



**World Health  
Organization**

ASSESSING THE NATIONAL CAPACITY  
TO IMPLEMENT EFFECTIVE  
TOBACCO CONTROL POLICIES

# **Operational Manual**

**on planning, conduct and follow-up  
of joint national capacity assessments**



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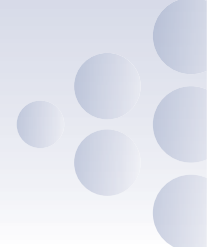
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The concept for this manual was developed by the National Capacity Building Unit for Tobacco Control of the WHO Tobacco Free Initiative between 2007 and 2012. Firstly, the methodology was elaborated based on over 15 years of successful WHO experience of review of HIV/AIDS and Stop TB programmes (1). The methodology was then tested in national tobacco capacity assessments conducted in Brazil (2) and Thailand (3) and updated with the comments of the members of the assessment teams and the experts involved in preparing and conducting the pilot missions, as well as information from the assessments that were conducted over the following few years. As of December 2011, 10 capacity assessment missions have been conducted (4).

This production was coordinated by Luminita Sanda, with the supervision and support of Armando Peruga. The text was written by (in alphabetical order): Vera Luiza da Costa e Silva and Fabio Luelmo (WHO consultants); Armando Peruga and Luminita Sanda (WHO National Capacity Building Unit for Tobacco Control). We thank all the contributors and acknowledge the many individuals, consultants, representatives of the governments that conducted assessments of the country capacity, and all WHO regional advisers for tobacco control and their teams, as well as the WHO country staff who contributed to the piloting and revision of this operational manual (in alphabetical order): Ms Stella Aguinaga-Bialous, Dr Asuncion Anden, Dr Ana Claudia Andrade, Dr Jose de Alberto Araújo, Dr Virginia Arnold, Dr Ponlekha Banhansupawat, Dr Jean-Pierre Baptiste, Dr Douglas Bettcher, Dr Adriana Blanco, Dr Banu Cakir, Ms Cynthia Callard, Dr Tania Cavalcante, Mr Alberto Cavalcanti, Dr Naowarut Charoenca, Dr Pantip Chotibenchamaporn, Dr Vera Luiza da Costa e Silva, Dr Ana Luiza Curi Hallal, Dr Annette David, Dr Sinha Dhirendhra, Dr Guilherme Eidt Gonçalves de Almeida, Dr Fatimah El-Awa, Dr Toker Erguder, Dr Karen Evison, Mr Christopher Fitzpatrick, Dr Trinidad Florante, Mr Hemant Goswami, Mr Wijesiri Gunasekara, Dr Kittu Gunpai, Dr Prakash Gupta, Mr Roberto Magno Iglesias, Dr Hassan Irmak, Dr Supranee Jiwesakapimas, Ms Paula Johns, Ms Dorota Kaleta, Dr Anna Koziel, Ms Dorcas Kiptui, Dr Chai Kritiyapichatkul, Dr Nyo Nyo Kyaing, Ms Stefanie Laniel, Dr Fabio Luelmo, Dr Kristina Mauer Stender, Dr Susy Mercado, Ms Julie Meyers, Dr Paulina Miskiewicz, Ms Mirta Molinari, Dr Joyce Nato, Dr Haik Nikogosian, Dr Sheila Ndyanabangi, Dr Ahmed Ezra Ogwel Ouma, Dr Panuwat Panket, Mr Tadeusz Parchimowicz, Dr Alice Payne Merritt, Dr Armando Peruga, Mr Patrick Petit, Dr Pham Thi Quynh Nga, Dr Phan Thi Hai, Dr Paulo César Rodrigues Pinto Corrêa, Dr Sathirakorn Pongpanich, Dr Neena Prasad, Dr Vinayak Prasad, Dr Sunida Preechawong, Dr Chardsumon Prutipinyo, Dr Khalilur Rahman, Dr Sawat Ramaboot, Dr Luis Fernando Rocabado, Dr Jaime Rojas-Hinojosa, Dr Pauly Rosell-Ubial, Dr Suthat Rungruanghiranya, Dr Luminita Sanda, Ms Rosa Sandoval, Dr Isra Sarntisart, Mr Benjamin Sensasi, Dr Nithat Sirichotirat, Ms Erin Smith, Ms Frances Stillman, Dr Chaisri Supornsilaphachai, Dr Tatri Taifahpoon, Dr Chairat Techatraisak, Dr Lakkhana Termsirikulchai, Dr Manopchai Thamkantho, Dr Agis Tsouros, Dr Lam Nguyen Tuan, Dr Suchada Tungthangthum, Dr Gajalakshmi Vendhan, Ms Ayda Yurekli, Dr Mostafa Zaman, Ms Barbara Zolty. We also thank all members of the assessment teams who conducted the capacity assessment missions and developed the specific country reports (see the country reports at [http://www.who.int/tobacco/control/capacity\\_building/assessments/en/index.html](http://www.who.int/tobacco/control/capacity_building/assessments/en/index.html)).

