subgroups increases as support for the protection of children increases .When it comes to raising the age of sale to 21 (*F change*=0.58, *p*=.680) and limiting sales to specialized shops (*F change*=0.79, *p*=.529), no interaction effects were observed (figures not shown).

Opposition to a governmental role in tobacco control

Opposition to a governmental role in tobacco control was interacting with support for the protection of children in relation to support for limiting sales to specialized shops (*F change*=4.95, *p*=.001). This interaction is plotted and can be seen in Figure 3e. The overall interaction effect is weak and in the expected direction (the more support for the protection of children against tobacco, the more policy support in all groups). When it comes to banning tobacco displays (*F change*=0.83, *p*=.507) and raising the age of sale to 21 (*F change*=0.64, *p*=.633), no interaction effects were observed (figures not shown).

Figure 3a: The association between support for the protection of children against tobacco with legislation and support for banning tobacco displays: interaction with smoking status.

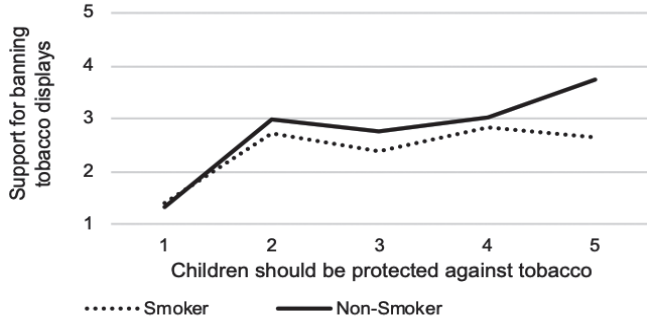


Figure 3b: The association between support for the protection of children against tobacco with legislation and support for raising the age of sale to 21: interaction with smoking status.

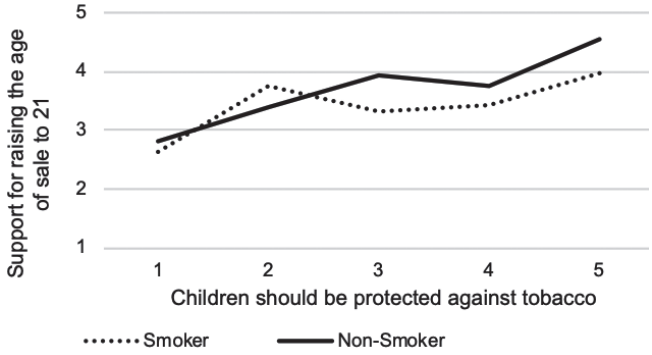


Figure 3c: The association between support for the protection of children against tobacco with legislation and support for limiting sales to specialized shops: interaction with smoking status.

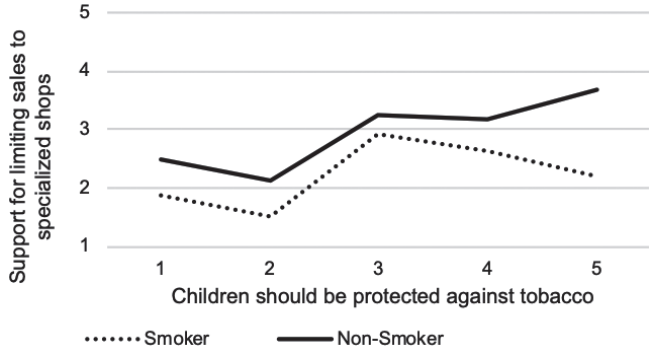


Figure 3d: The association between support for the protection of children against tobacco with legislation and support for banning tobacco displays: interaction with opposition to state intervention.

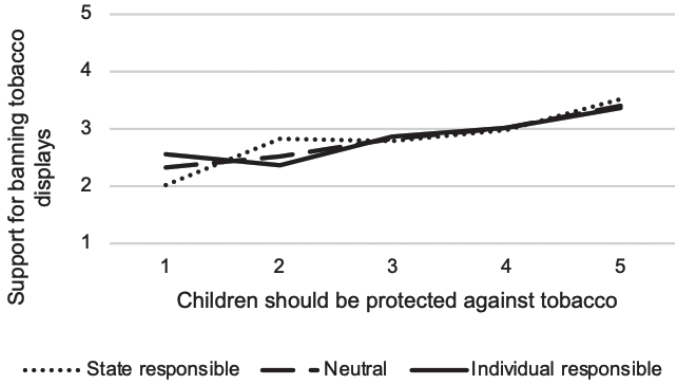
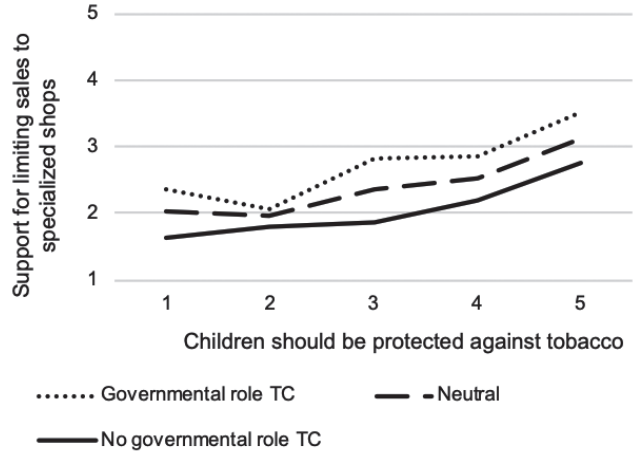


Figure 3e: The association between support for the protection of children against tobacco with legislation and support for limiting sales to specialized shops: interaction with opposition to a governmental role in tobacco control.



DISCUSSION

Support for the protection of children against tobacco with legislation was positively associated with support for three prospective tobacco control retail policies. These relationships were also observed for opponents of state intervention and opponents of a governmental role in tobacco control although the last group had less absolute policy support. There were interactions with smoking status indicating that the association between believing in the need to protect children against tobacco and support for tobacco retail policies was stronger among non-smokers than among smokers. This interaction effect was less pronounced for support for raising the age of sale to 21.

We did not find an association between respondents' opposition to state intervention in general and their support for tobacco control policies. This may be because opposition to state intervention was measured in a more classical 'right-to-left' way with reference to the extent in which the government provides for its people. Such a concept may be more readily associated with support for policies to ensure that all citizens are satisfied in their basic needs, such as welfare state policies (e.g. social welfare or labor market policies) rather than tobacco control. We did, however, find a negative association between opposition to a governmental role in tobacco control and support for these tobacco control policies. Thus, in this case, more specific ideological beliefs were more clearly related to policy support. This falls in line with the observation that more general (symbolic) ideological beliefs about the size and scope of government are not always related to specific policy issues, whereas more specific (operational) beliefs may (25). Cohen (24) argues that opposition to tobacco control may have nothing to do with tobacco per se, but tobacco may act as a vehicle for more government intrusion into the life of citizens. Our findings do not seem to support this argument since opposition to state intervention was not related to support for future policies and more specific opposition towards a governmental role in tobacco control was. These concepts were not related, perhaps indicated by the low correlation between the two. This may suggest that tobacco control is seen as a separate policy domain in which governmental intervention is approved.

Among smokers, support for the protection of children against tobacco was less strongly associated with support for banning tobacco displays and support for limiting sales to specialized shops. This finding can be explained by the reasoning that these policies would directly affect the smokers' personal situation. Other scholars found that people engaging in unhealthy behaviors are less likely to support policies which aim to restrict these behaviors (11). Congruent with this, smokers support raising the age of sale to 21 – a policy that would not directly affect the personal situation of adult smokers. Furthermore, it may be expected that if individuals (both smokers and non-smokers) agree that children should be protected against tobacco with legislation, they

will support raising the age of sale to 21, which is an intervention primarily aimed at children and young adults.

The interaction of state intervention and support for the protection of children in relation to support for banning tobacco displays seems at odds with our hypotheses: respondents who thought individuals are responsible for themselves had more policy support when they completely disagreed that children should be protected (Figure 3d). This interaction effect is possibly due to small sample sizes in individual cells: only 98 respondents in our sample (6%) completely disagreed with the statement that children should be protected against tobacco with legislation. In some of the subgroup categories with regard to opposition to state intervention, there were as little as 22 respondents (1,4%). Small sample sizes in these extremes may have caused slightly biased estimates.

One limitation of this study was the measurement of the independent variable which was operationalized as: *"Suppose legislation is possible to ensure that (your) children never start smoking. To what extent would you agree?"* This question already contains the word legislation and is therefore bound to be related to policy support. Future scholars may want to use a better measure. Furthermore, the reported results are passive-observant and cross-sectional. To generate evidence for a causal 'child effect' future scholars may want to use an experimental research design.

A focus on children may be especially appealing to opponents of state intervention and opponents to a governmental role in tobacco control because this approach is aimed at youth prevention, which does not interfere with (adult) civil liberties or free adult choice (9,24). Our results suggest that a focus on the protection of children against tobacco is able to build a broad public support for tobacco control policies, even among opponents of state intervention in general and opponents of a governmental role in tobacco control.

CONCLUSION

People's belief in the need to protect children against tobacco with legislation is positively related to support for prospective tobacco control policies. This means that tobacco control advocates and governments may use a child-frame to increase policy support.

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CHAPTER 4

The power balance of national level interest groups

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'Who calls the shots in tobacco control policy? Policy monopolies of pro and anti- tobacco interest groups across six European countries'. BMC Public Health, pp. 1–13. doi: https://doi.org/10.1186/s12889-019-7158-6

ABSTRACT

Background: One of the factors influencing variation in tobacco control policies across European countries is the relative policy dominance of pro and anti-tobacco control interest groups. Scholars investigating this power balance have predominantly conducted single country case studies. This study aims to explore and describe the relative dominance of pro and anti-tobacco control interest groups across six European countries by using a tobacco display ban as a case study. We examined whether there are patterns and similarities with regards to two components of policy monopolies: framing of tobacco and institutional arrangements.

Methods: 32 semi-structured interviews with 36 key stakeholders were conducted in Belgium, Finland, Germany, Ireland, Italy, and the Netherlands. These interviews were coded using the Framework Method.

Results: In countries where health Non-Governmental Organizations (NGOs) have a relative policy dominance, tobacco consumption was predominantly framed as a health issue, NGO communities were well developed, the industry was largely absent in terms of production and manufacture, the health ministries played central roles in the policymaking process, and FCTC article 5.3 was strictly interpreted. In countries where the tobacco industry has a relative policy dominance, tobacco was framed as a private problem, NGO communities were absent or weak, the industry was well represented, the health ministries played subordinate roles in the policymaking process, and FCTC article 5.3. was only interpreted in terms of transparency.

Conclusion: The ways in which tobacco consumption is framed in a country and the ways in which institutions are arranged correspond to the policy monopoly in place, with strong similarities across countries with the same policy monopoly.

BACKGROUND

Tobacco consumption causes 700,000 deaths per year in the European Union (1). A recent study in 126 countries investigated the effectiveness of five key tobacco control policy measures and concluded that countries fully implementing more measures experienced greater reductions in smoking prevalence (2). Tobacco control policy development in European countries is a functioning example of multilevel governance, as policy is developed at various levels (3). The international level of governance includes efforts by the World Health Organization through the Framework Convention on Tobacco Control (FCTC) and by the European Union through Tobacco Product Directives (TPDs), decisions, regulations, and recommendations. Alongside these international efforts, much of the responsibility for comprehensive tobacco control policy rests with national governments (4).

There are many different ways for national governments to reduce tobacco consumption, including tobacco taxation, smoke free legislation, health warnings, bans on advertising, promotion, and sponsorship and cessation programs (5). A display ban of tobacco products at points of sale is part of Article 13 of FCTC and is seen as an emerging intervention (6). European countries demonstrate considerable variation with regard to the implementation of this measure, as some national governments have implemented it more than a decade ago, while others have only recently began to prepare legislation or have not yet begun to discuss it. It is therefore well suited to be a case for a cross-national comparison of tobacco control policymaking.

In explaining variations in tobacco control policy, several theories may be used: 1) policy learning and diffusion theory, 2) theories focusing on the importance of political cultures (e.g. corporatism), 3) theories looking at aspects of institutionalism (e.g. federalism) and 4) theories which focus on the role of interest groups (7). While all of these theories may offer unique insights into how tobacco control policies are adopted, a growing body of policy research focuses on interest groups and their relative influence on the policy process (8,9). Advocacy by interest groups is an important concept in explaining achievements in tobacco control (10,11). Stronger regulations are readily attributed to the existence and activities of a relatively strong national network of health NGOs (10,12,13) and weaker or averted regulations are attributed to a relatively more dominant tobacco industry and associated businesses (14–16). It is claimed that without efforts from health NGOs, tobacco control policymaking remains in the hands of policy elites who are susceptible to economic arguments from the tobacco industry (11).

Empirical evidence on the relative power balance of pro and anti-tobacco interest groups is often based on single country case studies (3). Such studies are able to offer thick and rich descriptions of what is relevant in those countries, providing ‘illuminating accounts of who did

what to whom and when' (4). However, to better understand differences in tobacco control policy comprehensiveness across political systems, a cross-national approach is preferred (4). As (political) institutions differ between European countries, a comparison of various political systems can highlight the role of such institutions in the policy process (17). Single country case studies typically treat such variables as constants (18).

Policy dominance refers to a relative dominance in the process of policymaking of some interest groups rather than others. Although it is acknowledged that interest groups are clashing on an ongoing basis over time to advance their agendas (19), one interest group usually has more power than the other(s) within a given country. This relative dominance can be examined by drawing from the theory of policy monopolies. This interest group theory is well suited for a cross-national comparison, as it allows for the incorporation of framing and (political) institutions, which are both associated with the relative power of pro and anti-tobacco interest groups. A policy monopoly is defined as 'a monopoly on political understandings concerning the policy of interest and an institutional arrangement that reinforces that understanding' (20). A policy monopoly has two main components: 1) the dominant frame of a policy issue and 2) how institutions are arranged to reinforce a certain monopoly (21).

The first component refers to the political understanding of the issue (i.e. the dominant frame). It is argued that only one side of a complex policy issue tends to dominate the public and political discourse at a time, which has an effect on resultant policy outcomes (20). Often, only a single dimension of a multi-dimensional policy issue gains prominence in the political and public debate (11). In tobacco control, proponents and opponents of stricter legislation frame the issue of tobacco consumption in different ways, focusing on different dimensions of the policy issue (10). A relative policy dominance of the tobacco industry and associated businesses may be reflected by liberal-conservative policy frames which highlight positive dimensions of the policy issue, such as the economic benefits of tobacco consumption, employment associated with the tobacco sector, or free individual choice. A relative dominance by health NGOs, on the other hand, may be reflected by policy frames highlighting the negative aspects of the policy issue, focusing predominantly on the detrimental health effects of smoking.

The second component of policy monopolies refers to institutional arrangements, as policy monopolies are hypothesized to be institutionally reinforced (9,23). Institutions may be defined as 'relatively enduring features of political and social life that structure behavior and that cannot be changed easily or instantaneously' (23). Institutions are typically created and/or reorganized during short periods of increased attention to a policy issue and remain in place after the attention is directed to other issues, sustaining procedures and biases 'designed to achieve one set of goals rather than another' (21). Examples of institutional arrangements relevant

to the power interest groups have in tobacco control are how such groups are organized and a government's interpretation of FCTC's Article 5.3 which states that all signed parties 'act to protect policies from commercial and other vested interests of the tobacco industry in accordance with national law' (24).

By looking at the case of a tobacco display ban, we will investigate how the countries under study differ with regard to the relative policy dominance of pro and anti-tobacco interest groups. We will focus on the two main components of policy monopolies: the dominant frame of tobacco and institutional arrangements that reinforce a certain monopoly. We will describe and compare policy monopolies of pro or anti-tobacco control interest groups across six European countries.

METHODS

Project background

This study was part of a larger study conducted in seven EU countries: Belgium, Finland, Germany, Ireland, Italy, the Netherlands, and Portugal. The SILNE-R project aims to assess how smoking prevention strategies are adopted and implemented within seven countries, at national, municipal, and school levels, and how the process of adoption and implementation varies between countries, cities, and schools.

Stakeholder selection

National representatives of the SILNE-R project provided a list of key stakeholders relevant to national tobacco control policymaking, in some cases with help of national key informants known to the project. Thirty-four semi-structured interviews with key stakeholders were conducted in English, German, and Dutch. Stakeholders were selected because of their involvement in the tobacco control policymaking process in each country. To get different perspectives on tobacco control policymaking, at least five different types of national level key stakeholders were selected: a civil servant, a member of parliament, an academic expert, an employee of a national cancer fund or other health NGO and, if applicable, an employee of a national tobacco control alliance (see Table 2 for the list with stakeholder professions).

A total of 55 stakeholders were contacted for an interview via e-mail, of which 11 did not respond and 10 declined. Non-response was mostly observed from members of parliament. Provided reasons not to participate were either having other obligations or a heavy workload. Thirty-four interviews with 38 stakeholders (i.e. four interviews with two stakeholders per interview) were conducted between January 2017 and August 2017. Twenty-nine interviews were done face-to-face and 5 were done by phone. The interviews lasted 64 minutes on average and were transcribed verbatim. Each type of stakeholder was successfully interviewed in every country,

except for a Dutch civil servant (because of the salience of the policy issue at that time) and an Italian member of parliament (four members of parliament did not respond to the first invitation, nor the reminder).

Portugal was excluded from the study due to continued non-response of stakeholders. We were only able to conduct two phone interviews in Portugal and although these were rich in information, we decided more data was needed to make valid claims about the Portuguese policy process surrounding a tobacco display ban.

Confidentiality

To ensure confidentiality, we anonymized stakeholder professions as much as possible, on condition that these should not lead to the identification of individuals. Quotes were taken over literally from the transcripts, although we did not select quotes that could lead to identification of specific stakeholders.

Interview topics

The interviews started with an open question about the current status of a tobacco display ban in the country. Following this question, the first author used a topic list (see Appendix 1) to bring up various themes: organization of pro and anti-tobacco control interest groups (types of organizations, resources, reasoning, framing, beliefs, priorities, strategies, influence); governmental framing of tobacco consumption; government ideology; country specific themes; access to policymaking (informal rules, FCTC 5.3); administrative capacity; public support; tobacco industry presence; policy learning; and interaction with other policies. The interviewer encouraged spontaneously emerging themes.

Analysis

The framework method was employed because this methodology allows researchers to analyze the data both by groups of cases (e.g.: individual countries) and by themes (25). A codebook was developed by coding the Finnish interviews and by subsequently coding the German interviews. The large contrast between these two countries in terms of tobacco control policymaking facilitated the development of a comprehensive codebook. Themes were developed both inductively and deductively, as the main codes (framing and institutions) were theoretically informed and sub-codes were predominantly informed by the interviews.

Informed by the two components of policy monopolies, three main themes were formulated: 1) the dominant frame of tobacco consumption, 2) civil and business institutions (i.e.: businesses such as retailers and the tobacco industry in terms of manufacture and production, since these institutions also affect the ability of the pro-tobacco interest groups to obtain a relative policy

dominance), and 3) government institutions. The codebook was further refined and improved by means of multiple discussions with the second and third author. TGK reread the transcripts various times to ensure no themes were missed after modifications to the codebook in later stages. MCW read several transcripts to check for coding rigor, allowing for further refinement of the coding criteria. TGK then systematically coded the complete set of transcripts using MAXQDA version 12 (26). TGK developed a framework matrix per code, in line with the Framework Method. These matrices contained all coded text segments and were grouped per country. A country summary was made per code. The matrices were checked by MCW as well. The final codebook can be seen in Table 1. A full list of stakeholders (anonymized) can be found in Table 2.

Table 1: Overview of codes

Main codes	Code	Sub code
Dominant frame	Public health	- Tobacco as an addictive substance
		- Need to protect children's health
		- Economic burden to society
	Liberal-conservative	- Smoking as individual choice
		- Tobacco is a legal product
		- Nanny state/patronizing government
	No frames/discussion	
Civil and business institutions	Health advocacy institutions	-
	Retailers	-
	Tobacco industry	- Industry advocacy
		- Industry image
		- Economic presence (Manufacture and production)
Government institutions	Public health policy frameworks	-
	Interpretation FCTC article 5.3	-
	Health ministry centrality	-

Table 2: List of stakeholders per country

Country	Stakeholder function(s)	
Belgium	1.	Civil servant
	2.	Member of parliament (opposition)
	3.	Cancer fund employee
	4.	Academic expert
	5.	Academic expert
	6.	Prevention organization employee
Finland	1.	Civil servant
	2.	Member of parliament (opposition)
	3.	Cancer fund employee
	4.	Academic expert
	5.	Tobacco Control Alliance network employee
	6.	Enforcement agency employee
Germany	1.	Civil servant
	2.	Member of parliament (coalition)
	3.	Assistant of member of parliament
	4.	Cancer fund employee
	5.	Academic expert
	6.	Civil society organization employee
	7.	Civil society organization employee
Ireland	1.	Civil servant
	2.	Member of parliament (senate)
	3.	Cancer fund employee
	4.	Academic expert
	5.	Alliance network employee
Italy	1.	Civil servant
	2.	Civil servant assistant
	3.	Cancer fund employee
	4.	Academic expert
	5.	Academic expert
	6.	Civil society organization employee
	7.	Civil society organization assistant
The Netherlands	1.	Member of parliament (opposition)
	2.	Cancer fund employee
	3.	Academic expert
	4.	Tobacco Control Alliance network employee
	5.	Tobacco Control Alliance network employee

Table 3: Overview of findings and smoking prevalence per investigated country

Country	Policy monopoly	Display ban imple-mented	Frame	Health advocacy institutions	Retailers	Tobacco industry economic presence	Public health policy frameworks	Inter-pretation FCTC 5.3	Health ministry role	Smoking prevalence*
Finland	Health	Yes	Health	Developed	Opposition	Largely gone	Endgame strategy	Strict	Central	20%
Ireland	Health	Yes	Health	Developed	Opposition	Largely gone	Endgame strategy	Strict	Central	19%
The Netherlands	Unclear	No	Individual choice/ paternalistic government	Developed	Opposition	Largely gone	No	Strict	-	19%
Belgium	Unclear	No	Individual choice/ paternalistic government	Developed	Opposition	Largely gone	No	Transparency	-	19%
Germany	Tobacco industry and business	No	Private problem/ no discussion	Weak	-	Manufacture and production	No	Transparency	Subordinate	25%
Italy	Tobacco industry and business	No	Private problem/ no discussion	Absent	-	Manufacture and production	No	Transparency	Subordinate	24%

*Based on Eurobarometer (2017) item: *'Do you smoke?'* (1).

RESULTS

Overall, three clusters of countries emerged from the data: a policy monopoly by health groups in Finland and Ireland; a policy monopoly by the tobacco industry and associated businesses in Germany and Italy; and Belgium and the Netherlands had more complicated policy contexts, as they demonstrated elements both indicative of health and industry monopolies. Table 3 provides a summary of all findings and smoking prevalence per country.

Dominant frame

The dominant government frame refers to how policymakers within individual countries frame the issue of tobacco consumption. Our data suggested that in countries with a health policy dominance (Finland and Ireland), tobacco consumption was predominantly framed as a public health issue, and in countries with a policy dominance by industry and business groups (Germany and Italy), tobacco consumption was mostly framed as a private problem to be dealt with in the private sphere (i.e.: as opposed to a public health problem). Since a policy discussion about tobacco consumption is mostly absent in these two countries (see section below), it can be argued that tobacco consumption is not necessarily considered a policy problem, but rather a private problem for citizens to solve themselves.

In Belgium and the Netherlands, stakeholders indicated that members of the ruling liberal-conservative parties frame tobacco consumption as individual choice and do not want the government to be paternalistic. These frames are similar to the frames used in Germany and Italy, yet in the Netherlands and Belgium, stakeholders explicitly linked these frames to members of the ruling liberal-conservative parties. In Germany and Italy, the reluctance to interfere in 'private matters' seemed more wide-spread, crossing both party lines and policy domains.