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# Introduction

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Tobacco is a risk factor for six of the eight leading causes of death throughout the world and will threaten the lives of one billion people during the current century. This was recognized by World Health Organization (WHO) Member States and has resulted in the negotiation and adoption at the 56<sup>th</sup> World Health Assembly in May 2003 of the WHO Framework Convention on Tobacco Control (WHO FCTC), the first public health treaty negotiated under the auspices of WHO. As of November 2012, 175 countries and the European Union have become Parties to the WHO FCTC.

The core provisions of the WHO FCTC, aimed at reducing demand for tobacco products, are as follows.<sup>1</sup>

- Price and tax measures to reduce the demand for tobacco.
- Non-price measures to reduce the demand for tobacco, namely:
  - protection from exposure to tobacco smoke
  - regulation of the contents of tobacco products
  - regulation of tobacco product disclosures
  - packaging and labelling of tobacco products
  - education, communication, training and public awareness
  - tobacco advertising, promotion and sponsorship
  - demand reduction measures concerning tobacco dependence and cessation.

The core supply reduction provisions in the WHO FCTC apply to the following areas:<sup>2</sup>

- Illicit trade in tobacco products
- Sales to and by minors
- Provision of support for economically viable alternative activities.

The WHO FCTC and its guidelines provide the foundation for countries to implement and manage tobacco control. To help countries fulfil their WHO FCTC obligations, in 2008 WHO introduced the MPOWER package of six evidence-based tobacco control measures that are proven to reduce tobacco use and save lives. The MPOWER measures provide practical assistance with country-level implementation of effective policies to reduce the demand for tobacco. The MPOWER measures focus on demand reduction, although WHO also recognizes the importance of, and is committed to, implementing the supply-side measures contained in the WHO FCTC.

These measures are the best-buy and good-buy interventions (5) for substantially reducing tobacco use and scaling up the fight against noncommunicable diseases.

Each of the MPOWER measures corresponds to at least one demand-reduction provision of the WHO FCTC and forms an integral part of the WHO Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, endorsed at the 61<sup>st</sup> World Health Assembly in 2008. These best-buy/good-buy measures to reduce tobacco use are:

- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising, promotion and sponsorship
- **R**aise taxes on tobacco.

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1 WHO FCTC Arts. 6-14.

2 WHO FCTC Arts. 15-17.

The *WHO report on the global tobacco epidemic* (2008, 2009, 2011) (6, 7, 8) provides a stark reminder that only a small percentage of the global population is fully protected by these tobacco control measures. The vast majority of the world's population is not protected from the harm done by tobacco by effective demand reduction measures. There is, therefore, an urgent need for each country to assess its capacity to develop, implement and enforce effective measures to reduce the use of tobacco.

This publication describes a methodology for use by governments and civil society to assess a country's capacity to implement tobacco control policies effectively.

The assessment will provide the answer to two fundamental questions, namely:

- which policy areas require immediate attention<sup>3</sup> to reduce tobacco use in a given country?
- what can be done, and how, to strengthen capacity to support the implementation of the policy areas identified?

Governments will decide whether to carry out an assessment of national capacity for tobacco control and will also lead the process. WHO<sup>4</sup> will work with a national Government to coordinate, support and carry out the practical steps of the assessment.

All countries can benefit from a capacity assessment, but the process may be most beneficial and urgent in countries in which:

- the prevalence of tobacco use is high or the nature of the epidemic is worsening;
- there is a high burden of disease attributable to tobacco use;
- there are challenges in implementing specific measures of the WHO FCTC with defined deadlines, or
- one or more tobacco control interventions have been implemented and the time has come to evaluate progress and consider next steps.