> *"There was an absolutely unanimous agreement that this is a harmful product. That we are dealing with an industry that has been not just deceitful but has told lies in the past about their knowledge about the damage their product did. And that our government has a duty to protect our children."*
> Ireland, Member of Parliament

> *"It's something that is only very reluctantly done in Germany - to have a policy that really influences personal freedom of decision making. So, Germany has been very reluctant to do something like that. Not only in health but also in other policies."*
> Germany, civil society advocate

"Germany in particular is very similar to Italy, I think. They are very interested in environmental problems, but the behaviors linked to health are something more personal."
Italy, civil society advocate

"The VVD [liberal-conservative ruling party] is an anti-paternalistic party, and tobacco control policies are seen as paternalistic"
The Netherlands, civil society advocate

"The VLD is liberal-conservative and the mentality there is that everyone has to know for themselves what they do when it comes to protecting their health."
Belgium, Member of Parliament

No frames

An emerging theme from our interviews was that there was no policy debate and therefore, no framing. In Italy and Germany, stakeholders said that nothing other than the strictly necessary debates (e.g. the transposition of the European TPD) were held for the last 10 years. If politicians mention tobacco consumption occasionally, they seem to regard it as a minor problem, or at least a private problem to be dealt with in the private sphere.

"Smoking is not very high on the agenda generally - it's not really perceived as a big problem."
Germany, civil society advocate

"The parliament addresses tobacco problems only if there is some law in discussion. For example, the transposition of the directive, or when the taxes change, or when the smoking ban was proposed, or ten years ago the adoption of the Framework Convention on Tobacco Control. But in other periods they don't have an interest in tobacco control."
Italy, civil servant

Civil and business institutions

Health advocacy institutions

In order to push for tobacco control regulations in general and a tobacco display ban in specific, there needs to be dedicated tobacco control advocates in a given country. How well the NGO community is developed logically affects the ability of tobacco control groups to have and maintain policy dominance and be able to advocate for a tobacco display ban. Our data suggested that such groups were well organized and plentiful in Finland and Ireland, with various degrees of cooperation. In contrast, in Germany, such groups were considered weak and in Italy, such groups did not fully crystallize yet.

"In Finland there is a really large NGO community. Huge, powerful NGOs - but you also have to realize that most of the NGOs receive public money."
Finland, civil society advocate

"We don't have such a strong NGO structure as in many other countries. It's mostly health organizations and research institutions that deal with diseases like cancer and others. Therefore, they see tobacco as a big problem and engage in tobacco control. There are only very few NGOs, very small… not very powerful... With a few exceptions that only focus on tobacco control."
Germany, civil society advocate

"There is the need of creating a sort of infrastructure where non-governmental organizations, scientists, cancer patient associations, associations of people with heart attacks, go together in order to push for a new law. This does not exist in Italy at the national level, it is not developed."
Italy, civil society advocate

In Belgium and the Netherlands, stakeholders indicated that there is a well-organized NGO community and that there is cooperation between individual NGOs. Belgian stakeholders often contrasted their situation with the Dutch situation and stated that coordination between individual NGOs exists to a lesser degree than in the Netherlands and this was believed to be one of the reasons there has not been much policy development with regard to tobacco control over the last years.

"We are heading towards a new modus operandi; we're starting to delineate that now. But implicitly I'm saying that we are not strong enough right now."
Belgium, civil society advocate

"The idea behind our alliance is that if you work together, you are much more powerful, and it is better to speak with one voice instead of many different voices who all want something else. Concerning lobby, this works quite well, and if we send a letter, we always do that in name of the three big funds."
The Netherlands, civil society advocate

Retailers
In addition to the tobacco industry, associated businesses such as retailers are institutions that often oppose stricter future tobacco control legislation, and a tobacco display ban in specific.

In all countries, stakeholders indicated that tobacco retailers expressed themselves against display bans. In Italy and Germany, stakeholders mentioned such opposition less, but as simultaneously observed, a political tobacco control debate in these countries was claimed to be largely absent. In all other countries, retailers have voiced strong opposition towards such a ban. One of the factors brought forward by stakeholders which may explain this opposition is sponsorship contracts with the industry, which were mentioned in interviews from Belgium, Ireland, Italy, and the Netherlands. This is a type of income paid by the tobacco industry to retailers to display tobacco products. Small shopkeepers can be especially dependent on such income, as their total revenue is often lower compared to bigger shops or chains. As an example, in the Netherlands, retailers receive on average 10,250 euros per year to display tobacco packs at points of sale (27).

> *"You will not hear the tobacco industry in the media here in Belgium; it is especially the tradespeople who are very active. And why? Because they receive a lot of money from the tobacco industry because of the sponsorship contracts. He who pays the piper calls the tune."*
> Belgium, civil servant

Tobacco industry

Similar to how the organization of health groups affect their ability to have and maintain a health policy dominance in individual countries, the tobacco industry and how well it is represented within a country in terms of production and manufacture logically affects its ability to have and maintain an policy dominance and thus exert influence against the adoption of a tobacco display ban and other regulations.

In countries with a presumed policy monopoly by the tobacco industry and associated business (Germany and Italy), stakeholders indicated that the manufacture and production of tobacco still plays an important role in the domestic economy. Germany is the largest exporter of cigarettes in the EU and second in the world (28). Italy is the largest tobacco grower of all EU countries, producing 25% of total raw European tobacco crops (29). Moreover, the economic presence of the tobacco industry in Italy is expanding rather than diminishing, as the new Phillip Morris headquarters for IQOS has opened in 2016 in a village near Bologna, promising up to 600 jobs and investing 500 million euros in the Italian economy (30). The previous Prime Minister Matteo Renzi and other governmental representatives attended the opening ceremony.

> *"Politicians are very not very keen to face tobacco control. We had Renzi before, a prime minister that was promoting new things with tobacco. Italy is the nation where Philip Morris is testing IQOS. […] He [Renzi] was really proud of this and the tobacco industry did several investments for plants in several locations near Bologna. There was another 500 million euros promised by 2020 for the purchase of Italian tobacco."*
> Italy, academic expert

In virtually all German federal states, there are tobacco industry representations in terms of production and manufacture (31). German stakeholders perceived these local representations to be a deliberate tactic by the tobacco industry, enabling a route of influence from the local constituencies to the federal level, advocating against further tobacco control regulations.

> *"In every state they want to have a little location, not very big, but then they have the right to go to the politicians and say, 'You must do something for the jobs. Otherwise we will lose the jobs!'"*
> Germany, civil society advocate

> *"There are many actors who can approach individual members of parliament in the constituencies. The influence of the industry via the constituencies and individual members of parliament is stronger than via ministries of the federal government itself."*
> Germany, civil servant

Stakeholders from the other countries (Belgium, Finland, Ireland, and the Netherlands), indicated that the economic presence of the tobacco industry in terms of production and manufacture had diminished over time and is currently small or negligible.

In Ireland and Finland, stakeholders stated that the tobacco industry suffers from a bad public image. In both countries, it also seemed part of the NGOs' strategy to demonize the tobacco industry by labelling them untrustworthy, deceitful, or evil.

> *"Tobacco is not so difficult, because we have already been successful in demonizing -and rightly so - I mean, demonizing the tobacco industry. So that is much more straightforward than alcohol lobbying, which is much more difficult."*
> Finland, civil society advocate

> *"I think the NGOs have generated sufficient levels of distrust among the general public around the tobacco industry. There's no great love for them, they don't have presence so they don't provide loads of jobs and factories that you can identify."*
> Ireland, civil servant

Government institutions

Public health policy frameworks

Public health policy frameworks are governmental commitments to specified public health goals incorporated in national legislation and were only observed in countries where health groups had a clear policy dominance. Such frameworks facilitate the adoption of stricter tobacco control legislation, including display bans, to reach such goals.

Stakeholders in Finland and Ireland described the presence of such national public health policy frameworks. Both of these frameworks concerned endgame strategies with a specified goal of a smoking prevalence of less than 5% in a certain year (2030 in Finland, 2025 in Ireland). Furthermore, stakeholders indicated that both countries have an inter-sectoral approach to policymaking, as exemplified by the 'Health in all Policies' initiative in Finland (32), and the 'Healthy Ireland Framework' in Ireland (33).

> *"The Healthy Ireland Framework is an initiative that is a cross-sectoral initiative that was launched by the prime minister of the country. It has to do with actions across all these different sectors, but also working with community- and voluntary organizations."*
> Ireland, academic expert

Interpretation of FCTC's Article 5.3

An example of a formal institutional arrangement is FCTC Article 5.3, which aims to protect public health policymaking from tobacco industry involvement. All six countries in our study have signed and ratified the FCTC and thus signed to commit themselves to the implementation of article 5.3 as well. However, interpretation of this article varies widely across governments. Our data suggested that countries with a policy dominance by health groups (and the Netherlands) tended to interpret this article more strictly than countries with an industry policy dominance (and Belgium), which seemed to interpret it mostly in terms of transparency. Given the fact that the industry wishes to avoid legislation, including display bans, a weak interpretation of article 5.3 logically results in more influence of the tobacco industry and thus less stringent or no tobacco control legislation as an expected result.

In Finland and Ireland, the industry is invited to public consultations or allowed to send in their submissions on policy proposals, but this is considered part of a standard policy process. Stakeholders stated that the industry could voice their opinions, but that there are no further negotiations. A few stakeholders however also stated, that the industry can sometimes come up with useful additions to policy proposals, for example in relation to certain implementation issues. In Ireland, stakeholders indicated that they were met in relation to specific issues, such as commerce and smuggling.

"I think in principle if members of the [health] committee say: 'I want to listen to the representative of Philip Morris', then that person will be invited. In the FCTC, there is this famous article 5.3 which says that tobacco companies and tobacco industry must not be involved in tobacco policymaking, and that is very well followed in most of the Western countries, like in Finland. So, when the ministry and the government propose legislation, they don't negotiate with the tobacco industry anymore. The tobacco industry can send a letter to them if they want, but there's no negotiating anymore."
Finland, Member of Parliament

"Not that they won't listen. They listen, assess, and make a decision, in fairness. The WHO though, made it very clear that we shouldn't be meeting with tobacco companies when we are talking about tobacco policy. It is alright to meet in regard to other matters in relation to commerce and smuggling and all that stuff. That's fine."
Ireland, Member of Parliament

In the Netherlands, although it is not clear whether health groups have a policy monopoly, article 5.3 is strictly interpreted. A stakeholder stated that the ministries of Health and Finance developed an internal document describing rules of conduct to deal with advocates from the tobacco industry, which was perceived to be the result of a court case from a NGO against the Dutch state. According to the stakeholders, this resulted in an interpretation which includes the industry only when it comes to technical implementation issues and that these contacts need to be transparent. This interpretation is quite similar to the interpretation in Finland and Ireland.

"At this moment, the guideline for civil servants is that one should limit oneself to technical implementation issues."
Netherlands, academic expert

In the other countries (Belgium, Italy and Germany), stakeholders stated that FCTC's article 5.3 is predominantly interpreted in terms of transparency, and it was noted that there are no formal rules of conduct for civil servants. In Italy, a stakeholder indicated that ministries other than health seem to take many liberties with regard to their contacts with the tobacco industry, as long as they report all interactions afterwards. In Germany, a stakeholder stated that the Ministry of Food and Agriculture - responsible for tobacco product regulation - reports meetings with the industry on their website, with the subject of the meeting and with whom the meeting was held, but no further information is provided. When these documents are requested by means of a freedom of information act request, they are received with large parts blacked out.

"There is a sort of light interpretation because they intend article 5.3 only on the side of transparency. If the relations are transparent, you can do everything."
Italy, civil servant

"'The Ministry of Food and Agriculture says: 'We show what meetings we have on our internet site'. But all you see is for example the date and it says the ministry and there were for example [representatives from the] "Deutschen Zigarettenverband" [an organization representing five tobacco manufacturers] and they talked about taxes or something like that, and you don't get any more information. They say this fulfils 5.3. This is transparent. 'Look here: we have showed that we have met with them'. And the names of the people of the government are blacked out. If we do get information, then many things are blacked out."
Germany, civil society advocate

Health ministry centrality

When the health ministry plays a central role in policymaking, resultant policy is likely stricter and more health oriented than when other ministries such as trade and finance take the policy lead. Our data suggested that countries where there is a policy dominance by health groups (Finland and Ireland), the health ministry played central roles in the policy process, and in countries where the industry has more influence, the health ministry plays a more subordinate role in the process of policymaking (Germany and Italy).

In Finland and Ireland, the ministries of health took the policy lead and introduced new tobacco control initiatives, even in the absence of active advocacy from the health NGOs. This was said to be the case with the development of the previous tobacco acts in both countries, in which tobacco display bans were included as relatively minor issues in a large comprehensive packages of policy measures.

"He [health ministry civil servant] often was looking for the NGOs support for what he was doing, then the other way around. I think on many of the issues around some of these things he was very far-reaching and looking hard. So, the NGOs were behind him, supportive… He was the author of a lot of the legislation at the time."
Ireland, civil servant

"Well in Finland we had the working group for what should be done for tobacco policy. It was quite a large-scale working group, led by the Ministry of Health. […] They published their report in 2009 and there were many suggestions to improve the Tobacco Act […]. This [a display ban] was one of those suggestions which was ultimately implemented."
Finland, civil servant

In the Netherlands and Belgium, stakeholders said that technically the health ministry has responsibility for tobacco control policy, yet it was further remarked that there was an unwillingness of liberal-conservative ruling parties to regulate any health behaviors. In Belgium, stakeholders remarked that the liberal-conservative Minister of Health seems to explicitly exclude the Ministry of Health from the policy process, as she predominantly consults a small set of personal staff members and party-loyal political advisors.

> *"This minister relies very heavily on her small entourage and involves the ministry only little. She sometimes even makes decisions without the ministry knowing."*
> Belgium, civil society advocate

In counties with an industry policy dominance (Italy and Germany), stakeholders stated that the health ministry plays a less central role in tobacco policymaking. In Germany, this is very apparent, because the legislative jurisdiction with regard to tobacco policy when it comes to product regulation was said to reside in the Federal Ministry of Food and Agriculture. When it comes to prevention issues, the Federal Ministry of Health was said to have jurisdiction. However, when the Ministry of Health wants to make tobacco control policy, one stakeholder noted that they have to prompt other ministries to prepare it. In Italy, it seems that although officially the health ministry has formal jurisdiction with regard to tobacco control policy, in practice they are perceived to fulfil an underdog position. Other ministries, such as the Ministry of Agricultural, Food and Forestry policies, Economic Development, Economy and Finance all were, as an illustration, primarily involved with the transposition of the European TPD. The Ministry of Health was consulted last.

> *"For tobacco and alcohol policy, responsibility in terms of product regulation mainly resides in the Ministry of Food and Agriculture. Responsibility for prevention resides in the Ministry of Health. The health ministry cannot simply say, 'We will propose a bill and let's get it done'. It would be nice, but unfortunately this is not the case."*
> Germany, civil servant

DISCUSSION

In countries with a similar policy dominance (i.e. more relative influence from either pro or anti-tobacco interest groups), the same dominant frames were adopted, and civil and governmental institutions were arranged in comparable ways. In countries where there was a health policy monopoly, stakeholders indicated that tobacco consumption was framed as an incontestable public health problem, there were many well-developed health NGOs, the tobacco industry was largely gone and publicly discredited, the health ministry played a central role in tobacco control

policy development, and FCTC's Article 5.3 was more strictly interpreted. In these countries, tobacco display bans were adopted more than a decade ago, as parts of a larger comprehensive policy packages. A largely reversed image was observed in countries where there was a tobacco industry policy monopoly. In these countries, stakeholders indicated that tobacco consumption was generally framed as a private problem of citizens, the health NGO communities were weak or absent in the tobacco control area, the tobacco industry still played a role in the domestic economy, while health ministries played subordinate roles in the formation of tobacco control policies, and FCTC's article 5.3 was primarily interpreted in terms of transparency. In these countries, tobacco control issues, including a display ban, were not discussed in parliament for the last decade, apart from the necessary debates on transposition of European Tobacco Product Directives.

Our findings seem to illustrate an antagonism between pro and anti- tobacco control interest groups, where a relative policy dominance only seems to be maintained due to a lack of interference by opposing interest groups (19). This was the case in Ireland and Finland, where stakeholders stated there is a well-developed health NGO community and a largely absent (in terms of production and manufacture), and publicly discredited tobacco industry. In these two countries, the health NGOs were perceived to have a prominent role in shaping tobacco control policy.

In strong contrast to Finland and Ireland, stakeholders in Italy and Germany reported a considerable tobacco industry presence and a relatively weak or absent NGO community. This may leave the tobacco control policymaking process more susceptible to the tobacco industry, which may exert their influence through other more powerful ministries, particularly the ministries of Trade, Finance, and Agriculture.

Belgium and the Netherlands may be positioned in between these extremes, having mixed profiles containing elements both indicative of health and industry monopolies. Stakeholders from these countries stated that there is an NGO community in which independent NGOs join forces in advocating for tobacco control policy, but that members of the ruling liberal-conservative political parties are reluctant to impose regulations in the health domain because they are perceived to be paternalistic. This was especially noticeable in Belgium, where the Minister of Health is from a liberal-conservative party and is unwilling to include the Ministry of Health into the drafting of a new tobacco plan.

When considering these three types of countries, it is illustrative to refer to Young (34) who makes a distinction between three types of government - non-profits relationships. These relationships can be either complementary (in which the non-profits and government work

together in partnership), supplementary (in which goods or services are provided in addition to those provided by the government), or adversarial (in which non-profits urge the government to make changes in public policy) (34). The complementary type of relationship is most applicable to Finland and Ireland, as there is close cooperation and partnership between NGOs and the government. The supplementary type is more applicable to Belgium and the Netherlands, where the NGOs may or may not be consulted, depending on the current ideology of the ruling parties. The situation in Italy and Germany seems most compatible with the last category, in which demands for change are voiced but do not seem to find much resonance within the government.

Some findings of this study closely resemble factors identified by Cairney et al. (35) on basis of interviews with more than 300 policy participants across 39 countries. These authors describe 'ideal type' policy environments for tobacco control, where the department of health must take the policy lead; tobacco is framed as a public health problem; and the tobacco companies are excluded from the policy process, while consulting public health groups (35). They also describe the interrelatedness of some of these factors: having a health ministry that plays a central role in the process of policymaking automatically fosters the inclusion of public health groups and the exclusion of tobacco companies. Furthermore, having a central health ministry will likely keep the focus on health aspects of smoking (in contrast to other ministries such as trade and finance). Our findings confirm these factors, and our most progressive countries (i.e. Finland and Ireland) closely resemble their description of 'ideal type' policy environments.

This study is consistent with the assumption that national level tobacco control comprehensiveness is related to the relative power balance of national pro and anti-tobacco interest groups, as illustrated by the case of a tobacco display ban. The two countries that had a policy dominance by health groups, Finland and Ireland, were the only two countries in this study to adopt and implement a tobacco display ban in 2010 and 2002 respectively (36-37). These bans were considered relatively minor issues in a larger comprehensive package of policy measures. In countries in which the tobacco industry was suggested to have more relative policy dominance (Germany and Italy), there had been no tobacco control debate for the last decade or so, apart from the necessary debates on transposition of the TPD, suggesting policy inertia. In Belgium, a tobacco display ban was proposed within a larger policy package by two members of one of four ruling parties in Belgium in 2016 (38), but did not get a majority of votes in the House of Representatives, which is commonly observed in Belgium for proposals that seek alternative majorities (Keppens & Van Waeyenberg: Wisselmeerderheden in België doorgelicht, unpublished). In the Netherlands, the House of Representatives adopted a motion in 2015, calling on the government to reach a voluntary agreement with supermarkets to implement a display ban (39). After several attempts, the State Secretary for Health concluded that such a

voluntary agreement did not seem possible. In 2017, the parliament voted in favor of a legislative amendment to introduce a display ban (40).

A possible limitation of this study was that all findings rely on the perceptions of a limited number of key stakeholders per country. Although the stakeholders were carefully selected because of their central roles in the tobacco control policy process, their views may not be completely representative of tobacco control policymaking processes in their countries. However, the accounts from different stakeholders within a country demonstrated considerable similarities and compatibility, suggesting that they are indeed representative of the 'actual' policymaking processes in these countries.

Furthermore, we acknowledge that the policy processes underlying the variance in tobacco control policy comprehensiveness across different European countries are highly idiosyncratic and subject to numerous influences (e.g. historical, cultural) (4). However, despite these differences, we would like to emphasize that these countries also demonstrate considerable similarities with regard to framing and institutional arrangements, dependent on the policy monopoly in place.

Finally, the proposition that one of the two interest groups has a relative policy dominance may sound simplistic or even deterministic. Their relative power may better be conceived of as a continuum rather than in a strictly binary sense. The observation that one of the two interest groups has more power than the other within a country at a single point in time, does not automatically suggest that the other group is powerless. Pro- and anti-tobacco interest groups are known to clash on an ongoing basis over time to advance their respective agendas (19).

CONCLUSION

This study was the first empirical assessment of the power balance between pro and anti-tobacco control interest groups across six European countries. Findings indicate that both framing and institutional arrangements coincide with the policy monopoly in place and that there are remarkable similarities across countries with the same suggested monopoly. If health advocates want to challenge an industry monopoly to push for more stringent legislation, including tobacco display bans, they may elect to adopt an approach that not only focuses on framing, but also targets the institutional arrangements which reinforce a policy monopoly by the tobacco industry.

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CHAPTER 5

Lesson drawing from other countries

Submitted as: Kuijpers, T. G., Kunst, A. E. and Willemsen, M. C.

'Lesson drawing in tobacco control: do European governments draw lessons, from whom, and why?'.

ABSTRACT

Background: The main objective of lesson drawing from other countries is to use cross-national experience as a source of policy advice. The theory of 'family of nations' posits that countries draw policy lessons predominantly from countries within their families. Lesson drawing in tobacco control has however primarily been studied in the 'English-speaking' family. We examined in five European countries whether the government engages in lesson drawing, which countries are looked at, and why.

Methods: Semi-structured interviews with 29 interviewees were conducted in Belgium, Finland, Germany, Ireland, and the Netherlands. Relevant excerpts were grouped according to country and a bottom-up thematic analysis was performed.

Results: All governments except the German government engage in lesson drawing. All others look at Australia for lessons because of its global leadership in tobacco control. At the same time however, lessons are easily dismissed because Australia is an island and far away. The Irish government looks at other English-speaking countries around the globe. Governments in Belgium, Finland and the Netherlands tend to look at nearby European governments for lessons.

Conclusion: Our findings emphasize the importance of proximity and similarity to other countries for lesson drawing in tobacco control. Tobacco control advocates may use these findings to facilitate successful lesson drawing in their countries.

BACKGROUND

Countries have responded differently to the public health problems caused by tobacco consumption (1–3). Such international differences offer ample opportunity for countries to draw lessons in tobacco control from other countries (4,5). Lesson drawing, or policy learning, is a voluntary type of policy transfer in which lessons are drawn from a country's past and/or from other countries (4–6). The main objective of lesson drawing from other countries is to use cross-national experience as a source of policy advice (7).

The most critical question when countries draw lessons from other countries, is whether a certain policy instrument (or policy) is transferable from the 'exporting' country to the 'importing' country (8). During this 'prospective evaluation', the national context in which a policy instrument is implemented needs to be taken into account. Proponents of a certain policy instrument may argue that it is transferable, pointing to similarities between national contexts, hoping to increase support for the instrument (9). Opponents may argue that an instrument cannot be transferred because national contexts are too different (9). Given such debates, knowing which considerations play a role in accepting a policy lesson from another country can enable tobacco control advocates with knowledge to guide successful lesson drawing in the future (10).