This document describes the basic elements of a capacity assessment. It is intended for use both by governments and by civil society, as well as by WHO and other partners. The document answers such questions as: why a capacity assessment should be conducted; who should do it and how; and what methodology should be used.

The document has three main sections:

- Section 1 Rationale – introduces the rationale for conducting an assessment of national capacity to implement effective tobacco control policies, and describes the main elements to be assessed.
- Section 2 Practical steps – outlines how to prepare and conduct a capacity assessment, including detailed steps on what to do before and during the assessment exercise; and also how to deal with the post-assessment period and guide the post-assessment follow-up.
- Section 3 Tools – provides specific tools that are useful for planning and conducting the assessment, as well as for the post-assessment phase and follow-up.

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<sup>3</sup> Including "quick wins".

<sup>4</sup> "WHO" refers to all levels of the World Health Organization (i.e. headquarters, regional offices, country offices). Specific roles and responsibilities within the Organization will be defined internally for each capacity assessment, as required.

# Section 1 Rationale

This section provides the rationale for assessing national capacity for tobacco control to implement effective tobacco control policies, and describes the main elements to be assessed.

## 1.1 What is a national capacity assessment?

A national capacity assessment is a joint exercise between a Government and WHO, with the participation of national and international partners, to guide a country in the implementation of specific tobacco control measures by identifying its capacity (with its strengths and opportunities, as well as barriers and obstacles) for the implementation of these measures.

The assessment includes an analysis of the commitment and the organizational structure available to implement selected demand-reduction measures of the WHO FCTC (MPOWER measures) as best-buy interventions (5) for substantially reducing tobacco consumption and scaling up the fight against noncommunicable diseases. The assessment also examines the partnerships (within the Government and between the Government and other interested parties); human and financial resources and needs; and the technical, managerial and political processes indispensable for implementing the policies effectively. Countries may also wish to assess the implementation of other specific tobacco control measures, according to national circumstances and priorities and in the context of their obligations under the WHO FCTC: therefore, at countries' request, these additional measures may be included in the assessment exercise, bearing in mind the additional time and resources that this may entail.

Because a capacity assessment is mainly intended to guide Government policy, assessments may be conducted every five years, if necessary.

## 1.2 What is the end-product of the assessment?

The end-product of the assessment is a set of recommendations with potential actions to guide government and civil society at any stage in the process of developing, implementing or evaluating their approach to tobacco control (joint assessment report). This report is prepared jointly by the assessment team, in agreement with WHO and the host Government. The report may result in statements of national policy and priorities as a basis for the country's medium-term plan for tobacco control.

## 1.3 Benefits of assessing national capacity

Such an assessment provides the Government with a better understanding of the strengths and limitations of current tobacco control efforts and with some measure of the effectiveness of the existing tobacco control programme. Other immediate benefits include:

- ownership of a guidance document specific to the country that conducted the assessment exercise, which can be used as a resource tool by the various stakeholders in that country as part of their efforts to increase political commitment and resources for tobacco control;
- specific recommendations from the assessment team (WHO and independent experts) on how best to increase political commitment and how to reorient and optimize policy interventions;
- possibility of improvement for an existing country action plan (or, if there is no previous action plan, development of the plan) that can serve as a basis for a plan for cooperation between the Government and WHO, as well as other involved national or international organizations;



- overall, an improved environment for developing/strengthening coalitions for tobacco control between the Government, nongovernmental organizations, the private sector (excluding the tobacco industry and its allies) and donors;
- identification of specific areas in need of technical cooperation in national capacity building with potential international partners (by raising interest in joining the assessment exercise among international and national organizations, other than WHO).

Additionally, there are indirect benefits to a national capacity assessment – such as increased awareness of the health and economic impacts of tobacco, and greater understanding of what constitutes an effective tobacco control programme. Through its intense collaborative work in preparing, conducting and implementing recommendations during the follow-up years, the assessment is therefore a timely opportunity to build alliances and support between Governments and the nongovernmental sector.

#### **1.4 Who decides to conduct the assessment?**

It is up to the Government to decide to undertake a capacity assessment. Governmental commitment should be reflected in official documents – such as a letter of intent sent to WHO and an invitation sent to participating institutions. Once it has decided, the Government takes the leadership role at national level. WHO will normally collaborate with a host Government in coordinating and carrying out the assessment as part of its role to improve health. The methodology described in the present document is based on the assumption that WHO will be involved as a key partner in the capacity assessment.