The perceived transferability of policy instruments is likely higher when importer and exporter countries are more similar to each other. The theory of 'family of nations' posits that countries can be clustered on the basis of similarities in their public policy profiles (11,12). Studlar (13) analyzed patterns of tobacco control policy adoption across 14 countries over time, and concluded that three overlapping yet distinctive groups with similar policy profiles could be distinguished: an Anglo-American, a Scandinavian, and a European Union group. He observed policy convergence within these families and suggested lesson drawing as a key explanation. Other scholars who study diffusion of tobacco control policies have also used the concept of lesson drawing as an explanation for observed patterns of policy adoption across jurisdictions (14–16). Other tobacco control scholars typically adopt a more qualitative approach and study cases of policy transfer between two countries or jurisdictions. In these instances, lesson drawing is often used in addition to other theories of policymaking, highlighting the notion that there are multiple influences relevant to the process that eventually leads to policy adoption (17–21).

With two exceptions (13,16), scholars in tobacco control have only focused on lesson drawing between English-speaking countries, which have the most comprehensive tobacco control policies enacted, both in Europe and worldwide (2). Lesson drawing has hardly been studied across more culturally diverse groups of countries. In this paper, we will examine in five different European countries: 1) whether the national government engages in lesson drawing from

other countries, 2) from which countries it is open to learn lessons from, and 3) what their considerations are to draw lessons from these countries.

METHODS

We conducted semi-structured interviews with 36 key tobacco control stakeholders in Belgium, Finland, Germany, Ireland, Italy, and the Netherlands. Different types of stakeholders inside and outside government were selected in each country: a civil servant, a member of parliament, an academic expert, an employee of a national cancer fund or other health NGO and an employee of a national tobacco control alliance, when such an alliance existed. These stakeholders were active participants in tobacco control policy development in their respective countries. For a more elaborate discussion of the methods of data collection, selection of interviewees and a topic list, see Kuijpers et al. (22). Interviews from Italy (7 stakeholders), included in the original study, did not provide enough information on this topic and were excluded from analyses, leaving interviews with 29 stakeholders across five countries.

Interviews were conducted between January 2017 and August 2017. The interview was semi-structured and included a question on policy learning with regard to a tobacco display ban, which was the main focus of the study. Stakeholders frequently referred to other tobacco control policy instruments, however, to illustrate which countries were looked at for lessons in tobacco control and why. The first question was 'Did the government look abroad to other country experiences with a point-of-sale display ban?' Follow up questions were 'What countries?' and 'Why these countries?' All relevant excerpts from the transcripts were grouped according to country and a bottom-up thematic analysis was performed.

RESULTS

Belgium

Interviewees in Belgium indicated that, in relation to plain packaging, their government looked at Australia, France, and the United Kingdom. The main reason to draw lessons from these countries was because policymakers wanted to see how the implementation of that instrument worked out in countries where such measure had already been implemented. Reasons to dismiss lessons were: the country is an island (Australia and the United Kingdom), and smoking prevalence remains relatively high in spite of a restrictive tobacco control regime (France).

> *"Yes, she [minister of health] uses all kinds of excuses: […] 'Yes, maybe it was found to be efficient there, but Australia is an island and we need data from a country that is not*

an island'. So, they are waiting for results from France where the measure has just been implemented and it may take a while."
Belgium, academic expert

"France is a bizarre country. Because it is a country that takes many measures against smoking, but the measures oddly enough have much less effect than in other countries."
Belgium, academic expert

Finland

According to the interviewees, the Finnish government looks at Australia (plain packaging) and the other Nordic countries (display ban and plain packaging). Reasons to look at Australia were that it is a global leader in tobacco control and they have the same end-game goal (i.e.: a smoke-free society). Reasons to look at the other Nordic countries were because the countries are close, there is a shared historical collaboration with established communication channels (through the Nordic council), a shared culture, and similar political systems. A reason to dismiss lessons from Australia, was that it was far away. There were no cited reasons to dismiss lessons from the other Nordic countries.

"Currently our tobacco legislation is very advanced, but for many details some countries have gone further than Finland, so we must look at their good examples. Nowadays there is clear evidence from Australia that it [plain packaging] is a feasible and useful thing."
Finland, Member of Parliament

"We are living in a similar area [as other Nordic countries] and we have a similar culture. We have different nationalities but it's closer than Australia. Of course, concerning plain packaging we take the evidence from Australia. But if it's closer, it's easier to convince."
Finland, civil servant

Germany

All governments engaged in lesson drawing, except the German government. In contrast to the German NGO community, the government was not inclined to look abroad for lessons in tobacco control. The main cited reason is that there is no political majority for governmental intervention in this domain. Reasons to dismiss specific lessons from Ireland, as brought to their attention by the NGO community with regard to smoke-free legislation, were that it is distant, it has a dissimilar country size, and a different language.

"It is always interesting what Australia does, France also does some things with which we are engaged more closely, the United Kingdom is also much more progressive. These are the wonderfully interesting actors. However, the decisive factor is not knowing about what you could possibly do, but the main question is whether there is a political majority [for tobacco control] in a country, and in Germany there isn't."
Germany, civil servant

"Our approach is always to present the evidence, and there is so much evidence from other countries. That is the advantage of always being the last, or one of the last ones, to introduce something: we can always show how well the legislation works in other countries. […] But it just doesn't work. The problem is just that the political will is not there."
Germany, civil society advocate

"Germany is a big country and when you compare Germany with Ireland, it is not a comparison. You must compare it with France. This would be respected, but not with various small countries."
Germany, civil society advocate

Ireland

The Irish government was said to look at Australia (plain packaging), Canada (display ban), and the United Kingdom (plain packaging). Stated reasons to draw lessons from these countries were that they were global leaders in tobacco control (all countries) and that there are historical connections to Australia and Canada. There were no cited reasons to dismiss lessons from these countries.

"Yes, at the moment Australia is leading the way globally in terms of tobacco control. I think Canada is also very strong. But having said that, the United Kingdom and Ireland from a European perspective are at the top of the scale in terms of tobacco control measures. So, we do try and lead the way and try to push forward leading initiatives."
Ireland, civil society advocate

"Why Australia? Because they were the first one to bring in plain packaging."
Ireland, Member of Parliament

The Netherlands

Interviewees stated that the Dutch government looks at Australia (plain packaging and smoke-free) and England (display ban, plain packaging, and smoke-free). Australia was looked at because it is a global leader in tobacco control. However, at the same time, lessons from Australia were

dismissed because it is perceived as being "far away" and an isolated island subject to "different natural laws". Reasons to draw lessons from England were that it has a similar political system, similar tobacco control progressiveness, it is perceived to be a reliable country, and there are good scientific evaluations available. There were no cited reasons not to look at England.

> *"We would rather not [take Australia as an example], because it is far away and an isolated island with different natural laws compared to Europe."*
> The Netherlands, civil society advocate

> *"In general, European countries are preferred over countries somewhere else in the world, because countries outside Europe are less comparable. Western European countries are most preferred."*
> The Netherlands, civil society advocate

> *"[The Netherlands and England] generally have comparable legislative systems ... or at least fairly similar. Enforcement works pretty much the same, it has to be well organized and an exception must be laid down in a law".*
> The Netherlands, civil society advocate

DISCUSSION

All governments except the German government engage in lesson drawing from other countries. The remaining governments all look at Australia for lessons because it is perceived to be global leader in tobacco control. Australia had implemented policy instruments that were currently being discussed in several European countries, especially plain packaging. However, with the exception of the Irish government, governments in all countries have similar reasons to dismiss lessons from Australia: because it is far away and an island.

Governments in Belgium, Finland and the Netherlands are, in contrast to Ireland, more inclined to look at European countries close by for lessons in tobacco control. When providing reasons why countries are chosen as an example, similarities to nearby countries are emphasized in Finland and the Netherlands. These findings reinforce the idea that lesson drawing is facilitated by a perception of similar (policy) contexts (4,5). Ireland is an exception, as it looked at other English-speaking nations around the globe for lessons (Australia and Canada), rather than closer by non-English speaking countries. Moreover, the Belgian government chose Australia and two countries closer by (the United Kingdom and France) for lesson drawing with regards to plain packaging, but mostly to see how implementation of that instrument works out, not explicitly based on similarities to those countries.

Our findings roughly fall in line with the literature on 'family of nations', in which there is an English-speaking family (Ireland that looks at other English-speaking nations across the globe), a European Union family (Belgium and the Netherlands that predominantly look at other nearby European countries) and a Nordic family (Finland that looks at the other Nordic countries) (11,13). These families are hypothesized to look predominantly within their 'families' for lessons in tobacco control and therefore adopt similar policies, with policy convergence as a result (13).

However, in Studlar's study (13) the United Kingdom was categorized as being part of both the English-speaking *and* the European Union group ('overlapping' families). It may be the case that it serves as an example for other European countries as it has few smokers and the most comprehensive set of policy measures enacted (1), but that it imports policy instruments primarily from other progressive English-speaking nations across the globe. Moreover, this case conflicts with the idea that lesson drawing is confined to easily discernible family clusters. Our findings suggest that overall proximity and similarity between countries may be relevant to lesson drawing in tobacco control.

The finding that the German government is not inclined to draw lessons from abroad, suggests that political will is an important precondition for lesson drawing, in line with theories such as Kingdon's three streams and other work on lesson drawing in tobacco control (21,23). Lessons are means to a political end and their acceptance depends on the motive and opportunity of decision makers to translate them into domestic policy (24). This finding also adds to the critique that studying lesson drawing in itself is not sufficient to explain policy change (10). The German NGO community did engage in lesson drawing, and frequently presented foreign examples, yet these lessons did not find resonance with the government.

A previous case study of German tobacco control policymaking concluded that German policymakers are self-sufficient in terms of health research and policymaking capacity, which results in more inward-looking instead of outward-looking (25). In contrast, an Irish case study concluded that Ireland had little capacity in terms of research and policymaking and was therefore compelled to look at foreign evidence and experience (17). These cases suggest that country size and associated institutional arrangements may influence a country's propensity to lesson drawing.

An important study limitation is that it is difficult to evaluate whether a lesson has actually been drawn or not. We presented and summarized considerations that play a role during the prospective evaluation phase, but we have no data on whether a lesson is actually drawn and there are no rigorous tools available to assess this (26).

Scientific evidence about a policy is relevant to lesson drawing (27). A considerable body of research on the effectiveness and impact of tobacco control policies originates from countries within the English-speaking family of nations (the United States, Canada, Australia, and within Europe, the United Kingdom), but to a lesser extent from other parts of Europe (28). As our findings suggest that governments draw lessons more readily from other European nations nearby, it is important to invest more in European research on the effectiveness of tobacco control policies (29).

Tobacco control advocates may use the findings of this study to facilitate successful lesson drawing in tobacco control. They can do so by choosing best practice examples in tobacco control from countries similar or close to their own country, or by emphasizing similarities in (policy) contexts to those found with the global leaders in tobacco control.

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PART 2

Determinants of tobacco control partnership strength

CHAPTER 6

Characteristics associated with tobacco control partnership strength

Submitted as: Kuijpers, T. G., Kunst, A. E. and Willemsen, M. C.

'Which characteristics contribute to tobacco control partnership strength in Europe? An explorative study.'

ABSTRACT

Introduction: The activities of tobacco control partnerships are considered crucial in achieving FCTC objectives, yet countries differ considerably with regard to the strength of such partnerships in terms of their ability to influence tobacco control policy. While previous studies focused on features of the national policy environment that affect the strength of such partnerships, this study explores internal partnership characteristics that likely contribute to partnership strength.

Methods: An expert panel was organized with tobacco control advocacy experts from 10 different European countries: Denmark, France, Germany, Ireland, Lithuania, the Netherlands, Poland, Romania, Spain, and Sweden. Subgroup and plenary discussions were analyzed using a largely deductive coding approach based on Lasker et al.'s framework of determinants of health partnership functioning.

Results: Experts perceived the following characteristics to be important in relation to tobacco control partnership strength: (1) financial independence from government, (2) expertise in research and advocacy, (3) an evidence informed approach, (4) access to nationally relevant data, (5) connections to policymakers, journalists, researchers, and other partnerships, (6) partner heterogeneity (7) conflict resolution, (8) a central coordinating office, (9) clear rules or statutes, and (10) a shared vision/consensus.

Conclusion: this explorative study identified 10 internal characteristics that contribute to the strength of tobacco control partnerships. These characteristics may help establish new tobacco control partnerships or help existing partnerships to improve their strength.

INTRODUCTION

Smoking continues to be the biggest single preventable cause of death in the world (1). To address this problem, the World Health Organization through the Framework Convention on Tobacco Control (FCTC), proposed a list of key measures to reduce tobacco consumption (2). Countries that have implemented these measures have experienced greater reductions in smoking prevalence (3). Pro and anti-tobacco control interest groups are competing on an ongoing basis to advance their policy agendas (4) and the tobacco industry is known to oppose stricter tobacco control regulations in order to protect their economic interests (5,6). In the past decades, there has been an overall growth in the number of interest groups and they engage in advocacy more than ever before (7). Perhaps as a reflection of this development, theoretical frameworks which primarily focus on the role of interest groups in the policy process have emerged (8,9). Although the participation of groups in civil society is considered crucial in achieving FCTC objectives (10), countries differ considerably with regard to the strength of such groups (11).

Various terms are used in the literature to describe collaborations of organizations within civil society, such as'consortia', 'coalitions', 'alliances', and 'partnerships' (12). They all refer to arrangements in which organizations or individuals from civil society work together with a certain goal (12,13). For the remainder of this article we use the term 'partnership' to refer to such collaborations. Health partnerships can have different functions, for instance improving health service delivery (14), fostering public awareness or support (15), aiding in effective policy implementation (16), and advocating for the enactment of effective policies at the national level (16,17). We will focus on the enactment of effective policies at the national level, because despite the fact that the adverse health effects of smoking are widely known to policymakers (18) countries still demonstrate considerable variability with regard to their tobacco control policy comprehensiveness and the reason why countries differ so much is inherently political (19,20).

Whether partnerships succeed in getting effective tobacco control policies adopted by the government depends on characteristics of the partnership itself, on the policy context, and the interaction between these. Previous research identified several features of the policy context that influence partnership strength in influencing tobacco control policy: the ideological orientation of the ruling parties, health ministry centrality, a strong tobacco industry presence in terms of manufacture and production, and a government's level of openness to tobacco industry influence (11,21). In the present study, we will focus on characteristics of the partnership itself. For the purpose of this study, we will define partnership strength as *'the ability of the partnership to influence tobacco control policy'*, independent of the national policy environment.

A large number of internal partnership characteristics may possibly influence partnership strength. A widely cited framework on health partnership functioning was developed by Lasker et al. (14). They posit that there are four broad categories of determinants inherent to health partnerships that are likely related to their strength. The first category refers to resources, such as money, space, equipment and goods, skills and expertise, information, connections to people, organizations and groups, endorsements, and convening power. The second category refers to partner characteristics, such as heterogeneity and level of involvement. The third describes the relationships among partners, which refers to issues such as trust, respect, conflict, and power differentials. Lastly, the fourth category refers to partnership characteristics, such as leadership, administration and management, governance, and efficiency[1] (14).

When interest groups are considered in tobacco control studies, theoretical models are used such as the Advocacy Coalition Framework, the Punctuated Equilibrium Framework, or Kingdon's Three streams. Unfortunately, these models focus on policy change process in general, without particular attention to interest groups as such (8,9,22). As a result, previous research has not yet evaluated which characteristics are contributing to partnership strength in the domain of tobacco control (12,23). We will instead adopt a theoretical framework that takes tobacco control partnership as unit of analysis. This framework is predominantly based on research from the United States and refers to different types of health partnerships (14). We will explore which partnership characteristics are contributing to tobacco control partnership strength, using the framework of Lasker et al. (14) to interpret and structure our findings.

METHODS

Expert selection

To obtain relevant information about characteristics contributing to tobacco control partnership strength in terms of influencing policy, an expert panel was organized with tobacco control advocacy experts from 10 different European countries: Denmark, France, Germany, Ireland, Lithuania, The Netherlands, Poland, Romania, Spain, and Sweden. These experts are leaders or employees of the most important national level tobacco control partnerships, and are professionally engaged with political tobacco control advocacy on a daily basis. Experts were selected from diverse parts of Europe (Northern, Southern, Eastern, and Western Europe) to get a wide-ranging representation of the European experience. An employee of the European Network for Smoking and Tobacco Prevention (ENSP) helped selecting and approaching suitable experts. All approached individuals agreed to participate.

1 The original framework also included a fifth category referring to the 'external environment'. We will only take internal partnership characteristics into account.

Proceedings of the expert panel

The expert panel was organized at the ENSP congress in Madrid, June 2018. The ten experts were divided across three subgroups which were facilitated by the first, second, and third author. The authors had a moderating role; they avoided presenting own ideas. Experts were asked individually to report on the current situation in their countries: 1) whether their partnership was capable of influencing tobacco control policy at the national level, 2) how they exerted their influence, and 3) which characteristics they thought were most important in determining this capability. The latter characteristics were written down by the authors. 10 minutes of time was available per expert/country.

After these country descriptions, experts were asked to reach consensus on the five most important characteristics determining the capability of partnerships to influence national level tobacco control policy (20 minutes). In doing so, experts were asked to be sufficiently specific, such that these characteristics could ultimately be measured.

A plenary discussion followed, in which subgroups listed their five characteristics one by one. Experts were asked to reflect plenary on these characteristics and to reach consensus on the main key characteristics (30 minutes). A certain degree of data saturation was observed, as the characteristics per subgroup were highly comparable. To avoid influencing results, we did not employ nor mention the framework of Lasker et al. (14) during the subgroup discussions and the plenary panel. Audio recordings of both the subgroup discussions and plenary panel were transcribed verbatim for subsequent analysis.

Analytical strategy

The transcripts were thematically coded by TGK using MAXQDA version 12 (24). The framework of Lasker and colleagues (2001) served as a guide to code in a primarily deductive way, however allowing for emergent themes within these categories. For example, the topic medical expertise was highlighted by many experts as important, which fitted well into the framework of Lasker and colleagues. A new emergent theme was for example that one partnership had developed a scale to evaluate parliamentarians' usefulness for public health, while another partnership stressed the importance of knowing political party's stances towards tobacco control. These two topics were grouped under the new theme 'information on the political environment', which was placed under 'information' in the 'resources' category. A bottom-up emergent theme could be grouped within an existing category of Lasker et al. (14).

The codebook and individual codes were reviewed by the second and third author. Refinements and adjustments were applied after various feedback rounds.

Ethics approval

Experts explicitly agreed to participate in the study. This study is considered non-interventional or observational. It does not subject respondents to procedures or impose rules of behavior. Ethics approval by an ethics committee was therefore deemed unnecessary.

RESULTS

The following characteristics were perceived to be contributing to tobacco control partnership strength by tobacco control advocacy experts: (1) financial independence from government, (2) expertise in research and advocacy, (3) an evidence based approach, (4) access to nationally relevant data, (5) connections to policymakers, journalists, researchers, and other partnerships, (6) partner heterogeneity (7) conflict resolution, (8) a central coordinating office, (9) clear rules or statutes, and (10) a shared vision/consensus.

Table 1 summarizes these characteristics in relation to the original framework by Lasker et al. (14). Overall, subgroup discussions demonstrated remarkable similarities.

Table 1: Characteristics contributing to tobacco control partnership strength in European countries

Characteristic		Description	Category[1]	Subcategory[1]
1	Financial independence	The partnership is not funded by the government	Resources	Money
2	Expertise in research and advocacy	The partnership has expertise within the partnership to judge the validity of scientific data, transform such data to persuade policymakers and has advocacy expertise	Resources	Skills and expertise
3	Evidence based approach	The partnership uses scientific evidence to support its activities	Resources	Information
4	Access to nationally relevant data	The partnership has access to national data on prevalence, public attitudes, morbidity/mortality, and economy	Resources	Information
5	Connections to policymakers, journalists, researchers and other partnerships	The partnership has connections to policymakers at all levels of government, journalists, researchers, and other partnerships	Resources	Connections
6	Partnership heterogeneity	The partnership includes various types of partners	Partner characteristics	Heterogeneity
7	Conflict resolution	The partnership avoids or resolves conflicts	Relationships among partners	Conflict
8	Central coordinating office	The partnership has a central coordinating office	Partnership characteristics	Governance
9	Clear rules or statutes	The partnership has clear rules or statutes so that partners know their roles and responsibilities	Partnership characteristics	Governance
10	Shared vision/consensus	Partners share a common goal and have consensus about topics and (policy) solutions	Partnership characteristics	-

[1] According to the Framework by Lasker et al. (14)

1. Financial independence from government

Many experts stressed the importance of being financially independent from government. If the partnership is financially dependent, they may be less effective because the government may only want to subsidize activities that fit a certain political agenda. Furthermore, the partnership is constrained in what it can say or do because there is a dependency on its main target: the government.

> R1: *'That was a problem of course, because you cannot say everything you want to say about what's going on, because you have a financial relationship, so that was kind of uncomfortable.'*

> R6: *'That's one of the problems. Because what needs to be done is not always what they want you to do.'*

2. Expertise in research and advocacy

Members of the partnership were in some cases specifically selected because of certain skills or expertise, or they received additional training to acquire such skills. A key skill was being able to interpret and transform data. Members within the partnership should ideally have expertise to judge the validity of scientific data and to transform such data (e.g., translation of research into fact-sheets, position papers, or policy messages) in order to convince policymakers. This expertise could be obtained by including researchers or communication experts into the partnership.

> R2: *'I would suggest to only focus on expertise. Data is available, anybody can just access studies on Google. Is there expertise in your organization to judge the validity? That is most important because if there are experts, […] the decisions you make are based on evidence, otherwise they're based on something that [only] looks like evidence.'*

Knowledge about how to engage in advocacy was also considered important. Experts reported having extensive health expertise within their partnerships, but some argued that this may not be enough to convince policymakers. Professional advocacy and lobbying skills, including insight knowledge about the political environment and about the administrative procedures of the policy process were also considered valuable.

> R4: *'Advocacy is not a matter of health: it's a matter of public relations, it's a matter of lobbying, so you need professional lobbyists.'*

3. An evidence informed approach

Virtually all experts in the panel were stressing the importance of an evidence informed approach. This was preferred over a more 'activist', 'sentimental' or 'emotional' approach, which was thought to be less effective in exerting political pressure, but can nevertheless be used in addition to a 'core' evidence informed approach. An evidence informed approach was perceived to make the partnership more professional and credible.

> R8: *'One point that I would like to stress is an evidence base, I think that's something that's very important because, when we talk about civil society organizations, we also have some NGOs in [country] that are more at an activist level and well, they are not really taken seriously.'*

> R5: *'This is the basis of any effective science and evidence based tobacco control activities, programs, policies! If you don't have the data, then you don't have arguments, especially in the front of potential funders or government. That's the real basis.'*

4. Access to nationally relevant data

Access to various types of nationally relevant and reliable data on smoking prevalence, public attitudes, morbidity, mortality, and economic data were thought to be important, especially when the partnership works evidence based. Furthermore, some experts mentioned the importance of having access to data about the national political environment. Examples were data on parliamentarians view points on public health and data on standpoints of political parties with regard to tobacco control issues.

> R2: *'One of our main activities is the scale that we have for measuring the politician's usefulness for public health. It has subscales for tobacco, alcohol and gambling and it is based purely on their voting.'*

> R4: *'Another strong side is: we have a comprehensive, long term and multi-tool monitoring system that can be used by anyone.'*

5a. Connections to policymakers

Almost all experts stated that having connections to policymakers was essential. This referred to relationships with policymakers at all levels of government: ministers, secretaries of state, civil servants, and Members of Parliament (MP's). Experts stated that such connections are crucial in exerting political influence. It was considered important to be recognized by policymakers as an important stakeholder in national tobacco control policymaking.

R3: *'[…]….and with the government administration. We have good contact with them, we can call them and they call us. We are very close to them, that's very, very, important.'*

5b. Connections to journalists

Connections to journalists and the media were deemed important as the media is able to spread misinformation about tobacco or able to portray the partnership in ways troublesome for their public image. It was perceived to be important to be recognized by journalists as expert authority on the subject and being directly contacted by journalists to provide opinions on a topic. Two experts mentioned they had included journalists or journalist associations as partners in their partnership.

R3: *'I think we have visibility in [country]. A lot of journalists call us if they have any doubt about tobacco policies.'*

5c. Connections to researchers

Because nationally relevant data is considered of vital importance to the partnership and expertise to interpret such data, connections to researchers were believed to be important. Some partnerships took great effort in establishing connections to researchers from universities or national public health institutes, or by incorporating such research institutes into the partnership. Having connections to researchers can allow the partnership to influence the research agenda of scientific organizations that fund or carry out research, to better fit the needs of the partnership.

R6: *'I think we had a further point: trying to set the research agenda. The information available is not always what you need.'*

R9: *'We work with our partners, we don't do research a lot because different societies that are in our coalition do research, they are strong, but we think that they, the people who do research have to do the research, not our coalition.'*

5d. Connections to other partnerships

Connections to national partnerships in other countries were also mentioned by some experts. Such connections may inspire activities and promote best practices. Connections to local partnerships were mentioned as a way to build grassroots support from the bottom-up: getting many policies enacted at local levels (e.g. smoke free venues) and hoping that the national level will eventually follow suit.

R5: *'International networking was in the past and still is at least for us, the real window for best practice in tobacco control.'*

R10: *'[…] there is a big difference between the local politicians and the politicians here [at the national level]. The local politicians say: well, of course we will do it! We want to have smoke free beaches, smoke free playgrounds et cetera et cetera… all this.'*

6. Partner heterogeneity

A point mentioned by nearly all experts, was the importance of engaging many different types of partners in the partnership. Having medical professionals in the partnership was considered most important as they have credibility, authority, and competence in the health domain and they can help keeping the political and public debate health focused.

R9: *'I think we are strong because we collect all the sensibilities about tobacco, prevention and control. People work in different fields of tobacco control and prevention.'*

R6: *'It has to come from a credible source. So when you put somebody forward, they have to have credibility, usually in their own domain.'*

Obtaining and demonstrating a broad and diverse support base in society was stated to be important in creating political pressure. If a lot of different organizations speak out for the same cause, a broad and diverse support base can be demonstrated. This may be done with regard to specific issues, for example involving children's associations for policies that affect children, or in general, involving as many partners as possible, creating a societal movement.

R1: *'Currently we have over a hundred partners from different sectors. Of course there are the health foundations and we also have the health sector, like doctors, but we also have sports' organizations and organizations related to education. We try to cover the broad perspective and I think we are trying to make it broader and broader. So we try to make friends with everyone. Well… Everyone except for the tobacco industry.'*

Involving many different partners may also be a way to acquire access to resources (e.g. person hours, credibility or specific types of expertise). Hence, journalists may be included to establish or maintain a good public image, jurists may be included to have access to legal expertise (e.g. going to court when policymakers are unresponsive or counteracting court cases from the tobacco industry), economists may be included to have access to economic expertise (e.g. information on the economic burden of smoking to society) and researchers may be included to have access to different types of nationally relevant data and ideally, to be able to inform their research agendas.

R5: *'In our association we now have economists and lawyers and we conducted some good economic studies. The tobacco industry claims that they are the second industry contributing to the budget after the car industry in [country]. Now we have the data, we can reveal the real situation.'*

7. Conflict resolution

Two experts mentioned conflict among partners, for example for impact, visibility, and recognition as a barrier to partnership strength. In one case this has led to the discontinuation of an effective partnership in the past: the partnership as a whole enjoyed more public recognition than the individual partners and therefore some partners withdrew their financial support to the partnership. Therefore, ways to avoid or solve conflicts can be crucial for the continuation of the partnership.

R6: *'Visibility. Credits. I mean for NGOs, for charitable organizations, this is often their prominence in society: the recognition that they want.'*

R8: *'[the partners compete] for impacts, attention, and influence, that is my feeling.'*

8. A central coordinating office

A central coordinating office may help devolving tasks, coordinate activities, and support the individual partners. It was perceived to be beneficial that such an office has only one issue to focus on, namely tobacco control advocacy.

R1: *'We [the coordinating office] are just supporting and coordinating and make sure everything runs smoothly.'*

9. Clear rules or statutes

Clear rules and statutes may provide clarity to members so that they know what is expected from them in terms of roles and responsibilities. Roles may refer to the specific ways in which partners are expected to contribute to the objectives of the partnership. The roles may be flexible, as partners may be solely involved in the partnership in relation to specific issues (e.g. youth organizations that are actively engaged in a ban on smoking in cars with minors). Responsibilities may refer to certain domains that may be covered by specific partners (e.g., an organization that solely advocates for smoke-free environments).

R2: *'Another strong thing is […] making the rules of the game very clear. Which are: we are interested in control policy […] and only at the policy level.'*

10. A shared vision/consensus

Consensus on topics or on (policy) solutions was perceived to be important and seen as a starting point to work from. Having no consensus could impede fast decision making, as some consensus-based partnerships wait for agreement on a certain topic before publicly announcing their standpoints. International organizations such as the World Health Organization through FCTC could aid in providing consensus within the partnership.

> R8: *'At that time it was still very difficult to find a consensus. […] I mean before FCTC time and all of that. So, it took a while to really come to a consensus and to find a basis to work from.'*

> R2: *'We balance the need for consensus with a focus on international documents and evidence. So, if evidence is there, it's a forced consensus. […] If one day we will see that e-cigarettes really work for the better, we will probably adopt it.'*

Furthermore, many experts mentioned the importance of reaching consensus with regard to a common strategy: a strategy where all organizations join forces in their own way, working for the same ultimate cause. This common strategy could be laid out in 'roadmaps', for example towards a smoke free generation or society.

> R1: *'Well a common strategy, I would definitely say, that is essential, if you speak with one voice, which helps a lot. You don't have to have exactly the same role: so it's not the case that everyone has to communicate through the partnership, all organizations can play their own part and I think that's very important as well [..] … we talked about not wanting to be divided in the tobacco control community and I think on the national level that's essential.'*

> R9: *'We have strategy line; we have a consensus about… We call it our 'Roadmap to end tobacco in [Country]'.'*

DISCUSSION

This is the first explorative study investigating characteristics contributing to tobacco control partnership strength in a European setting. The adapted framework may offer valuable yet tentative insights for improvement of partnership strength, independent of wider political context characteristics.

There are some weaknesses to this study: our expert panel did not objectively 'test' the relative importance of the characteristics presented in our framework of tobacco control partnership strength. It tentatively summarized the expert opinions of ten experts on tobacco control

advocacy, sharing their own nation-bound experiences. The approach of tobacco control advocates is often instinctive and few advocates reflect knowingly on the rationale behind their day-to-day strategies (25). Because of this, experts may not always be aware of the importance of some characteristics for their partnership. Moreover, evaluating strength of partnerships in terms of policy adoption may be hard generally, as it implies the attribution of advocacy efforts to the adoption of policies: a link that is hard to empirically establish (25,26).

Some factors specified in the original framework by Lasker et al. (14) did not emerge during our expert panel, such as leadership. Leadership is often identified as an important factor in health promotion collaboration success (12,23). Leaders may play a connecting, motivating and moderating role within their partnerships and provision of such leadership can be formal or informal (14,27). It may be that such informal leadership generally goes unnoticed. Another explanation is that most expert panel members were non-profit organization leaders themselves, and it may be difficult for them to consciously reflect on their own contributions in relation to partnership strength.

Furthermore, money is recognized in reviews of the literature as a facilitator of health promotion collaborations (12,23). In our expert panel, funding was discussed but did not emerge as a necessity for partnership strength. Some partnerships consisted solely or for large parts out of volunteers and they considered themselves effective. Yet, the only partnership that consisted completely out of volunteers had a very narrow strategy, focusing only on policy adoption. It can be logically argued that when a partnership engages in more activities (e.g. improving health service delivery, fostering public awareness or support, and aiding in effective policy implementation) money becomes increasingly important.

We have explored characteristics that likely contribute to partnership strength in a European setting, resulting in adaptations of the framework Lasker et al. (14), making it more relevant to the field of tobacco control in a European setting. Our adapted framework may be used for several purposes: 1) it may serve as starting point for the establishment of new tobacco control partnerships in countries that have no such partnerships, 2) it may be used for the evaluation or monitoring of existing partnerships and, 3) it may serve as a starting point for a tentative comparison of the prevalence of such characteristics related to tobacco control partnership strength across European partnerships.

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CHAPTER 7

Assessment of characteristics related to strength in European partnerships

Submitted as: Kuijpers, T. G., Kunst, A. E. and Willemsen, M. C.

'Tobacco control partnership strength: An overview and comparison of 18 European partnerships.'

ABSTRACT

Introduction: To reach tobacco control objectives, it is important that national tobacco control advocacy partnerships or alliances work effectively to put tobacco control on national policy agendas. A previous study identified characteristics related to tobacco control partnership strength. We will assess the prevalence of such characteristics across 18 European partnerships.

Methods: We developed a tool to measure the prevalence of characteristics related to tobacco control partnership strength. The tool consists of three dimensions: resources (12 items), member characteristics (2 items), and partnership characteristics (8 items). The tool is based on a previous study on tobacco control partnership strength, supplemented with additional insights from the literature. The survey was pilot-tested twice before it was administered to 18 partnerships across 17 European countries.

Results: Whereas several characteristics related to partnership strength were highly prevalent across European partnerships, some were not. Of all 18 partnerships, 5 did not include professional lobbyists, 7 did not have access to national information on tobacco industry presence and lobbing, 9 had no influence on national research agendas, and 7 did not maintain working relationships with the relevant Minister or Secretary of State. Furthermore, 5 of 18 partnerships had no agreement on roles and responsibilities of member organizations, and 6 had no agreement on how credits are divided across member organizations. A leadership figure was not present in 6 of 18 partnerships.

Conclusion: European tobacco control partnerships do not have all characteristics that would increase partnership strength. Findings suggest that there is room for improvement of European tobacco control partnerships.

INTRODUCTION

Tobacco consumption represents an important public health problem, especially in the European region, which has the highest level of smoking prevalence world-wide (29%) (1). To address smoking comprehensively, the World Health Organization proposed a number of policy objectives through the Framework Convention on Tobacco Control (FCTC) (2). To ensure adequate implementation and enforcement of such objectives, it is important that national tobacco control interest groups, partnerships, coalitions, networks, or alliances (from now on: 'partnerships') put tobacco control on national policy agendas (2). However, previous empirical findings suggest that there is a considerable variance with regard to how well such groups are organized across various European countries (3).

Efforts to advance tobacco control by tobacco control partnerships are typically counteracted by the tobacco industry (4,5). Industry involvement in tobacco control policymaking is consequently seen as a major obstacle in the formulation of comprehensive tobacco control policies (2). Many scholars have investigated tobacco industry 'interference' with tobacco control policy, by examining industry lobby tactics and conduct (4,6).

Health advocacy is less often the focus of empirical study (7). In the literature on health promotion partnerships, there have been two recent reviews investigating partnerships working on a wide range of health behaviors, including smoking, and a wide range of success indicators, including policy adoption (8,9).

With regard to tobacco control, three recent studies focused on tobacco control partnerships. These studies examined differences between youth and adult partnerships in the United States (US) (10), performed network analyses on a US government agency concerned with tobacco control (11), and carried out an ethnographic study of decision-making processes in a local tobacco control partnership in the United Kingdom (12). However, they did not exclusively focus on partnership strength in terms of political advocacy.

As there was no such empirical evidence, we explored in a previous study which partnership characteristics are associated with tobacco control partnership strength, in terms of their ability to influence tobacco control policy at the national level. Ten characteristics were found relevant: 1) financial independence from government, 2) expertise in research and advocacy, 3) an evidence based approach, 4) access to nationally relevant data, 5) connections to policymakers, journalists, researchers, and other partnerships, 6) partner heterogeneity, 7) conflict resolution, 8) a central coordinating office, 9) clear rules or statutes, and 10) a shared vision/consensus (Chapter 6).

In the current study, we will use the findings of this study on tobacco control partnership strength to 1) assess the prevalence of characteristics related to partnership strength across European partnerships, and 2) compare these European partnerships with the total number of characteristics.

METHODS

Development of a tool for measurement

We developed a tool based on a previous study on tobacco control partnership strength (Chapter 6). Characteristics found to be related to partnership strength were transformed into a 22-item tool. This was done through an iterative process comprising various rounds of feedback and discussions with the second and third author. The tool assesses characteristics on three dimensions: resources of the partnership, including connections (12 items), member characteristics (2 items), and partnership characteristics (8 items). An overview of all items of the tool can be found in Table 1. The complete tool with answer categories, further clarifications of terms, and scores can be found in Appendix 2.

Additional insights from the literature were also considered. In particular, reviews of the literature on health promotion partnerships which emphasize the importance of leadership for partnership functioning, success or effectiveness (8,9,13). We therefore added a leadership item to the 'partnership dimension' of the tool (Table 1, item 18).

Table 1: Items of the Tobacco Control Partnership Strength Tool

Resources		
Financial Independence	1.	The partnership receives structural funding from the national government.
Expertise	2.	The partnership includes professional scientists who are able to interpret and appreciate scientific information.
	3.	The partnership includes professional communication experts.
	4.	The partnership includes professional lobbyists.
Information	5.	The partnership's messages and policy proposals are informed by scientific evidence.
	6.	The partnership has access to information on the following aspects of the national situation (multiple answers possible):
	7.	The partnership has a direct influence on the research agenda of scientific organizations that fund or carry out research.
Relationships	8.	The partnership has working relationships with at least one Member of Parliament, with functional contacts at least once in every 6 months.

Table 1: Continued

Resources		
	9	The partnership has working relationships with the relevant civil servants of the ministry that is primarily responsible for tobacco control, with functional contacts at least once in every 3 months.
	10.	The partnership has a working relationship with the minister (or secretary of state) who is primarily responsible for tobacco control, with functional contacts at least once in every 12 months.
	11.	The partnership has working relationships with at least 2 journalists, with functional contacts at least once in every 6 months.
	12.	The partnership has working relationships with at least one tobacco control partnership in another country, with functional contacts at least once in every 6 months.
Member characteristics		
Member heterogeneity	13.	The partnership includes the following types of organizations as formal partners (multiple answers possible):
Support base	14.	The total number of formal partners is:
Partnership characteristics		
Governance	15.	The partnership has a reached agreement that clearly defines the roles and responsibilities of formal partners.
	16.	The partnership has a central office with staff dedicated to coordination of the partnership.
	17.	The partnership has a reached agreement on how credits are divided across formal partners.
Leadership	18.	The partnership includes one or more person(s) who is/are able to connect and inspire formal partners, and moderate potential conflicts.
Strategy	19.	The partnership has a reached agreement on the common goal that is embraced by all formal partners.
	20.	The partnership has a reached agreement on a common strategy that is embraced by all formal partners.
Conflict resolution	21.	The partnership is able to formulate a shared public position even on issues that may be subject to internal debate.
	22.	The partnership is able to avoid or resolve conflict between formal partners.

Pilot testing

We conducted two pilot tests to make the tool administrable to tobacco control partnerships across Europe. We carried out the first pilot test at the Dutch Alliance for a Smoke free Society (Alliantie Nederland Rookvrij). Two employees filled in the tool separately and provided written feedback on all aspects they deemed odd or unclear. The tool was discussed per item and amended accordingly.

The second pilot test consisted of sending an online version of the tool to international tobacco control advocacy experts recruited by an employee of the European Network for Smoking and Tobacco Prevention (ENSP). Seven of nine approached experts filled in the tool and provided feedback on items. We explicitly asked them to comment whether: 1) items were formulated clearly, 2) items were formulated unambiguously, 3) they were able to answer the questions with the information that they had, and 4) they missed certain topics. This feedback led to several additional amendments to the tool.

Most amendments concerned the precise clarification and delineation of the meaning of terms (e.g., 'Structural funding' was more precisely defined as 'funding on a weekly/monthly/yearly basis, as opposed to incidental funding for one or a few specific projects'). Furthermore, various experts requested a clear partnership definition. We therefore defined a partnership as 'a group of people and/or organizations who coordinate their efforts during a long term with the aim of fostering tobacco control policies at the national level', based on a definition of coordination by Winer et al. (14).

Selection of respondents

An employee of the ENSP approached 77 tobacco control advocates across 30 European countries through their network. These experts included the seven experts involved in pilot testing. The ENSP employee sent an initial e-mail invitation to complete the tool, followed up by a first and second reminder when respondents did not answer. Respondents from five countries did not answer to the invitation and the reminders (Austria, Croatia, France, Hungary and Latvia). Respondents from five other countries replied, stating there was no such tobacco control partnership in their countries (Cyprus, Luxembourg, Malta, Poland, and Slovakia). Finally, 25 respondents filled in the tool for 25 partnerships across 20 European countries (i.e.: 2 partnerships in Spain, 2 in Greece, 4 in Italy).

In and exclusion criteria

We formulated additional in- and exclusion criteria for analysis, as some organizations on closer inspection did not appear to meet our definition of a partnership. We decided that a partnership should consist out of at least two organizations (i.e.: no single organizations), be based in civil society (i.e.: be non-governmental), and should not be restricted to scientific organizations only (i.e.: no scientific epistemic communities). These additional criteria led to the exclusion of seven partnerships across three countries: Estonia (1 governmental organization), Italy (3 scientific communities and 1 single organization), and Greece (2 single organizations).

Assigning scores

We scored the answer categories to count the number of characteristics related to partnership strength (see Appendix 2: numbers in parentheses). We allocated a higher score to answer categories that contribute to partnership strength, according to previous empirical work. For example, having research expertise is found to make tobacco control partnerships stronger, in terms of political advocacy. Therefore, as a response to the item 'The partnership includes professional scientists who are able to interpret and appreciate scientific information', we allocated one point to the answer 'yes' and zero points to 'no'. We did not assign relative weights to some rather than other items, since there is no empirical evidence on which characteristics are more important than others in relation to partnership strength.

The allocation of scores to the answer categories led to a total score of 18 for the resources dimension, 19 for the member characteristics dimension, and 8 for the partnership characteristics dimension. To make the dimensions mutually comparable, we divided the scores per partnership, per dimension by the maximum dimension score (which resulted in a maximum score of 1 per dimension). In the presentation of the comparison between the 18 European partnerships, we anonymized the partnerships by assigning a random number.

RESULTS

Of all 25 countries that responded to our invitation, 8 countries did not have a partnership according to our definition and inclusion-criteria (32%, Table 2). We analyzed and compared 18 partnerships across 17 countries (of which two partnerships in Spain).

Table 2: Tobacco control partnerships across 25 European countries (English translations where possible)

Country	Partnership present*	Name
Belgium	yes	Belgian Alliance for a Smoke Free Society
Bulgaria	yes	Smoke Free Life Coalition
Czech Republic	yes	Society for Treatment of Tobacco Dependence
Cyprus	no	-
Denmark	yes	Smoke free Future
Estonia	no	-
Finland	yes	Tobacco Free Finland 2030
Germany	yes	German Smoke Free Alliance
Greece	no	-
Ireland	yes	Tobacco Free Initiative
Italy	no	-
Lithuania	yes	Lithuanian Tobacco and Alcohol Control Coalition
Luxembourg	no	-
Malta	no	-
Netherlands	yes	Alliance for a Smoke free Netherlands
Norway	yes	Tobakksfritt
Poland	no	-
Portugal	yes	Portuguese Tobacco Prevention Coalition
Romania	yes	Romania Breathes Coalition
Slovakia	no	-
Slovenia	yes	Slovenian Coalition for Public Health, Environment and Tobacco Control
Spain	yes	1. National Committee for Tobacco Prevention
	yes	2. Nofumadores
Sweden	yes	Tobaksfakta
Switzerland	yes	Swiss Association for Smoking Prevention
United Kingdom	yes	Smoke-free Action Coalition

*according to our formulated definition and inclusion-criteria

Descriptive statistics

Resources

The resources dimension (including working relationships) consists of 12 items (items 1-12, Table 1). Table 3 summarizes the results for this dimension with regard to the 18 partnerships. Of all 18 partnerships, 15 did not receive structural funding from the government. Concerning expertise, 15 partnerships included scientists and 15 included communication experts. Thirteen partnerships included professional lobbyists. All partnerships indicated that they work (more or less) in an evidence informed manner, which means that their messages and policy proposals are informed by scientific evidence. All 18 partnerships had access to information about the national context concerning smoking prevalence and trends, while only 11 partnerships had access to information on tobacco industry presence and lobbying. Half of partnerships had (some) influence on the research agenda of scientific organizations that fund or carry out research. Most partnerships maintained working relationships with civil servants (17 out of 18 partnerships, with contacts at least once every three months). Less partnerships maintained working relationships with the Minister of Health or Secretary of State (11 out of 18 partnerships, with contacts at least once per 12 months).

Table 3: Resources of 18 European tobacco control partnerships

#		Yes (n)	More or less (n)	No (n)
	Financial independence			
1	Receives structural funding from the national government	17% (3)	-	83% (15)
	Expertise			
2	Includes professional scientists	83% (15)	-	17% (3)
3	Includes professional communication experts	83% (15)	-	17% (3)
4	Includes professional lobbyists	72% (13)	-	28% (5)
5	Messages and policy proposals are informed by scientific evidence	89% (16)	11% (2)	0% (0)
	Information:			
6	Partnership has access to:			
	Smoking prevalence and trends	100% (18)	-	0% (0)
	Tobacco-related morbidity and mortality	94% (17)	-	6% (1)
	Public attitudes towards tobacco control	94% (17)	-	6% (1)
	The economic burden of tobacco use	83% (15)	-	17% (3)
	Effectiveness of policy measures	78% (14)	-	22% (4)
	Attitudes of individual policymakers or parties towards tobacco control	78% (14)	-	22% (4)
	Tobacco industry presence and lobbying	61% (11)	-	39% (7)
7	Direct influence on the research agenda of scientific organizations that fund or carry out research	11% (2)	39% (7)	50% (9)
	Working relationships (with functional contacts…)			
8	Member of Parliament (at least once per 6 months)	89% (16)	-	11% (2)
9	Civil servants (at least once per 3 months)	94% (17)	-	6% (1)
10	Minister/secretary of state (at least once per 12 months)	61% (11)	-	39% (7)
11	Journalists (at least once per 6 months)	89% (16)	-	11% (2)
12	TC partnerships abroad (at least once per 6 months)	94% (17)	-	6% (1)

Member characteristics

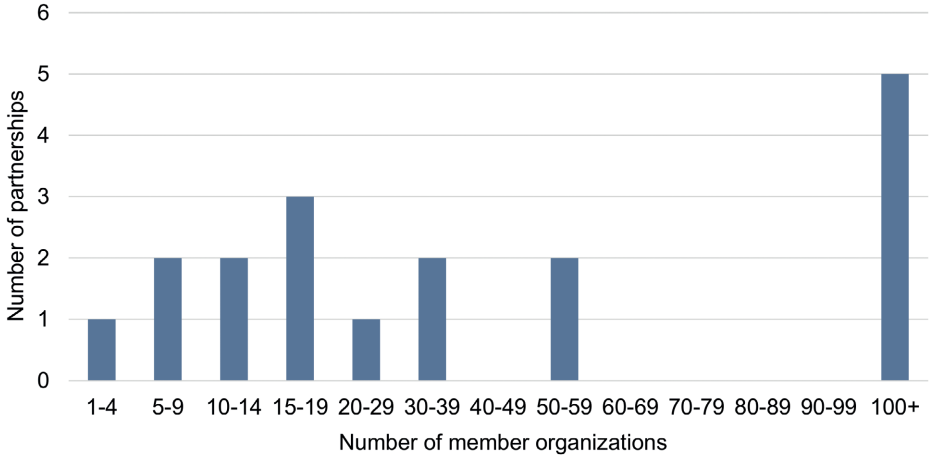
The member characteristics dimension consists of 2 items (items 13-14, Table 1).

Table 4 shows the types of members that were included in the partnerships. All 18 partnerships included medical organizations, yet only 4 out of 18 partnerships included commercial companies. The total number of partnership member organizations can be found in Figure 1. Of all 18 partnerships, 8 included less than twenty member organizations. Five partnerships included more than a hundred member organizations.