In addition, the Government may choose to involve other organizations/partners in the assessment exercise. These may be national bodies (such as nongovernmental organizations, educational establishments or research institutions) or international ones (such as nongovernmental organizations or Government and private institutions involved in global tobacco control). None of these organizations that assign their experts to participate in the assessment will have a leadership or organizational role. However, external participation gives the evaluation additional strength, increases the political impact of the conclusions and recommendations, allows wider dissemination of the findings, and facilitates use of the experience of one country in improving tobacco control in others. It may also contribute to international technical and financial cooperation with the country's efforts, and can facilitate intercountry agreements to control the movement of tobacco across borders. The Government, in consultation with WHO, will select possible external experts as members of the assessment team, but ultimately it is the Government that approves the selection of external assessors and also identifies the national participants. The Government also approves and implements the recommendations if it so decides.

The assessment is not intended to be a tool for comparing or ranking countries. Rather, it is a resource for countries to identify ways of improving their own capacity to implement and enforce the tobacco control policies that will most effectively reduce tobacco use and the health, social and economic harms associated with it.

Therefore, it is the Government that:

- decides to conduct the capacity assessment
- requests the cooperation of WHO and other organizations
- approves the selection of external reviewers
- identifies national participants
- approves the recommendations
- decides about implementing the recommendations.

## 1.5 What should be assessed?

The measures assessed are the WHO FCTC demand reduction measures which form part of the MPOWER package. Every country can propose additional policies to be included as part of the capacity assessment exercise, according to its priorities.

Gauging whether the measures are being implemented is the first concern of the assessment. Therefore the initial step is to review existing policy efforts and priorities by analysing whether political will, effort, drive and resources are being devoted to the measures being assessed. However, “policy efforts” are not the only element to be assessed. To implement MPOWER and other relevant measures, a country needs to have a control programme structure, a plan of action, appropriate financial and human resources, infrastructure, partnerships and political will committed to design, implement and enforce these policies. Therefore, a country’s capacity to implement each policy is assessed against a set of elements of an effective programme that can be termed the “five Ps”: *policy, programme, people, provision of funds and partnerships*.

- **Policy efforts**

The adoption, implementation and enforcement of each measure requires specific policy interventions or efforts. The capacity assessment must review the current policies and the existing initiatives to improve tobacco control and reduce the prevalence of tobacco use – including legislation, enforcement and advocacy. One of the key indicators of national commitment is the ratification of the WHO FCTC and the status of implementation of the Convention.

- **Programme infrastructure, management and organizational development**

The existence of specific dedicated Government structures working in coordination is important for developing and implementing effective tobacco control. Typically, a national tobacco control programme or an equivalent Government structure serves as the locus of management – i.e. planning, implementation and evaluation – for tobacco control. Further, it is usually the national tobacco control programme that is in a position to support action and follow-up and propose priorities and next steps to decision-makers, policy-makers, legislators and others. Ideally, the national tobacco control programme leads the development of the national tobacco control plan, coordinates interactions between different parts of the Government, fosters partnerships between Government bodies and nongovernmental organizations and plays a lead role in resource allocation and mobilizing national and international expertise and assistance. A review of programme infrastructure, management and organizational development will assess the leadership and national commitment, the distribution and location of responsibilities and the infrastructure, planning and management efforts directed at advancing tobacco control activities in general and the individual MPOWER measures in particular.

- **People (human resources and their development)**

For tobacco control to be effective, there must be a cadre of well-trained, committed and knowledgeable individuals who have the political, technical and managerial skills needed to set priorities, draft and shepherd legislation through lawmaking bodies, develop effective advocacy campaigns (including mass-media counter-marketing campaigns), build public support, implement and monitor policies and programmes, and evaluate outcomes. The capacity assessment will not evaluate the performance of individual staff members. However, a review of human resources for tobacco control will assess whether the assembled professional capacity is sufficient and whether there is a need to strengthen the political, technical and managerial skills needed to advance tobacco control activities.

- **Provision of financial resources**

Effective tobacco control is dependent on adequate provision and the efficient use of funds. Therefore a review of the financial aspects of a tobacco control programme should include an assessment of current funding level and sources of funding (governmental and nongovernmental) and the allocation of resources.