Table 4: Member characteristics: Heterogeneity of 18 European tobacco control partnerships

#		Yes (n)	More or less (n)	No (n)
13	*Heterogeneity*			
	Medical organizations	100% (18)	-	0% (0)
	Patient organizations	78% (14)	-	22% (4)
	Educational organizations	56% (10)	-	44% (8)
	Youth or family organizations	61% (11)	-	39% (7)
	Sports organizations	39% (7)	-	61% (11)
	Commercial companies	22% (4)	-	78% (14)

Figure 1: Member characteristics: number of member organizations of 18 European tobacco control partnerships (# 14)



Partnership characteristics

The partnership characteristics dimension consists of 8 items (items 15-22, Table 1). Results can be seen in Table 5. Thirteen out of 18 partnerships had agreement on the roles and responsibilities of member organizations (7 partnerships had agreement, 6 had some agreement). Twelve Partnerships had an agreement on how credits are divided across member organizations (3 partnerships had agreement, 9 had some agreement). Such credits may refer to public recognition of expertise and authority of individual members, their made efforts, and their public visibility. Of all 18 partnerships, 12 indicated having a leadership figure that connects, inspires and resolves conflict within the partnership. Concerning strategy, 17 out of 18 partnerships had an agreement on common goals (11 partnerships had agreement on a common goal, 6 had some agreement) and 16 partnerships had agreement on a common strategy (9 partnerships had agreement, 7 had some agreement). Furthermore, 16 out of 18 partnerships were able to formulate a shared public position on tobacco issues (14 partnerships were able, 2 partnerships

were more or less able). Lastly, 16 partnerships were able to avoid or resolve conflicts between member organizations (6 partnerships were always able, 10 partnerships were usually able).

Table 5: Partnership characteristics of 18 European tobacco control partnerships

#		Yes (n)	More or less (n)	No (n)
	Governance			
15	Agreement on roles and responsibilities of members	39% (7)	33% (6)	28% (5)
16	Central office with coordinating staff	67% (12)	-	33% (6)
17	Agreement on how credits are divided among members	17% (3)	50% (9)	33% (6)
	Leadership			
18	Presence of connecting, inspiring and conflict resolving person(s)	67% (12)	-	33% (6)
	Strategy			
19	Agreement on the common goal	61% (11)	33% (6)	6% (1)
20	Agreement on a common strategy	50% (9)	39% (7)	11% (2)
	Conflict resolution			
21	Ability to formulate a shared public position	78% (14)	11% (2)	11% (2)
22	Ability to avoid or resolve conflicts between members	89% (16)*	-	11% (2)

**Combined answer categories: yes always (6), yes usually (10), no usually not (2), and no, never (0)*

Comparison of prevalence of characteristics across partnerships

As can be seen in Figure 2, there was variance across European partnerships with regards to the prevalence of characteristics related to partnership strength. With a maximum score of 3, the lowest scoring partnership (number 14) scored 0.45 and the highest 2.63 (number 13). Figure 3 shows the dispersion of total partnership scores per dimension using boxplots. Interquartile ranges (IQR) were 0.19 (IQR 0.72 to 0.91) for resources, 0.47 (IQR 0.24 to 0.71) for member characteristics, and 0.34 (IQR 0.47 to 0.81) for partnership characteristics.

We calculated correlations between the dimensions. Member characteristics had moderately strong correlation with resources (r = .47) and partnership characteristics (r= .43). The correlation between resources and partnership characteristics was strongest (r = .79).

Figure 2: A comparison of prevalence of characteristics related to tobacco control partnership strength across 18 European partnerships

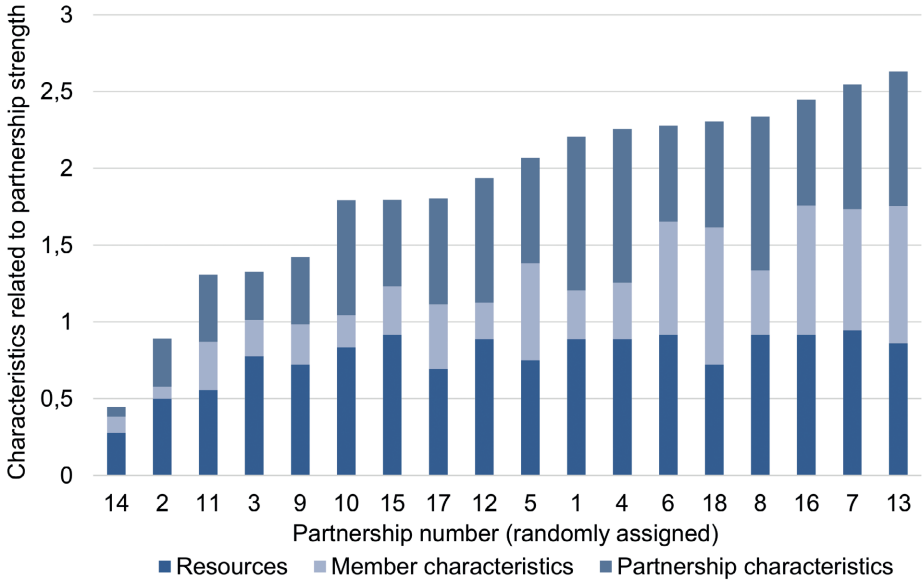
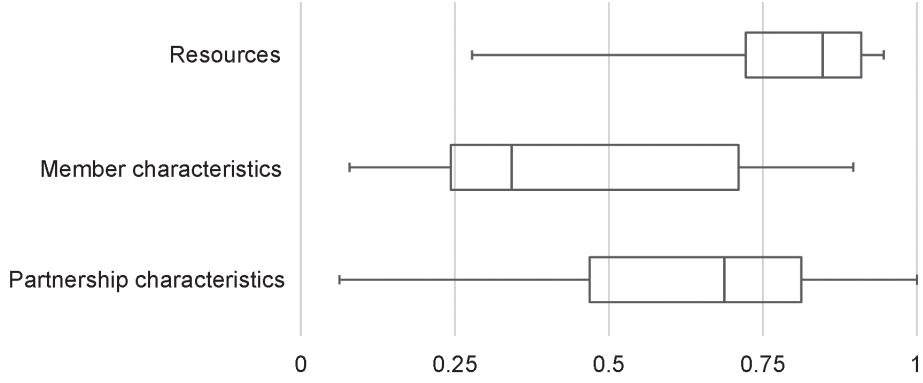


Figure 3: Dispersion of total scores per dimension



DISCUSSION

We assessed the prevalence of characteristics related to partnership strength across 18 European tobacco control partnerships. European partnerships differ concerning the prevalence of characteristics related to their strength, as some characteristics were observed more often than others. Overall, European partnerships scored relatively high on the resources dimension, suggesting there is considerable expertise, ample access to national information and good

connectivity to policymakers, journalists and other partnerships. The relatively low total scores on the member characteristics dimension suggests that European partnerships may further increase their volume and heterogeneity. The partnerships also scored relatively high on the partnership characteristics dimension, yet there was still room for improvement, for example in reaching agreement on roles and responsibility or agreement on the adequate division of credits among member organizations.

Most European partnerships included scientists and communication experts, yet only 13 partnerships included professional lobbyists. The American Cancer Society emphasizes the importance of professional lobbyists for advocacy in tobacco control partnerships or coalitions (15). Such lobbyists may be hired, or existing employees may be trained to acquire such skills.

A considerable number of partnerships have ample access to various types of nationally relevant data. However, there was room for improvement concerning access to data on tobacco industry presence and lobbying, as five partnerships did not have access to this type of information. Respondents from half of the partnerships indicated they had influence on the research agenda of national organizations that fund or carry out research. Partnerships may invest in relationships with such organizations (e.g. universities or statistical offices), in order to generate national data needed for effective advocacy.

Almost all partnerships maintained working relationships with civil servants (17 of 18 partnerships), less with Members of Parliament (16 of 18 partnerships) and least with the Minister or Secretary of State (11 from 18 partnerships). The highest-ranking policymakers within a policy domain are not necessarily the most important ones to target (16). It can be argued that civil servants offer the most effective route of influence, as they are more likely to remain in office when there is a regime change, compared to ministers or members of parliament. Moreover, they frequently play important insider roles in advancing tobacco control (17).

When it comes to partnership characteristics, 5 partnerships had no agreement regarding roles and responsibility of member organizations, and 6 partnerships had no agreement on how credits are divided between member organizations. Previous research suggests that in terms of productivity, it is important for partnerships to have clear roles and responsibilities for their members (8,9). Furthermore, inadequate division of credits could lead to a discontinuation of a partnership, as organizations want public recognition, especially when they are charities (Chapter 6). To increase productivity and to prevent a possible discontinuation of the partnership, it may be important to reach agreement in these areas. A connecting leader could play a role in these domains. However, 6 out of 18 partnerships in our study indicated that they did not have such a leadership figure.

A noteworthy finding was that 5 out of 18 partnerships had more than a hundred formal partners. This may perhaps be explained by a different strategy of some partnerships compared to others. Some partnerships may want to demonstrate a broad public support base to better influence policymakers (18). Alternatively, it could be that such large partnerships gathered momentum over time and therefore many organizations elected to join voluntarily (i.e.: a so-called 'bandwagon effect') (15,19). In contrast, some partnerships may prefer a small number of member organizations, as this may accelerate reaching consensus or decision-making processes. The critical issue may however not be the overall size of the partnership per se, but whether the specific mix of member organizations and the ways in which they participate help to achieve the goals of the partnership (13).

Our tobacco control partnership tool proposes a specific model of collaboration, in which a partnership consists of various organizations pursuing a common goal (reducing smoking prevalence) and a specific way of reaching that goal (political advocacy). In this model, more resources, more members, more heterogeneity, and more agreement on issues is presumed to result in a stronger partnership and more influence. However, it can be questioned whether there is such a 'one-size-fits-all' model for effective political advocacy, given the fact that countries have unique tobacco control policy environments (3,20). It may for example be the case that the scientific communities in Italy, although excluded from our study as they did not meet our definition of a partnership, are recognized as authorities in the national tobacco control policy debate and therefore play prominent roles in defining the problem and proposing viable policy solutions (21).

There are a few methodological caveats to the tool presented in this study. Firstly, the validity of the tool remains to be determined. Even though the positive and relatively strong correlations between the dimensions suggest that they measure dimensions of the same construct, we do not know whether it indeed measures the construct 'partnership strength' in terms of effective political advocacy. Secondly, having one respondent to fill in the tool per partnership may have introduced some level of measurement error due to subjectivity. A point of improvement in further research may therefore be to apply different assessment strategies, for example consensus meetings with a few members of the partnership, or by selecting two or more independent respondents and improving the inter-rater reliability. Considering these methodological shortcomings, we refrained from drawing country specific conclusions.

Despite these shortcomings, our tool allowed us to demonstrate differences across partnerships in their prevalence of characteristics related to their strength. The tool may function as a practical starting point for tobacco control advocates that wish to improve the strength of their partnerships and may inspire future research in this important field.

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CHAPTER 8

General discussion

This thesis had a dual focus. In part I we examined determinants of tobacco control policymaking in European countries. In part II we focused on which characteristics contribute to European tobacco control partnership strength, which is an important determinant of tobacco control policymaking.

Overview

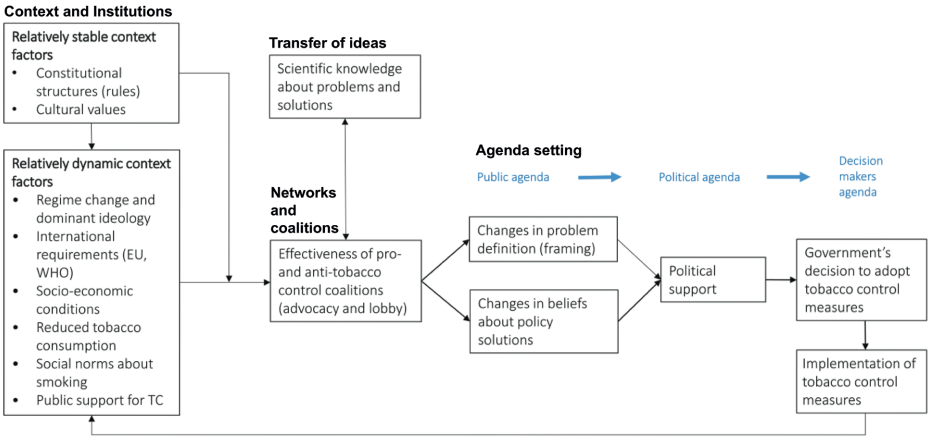
Cairney's five core components related to tobacco control policymaking served as a guide to investigate aspects of the policy process throughout this thesis (1,2). Table 1 shows which of these components were studied in which chapter(s).

Table 1. Overview of core components of tobacco control policymaking as addressed in the chapters of this thesis

Core component	Chapters
Societal factors	3,4
Institutions	4
Agenda setting/framing	2,3
Interest groups	4,6,7
The role and transfer of ideas	5

In Figure 1, the integrative framework of tobacco control policymaking by Willemsen (1) is shown. It posits how policymaking takes place. The five core components of policymaking in Table 1 are represented within this framework. The framework shows how these components related to policymaking may interrelate. Studies in this thesis investigated aspects of this framework separately. Studies varied inasmuch as they incorporated more or less of such aspects in a single study. Chapter 4, for example, investigated multiple aspects simultaneously (effectiveness of pro- and anti-tobacco control interest groups, international requirements, dominant ideology, socio-economic conditions), whereas Chapter 5, for example, exclusively focused on one aspect of policymaking (transfer of ideas).

Figure 1: An integrative model of tobacco control policymaking (Willemsen, 2018).



Main findings

Below we discuss per component which insights this thesis generated.

Societal factors

The societal factors relate to smoking prevalence, the importance of the tobacco industry for the national economy, and public attitudes towards tobacco control (2). In this thesis we found (Chapter 3) that public support for prospective tobacco control policies is higher among individuals who believe children should be protected against tobacco. We investigated this relationship in subgroups known to be skeptical towards more future tobacco control regulations: smokers, opponents of big government and opponents of a governmental role in tobacco control. Results showed that there was indeed a positive association between support for the protection of children against tobacco and support for three prospective policies. These results suggest that an issue frame highlighting the protection of children may help to increase public support, even among segments ideologically opposed towards tobacco control. It should be noted that smokers had less support for prospective measures than non-smokers, even if they believed children should be protected.

Chapter 4 highlighted the importance of tobacco industry presence (in terms of employment) as an obstacle to the development of comprehensive tobacco control. Previous work found that the economic presence of the tobacco industry indeed strengthens its negotiating position, due to claims of threatened employment when restrictive policies are implemented (3). Policymakers are usually susceptible to economic arguments (4). This thesis confirmed this mechanism. For example, in Chapter 4 we found that in Germany, having industry representations (both manufacture and production) in all federal states allowed industry representatives to exert

influence on state level politicians, who are also represented (i.e.: influential) in the federal government.

Institutions

Public policy scholars who study institutions generally connect policy outcomes with institutions that influence the progress of a policy (2). We defined institutions as "relatively enduring features of political and social life that structure behavior and that cannot be changed easily or instantaneously" (5). In Chapter 4, we found that there are several institutional arrangements associated with the relative influence that interest groups have in the tobacco control policy process. These include: the role that the health ministry plays in tobacco control policymaking, and the interpretation of Article 5.3. of the Framework Convention on Tobacco Control (FCTC). Cairney et al. (6) have emphasized the importance of a health ministry that needs to take the policy lead, which automatically fosters the inclusion of public health groups at the expense of pro-tobacco interests. However, our study was among the first to include various different institutional arrangements across several countries simultaneously. We found that policy monopolies correspond to the ways in which institutions are arranged. We observed similarities with regard to such institutions across countries with the same policy monopoly. In countries with an industry monopoly, for example, the health ministries play subordinate roles in the process of policymaking and FCTC Article 5.3. is interpreted in a limited way, restricted to promises of transparency.

Different policy outcomes were observed when health groups had a policy monopoly, compared to when the tobacco industry had a policy monopoly. In countries where there was a health policy monopoly, tobacco display bans were implemented already more than a decade ago as part of a large comprehensive tobacco control policy package. In countries that had a tobacco industry policy monopoly, there was policy inertia for a decade or more.

Agenda-setting / Issue framing

In Chapter 2, we referred to a body of literature that provides mostly 'anecdotal' (as opposed to scientific) evidence about the first phases of policymaking, which includes agenda setting. However, not much empirical research has been conducted on these phases as far as youth tobacco product access and exposure policies are concerned. We studied issue framing in Chapter 3, which is a key factor in the first phases of policy making. Findings suggest the possible benefits of using a child-frame, which is increasingly being used by tobacco control advocates in many countries (2,7,8).

In Chapter 4, we looked at the dominant governmental frame of tobacco consumption across six countries, and whether it corresponded to the policy monopoly in place. This turned out to be

the case: in countries where the tobacco industry had a policy monopoly, tobacco consumption was clearly understood as a private problem, as opposed to a public health problem. In countries where there was a clear health policy monopoly, tobacco consumption was clearly understood as a health issue.

Interest groups

Chapter 4, 6 and 7 concerned the role that interest groups play in the tobacco control policy process across European countries. Chapter 4 focused on pro and anti-tobacco control interest groups and on features of the policy environment that could facilitate or hinder their respective influence on the policy process. Because findings of Chapter 4 indicated that there is variance across countries with regard to how well the NGO tobacco control community is developed, we focused more on this aspect of tobacco control policy making in part II of the thesis.

Chapter 6 examined which characteristics contribute to tobacco control partnership strength. We organized an expert panel with tobacco control advocacy experts from 10 different European countries. We found ten characteristics related to tobacco control partnership strength in terms of influencing policy: (1) financial independence from government, (2) expertise in research and advocacy, (3) an evidence based approach, (4) access to nationally relevant data, (5) connections to policymakers, journalists, researchers, and other partnerships, (6) partner heterogeneity (7) conflict resolution, (8) a central coordinating office, (9) clear rules or statutes, and (10) a shared vision/consensus. These characteristics were classified into one of four categories of a health promotion partnership framework proposed by Lasker et al. (9): resources, member characteristics, relationships between members, and partnership characteristics.

In Chapter 7, we made a tentative comparison of the prevalence of such partnership characteristics across 17 European countries. We did this by means of a 22-item tool across 3 dimensions (see Appendix 2). Some partnerships could improve with regard to a number of characteristics related to their potential strength. These characteristics included: having professional lobby expertise; access to national information on tobacco industry and lobbying; influence on national research agendas; agreement on roles and responsibilities; and agreement on how credits are divided among member organizations (e.g. visibility and recognition in society). Our comparison indicated that some European partnerships indeed have more characteristics related to partnership strength than others. Furthermore, one third of investigated countries did not include a national level tobacco control partnership according to our definition and criteria.

The role of ideas

Chapter 5 investigated considerations which play a role in lesson-drawing from other countries. We found that the German government is not inclined to look at other countries for lessons.

When governments are inclined to look at foreign examples, it seems more important that those 'exporter' countries are similar and close to the 'importer' country, than that they are progressive in terms of tobacco control policy. This provides tobacco control advocates with opportunities to facilitate successful lesson-drawing in their countries. They may, for example, choose countries close by to draw lessons from, preferably if there are scientific studies available. When they choose global leading countries in terms of tobacco control, they may emphasize similarities to these countries in terms of policy or country contexts.

Theoretical considerations

As Clavier et al. (10) and Breton et al. (11) pointed out, the process of policymaking in health promotion, including the field of tobacco control, has received scant scientific attention. Therefore, the studies presented in this thesis focusing on determinants of tobacco control policymaking (part I) have been relatively novel contributions to this field of study. In the following section, we will describe what we have learned from these studies.

In Chapter 4, we applied the Punctuated Equilibrium Theory, or more specifically, its (sub) theory of policy monopolies, to compare countries with regard to the relative influence that pro and anti-tobacco control interest groups have on the policy process. The theory of punctuated equilibrium posits that a policy remains stable most of the time, and that policy change occurs in response to punctuations of an equilibrium (12). This may happen when competing groups are successful in framing the dominant policy image and propose viable solutions fitting that frame. The competing group then determines how the issue is seen, understood and subsequently solved, at the expense of the other group. The authors of the Punctuated Equilibrium Theory have addressed the possibility that policy monopolies may be the main cause of a policy equilibrium (i.e.: policy stability) (13). Such considerations highlight the importance of policy monopolies in explaining policy change and stability. We have found this theory useful in comparing multiple countries simultaneously with regard to the relative power of interest groups. Especially because it takes into account explanatory variables which vary across countries: how tobacco is framed and how institutions are arranged.

In times of policy stability, policy monopolies by either pro or anti-tobacco control interest groups are hypothesized to 'dampen pressures for change' from competing interest groups (14). The findings from Chapter 4 confirmed this mechanism: in countries where the tobacco industry had more influence on the policy process (Germany and Italy), there was policy inertia for at least a decade, and calls for change from tobacco control advocates did not resonate with policymakers. In these countries, the tobacco industry was able to keep the issue off the political agenda, or health groups were unable to put the issue on the political agenda. In countries where health groups had a policy monopoly (Finland and Ireland), the tobacco industry was excluded

from the policy process as a legitimate stakeholder, by a strict governmental interpretation of FCTC Article 5.3, and by an NGO community that fostered a bad public industry image. In these countries, large comprehensive policy packages in the domain of tobacco control were being enacted since a decade or longer.

Other theoretical frameworks may be better suited when studying the process of policymaking in a single country, particularly the Advocacy Coalition Framework, whose authors recommend its use on a single country case for periods of at least a decade (15), and Kingdon's Multiple Streams Approach, which is a dynamic theory of policy change that can also be used on a single case over time (16). In practice, these theories are indeed often applied to single country case studies. Such approaches offer valuable theoretical insights into policymaking, yet the relevance of these insights is largely bound to specific countries (17). In contrast, a systematic cross-national comparison (Chapter 4) has the potential to discover variables that are treated like constants in single country case studies (18), such as the role of the health ministry in policymaking, the economic presence of the tobacco industry, and the interpretation of FCTC Article 5.3.

The scientific field of Health Promotion

Health promotion scholars typically focus on changing individual health behaviors and cognitions, while having less consideration for political determinants of health, such as policy measures. These scholars employ theoretical models such as the PRECEDE-PROCEED model (19), the I-change model (20), the Health Belief Model (21) and/or the Theory of Planned Behavior (22). When such models integrate policy measures, they are included as wider environmental factors, or contextual determinants of individual health behavior (19,20). Although the importance of policy measures as determinants of health behavior is acknowledged in health promotion, scholars do not often study them in isolation (23).

When health scholars do occasionally pay attention to policy measures, they have the tendency to investigate impacts of such measures. In other words: they focus on what happens *after* the implementation of policy measures, instead of what *determines* the adoption of such measures. The International Tobacco Control (ITC) project is an example of how policy impacts are evaluated, in terms of behavioral and psychosocial outcomes in smoker populations (24). Although it is important - also for policymakers - to know whether policy measures 'work' by demonstrating their (un)intended effects in populations, findings in this thesis emphasize that policy change is dependent on many other factors than knowledge of policy impacts alone (25).

For the sake of public health, it is certainly important to investigate individual health behaviors, but policy measures have the potential to improve the health of millions of citizens simultaneously. Health promotion would benefit from more attention to the initial phases of

the process of policymaking, in addition to a focus on changing behaviors and cognitions of individuals, and impacts of policy measures. This may mean that more collaboration between those working within the field of health promotion and public policy scholars is called for.

Methodological considerations

Strengths

The strength of this thesis lies in its focus on determinants of tobacco control policy (part I) and on tobacco control partnerships as unit of analysis (part II), its realist-inspired methodology, and its cross-country comparative approach. These strengths are discussed below.

Focus on determinants of tobacco control policymaking

This thesis focused on the adoption of tobacco control policies, instead of the impact of tobacco control policies on individual behavior, cognitions, or health. Providing more insight in how policy develops, can explain why countries differ with regards to their tobacco control policy comprehensiveness, and can enable tobacco control advocates to better exploit opportunities for policy change (26). Furthermore, interest groups are usually studied by means of theoretical frameworks that consider the policy process more broadly. We adopted an innovative approach by looking at tobacco control partnerships as unit of analysis, to assess what contributes to partnership strength, independent of the wider policy context. This approach gives practical starting points for advocates to monitor and improve their partnerships and to compare their partnerships to others in Europe.

Realist inspired

The realist inspired approach of Chapter 4 of this thesis goes beyond a focus on correlations between independent and dependent variables. It aims to explain *how* policy processes happen, with a special focus on context (27). In different words: it aims to assess *how* determinants of policymaking relate to policy outcomes, taking into account different policy and country contexts (Chapter 4).

Our approach in Chapter 4 and 6 was to first identify some of the (implicit) characteristics that are relevant to the process of policymaking or advocacy. Then, the relationship between these characteristics and policy outcomes was determined by making hypothesized mechanism(s) explicit. For example: national data on parliamentarian or political party attitudes towards tobacco control are an important resource for tobacco control partnerships, as it provides information on where to lobby most effectively (Chapter 6).

Comparative

As argued before, a comparative study across multiple countries has the potential to discover more general patterns of policymaking transcending single country idiosyncrasies (17). We tried to determine such patterns. The study in Chapter 4 highlighted that some characteristics related to policymaking only become apparent in a cross-national study-setting, such as the centrality of the health ministry. In a single country case study, such variables are necessarily treated as constants (29). Another example of a transcending pattern of policymaking, are the roles that proximity and similarity play in lesson-drawing from other countries in tobacco control (Chapter 5). By comparing multiple countries simultaneously, we discovered that overall, governments are inclined to learn policy lessons from nearby and similar countries.

Limitations

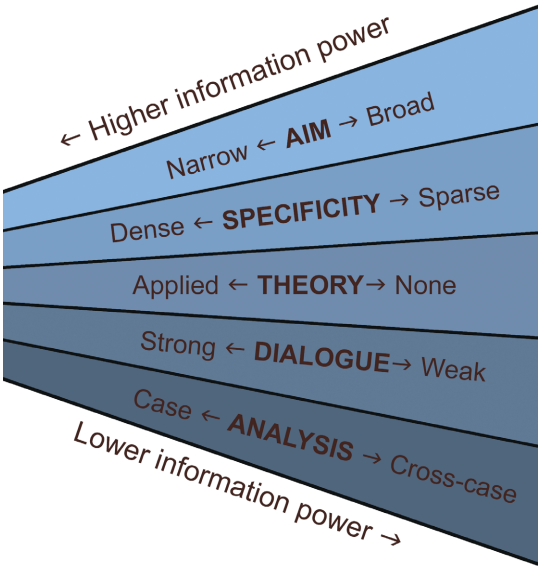
The main limitations of this thesis were that: we had to rely on a limited number of interviewees, we employed a single data source as opposed to multiple data sources, and we could not test for the relative importance of determinants. These limitations are further discussed below.

Limited number of interviewees

In Chapter 4 and 5, we drew country-level conclusions for six countries based on 32 interviews (Chapter 4) and for five countries based on 27 interviews (Chapter 5). It could be argued that these samples are small in total size. However, the needed sample size in qualitative studies is determined on different grounds from sample sizes in quantitative studies, where a larger sample is always preferred to detect (sometimes small) population effects.

According to Malterud et al. (30), the required size of a sample in qualitative research to have sufficient 'information power' depends on: the aim, the sample specificity, the use of established theory, quality of dialogue, and the analysis strategy (Figure 2). The higher the information power, the smaller the sample needs to be. Our study had a narrow focus (determinants of policy adoption, the case of a display ban), assured a dense sample specificity (by purposively selecting policy participants), applied two theories of policymaking (The Advocacy Coalition Framework and The Punctuated Equilibrium Theory (14,31)), assured a high dialogue quality (by attending a course in interviewing-skills and using a theoretically informed topic list), and was cross-case (comparing multiple countries). With the exception of the last dimension, all other dimensions contribute to a high level of information power. More importantly, the interviews demonstrated considerable similarities and compatibility within countries, suggesting data saturation.

Figure 2: Information power and its dimensions



One data source as opposed to multiple data sources

We could have used other data sources to supplement our interview and expert panel data (Chapter 4-6), such as policy documents (e.g.: submissions to public hearings, white papers), media coverage, or internal industry documents (32). Using more than a single data source in a study is called 'data triangulation' and is more commonly observed in qualitative, naturalistic studies such as undertaken in this thesis (33). An important downside of data triangulation is that it is much more time-consuming in comparison to single data analysis strategies (33). Unfortunately, we did not have the time and resources to supplement our data with other data sources. As we investigated policy processes, we expected most accurate information from stakeholders that were involved in the process of policymaking in their countries. However, these interviews could have been supplemented with more objective sources to verify the validity of stakeholder perceptions.

The relative importance of determinants

The studies in Chapter 4-6 did not test whether some determinants, considerations or characteristics were more important for tobacco control policymaking or advocacy than others. In Chapter 4, we do not make claims about which institutional arrangements or which types of framing are more important than others in explaining policy monopolies by pro or anti-tobacco control interest groups. In Chapter 5, we do not know which considerations in lesson-drawing take precedence over others. In Chapter 6, we present a list of 10 key characteristics related to tobacco control partnership strength, but we do not know which of these characteristics are

most important in explaining strength. We could not avoid or correct this limitation. Future researchers in this area may therefore use an appropriate study design to test the relative importance of determinants, considerations, or characteristics investigated in this thesis.

Generalizability

Generalizability to other countries

In line with findings of Chapter 5, we think that findings of this thesis may be generalizable to countries within Europe (nearby countries), as the data are predominantly collected within European countries. Furthermore, and also in line with Chapter 5, we argue that findings may also be generalizable to countries outside Europe, when there are enough similarities between those countries and the sample countries. We propose a number of attributes which may be relevant in determining generalizability to countries outside the EU: the degree of democracy, various institutional dimensions, and the stage in the tobacco epidemic model.

A potential aspect that is likely relevant to generalizability may be the degree of democracy of a given country. All countries included in this thesis guarantee civil rights such as the freedom of assembly and association (34). Furthermore, they secure basic democratic principles such as the organization of free and fair elections, and political participation (34). These rights and principles are not necessarily secured in all countries across the globe. Findings of this thesis may therefore be less generalizable to more autocratic and authoritarian regimes such as China, Russia or Turkey (35).

Institutional aspects that may be relevant to generalizability are federalism versus unitarianism and having a presidential versus a parliamentarian system (36). Most of the countries in our study had a unitary system of governance combined with a parliamentarian multi-party political system. Findings may be less generalizable to federal or presidential countries (or countries with both characteristics such as the United States). A parliamentarian system may for example offer more routes of influence for advocacy, as the governing coalition (and parliament as a whole) typically consists of multiple parties (13). In federal systems, national level advocacy may be less relevant, as policy change at lower levels can be more important to the formulation of comprehensive tobacco control (37). Findings of this thesis based on smaller European countries may therefore be better generalizable to lower levels of US government, such as US states, than to the federal level.

Further, the stage in which a country is, in terms of the tobacco epidemic model can be relevant in determining generalizability (39). Europe is in the fourth stage of the tobacco epidemic, yet many countries in Africa are in the first, and many countries in Asia are in the second stage of the model. Such countries currently experience a very high smoking prevalence, especially

among men (40). In countries at a later stage in the tobacco epidemic model, smoking prevalence is lower, which corresponds to a societal non-smoking norm (41). In such countries, there is generally more public support for comprehensive tobacco control than in countries with higher prevalence, earlier in the tobacco epidemic model. This relationship may largely be explained by the fact that smokers are more opposed towards tobacco control than non-smokers (42–44).

Generalizability to other policy measures

Chapter 4 specifically concentrated on the policy process of a tobacco display ban. A display ban was one of three access and exposure policy measures investigated in Chapter 2 and 3 (in addition to an increase in age of sale and limiting the number of sale outlets). Chapter 5 focused on various policy measures, even though data were collected with the primary goal of investigating the policy processes related to a display ban. Chapter 6 and 7 focused on advocating for the adoption of MPOWER policy measures in general.

The question arises whether the insights in this thesis, and most notably those of Chapter 4, can be generalized to other tobacco control policy measures, or tobacco control in general. A display ban is a supply-side policy measure which is predominantly adopted to protect children and smokers who are in the process of quitting smoking from exposure to tobacco products at points of sale (45). It can be argued that different considerations play a role when other policy measures are considered.

As was explained in the introductory chapter, there are many other policy measures available to governments to bring down smoking prevalence, such as increasing the excise tax for tobacco products, smoke-free environments, an increase in age of sale, limiting the number of sale outlets, plain packaging, health warnings, mass media campaigns, et cetera (46). It is likely that there are variations in the policy processes related to different policy measures. For example, when excise tax is considered, the Ministry of Finance may play a more prominent role in the policy process than the Ministry of Health (health ministry centrality; Chapter 4). When smoke-free venues are considered, there are other pro-tobacco actors in the policy debate, such as the hospitality industry (instead of retailers; Chapter 4). It can also be argued that the effectiveness of frames depends on the policy measure. A liberal-conservative frame which posits that smoking is a private problem (as opposed to a public health problem; Chapter 4) is likely more effective with regard to supply-side restrictions than to smoke-free environments, as a problem can hardly be called ‘private’, when second-hand smoke harms the health of non-smokers.

Despite these possible variations, there may also be notable parallels between policy processes with regard to different policy measures. Tobacco control advocates may always want more and stricter legislation, the tobacco industry may always want less and more lenient legislation.

Furthermore, some more structural socio-economic features do likely not vary as a function of the policy measure, such as how well the industry is represented in terms of employment, or a government's interpretation of FCTC article 5.3.

Generalizability to other policy domains

Findings of this thesis may be generalized to other policy domains, such as alcohol policy. Even though some scholars have argued that there is "tobacco exceptionalism" (47), which posits that tobacco is distinct in its harmfulness and that the tobacco industry requires a specific kind of treatment, there are considerable similarities between the policy domains of tobacco and alcohol. Both industries are dominated by large multinational corporations, which sometimes have more resources than national governments (48). Their economic interests are directly threatened by the implementation of comprehensive public health policies to regulate these products, which is why they both strongly oppose implementation of such policies (47). Furthermore, both industries are found to employ similar strategies in influencing policy (49) and there are interlinkages between the two industries at top management level (50). Countries also vary considerably in their implementation of comprehensive alcohol control policies to address the public health problems caused by alcohol consumption (51). Lastly, there are also notable parallels in the policy instruments that can be implemented to address tobacco and alcohol consumption. Governments may choose to regulate the supply-side through restrictions on product marketing or availability, or the demand-side through tax and price policies (52).

Implications for science

There is scant empirical evidence about determinants of tobacco control policymaking. In Chapter 2, we observed that tobacco control scholars typically study impacts of policy, rather than determinants of policy adoption, at least in the case of raising the age of sale, banning tobacco displays at points of sale, and limiting the number and type of tobacco outlets. More insight in the process of policymaking is needed, because the reason why some countries have weaker tobacco control policies than others is predominantly political (53). Furthermore, more insights into determinants of policymaking can provide tobacco control advocates in civil society with relevant knowledge about the policy environment in which they operate (54,55).

Future research could further extend the explorative work on tobacco control policy advocacy we conducted in chapter 6 and 7. Tobacco control advocacy is rarely the focus of study in tobacco control. Scholars could use complementary study designs to verify, supplement or modify the explored characteristics related to partnership strength. We studied perceptions of tobacco control advocacy experts to identify these characteristics. This is however, a rather subjective method. Future scholars may come up with other study designs to objectively measure advocacy

strength. This is a substantial challenge, however, because the link between advocacy activities and resultant policy outcomes is quite hard to establish (56).

Future scholars could alternatively also focus on political ideology in tobacco control (57). A liberal-conservative attitude of citizens or policymakers was in this thesis mostly understood as an obstacle to the formulation of comprehensive tobacco control policies. However, a liberal-conservative attitude could also be compatible with tobacco control. Tobacco control is often seen as a threat to freedom (freedom from interference), however, as tobacco consumption is increasingly understood as an addiction, tobacco control could also be seen as an enabler of freedom (freedom from addiction) (58). Future scholars could thus try to identify ways in which tobacco control can be made an acceptable idea for all ideological segments in society and government.

Overall, future scholars could focus more on effective policy frames. In the Netherlands, the frame of the protection of children against tobacco seems effective in mobilizing policymakers to implement tobacco control policies (59). In other European countries such as the United Kingdom and France, health inequalities are found to be an appealing problem frame to policymakers (60). Future scholars could establish per European country, which frame seems most appealing to citizens and policymakers. It should be simultaneously investigated, however, to what extent various frames are actually effective in terms of producing comprehensive policy outcomes. Addressing health inequalities, for example, requires a difficult coordination across several policy sectors, and could therefore make the problem seem too difficult for policy intervention (60).

Implications for advocacy practice

Most studies in this thesis provide implications for tobacco control advocacy practice. We recommend advocates to enforce a better interpretation of FCTC Article 5.3, to make the health ministry responsible for tobacco control, to establish or further develop the national tobacco control NGO community, to denormalize the tobacco industry, and to draw lessons from successful nearby and/or similar countries in tobacco control.

A stricter interpretation of FCTC Article 5.3. could potentially be achieved through court cases. This strategy was observed to be successful in The Netherlands. The court case of an NGO against the Dutch state resulted in the development of an internal document describing rules of conduct to deal with advocates from the tobacco industry. Another way of enforcing a strict implementation of Article 5.3., is to develop formal codes-of-practice for policymakers. Such codification prevents the risk that general commitments to adhere to the guideline cease to exist when there is a change of government (61).

In most European countries, the responsibility for tobacco control resides within the health ministry. In Germany this was however not the case. German advocates could direct attention to this case, also pointing to many other European countries where the jurisdiction for health policy resides in the health ministry.

The NGO community in some countries was better developed than in other countries. Chapter 6 and 7 provide practical starting points for tobacco control partnerships, alliances or coalitions, to self-assess their partnerships and see whether they can increase the number of characteristics related to partnership strength. For example: acquiring lobby expertise, and finding ways to influence the research agenda of national statistical offices, public health institutes, or universities.

When enforcement of a strict interpretation of Article 5.3 is unsuccessful, tobacco control advocates may try to exclude the tobacco industry from the policy process by giving them a bad public image. They may do this by labelling them untrustworthy, deceitful, or evil. This was a strategy observed in Finland and Ireland.

Lastly, lessons in tobacco control can be drawn by tobacco control advocates and used in their communications to policymakers. They could choose best practice examples from nearby or similar European countries, or emphasize similarity in (policy) contexts to global leaders in tobacco control.

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ABBREVIATIONS

ACF	Advocacy Coalition Framework
CEO	Chief executive officer
COPD	Chronic obstructive pulmonary disease
ENSP	European Network for Smoking and Tobacco Prevention
EU	European Union
FCTC	Framework Convention on Tobacco Control
ITC	International Tobacco Control Policy Evaluation Project
IQR	Interquartile range
MP	Member of Parliament
NGO	Non-governmental organization
POS	Point of sale
RAMESES	Realist And Meta-narrative Evidence Synthesis: Evolving Standards
SES	Socio-economic status
SSCI	Social Sciences Citation Index
TAD	Tobacco Advertising Directive
TCS	Tobacco Control Scale
TPD	Tobacco Products Directive
US	United States
WHO	World Health Organization

VALORIZATION ADDENDUM

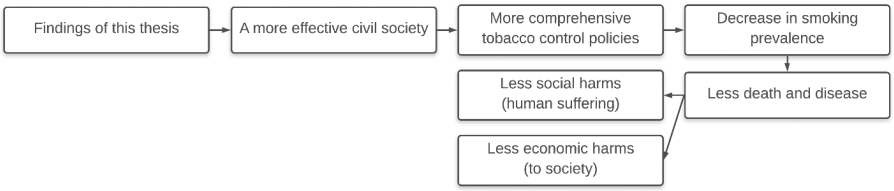
According to the Rathenau institute and the Dutch government, valorization refers to a "process of creating value from knowledge by making knowledge suitable and/or available for economic and/or societal use and translating that knowledge into products, services, processes and entrepreneurial activity" (Rathenau Institute, 2016).

The aim of this valorization addendum is to describe the societal relevance and impact of findings presented in this thesis. Five questions are answered: 1) What is the social and economic relevance of the research results 2) For which people, outside of academic circles, are your results of interest? 3) Are there actual research products in which your results are applied? 4) To what extent are these products innovative compared to existing products? And 5) How will these be implemented?

Relevance

As tobacco consumption causes diseases and premature deaths, the associated social harms resulting from human suffering are considerable (1). Comprehensive tobacco control policies have the potential to reduce smoking prevalence (2–4). More ambitious policies should be adopted in Europe to reduce smoking prevalence, to ultimately reduce death and disease and associated social harm (suffering). In order to achieve this, civil society plays a crucial role. It needs to work effectively to foster tobacco control policies at the national level. This thesis had a dual focus: 1) examining the policy environment more precisely using cross national policy adoption designs (i.e.: determinants of policymaking) and 2) examining how civil society can improve itself. Both these aims may help civil society to work more effectively. When they become more effective, comprehensive evidence based policies may be more readily enacted as a result, smoking prevalence will then likely decrease, which causes less people to die and get sick, which will in turn reduce human suffering and associated costs for society (Figure 1).

Figure 1: Flowchart of hypothesized relationship between findings of this thesis and social and economic benefit



Secondly, in terms of economic relevance, tobacco consumption brings about enormous financial costs for societies because of high healthcare costs and absenteeism etc., even when taking

into account the considerable treasury income from tobacco excise duty (5). When smoking prevalence decreases, it will ultimately save society a great amount of money, which can be spent on alternative issues which may benefit the population (e.g. improving healthcare or education).

Target groups

More insight into tobacco control policymaking is relevant for various stakeholders outside academia. Most obviously, this refers to actors in civil society (tobacco control advocates) who benefit from a more detailed assessment of the policy environment and a list of characteristics that may help them to assess and improve the strength of their advocacy. As targeted end-users of the knowledge generated in this thesis, these advocates were actively consulted and involved during the project and most of the data was collected from them.

Next to civil society advocates, policymakers may benefit from findings presented in this thesis. As an example: in Chapter 3, we find that public support may be galvanized by presenting it in terms of child-protection. Policymakers that use this frame, may effectively bridge differences between opponents and proponents of big government and a governmental role in the domain of tobacco control. Furthermore, as the policy process is often called complex, policymakers that are relatively unexperienced with health issues that get tobacco control in their portfolio may read this thesis to get some more insight into the various aspects relevant to this domain.

Furthermore, the tobacco industry increasingly focuses on low- and middle-income countries in Asia and Africa as a market for their products, as European countries adopt stricter legislation over time (6). It is important for comprehensive tobacco control in such countries, that their governments understand the importance of avoiding interaction with the tobacco industry (7). This thesis will provide them with the general insight that tobacco control is a continuous tug-of-war between the tobacco industry and civil society. As civil society in these countries is typically weaker or completely absent, economic interests are likely to prevail over public health. Furthermore, tobacco control advocates in those countries may use the tool developed by us (Chapter 7) as a guide to establish or improve their partnerships to become more effective.

Lastly we must also be aware that the findings in this thesis may have unintended negative consequences, as tobacco industry representatives may also benefit from a more thorough assessment of the policy environment, and more insight in what contributes to the strength of their political opponents in this political domain.

Products

A tangible product which has resulted from the findings in this thesis, is the tool we developed to measure characteristics related to tobacco control partnership strength. This tool measures

such characteristics on three dimensions: resources (including connections to policymakers), partner characteristics, and partnership characteristics. It has a great potential to benefit population health and science, as the tool 1) can offer tobacco control advocates insights into the organization of their partnerships, 2) can offer starting points for establishing or improving tobacco control partnerships, 3) can be used as a benchmark to compare partnerships within and across European countries, 4) can be used to monitor changes in partnership organization over time, 5) can contribute to theory-building in the broader field of determinants of health partnership strength… Possible applications are numerous. Future scholars are invited to further develop this tool, preferably by testing its validity, or appointing relative weights to individual items or subscales to calculate 'scores' on which countries can be more easily compared.

Another relevant process worth considering is the data collection itself as possible intervention (8). Tobacco control advocates typically do not reflect much on their day-to-day activities and their approach is often largely intuitive (9). By asking them which factors they believe are associated with success in influencing national policy, they are forced to reflect on (the effectiveness of) their practices. This may lead them to work differently (hopefully more effectively), and the expert panel then functions as an informal intervention. This logic also extends to our interviews conducted for Chapter 4 and 5: it may be possible that discussing tobacco control in particular had an agenda-setting function for Members of Parliament and/or civil servants. If this is true, then this research as such can be considered a form of advocacy. For tobacco control advocates interviewed in this project, it may have had an effect as well: the focus on the case of a tobacco display ban may have primed interviewees to advocate for this specific policy measure. Filling out the tool eventually, as it was sent out through ENSP to all European partners, may also have changed their perceptions about what constitutes an effective partnership. Furthermore, we sent the partnerships individual country feedback, allowing them to compare themselves with partnerships across Europe and possibly, within their country.

This thesis itself also constitutes a product, which will be sent through the format of an e-book to all advocacy contacts that participated in this research, such as the Alliance for a Smoke-free Netherlands, the DKFZ in Germany, and other ENSP colleagues. We will provide a German summary of this thesis as well, to overcome potential language issues.

Three additional 'products' have resulted from the SILNE-R project and the Trimbos institute. A SILNE-R group was created on researchgate.com (a website), in which references to published articles are shared. This group has 41 followers across various countries and disciplines. Furthermore, The Trimbos institute shared two online news items on its official website to disseminate the findings of Chapter 3 and 4 upon publication. They have also tweeted a link to these publications. These activities have likely boosted the number of downloads of the article

in Chapter 3 for example, which was 476 in the first year, of which 115 (24%) were emanating from IP addresses in The Netherlands.

Innovation

The tool developed and administered in Chapter 6 and 7 is the first ever attempt to operationalize and assess tobacco control partnership strength. Previous endeavors have focused on health partnerships in general, which sometimes included tobacco control partnerships, in addition to such partnerships in other domains (10,11). By assessing the characteristics related to tobacco control partnership strength specifically, characteristics that are specifically relevant for tobacco control can be determined. In other words: an approach that focuses on health partnerships in general, may not do justice to the idiosyncrasies of this particular policy domain. Although there are obvious parallels between tobacco and alcohol (a powerful industry, both are bad for health), there are also aspects that make them unique (12). For example: the social norm towards smoking is different from the social norm regarding alcohol, and the industry is irrefutably regarded an unreliable partner in formulating policy, something that remains debated in the field of alcohol policy in which voluntary agreements with the industry are still often accepted.

Planning and implementation

We have actually already 'implemented' our tool (e.g. administered it to tobacco control partnerships across and within EU countries). We hope that future scholars will further develop it in terms of reliability and possibly by assigning relative weights to the individual items.

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SUMMARY

Per year, 700,000 Europeans die from the consequences of tobacco consumption. Smoking causes a wide range of illnesses, including various types of cancer, cardiovascular diseases and respiratory diseases. In addition to its detrimental effect on public health, smoking causes a considerable economic burden to society. Policy measures can be enacted to address tobacco consumption, particularly through the MPOWER policy package provided by the World Health Organization through the Framework Convention on Tobacco Control (FCTC). Although responsibility for tobacco control is partly devolved to European and local levels, a considerable part of the responsibility for tobacco control still rests at national levels. As a consequence, there is considerable variance in tobacco control policy comprehensiveness across countries. This variance is demonstrated by benchmarking studies such as the Tobacco Control Scale, which shows the number of implemented policy measures in a country and provides a total score per country. To understand *why* some countries have more comprehensive tobacco control policies than others, we must study the policy making process itself. Better insight into policymaking can provide tobacco control advocates with more opportunities to influence policy, which will ultimately benefit public health.