- **Partnerships**

The assessment should review the extent to which there is effective cooperation within the Government between the focal structures pertaining to the health system and other relevant Government structures. The assessment should also determine whether there are functioning and effective partnerships that bring the Government into positive working relationships with nongovernmental organizations and other stakeholders, and also identify potential opportunities in developing new partnerships.

# Section 2 Practical steps

This section outlines how to prepare and conduct a capacity assessment, including detailed instructions showing what to do before and during the assessment exercise; and also how to deal with the post-assessment period and guide the post-assessment follow-up.

There are three main stages of work to be done by the Ministry of Health and WHO in connection with a joint assessment of national capacity for implementing effective tobacco control policies:

- 2.1. pre-assessment stage
- 2.2. in-country assessment
- 2.3. post-assessment (follow-up).

## 2.1 Pre-assessment stage

The pre-assessment stage is a critical part of the exercise. Successful assessments are thoroughly planned and prepared. A number of steps need to be taken to ensure that the assessment exercise is well prepared. These steps involve a first contact between the host Government and WHO aiming at **formal engagement** in a joint in-country assessment, followed by joint planning and preparation with direct involvement of assigned focal points from both the host Government and WHO.

The preparatory stage comprises three main steps, as follows.

- 2.1.1 Formal engagement
- 2.1.2 Planning
  - 2.1.2.1 *Assignment of assessment focal points*
  - 2.1.2.2 *Proposal of overall scope and objectives of the assessment*
  - 2.1.2.3 *Planning visit*
- 2.1.3 Preparation

### 2.1.1 Formal engagement

Preliminary discussions with the host authorities, the Government or interested local partners will lead to a *formal invitation* to carry out an assessment of tobacco control capacity in the country. Usually, the Ministry of Health approaches WHO on behalf of the interested Government, through the relevant WHO Country Representative and/or WHO Regional Office or the National Capacity Building Unit for Tobacco Control of the WHO Noncommunicable Diseases and Mental Health cluster. WHO will discuss with the interested Government the nature and scope of the capacity assessment and will then decide on involvement as well as internal leadership. Subsequently WHO will respond to the Government, also formally.

### 2.1.2 Planning

In line with the assessment methodology, WHO will inform the interested Government, at an early stage, about the availability of WHO staff and external experts/consultants who may assist in the process. The technical coordination and final responsibility for the report should reflect WHO's structure, technical capacity and expertise, balanced by the requests and priorities of the host country authorities.

As soon as formal engagement has been achieved, WHO and the host Government need to discuss and agree on a plan that will include detailed steps for the joint preparation of the in-country assessment. This plan is drawn up, discussed and facilitated by assigned local focal points representing WHO and the host Government.

### **2.1.2.1 Assignment of assessment focal points**

Two focal points should be assigned for the planning and preparatory work: one will coordinate and facilitate action on behalf of WHO (WHO Focal Point – WFP) and the other on behalf of the host Government (Country Focal Point – CFP). The focal points are assigned by agreement between the Government (Ministry of Health) and WHO, possibly through an exchange of letters. These letters should mention the department(s) responsible for the planning and preparation work and for assigning the focal points for the assessment.

The focal points must stay in regular contact throughout the entire assessment exercise. They will have at least one face-to-face planning meeting.

The Country Focal Point (CFP) is appointed by the host Government. His/her main role is to oversee and facilitate the preparatory work of the capacity assessment – including ensuring the involvement of key national partners and building up national interest in the review. He/she may be the national coordinator of the country tobacco control programme or the national focal point for tobacco control, although other functions are not excluded.

The Programme Manager for Tobacco Control of the WHO Noncommunicable Diseases and Mental Health cluster or, by agreement, the regional adviser for tobacco control will appoint the WFP, who will usually be a member of WHO headquarters staff or, as appropriate, WHO regional office staff. Where a WHO Country Office exists, the nominated WFP will work in close collaboration with the staff specifically assigned by the Head of the WHO Country Office to support the preparation of the joint assessment. The main role of the WFP is to provide technical advice on the content and process of the assessment, share practical experience from assessments conducted with other governments, and give support from the international perspective (e.g. communicate with international organizations to arrange the assignment of their experts as members of the assessment team, brief assigned experts on their terms of reference, coordinate the logistics of invitations, visa issuance, etc.).

The two focal points have a joint responsibility for all stages of the assessment exercise. Each of them will contribute according to their capacity and level of authority. As an example, while the WFP may be more familiar with the pool of appropriate (regional and/or international) experts for the country concerned and have more capacity to contact and engage with them, the CFP will be the one to identify and propose the national members of the assessment team, contact them, brief them locally and prepare them.

#### **The joint responsibilities of the two focal points are as follows:**

- to prepare in-country visits during the entire assessment process (the engagement/planning visit, the main assessment mission and, if appropriate, the follow-up visit);
- to identify budgetary sources (WFP – external sources; CFP – local sources);
- to identify the specific objectives of the assessment in line with the main goal established by the Ministry of Health and WHO;
- to draw up a draft joint plan of activities with clear roles and responsibilities and a time frame for preparing the main assessment mission;

- to provide background information/documents for all meetings of the planning visit and main assessment mission;
- to identify possible assessment team members and ensure their participation (national members will be identified, invited and briefed by the CFP, international members by the WFP);
- to prepare the terms of reference (TOR) for the members of the assessment team;
- to prepare background information for the assessment team (tobacco control country profile, relevant legislation, previous reliable reports, etc.) and prepare data collection tools for assessment team members;
- to oversee implementation of the agreed plan for preparing the main mission (this includes logistics and use of the agreed budget);
- to work and coordinate with the assessment team in the development of the executive summary and final report and, in due course, submit the final assessment report for approval by WHO and the Ministry of Health;
- to monitor and liaise in the implementation of the assessment recommendations and the national plan.

Usually, as the process of preparing the assessment involves communication with higher levels (heads of international organizations and national agencies, senior officials, etc.) but also administrative support for the logistics and other office work, the focal points will usually benefit from a team to support them (the “*support team*” for the assessment exercise). Members of this support team are assigned by the responsible departments at WHO and the Ministry of Health. More specifically, the support team supervises data collection and analysis and helps to link all tobacco control institutions in preparation for the assessment. On the one hand, when selecting support team members, it is necessary to consider their position, their facility in contacting key interviewees and their availability. On the other hand, support team members should be knowledgeable about the technical aspects of tobacco control, programme organization and the overall state of tobacco control activities in the country. They should be aware of the political and economic impact of tobacco use and tobacco control measures. The focal points consult the support team members regarding the list of key-informant institutions, selection of assessment team members, and choice of field sites to be visited. The members of the support team may be selected from:

- Ministry of Health or other authorities related to the ministry, including regional and municipal health authorities;
- other relevant ministries (finance, environment, labour, etc.);
- other international agencies and potential donors;
- relevant nongovernmental organizations;
- health professional associations, academic institutions, etc.

Representatives of the tobacco industry or of Government tobacco institutes and monopolies should never be consulted or included in the preparatory work of the support team.

### **2.1.2.2 Proposal for overall scope and objectives of the assessment**

While the main overall goal of the assessment is set by WHO and Ministry of Health representatives involved in the engagement steps, the focal points will draft the detailed objectives intended to achieve the overall goal. These should be clearly described and should be discussed with the support team and relevant Government representatives during the planning visit. The assessment may be comprehensive (dedicated to all MPOWER measures, national coordinating mechanisms and other policy areas considered as a priority by the Government) or selective (only those policy aspects that are considered an immediate priority).

Box 1. Example of goal and objectives of an assessment

**Goal**

To conduct a comprehensive analysis of current tobacco control policies in the country and the capacity for implementation and make practical recommendations about potential approaches to counter the tobacco epidemic, including governance, policy, monitoring and surveillance aspects, always in line with the WHO FCTC provisions and Guidelines.

**Objectives**

To review:

- the health and economic tobacco burden (tobacco consumption, including trends over the past few years, and predictions of prevalence based on different models of programme efficiency, economic costs of tobacco use, etc.);
- tobacco industry interference, marketing strategies and economic relevance;
- the timeline of tobacco control activities in the country, with key elements of governance and policy, in order to put tobacco control in context;
- the country's capacity for monitoring and surveillance activities (regarding the tobacco epidemic and the response to it, as well as tobacco industry interference);
- current tobacco control strategies and policies, and existing capacity for implementation and enforcement for each of the assessed policies
- capacity elements of the current tobacco control programme (leadership and national coordination mechanism; partnerships; infrastructure and organizational development; planning and monitoring; financing and human resource allocation for the relevant Government and nongovernmental organizations, as well as potential changes over the next five years that may affect the national programme).