Theories of policymaking can be disaggregated into five core components of policymaking: societal factors, the role of institutions, agenda setting/framing, interest groups, and the role and transfer of ideas. The overall aim of this thesis is to examine what underlies the considerable variations in tobacco control policy comprehensiveness across European countries, by investigating these components.

Aims

The thesis addressed two specific aims:

1. To examine determinants of tobacco control policymaking in European countries
2. To examine which characteristics are related to tobacco control partnership strength and how European partnerships compare with regards to these characteristics.

The first aim was addressed in **part I** of this thesis.

In **Chapter 2**, we reviewed the scientific literature to evaluate what is known about the policy process of three youth access and exposure policies. Of all 200 investigated articles, only one article provided scientific evidence on the initial three phases of the policy process, as opposed to mere 'anecdotal' evidence. Based on this finding, we concluded that the policy process leading to the adoption of these policy measures is grossly understudied. We call on researchers to conduct more research on the initial phases of the process of tobacco control policymaking (agenda setting, policy formulation, policy legitimation).

In **Chapter 3**, we found that support for the protection of children against tobacco was positively related to support for three prospective youth access and exposure policies. We examined this relationship for three groups known to be opposed towards tobacco control: smokers, opponents of a big government, and opponents of a governmental role in tobacco control. Although smokers always had less support for three future policy measures, there was a 'child-effect' in all investigated subgroups. These findings suggest that a 'frame' focusing on the protection of children against tobacco may be instrumental in raising support for tobacco control policies, even among more skeptical segments in society.

In **Chapter 4**, we investigated whether pro or anti-tobacco control interest groups have more influence on the policy process across six European countries. We discovered that the dominant frame of tobacco consumption and the arrangement of institutions are associated with the group that has a policy monopoly (i.e.: most influence on policymaking). In Ireland and Finland, for example, health groups have more influence than the tobacco industry on the tobacco control policy process. In these countries, tobacco consumption is understood as a health problem, tobacco control interest groups are plentiful and well-organized, the tobacco industry in terms of production and manufacture is largely gone, the health ministries play a leading role in tobacco control policymaking, governmental endgame strategies are in place, and FCTC Article 5.3 is strictly interpreted. A reversed image is observed in Germany and Italy, where the tobacco industry was observed to have more influence on tobacco control policy, compared to tobacco control groups. Belgium and The Netherlands had mixed profiles containing elements of both health and tobacco industry policy monopolies. When tobacco control advocates wish to challenge a tobacco industry policy monopoly, they may, besides focusing on framing, address the institutional arrangements that maintain and reinforce a policy monopoly by the tobacco industry.

In **Chapter 5**, we investigated lesson-drawing from other countries in tobacco control. We found that the German government does not engage in lesson-drawing. Other governments look at Australia for its global leadership in tobacco control, yet lessons from Australia are dismissed because it is 'far away' and 'an island'. It appears that, except for Ireland, European governments tend to look at closer by and similar countries in Europe. These findings can be used by tobacco control advocates, who may choose best practice examples in tobacco control closer to their countries, or emphasize similarities in country or policy contexts with global leading countries.

The second aim was addressed in **part II** of this thesis: determinants of tobacco control partnership strength and a comparison of European partnerships regarding the prevalence of such characteristics.

In **Chapter 6**, we explored through an expert panel with ten European tobacco control advocates, which characteristics are perceived to be related to tobacco control partnership strength. Ten characteristics were found: (1) financial independence from government, (2) expertise in research and advocacy, (3) an evidence informed approach, (4) access to nationally relevant data, (5) connections to policymakers, journalists, researchers, and other partnerships, (6) partner heterogeneity (7) conflict resolution, (8) a central coordinating office, (9) clear rules or statutes, and (10) a shared vision/consensus. Such characteristics may be used to establish new partnerships, to improve existing partnerships, or to assess and compare European partnerships with.

In **Chapter 7**, we assessed characteristics found to be related to tobacco control partnership strength, across 18 European partnerships. A 22-item tool was developed on three dimensions: resources (12 items), member characteristics (2 items), and partnerships characteristics (8 items). Of all investigated countries, 32% did not have a partnership. Across the assessed partnerships, some characteristics were highly prevalent, and some were not. This suggests that there is room for improvement of partnerships. Our tool could be used to practically monitor and improve partnerships.

What can we conclude from these studies?

Tobacco control partnerships, interest groups, alliances or coalitions are a central and indispensable part of the tobacco control policy process. Their effectiveness is determined by a number of internal partnership characteristics, including resources (national or international information, expertise, and connections) member characteristics (heterogeneity and volume) and partnership characteristics (governance, leadership, strategy, and conflict resolution). They play an important role in raising and demonstrating public support, pointing to foreign best practices, appealing to obligations from international treaties, and excluding the tobacco industry from the policy process. The effectiveness of these groups is however also influenced by factors in the broader policy environment, which vary across countries. These include the dominant frame of tobacco, the ideology of the ruling parties, the implementation of FCTC Article 5.3, and the centrality of the health ministry.

Strengths of the thesis

This thesis had some main strengths. Its focus is innovative within the tobacco control research field, as it investigates determinants of tobacco control policy adoption, instead of impacts of policies on populations. Furthermore, its approach is realist-inspired, which means that it focuses on *how* policymaking or advocacy works. It focuses on 'inner workings' or 'mechanisms' and takes, when possible, context into account. Furthermore, studies that compare more than two countries simultaneously are rare. The potential to reach general conclusions is however far

greater with a cross-country comparative approach. Such an approach can discover variables that are necessarily treated as constants in single-country case studies.

Implications for science

In line with findings of Chapter 2, we call on researchers to devote more attention to the tobacco control policy process. Primarily because we can then better understand country variations in tobacco control policy comprehensiveness. Furthermore, it is important for tobacco control advocates to have more insight into how policymaking works, to use the political arena more effectively. Future research could extend the explorative work on tobacco control advocacy in this thesis, focus more elaborately on political ideology, or focus on effective country-specific policy frames.

Implications for practice

Most studies in this thesis provide implications for tobacco control advocacy practice. We recommend advocates to enforce a stricter interpretation of FCTC Article 5.3, to make the health ministry responsible for tobacco control (for example in Germany), to establish or further develop the national tobacco control NGO community, to denormalize the tobacco industry, and to draw lessons from successful nearby and/or similar countries in tobacco control.

ZUSAMMENFASSUNG

Jedes Jahr sterben 700.000 Menschen in Europa an den Folgen von Tabakkonsum. Rauchen verursacht eine Vielzahl von Krankheiten, einschließlich verschiedener Formen von Krebs, Herz-Kreislauf-Erkrankungen und Erkrankungen der Atemwege. Zusätzlich zu den schädlichen Auswirkungen auf die Volksgesundheit, verursacht Rauchen eine erhebliche wirtschaftliche Belastung für die Gesellschaft. Verschiedene politische Maßnahmen können beschlossen werden, um Tabakkonsum in Angriff zu nehmen, besonders mit Hilfe des MPOWER Maßnahmenpakets, welches von der Weltgesundheitsorganisation im Rahmenübereinkommen zur Eindämmung des Tabakgebrauchs (FCTC) angeboten wird. Obwohl die Verantwortlichkeit für Tabakkontrolle teilweise europäischen und lokalen Parteien zufällt, liegt doch ein erheblicher Teil der Verantwortlichkeit für Tabakkontrolle bei nationalen Parteien. Daraus ergibt sich, dass es bedeutende Unterschiede zwischen Ländern im Umfang ihrer Tabakkontrollmaßnahmen gibt. Diese Unterschiede werden in Benchmarkingstudien wie der Tobacco Control Scale aufgezeigt. Diese zeigt die Anzahl der eingeführten Kontrollmaßnahmen in jedem Land und erstellt außerdem einen Gesamtwert pro Land. Um verstehen zu können warum einige Länder umfangreichere Tabakkontrollmaßnahmen handhaben als andere, muss man den Prozess zur Entstehung von Kontrollmaßnahmen untersuchen. Ein besseres Verständnis für die Entstehung von Kontrollmaßnahmen kann Verfechtern von Tabakkontrolle mehr Möglichkeiten bieten die Politik zu beeinflussen, was schlussendlich der Volksgesundheit zu Gute kommen wird.

Theorien zur Entstehung von Kontrollmaßnahmen können in fünf Kernkomponenten aufgeteilt werden: gesellschaftliche Faktoren, die Rolle von Institutionen, das Setzen konkreter Themenschwerpunkte, Interessensgruppen sowie die Rolle und der Transfer von Ideen. Das allgemeine Ziel dieser Thesis ist, zu untersuchen, was den großen Unterschieden im Umfang der Tabakkontrollmaßnahmen zwischen europäischen Ländern zugrunde liegt, indem diese Komponenten genauer erforscht werden.

Zielsetzungen

Die Thesis verfolgt zwei spezifische Zielsetzungen:

1. Es soll untersucht werden, welche Determinanten bei der Entstehung von Maßnahmen zur Tabakkontrolle eine Rolle spielen
2. Es soll untersucht werden, welche Merkmale zu der Stärke von Koalitionen in der Tabakkontrolle in Bezug stehen und wie europäische Koalitionen sich in diesen Merkmalen unterscheiden

Die erste Zielsetzung wird in Teil I dieser Thesis behandelt.
In **Kapitel 2** haben wir die wissenschaftliche Literatur untersucht, um zu beurteilen was über die Entstehungsprozesse von drei Maßnahmen zur Tabakkontrolle bei Jugendlichen bekannt ist: Das Verdecken von Tabakprodukten in Verkaufsstellen, das Erhöhen der Altersgrenze zum Verkauf von Tabak und das Einschränken der Anzahl und der Art der Verkaufsstellen. Von allen 200 untersuchten Artikeln erbrachte nur ein einziger einen wissenschaftlichen Beweis für die ersten drei Phasen der Entstehung von Maßnahmen, im Gegensatz zu rein „anekdotischem" Beweis. Basierend auf diesen Ergebnissen schlussfolgerten wir, dass der Maßnahmenprozess, der zur Übernahme dieser Maßnahmen führt, viel zu wenig untersucht wird. Wir rufen Wissenschaftler dazu auf, mehr Forschung zu den ersten Phasen des Prozesses der Entstehung von Tabakkontrollmaßnahmen (das Setzen konkreter Themenschwerpunkte, Formulierung und Legitimation der Maßnahmen) zu betreiben.

Ein Ergebnis in **Kapitel 3** ist, dass Befürwortung für den Schutz von Kindern gegen Tabak positiv mit der Befürwortung für drei zukünftige Maßnahmen für Jugendliche gegen Zugang und Bloßstellung von Tabak zusammenhing. Wir haben diesen Zusammenhang in drei Gruppen untersucht, die Tabakkontrolle bekanntermaßen ablehnen: Raucher, Gegner von großen Regierungen und Gegner von einer Rolle der Regierung in der Tabakkontrolle. Obwohl Raucher die drei zukünftigen Maßnahmen alle weniger befürworteten, gab es in allen untersuchten Untergruppen einen „Kind-Effekt". Diese Ergebnisse deuten darauf hin, dass ein „Frame", der den Schutz von Kindern gegen Tabak fokussiert, hilfreich sein kann um Befürwortung für Kontrollmaßnahmen zu stärken, selbst in den skeptischeren Teilen der Bevölkerung.

In **Kapitel 4** haben wir untersucht, ob Befürworter oder Gegner von Tabakkontrolle mehr Einfluss auf den Entstehungsprozess von Kontrollmaßnahmen in sechs europäischen Ländern haben. Das diesbezügliche Ergebnis ist, dass die Art wie Tabakgebrauch von der Regierung dargestellt wird und die Art wie Institutionen eingerichtet sind, damit zusammenhängen welche Interessensgruppe den größten Einfluss auf den Entstehungsprozess von Kontrollmaßnahmen hat. Zum Beispiel haben Gesundheitsorganisationen in Irland und Finnland einen größeren Einfluss auf den Entstehungsprozess als die Tabakindustrie. In diesen Ländern wird Tabakkonsum als Gesundheitsproblem verstanden, Interessensgruppen von Befürwortern von Tabakkontrolle sind stark vertreten und gut organisiert, die Tabakindustrie ist bezüglich Produktion und Manufaktur größtenteils verschwunden, die Gesundheitsministerien nehmen eine Führungsrolle in der Tabakkontrolle ein, die Regierung setzt „Endgame"-Strategien ein, und Artikel 5.3 der FCTC wird streng ausgelegt. Ein gegensätzliches Bild zeigt sich in Deutschland und Italien, wo die Tabakindustrie im Vergleich zu Befürwortern von Tabakkontrolle einen größeren Einfluss auf den Entstehungsprozess von Tabakkontrollmaßnahmen hat. Belgien und die Niederlande zeigten gemischte Profile, die Elemente von sowohl Gesundheits- als auch Tabakindustriemonopolen

aufwiesen. Wenn Befürworter von Tabakkontrolle ein Monopol der Tabakindustrie anfechten wollen, sollten sie nicht nur die Darstellungsweise beachten, sondern sich auch mit den Institutionen befassen, die ein solches Monopol aufrechterhalten und stärken.

In **Kapitel 5** haben wir untersucht, wie Regierungen Lehren ziehen aus der Tabakkontrolle in anderen Ländern. Ein Ergebnis ist, dass Deutschland sich nicht am Ausland orientiert, um Lehren aus den Erfahrungen anderer Länder zu ziehen. Andere Regierungen orientieren sich an Australien, da es weltweit die Führungsrolle in der Tabakkontrolle einnimmt. Allerdings werden Erfahrungen aus Australien oft verworfen, weil es „weit weg" und „eine Insel" ist. Es scheint als würden sich europäische Regierungen, mit Ausnahme der irischen, an geographisch näheren und ähnlicheren Ländern in Europa orientieren. Diese Ergebnisse können von Befürwortern von Tabakkontrolle genutzt werden, indem sie bewährte Verfahren in der Tabakkontrolle, die näher am eigenen Land sind als Beispiel nutzen, oder indem sie die Ähnlichkeiten der Länder oder Politiklandschaften der führenden Länder mit dem eigenen Land betonen.

Die zweite Zielsetzung wird in Teil II dieser Thesis behandelt. Diese lautet: Determinanten der Stärke von Koalitionen in der Tabakkontrolle definieren und einen Vergleich von europäischen Koalitionen bezüglich der Prävalenz solcher Merkmale durchführen.

In **Kapitel 6** haben wir mithilfe eines Expertenpanels von zehn europäischen Befürwortern von Tabakkontrolle untersucht, welche Merkmale in ihrer Wahrnehmung mit der Stärke von Koalitionen in der Tabakkontrolle zusammenhängen. Zehn Merkmale wurden identifiziert: (1) finanzielle Unabhängigkeit von der Regierung, (2) Fachwissen in Forschung und Fürsprache, (3) ein auf Beweisen basierendes Vorgehen, (4) Zugang zu national relevanten Daten, (5) Verbindungen zu Entscheidungsträgern, Journalisten, Wissenschaftlern und anderen Koalitionen, (6) Partnerheterogenität, (7) Konfliktlösungen, (8) ein zentral koordinierendes Büro, (9) klare Regeln oder Statuten und (10) eine gemeinsame Vision/Konsens. Solche Merkmale können genutzt werden, um neue Koalitionen aufzubauen, bestehende Koalitionen zu verbessern oder um zu untersuchen inwiefern diese Merkmale innerhalb europäischer Koalitionen vorhanden sind.

In **Kapitel 7** haben wir in 18 europäischen Koalitionen die Merkmale gemessen, die mit der Stärke von Koalitionen in der Tabakkontrolle zusammenhängen. Hierzu wurde ein Instrument mit 22 Fragen entwickelt, welches drei Dimensionen umfasst: Hilfsmittel (12 Fragen), Merkmale der Mitglieder (2 Fragen) und Merkmale der Koalitionen (8 Fragen). Von den untersuchten Ländern bestand in 32% keine Koalition. Verteilt über die verschiedenen Koalitionen waren einige Merkmale stärker vorhanden als andere. Das deutet darauf hin, dass es Verbesserungspotenzial

für die Koalitionen gibt. Unser Instrument könnte zur praxisorientierten Kontrolle genutzt werden, um die Koalitionen zu verbessern.

Fazit aus diesen Studien

Koalitionen in der Tabakkontrolle, Interessensgruppen, Allianzen oder Verbünde sind ein zentraler und unverzichtbarer Bestandteil des Entstehungsprozesses von Tabakkontrollmaßnahmen. Ihre Effektivität wird von einer Anzahl interner Koalitionsmerkmalen bestimmt, wie zum Beispiel Hilfsmittel (nationale und internationale Informationen, Fachwissen und Verbindungen), Merkmale der Mitglieder (Heterogenität und Umfang) und Merkmale der Koalition (Führung, Leitung, Strategie und Konfliktlösung). Sie spielen eine wichtige Rolle, um die öffentliche Befürwortung zu erhöhen, bewährte Verfahren aus dem Ausland dazustellen, auf Verpflichtungen aus internationalen Abkommen hinzuweisen und die Tabakindustrie aus dem Entstehungsprozess von Kontrollmaßnahmen auszuschließen. Die Effektivität dieser Gruppen wird allerdings auch noch von anderen Faktoren der breiteren politischen Landschaft beeinflusst, welche sich zwischen den Ländern unterscheiden. Diese beinhalten die vorherrschende Auffassung von Tabak, die Ideologie der regierenden Parteien, die Umsetzung von FCTC Artikel 5.3 und die Zentralität des Gesundheitsministeriums.

Stärken dieser Thesis

Diese Thesis beinhaltet einige wesentliche Stärken. Ihr Fokus ist innovativ innerhalb des Forschungsbereichs Tabakkontrolle, da sie Determinanten von Verabschiedungen von Tabakkontrollmaßnahmen untersucht, anstelle der Wirkung von Kontrollmaßnahmen auf die Population. Außerdem ist das Vorgehen „realistisch“ inspiriert, was bedeutet, dass es fokussiert wie Kontrollmaßnahmen und deren Fürsprache entstehen und gelingen. Die Schwerpunkte sind die „innere Verarbeitung“ oder „Mechanismen“ und berücksichtigen, wenn möglich, den Kontext. Des Weiteren sind Studien, die mehr als zwei Länder miteinander vergleichen selten. Das Potenzial für allgemein gültige Schlussfolgerungen ist allerdings viel größer bei solchen Ländervergleichsstudien. Ein solches Vorgehen kann Variablen aufdecken, die in Einzelländerstudien notwendigerweise als Konstante behandelt werden müssen.

Auswirkungen auf die Wissenschaft

Basierend auf den Ergebnissen in Kapitel 2 rufen wir Wissenschaftler dazu auf, dem Entstehungsprozess von Tabakkontrollmaßnahmen mehr Beachtung zu schenken. Dies ist vor allem wichtig, um die Variationen im Umfang von Tabakkontrollmaßnahmen besser zu verstehen. Außerdem ist es für Befürworter von Tabakkontrolle wichtig, mehr Einsicht in den Entstehungsprozess zu bekommen, um die politische Arena besser nutzen zu können. Zukünftige Forschungsprojekte könnten die explorative Arbeit zur Fürsprache in der Tabakkontrolle

ausweiten und sich dabei ausführlicher auf politische Ideologien konzentrieren oder effektive länderspezifische Rahmen für Maßnahmen fokussieren.

Auswirkungen auf die Praxis

Die meisten Studien in dieser Thesis zeigen Auswirkungen für die Praxis der Fürsprache in der Tabakkontrolle. Wir empfehlen Befürwortern für eine strengere Interpretation von FCTC Artikel 5.3 zu plädieren, das Gesundheitsministerium für Tabakkontrolle verantwortlich zu machen (zum Beispiel in Deutschland), die nationale Gemeinschaft nichtstaatlicher Organisationen für Tabakkontrolle aufzubauen oder zu stärken, die Tabakindustrie zu denormalisieren und Lehren aus erfolgreichen geographisch nahen und/oder ähnlichen Ländern bezüglich ihrer Tabakkontrolle zu ziehen

SAMENVATTING

Per jaar sterven 700.000 Europeanen aan de gevolgen van tabaksgebruik. Roken veroorzaakt een breed scala aan ziekten, waaronder verschillende soorten kanker, hart- en vaatziekten en aandoeningen van de luchtwegen. Naast het schadelijke effect op de volksgezondheid, veroorzaakt roken een aanzienlijke economische last voor de samenleving. Beleid kan worden geïmplementeerd om roken aan te pakken, zoals bijvoorbeeld de maatregelen die worden voorgesteld door de Wereldgezondheidsorganisatie via het Kaderverdrag Tabaksontmoediging (FCTC). Hoewel de verantwoordelijkheid voor tabaksbeleid deels ligt bij de Europese Unie of bij lokale niveaus, wordt een aanzienlijk deel van het tabaksbeleid op nationaal niveau besloten. Dit is een van de redenen dat er behoorlijke verschillen zijn tussen landen met betrekking tot de veelomvattendheid van hun tabaksbeleid. Om te begrijpen waarom sommige landen een ambitieuzer tabaksbeleid voeren dan andere landen, moet het beleidsvormingsproces nader worden bestudeerd. Meer inzicht in hoe beleid tot stand komt kan gezondheids-belangenbehartigers meer kansen bieden om het beleid te beïnvloeden, wat uiteindelijk ten goede zal komen aan de volksgezondheid.

Theorieën over beleidsvorming kunnen worden onderverdeeld in vijf kerncomponenten: maatschappelijke factoren, de rol van instituties, agendering/framing, belangengroepen en de rol en overdracht van kennis en ideeën. Het algemene doel van dit proefschrift is om met behulp van deze componenten te onderzoeken wat ten grondslag ligt aan de aanzienlijke variatie in tabaksbeleid tussen Europese landen.

Doelstellingen

Dit proefschrift richtte zich op twee specifieke doelen:

1. Onderzoek naar de determinanten van tabaksbeleid in Europese landen
2. Onderzoek naar welke kenmerken gerelateerd zijn aan de sterkte van tabaks-ontmoedigingscoalities en hoe Europese coalities zich tot elkaar verhouden met betrekking tot de prevalentie van deze kenmerken.

Het eerste doel werd behandeld in **deel I** van dit proefschrift.

In **Hoofdstuk 2** hebben we de wetenschappelijke literatuur bestudeerd om te kijken wat er bekend is over het beleidsproces van drie beleidsmaatregelen om roken bij jongeren te ontmoedigen. Van alle 200 onderzochte artikelen gaf slechts één artikel wetenschappelijk bewijs over de eerste drie fasen van het beleidsproces met betrekking tot een uitstalverbod voor tabaksproducten, in tegenstelling tot puur 'anekdotisch' bewijs gevonden in de andere artikelen. Op basis van deze bevinding hebben we geconcludeerd dat het beleidsproces met betrekking tot deze maatregelen te weinig is onderzocht. We roepen daarom onderzoekers op

om meer onderzoek te doen naar de eerste fasen van het beleidsvormingsproces (agendering, formulering, legitimering) bij tabaksontmoediging.

In **Hoofdstuk 3** hebben we gevonden dat steun voor het beschermen van kinderen tegen tabak positief samenhangt met steun voor drie toekomstige beleidsmaatregelen. We onderzochten deze relatie bij drie subgroepen waarvan bekend is dat ze onwelwillend zijn ten opzichte van tabaksbeleid: rokers, tegenstanders van een grote overheid en tegenstanders van een sterke overheidsrol in het tabaksdomein. Hoewel rokers altijd minder steun bleven hebben voor deze drie toekomstige beleidsmaatregelen, hadden mensen in alle groepen meer steun voor beleidsmaatregelen als zij vonden dat kinderen moeten worden beschermd tegen tabak. Deze bevindingen suggereren dat een communicatie- 'frame' dat gericht is op de bescherming van kinderen tegen tabak, van belang zou kunnen zijn om steun voor (toekomstig) tabaksbeleid te vergroten, zelfs in meer onwelwillende segmenten van de samenleving.