To prepare specific recommendations for improving:

- the existing tobacco control programme or alternatively, if no national tobacco programme exists, for creating one;
- the capacity for implementation and enforcement of the assessed tobacco control policies, as the basis for an action plan for short- and medium-term implementation by the Government in collaboration with WHO and other international partners.

Planning is a critical part of the assessment. The better the planning, the better the assessment will be. It is important to start preparing early and to allow sufficient time for the preparatory work. WHO, in collaboration with the hosting government, prepares and conducts a planning visit at an early stage, as soon as the focal points have been assigned, and if possible allowing at least 3-4 months before the original proposed dates for the assessment exercise. This visit may last 2-3 days. The main participants involved in preparing and conducting this visit are the WFP and CFP, other Ministry of Health and WHO representatives assigned to this visit, and members of the support team. Other relevant stakeholders from governmental institutions/agencies and nongovernmental organizations at national/regional level will be invited for one working session during the planning visit (see Section 3.2 below).

The main **objectives** of this visit are:

1. to raise awareness and secure support from the relevant country authorities (other than the Ministry of Health, which is already aware and engaged) for the upcoming capacity assessment mission;
2. to reach preliminary agreement on preparatory activities between the Ministry of Health and WHO teams;
3. to plan the entire preparatory process for the capacity assessment mission, reaching agreement on a detailed plan of action.

The expected results of the engagement/planning visit are:

1. agreement on the dates of the assessment mission;
2. tentative agenda of the assessment mission;
3. plan of action for the preparation phase (list of activities with roles/responsibilities and timescale);
4. agreement on distribution of roles for the preparatory work; agreement on time frames and communication channels and frequency;

5. identification and preliminary selection of key-informant institutions/individuals and sites for field visits;<sup>5</sup>
6. draft list of possible members of the assessment team and agreement about members' terms and responsibilities;
7. agreed list of documents as background information for the assessment team members (e.g. relevant legislation and country reports, tobacco control country profile);
8. plan for the dissemination of the assessment findings;
9. plan of the logistics necessary for preparing the assessment mission;
10. plan of the budget necessary for preparing the assessment mission and production/dissemination of the report.

Once all the above results are achieved, the focal points, together with the support team, are ready to start the preparation work.

All the discussions and planning steps agreed during the planning visit should take into account the existing WHO methodology for capacity assessment; any proposal for a change from this methodology should be carefully discussed at this stage. Once the following phase starts (assessment is prepared/ carried out), it is not recommended that the agreed methodology should be changed, as it may have an impact on the mobilized resources, and potentially the agreed scope and objectives of the entire exercise.

### **2.1.3 Preparation**

As soon as the planning process has been finalized, the Ministry of Health and WHO will take the agreed steps, aiming at effective preparation of the assessment exercise and ensuring its successful achievement, in a context of reasonable use of resources according to the available budget and staff.

There are six critical steps that need to be taken for the preparation of the assessment:

- 1) prepare the assessment team
- 2) prepare assessment documents
- 3) prepare final assessment schedule
- 4) prepare and secure venues
- 5) arrange for interpretation/translation services
- 6) prepare for dissemination of the assessment report.

#### **1) Prepare the assessment team**

The capacity assessment team is in charge of implementing the in-country assessment mission.

The assessment team comprises the two assessment coordinators, who act as team leaders, selected members of the support team, and experts in different aspects of tobacco control. The number of team members depends on the size of the country and the objectives and scope of the assessment. To enable the work of the assessment team to proceed smoothly and to cover all policy areas in the assessment, the team should comprise around four international experts and six national experts. So, a full team may amount to 10 or more members (the smallest number of people who can together competently assess the situation is preferred). A combination of experts coming from various organizations as team members ensures a certain objectivity of the assessment, delivering to the public a strong message about the Government's interest in cooperation and coalition building.

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<sup>5</sup> The final list will be available only after the interviews have been confirmed by the proposed key-informant institutions.



The overall preparation of the team involves several aspects that are described below:

- 1(a) selecting assessment team members
- 1(b) defining team responsibilities
- 1(c) briefing the assessment team
- 1(d) arranging travel and accommodation for the team.