In **Hoofdstuk 4** hebben we onderzocht of gezondheids-belangenbehartigers of de tabaksindustrie meer invloed hebben/heeft op het beleidsproces in zes Europese landen. We vonden dat de manier waarop tabaksgebruik wordt 'geframed' (ingekaderd) door de overheid en de manier waarop instituties zijn geordend, samenhangen met welke belangengroep het meeste invloed heeft op het tabaksbeleid. In Ierland en Finland hebben gezondheids-belangenbehartigers bijvoorbeeld meer invloed op het tabaksbeleid dan de tabaksindustrie. In deze landen wordt tabaksgebruik onmiskenbaar beschouwd als een gezondheidsprobleem, is er een goed ontwikkelde gemeenschap van Niet Gouvernementele Organisaties (NGO's), is de tabaksindustrie qua productie en fabricage grotendeels uit het land verdwenen, spelen de gezondheidsministeries een leidende rol in het ontwikkelen van tabaksbeleid, zijn er eindspelstrategieën vanuit de overheid van kracht en wordt FCTC-artikel 5.3 strikt geïnterpreteerd. Een grotendeels tegengesteld beeld is zichtbaar in Duitsland en Italië, waar we vaststelden dat de tabaksindustrie meer invloed had op het tabaksbeleid dan belangenbehartigers van de gezondheidszijde. België en Nederland zaten tussen deze twee extremen in en hadden gemengde profielen die elementen bevatten van zowel gezondheidsmonopolies als tabaksindustriemonopolies. Wanneer belangenbehartigers aan de gezondheidszijde een monopolie van de industrie willen uitdagen, kunnen zij, naast zich te richten op effectieve 'framing', de instituties aanpakken die een monopolie bekrachtigen en in stand houden.

In **Hoofdstuk 5** hebben we onderzocht hoe overheden leren van voorbeelden uit het buitenland. We hebben geconcludeerd dat de Duitse overheid nauwelijks naar het buitenland kijkt voor lessen binnen tabaksontmoediging. De andere regeringen (België, Finland, Ierland en Nederland) kijken zonder uitzondering naar Australië voor zijn wereldwijde leiderschap in tabaksontmoediging. Lessen uit Australië worden echter ook gemakkelijk weer verworpen, omdat het "ver weg"

en “een eiland” is. De bevindingen suggereren dat, met uitzondering van Ierland, Europese regeringen de neiging hebben om naar landen te kijken die dichtbij liggen en vergelijkbaar zijn. De bevindingen kunnen worden gebruikt door gezondheids-belangenbehartigers. Zij kunnen bewuster goede voorbeelden dichtbij huis kiezen, of overeenkomsten met de wereldwijd leidende landen in tabaksontmoediging sterker benadrukken, bijvoorbeeld met betrekking tot landkenmerken of de beleidscontext.

Het tweede doel werd behandeld in **deel II** van dit proefschrift: kenmerken die samenhangen met de sterkte van tabaksontmoedigingscoalities en een vergelijking van Europese coalities ten aanzien van de prevalentie van zulke kenmerken.

In **Hoofdstuk 6** hebben we middels een deskundigenpanel met tien Europese gezondheids-belangenbehartigers onderzocht welke kenmerken samenhangen met de sterkte van tabaksontmoedigingscoalities. We vonden tien kenmerken: (1) financiële onafhankelijkheid van de overheid, (2) expertise op het gebied van onderzoek en belangenbehartiging, (3) een evidence-based benadering, (4) toegang tot nationaal relevante informatie, (5) connecties met beleidsmakers, journalisten, onderzoekers, en andere coalities, (6) partnerheterogeniteit (7) goede conflictoplossing, (8) een centraal coördinatiebureau, (9) duidelijke regels of statuten, en (10) een gedeelde visie/consensus. Deze kenmerken kunnen worden gebruikt om nieuwe coalities mee op te richten, bestaande coalities mee te verbeteren, of om na te gaan wat de prevalentie van deze kenmerken is bij Europese tabaksontmoedigingscoalities.

In **Hoofdstuk 7** hebben we bij 18 Europese tabaksontmoedigingscoalities vastgesteld hoeveel kenmerken zij hebben die samenhangen met hun sterkte. We ontwikkelden een instrument met 22 items op drie dimensies: middelen (12 items), kenmerken van leden (2 items) en coalitiekenmerken (8 items). Van alle onderzochte landen had 32% geen tabaksontmoedigingscoalitie. Bepaalde kenmerken kwamen vaker voor bij Europese tabaksontmoedigingscoalities dan anderen, wat suggereert dat er ruimte is voor verbetering van sommige coalities. Ons instrument kan gebruikt worden om tabaksontmoedigingscoalities te monitoren en eventueel te versterken.

Wat kunnen we concluderen uit deze studies?

Belangengroepen in de maatschappij (bijvoorbeeld coalities, partnerships, allianties, etc.) zijn een centraal en onmisbaar onderdeel van het tabaksbeleidsproces. Hun effectiviteit wordt bepaald door een aantal interne coalitiekenmerken, waaronder middelen (nationale of internationale informatie, expertise en connecties), kenmerken van leden (heterogeniteit en volume) en coalitiekenmerken (bestuur, leiderschap, strategie en conflictoplossing). Belangengroepen spelen een belangrijke rol bij het verhogen en tonen van maatschappelijke steun voor beleidsmaatregelen, het wijzen op goede voorbeelden uit het buitenland, het appelleren

aan verplichtingen in het kader van internationale verdragen (Artikel 5.3 van de FCTC) en het excluderen van de tabaksindustrie van het beleidsproces. De effectiviteit van deze groepen wordt echter ook beïnvloed door factoren in de bredere beleidsomgeving, die van land tot land kunnen verschillen. Hieronder vallen onder andere de dominante 'framing' van tabaksgebruik, de ideologie van de regerende partijen, de interpretatie van Artikel 5.3 van de FCTC en de rol die ministeries van volksgezondheid spelen in het beleidsproces.

Sterke punten van het proefschrift

Dit proefschrift kende een aantal sterke punten. De focus is innovatief binnen het tabaksonderzoek, omdat het zich richt op determinanten van beleidsvorming, in plaats van op effecten van beleid op individuen of de bevolking. Bovendien heeft het proefschrift een 'realistisch geïnspireerde benadering', wat inhoudt dat het onderzoek zich richt op *hoe* beleidsvorming of belangenbehartiging werkt. Het richt zich op 'innerlijke werkingen' of 'mechanismen' en houdt waar mogelijk rekening met de context. Bovendien zijn beleidsstudies waarin meer dan twee landen met elkaar vergeleken worden schaars. Het vermogen om tot algemene conclusies te komen is veel groter bij een landen-vergelijkende aanpak. Zo'n aanpak kan variabelen ontdekken die noodzakelijkerwijs als constanten worden gezien bij studies binnen enkele landen.

Implicaties voor de wetenschap

In overeenstemming met de bevindingen van hoofdstuk 2 roepen we onderzoekers op meer aandacht te besteden aan determinanten van beleidsvorming binnen tabaksontmoediging. In de eerste plaats, omdat we dan de verschillen tussen landen in de veelomvattendheid van hun tabaksbeleid beter kunnen begrijpen. Verder is het belangrijk dat gezondheids-belangenbehartigers meer inzicht krijgen in hoe beleidsvorming werkt, om de politieke arena effectiever te kunnen gebruiken. Toekomstig onderzoek zou het verkennend onderzoek naar belangenbehartiging in dit proefschrift kunnen uitbreiden, zich kunnen richten op politieke ideologie binnen tabaksontmoediging of op effectieve landspecifieke beleids-'frames'.

Implicaties voor de praktijk

Verschillende studies in dit proefschrift hebben direct implicaties voor de praktijk van gezondheids-belangenbehartiging. We bevelen belangenbehartigers aan om een striktere interpretatie van Artikel 5.3 van de FCTC af te dwingen, om ministeries van volksgezondheid verantwoordelijk te maken voor tabaksbeleid (bijvoorbeeld in Duitsland), om nationale NGO-gemeenschappen of coalities voor tabaksontmoediging op te richten of om deze verder te versterken, om de tabaksindustrie te denormaliseren en om lering te trekken uit succesvolle nabijgelegen en/of vergelijkbare landen op het gebied van tabaksontmoediging.

CURRICULUM VITAE

Thomas Gertjan Kuijpers was born in Groesbeek, the Netherlands, on November 28, 1988. In 2011 he finished his bachelor degree in Psychology at the Radboud University in Nijmegen. During his bachelor he completed the interdisciplinary honours program and worked as a research assistant at the Max Planck Institute for Psycholinguistics. Upon graduation, he completed a minor in Sociology at the University of Texas at El Paso. In 2014, he graduated from the research master program 'Migration, Ethnic Relations and Multiculturalism' at the University of Utrecht. After working as a bartender for a year, he started his PhD at Maastricht University in 2015 where he completed his PhD in 2019.

DANKWOORD

Mijn PhD begon in september 2015. Tijdens het schrijven van mijn PhD besloot het Verenigd Koninkrijk de EU te verlaten (23 juni 2016), werd Donald Trump verkozen als president van de Verenigde Staten (8 november 2016), waren er wereldwijd ruim 68 miljoen vluchtelingen gedwongen ontheemd (eind 2017) en kondigde Angela Merkel aan zichzelf niet opnieuw verkiesbaar te stellen (29 oktober 2018). In het kader van zulke gebeurtenissen was het niet lastig het schrijven van mijn PhD te relativeren.

Dat schrijven is tot stand gekomen met behulp van een aantal mensen die ik daarvoor erg dankbaar ben.

Allereerst **Marc**: naast wetenschapper ben je ook een enthousiaste tabaksontmoediger. Het kan jou absoluut niet verweten worden in een ivoren toren te zitten. Je houdt altijd in de gaten wat voor maatschappelijk nut onderzoek kan hebben en je vertaalt wetenschappelijke inzichten schijnbaar moeiteloos naar een algemeen publiek. Ik denk dat jij als wetenschappelijk expert écht een meerwaarde hebt (gehad) voor het tabaksontmoedigingsbeleid in Nederland. Naast deze professionele kwaliteiten vind ik je ook een heel sociaal en aimabel persoon. Je was nooit te beroerd met mij en andere collega's te borrelen of dineren. Je begeleidingsstijl was soms redelijk *'laisser-faire'* en hoewel dat in het begin wennen was, heeft het uiteindelijk ook veel aan mijn ontwikkeling als zelfstandig onderzoeker bijgedragen. Marc, ontzettend bedankt voor alles!!

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Jess: mijn steun en toeverlaat de eerste 2 jaar van mijn PhD. Je hebt me wegwijs gemaakt in het bestaan als buiten-promovendus bij de Alliantie Nederland Rookvrij. Ik zal de zomerse dagen in de Utrechtse binnenstadbibliotheek niet vergeten: tikkend aan onze proefschriften tussen de hese koormeisjes. We hebben zo vaak de slappe lach gehad om alles, maar vooral om alle tragiek.

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APPENDIX 1: TOPIC LIST FOR INTERVIEWS CONDUCTED FOR CHAPTER 4 AND CHAPTER 5

Main Questions	Possible additional questions	Clarifying questions
1. Can you tell me something about how the current status of the POS display ban in [country]? 2. Is it discussed in parliament? Why (not?)	1. How? Why?	Can you tell me a bit more about that? Can you give an example?
Per country there are usually two sides when it comes to tobacco control measures: a side that tries to promote more stringent tobacco control measures (the health-side), and a side that tries to prevent or delay more stringent tobacco control measures (the tobacco side). 3. What can you tell me about the health side in [country]?	1. Are they organized? How? 2. Can you tell me something about their resources? E.g. money, size, expertise? 3. What kind of organizations are part of this side? 4. Does the health-side collect data about smoking prevalence and public support? Why?	How? Why? Can you tell me a bit more about that? Can you give an example?
4. What can you tell me about the pro-tobacco side in [country]?	5. Is there a reasoning behind a POS display ban (both sides?) Arguments? 6. Do all parties at the health-side have the same beliefs about a POS display ban? As a policy solution? 7. Is the POS display ban a priority of the health-side? Why (not)? 8. What can you tell me about the strategy of the health-side to realize a POS display ban? 9. What can you tell me about the strategy of the tobacco-side to block a POS display ban?	How? Why? Can you tell me a bit more about that? Can you give an example?
5. What can you tell me about the influence of both sides on the policy process surrounding the POS display ban?	1. Do you think one of the sides exerts more influence on the policy process than the other? How? Why?	
6. How do NGO's talk about (frame) a POS display ban? 7. How does the tobacco industry talk about (frame) a POS display ban?	1. Does the government adopt one of these frames? Can you give an example?	

Main Questions	Possible additional questions	Clarifying questions
8. What can you tell me about the general ideological outlook of the government when it comes to smoking?	1. To what extent do you think is related to the influence both sides have on the policy process of the POS display ban?	Can you tell me a bit more about that?
	2. Do you think that ideology plays a role in the policy process? How?	Can you give an example?
9. Do you think there are country-specific characteristics that are of influence on tobacco control in [country]?		How?
		Why?
10. To what extent are public parties incorporated in the policy process (of a POS display ban)?	1. Who has access to the policy process?	Can you tell me a bit more about that?
	2. Are there rules (explicit or implicit) for who can or cannot access the policy process? (FCTC 5.3)	Can you give an example?
	3. Can everybody get access to the policy process?	How?
		Why?
	4. Do you think that one of the two sides has more access to the policy process than the other?	Can you tell me a bit more about that?
11. Can you tell me something about the administrative capacity of the civil servants that work on tobacco? The ministry?	1. Is there a separate unit that works on tobacco?	Can you give an example?
	2. How many people work on the topic?	How?
12. What role does public support play in relation to a POS display ban?		Why?
13. Can you tell me how important the tobacco sector is for the national economy?	1. Do you think this is related to the influence the tobacco-side has on politics? How?	
	2. Do you think this affects the progression of a POS display ban?	
14. Did the government look abroad to other country experiences with a POS display ban?	1. What countries? Why these countries?	
15. To what extent do you think other tobacco control policies has had an influence on the adoption of the POS display ban?	1. What policies? 2. Why these policies? 3. How?	

APPENDIX 2: THE TOBACCO CONTROL PARTNERSHIP TOOL DEVELOPED IN CHAPTER 7

	Subcategory	#	Item (score)	Clarification
Resources	Financial independence	1.	The partnership receives structural funding [1] from the national government. □ Yes, it does receive funding (0) □ No, it does not receive funding (1) ***Optional Comments:***	1 Structural funding refers to funding on a weekly/monthly/yearly basis, as opposed to incidental funding (e.g. for one or a few specific projects).
	Expertise	2.	The partnership includes professional scientists[1] who are able to interpret[2] and appreciate[3] scientific information. □ Yes (1) □ No (0) ***Optional Comments:***	1 Professional scientists are professionals which are scientifically trained (i.e.: received education) and have ample experience in this field. 2 Interpreting in this case refers to for example understanding the methods, results and conclusions of scientific information. 3 Appreciating refers to for example appreciating the reliability, validity, quality, generalizability and implications of scientific information.
		3.	The partnership includes professional communication experts[1]. □ Yes (1) □ No (0) ***Optional Comments:***	1 Professional communication experts are professionals which are formally trained (i.e.: received education) in the field of communication and/or who have ample experience in this field.
		4.	The partnership includes professional lobbyists[1]. □ Yes (1) □ No (0) ***Optional Comments:***	1 Professional lobbyists are professionals formally trained (i.e.: received education) in the field of lobbying (influencing public policy) and/or who have experience in this field.

	Subcategory	#	Item (score)	Clarification
Resources	Information	5.	The partnership's messages and policy proposals are informed by scientific evidence[1]. □ Yes, completely (1) □ Yes, partly (0.5) □ No (0) ***Optional Comments:***	1 Informed by scientific evidence means that messages communicated to policymakers and the public have a sound evidence base. Policy proposals (e.g. specific policy instruments) are scientifically evaluated against scientific data and insights.
		6.	The partnership has access to information[1] on the following aspects of the national situation (multiple answers possible): □ Smoking prevalence and trends (1) □ Tobacco-related morbidity and mortality (1) □ Effectiveness of policy measures (1) □ The economic burden of tobacco use (1) □ Public attitudes towards tobacco control (1) □ Tobacco industry presence and lobbying (1) □ Attitudes of individual policymakers or parties towards tobacco control (1) ***Optional Comments:***	1 Information refers to research reports or scientific articles relevant to the national situation.
		7.	The partnership has a direct influence[1] on the research agenda of scientific organizations that fund or carry out research. □ Yes, a lot of influence (1) □ Yes, some influence (0.5) □ No, no influence (0) ***Optional Comments:***	1 direct influence refers to having an influence on what type of research is being carried out within the country. For example: if there is a need for a country-specific evaluation of the effectiveness of plain packaging, such a study could be stimulated or even sponsored by the partnership.

	Subcategory	#	Item (score)	Clarification
Resources	Relationships	8.	The partnership has working relationships[1] with at least one Member of Parliament, with functional contacts at least once in every 6 months. □ Yes (1) □ No (0) ***Optional Comments:***	1 Working relationships refer to professional relationships, with functional contacts that are mutually reinforced (sending and receiving e-mails, calling on the phone, professional meetings, etc.). Seeing and talking to MPs occasionally at unplanned events does not qualify as a working relationship.
		9.	The partnership has working relationships[1] with the relevant civil servants of the ministry that is primarily responsible for tobacco control[2], with functional contacts at least once in every 3 months. □ Yes (1) □ No (0) ***Optional Comments:***	1 Working relationships refer to professional relationships, with functional contacts that are mutually reinforced (sending and receiving e-mails, calling on the phone, professional meetings, etc.). Seeing and talking to civil servants occasionally at unplanned events does not qualify as a working relationship. 2 The ministry that is primarily responsible for tobacco control refers to the ministry that has jurisdiction in most fields of tobacco control. For example: in Germany, responsibility for most potential tobacco control measures resides in the Ministry of Consumer Protection, not in the Ministry of Health. The Ministry of Health cannot autonomously propose a bill.

	Subcategory	#	Item (score)	Clarification
Resources		10.	The partnership has a working relationship[1] with the minister (or secretary of state) who is primarily responsible for tobacco control[2], with functional contacts at least once in every 12 months. □ Yes (1) □ No (0) ***Optional Comments:***	1 Working relationships refer to professional relationships, with functional contacts that are mutually reinforced (sending and receiving e-mails, calling on the phone, professional meetings, etc.). Seeing and talking to the minister (or secretary of state) occasionally at unplanned events does not qualify as a working relationship. 2 The ministry that is primarily responsible for tobacco control refers to the ministry that has jurisdiction in most fields of tobacco control. For example: in Germany, responsibility for most potential tobacco control measures resides in the Ministry of Consumer Protection, not in the Ministry of Health. The Ministry of Health cannot autonomously propose a bill.
		11.	The partnership has working relationships[1] with at least 2 journalists, with functional contacts at least once in every 6 months. □ Yes (1) □ No (0) ***Optional Comments:***	1 Working relationships refer to professional relationships, with functional contacts that are mutually reinforced (sending and receiving e-mails, calling on the phone, professional meetings, etc.).
		12.	The partnership has working relationships[1] with at least one tobacco control partnership in another country, with functional contacts at least once in every 6 months. □ Yes (1) □ No (0) ***Optional Comments:***	1 Working relationships refer to professional relationships, with functional contacts that are mutually reinforced (sending and receiving e-mails, calling on the phone, professional meetings, etc.).

	Subcategory	#	Item (score)	Clarification
Partner Characteristics	Heterogeneity	13.	The partnership includes the following types of organizations as formal partners[1] (multiple answers possible): □ Patient organizations (1) □ Youth or family organizations (1) □ Educational organizations (1) □ Medical organizations (1) □ Scientific organizations (1) □ Sport organizations (1) □ Municipalities (1) □ Commercial companies (1) ***Optional Comments:***	1 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.
	Support base	14.	The total number[1] of formal partners[2] is: □ 1-4 (0.5) □ 5-9 (1) □ 10-14 (1.5) □ 15-19 (2) □ 20-29 (3) □ 30-39 (4) □ 40-49 (5) □ 50-59 (6) □ 60-69 (7) □ 70-79 (8) □ 80-89 (9) □ 90-99 (10) □ 100+ (11) ***Optional Comments:***	1 Total number refers to organizations counted at the highest possible level: for example, if an umbrella sports-organization is a formal partner, the members of that umbrella organization are not counted individually. 2 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.

	Subcategory	#	Item (score)	Clarification
Partnership Characteristics		15.	The partnership has a reached agreement[1] that clearly defines the roles[2] and responsibilities[3] of formal partners[4]. □ Yes (1) □ More or less (0.5) □ No (0) ***Optional Comments:***	1 Reached agreement refers to a reached agreement between coordinating bodies/persons and formal members (also: between formal members). 2 Roles refer to which tasks that formal members have, and the ways in which they are expected to contribute to reaching the objectives of the partnership. 3 Responsibilities refers to which specific domain the formal member covers. For example, it may be that the heart association takes responsibility to realize more smoke-free playgrounds. 4 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.
	Governance	16.	The partnership has a central office[1] with staff dedicated[2] to coordination of the partnership. □ Yes (1) □ No (0) ***Optional Comments:***	1 Central office refers to an office with an actual address, with one or more (paid or unpaid) staff members. 2 Dedicated means that coordination of the partnership is part of the tasks of the staff.

	Subcategory	#	Item (score)	Clarification
Partnership Characteristics		17.	The partnership has a reached agreement[1] on how credits[2] are divided across formal partners[3]. □ Yes (1) □ More or less (0.5) □ No (0) ***Optional Comments:***	1 Reached agreement refers to a reached agreement between coordinating bodies/persons and formal members (also: between formal members). 2 Credits refer for example to public recognition of expertise and authority of individual partners, the efforts made by partners, and their public visibility. 3 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.
	Connecting person	18.	The partnership includes one or more person(s) who is/are able to connect[1] and inspire[2] formal partners[3], and moderate potential conflicts. □ Yes (1) □ No (0) ***Optional Comments:***	1 Connect refers to bringing formal partners into contact with each other. 2 Inspire refers to prompting formal partners to come up with innovative ideas, to dedicate resources and/or to undertake action. 3 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.

	Subcategory	#	Item (score)	Clarification
Partnership Characteristics	Strategy	19.	The partnership has a reached agreement[1] on the common goal[2] that is embraced by all formal partners[3]. □ Yes (1) □ More or less (0.5) □ No (0) ***Optional Comments:***	1 Reached agreement refers to a reached agreement between coordinating bodies/persons and formal members (also: between formal members). 2 Common goal refers to a common goal, agreed upon formal partners of the partnership, which may be aspirational (e.g. a tobacco-free generation or society) or more limited (e.g. complete protection of non-smokers). 3 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.
		20.	The partnership has a reached agreement[1] on a common strategy[2] that is embraced by all formal partners[3]. □ Yes (1) □ More or less (0.5) □ No (0) ***Optional Comments:***	1 Reached agreement refers to a reached agreement between coordinating bodies/persons and formal members (also: between formal members). 2 Common strategy refers to a common strategy, formulated by formal partners of the partnership, such as series of policy goals, or a roadmap, including an explicit strategy on how to achieve these goals. 3 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.

	Subcategory	#	Item (score)	Clarification
Partnership Characteristics		21.	The partnership is able to formulate a shared public position[1] even on issues that may be subject to internal debate[2]. □ Yes (1) □ More or less (0.5) □ No (0) ***Optional Comments:***	1 Shared public position refers to a publicly announced position (standpoint) on a certain issue, shared by all formal partners of the partnership. 2 Issues subject to debate refer to issues on which might cause disagreement between formal partners, for example regarding e-cigarettes or priority setting between alternative strategies.
	Conflict resolution	22.	The partnership is able to avoid or resolve conflict[1] between formal partners[2]. □ Yes, always (1) □ Yes, usually (0.5) □ No, usually not (0) □ No, never (0) ***Optional Comments:***	1 Conflict refer to conflicts between partners for example with regards to public visibility, public recognition, funding, strategy line etc. 2 Formal partners refers to partners whose membership is laid down in a contract, a memorandum of understanding or similar documents.