### ***1(a) Selecting assessment team members***

The final report will have higher technical authority, and so more political weight, if the assessment team includes persons well recognized for their expertise and/or position in tobacco control or other relevant fields. It is important to have a balance of international and national experts. International experts bring specific expertise, experience from other countries and new perspectives on local problems, while national team members provide local experience and understanding of the local situation and history. International team members are selected on the basis of their expertise in programme management (particularly in development and coordination of national tobacco control programmes; policy development; gaining political commitment and mobilizing resources; project management; financial management; partnerships; etc.), as well as in the area of specific tobacco control interventions (legislation, enforcement and/or other legal aspects of tobacco control; public health/epidemiology/tobacco consumption and burden; health/tobacco economics; tobacco cessation; advocacy; tobacco industry structure and tactics, media and advertising; etc.) International experts should have excellent verbal and written communication skills, should be computer-literate and have a proven ability to understand and cope with cultural differences. They will be in direct contact with key informants during the interviews, so they will need to show attention and concern for local etiquette, basic rules for introductions or any other codes of courtesy used in the country. Preferably, they should have experience from other countries similar to the country being assessed.

National experts should have a good knowledge and understanding of the issues facing tobacco control in the social and political context of the country concerned. They should be ready to provide background information for international experts and interact fluently with their international colleagues in the agreed working language of the team. Sometimes they may be asked to act as interpreters (for example, if the team breaks into small groups and no interpreter is available at a particular moment). They may include:

- representatives of public health institutions, medical schools and academic institutions, relevant nongovernmental organizations, self-help groups, patients' organizations, regional or municipal authorities, trade unions, businesses, health professional associations (lung health/cancer), labour organizations, environmental groups;
- national advocates and interest groups (either current or potential), media specialists or local politicians;
- staff of the central unit for tobacco control, or other relevant staff, including staff of smoking cessation services;
- officials from other departments of the Ministry of Health (including the health promotion unit, and those addressing disease control, such as noncommunicable diseases, mental health, lung and heart disease or other agencies/ministries);
- regional coordinators for tobacco control programmes/local experts or staff from intermediate levels of the health services (regional or provincial health offices, tobacco control services, health promotion services, etc.) if relevant to the tobacco control programme.

No representatives of the tobacco industry or any of its allies should ever be included in the assessment team.

The members of the assessment team are identified according to the above criteria and selected by the focal points to make up a preliminary list of assessment team members. The support team may also be consulted about this draft list, and this usually happens during the engagement/planning visit. The focal points will then investigate the availability and interest in the assessment of the proposed experts (WFP contacts the international experts, CFP contacts the national experts). Freelance experts/independent consultants may be contacted directly, while in the case of experts employed by an organization, the head of that organization should also be consulted. Alternatively, a specific international/national organization may be invited to contribute to the assessment by assigning one of its experts. The assigning organization may agree to cover the participation costs for its expert, so the overall budget of the assessment may also benefit. As soon as the preliminary list is confirmed, the final proposed membership of the assessment team (with experts' names and CVs) will be submitted to the appropriate levels of decision - making of the Ministry of Health for formal acceptance.

### **1(b) Defining team responsibilities**

The team collects the necessary information to assess the country's capacity to implement effective tobacco control policies, prepares reports and briefing notes, discusses the findings, and draws up a summary of findings and preliminary recommendations. More detailed information on the responsibilities of the assessment team members can be seen in the sample terms of reference (Section 3.4). The two focal points must define the roles and responsibilities of each member of the team and circulate them to all team members as early as possible, as shown in Box 2.

Box 2. Roles of all participants:

The key roles of all participants are:

- to analyse the information available (country profile and other documents) on tobacco use, control strategies and programme organization;
- to check through observation and interviews whether the information provided is consistent with reality and is sufficient for deciding policy and interventions;
- to identify areas for improvement and to propose priorities for action;
- to propose issues for operational research;
- to draft the assessment report.

Additional roles of international participants, in agreement with hosting government, will be:

- to analyse the national programme experience as a model for other countries.

### **1(c) Briefing the assessment team**

Each member of the assessment team will be briefed as soon as the list is approved by the Ministry of Health. The briefing should be conducted in detail on the phone, or face-to-face (as appropriate). The WFP will be responsible for briefing the international members (usually by phone), and the CFP will be responsible for briefing the national members of the team. The national members may also be briefed in a single meeting that brings all of them together for several hours. The international and national consultants should each sign a Declaration of Interest, specifying their past or present, paid or unpaid, involvement with the tobacco or pharmaceutical industries and other commercial interests.

### ***1(d) Arranging travel and accommodation for the team***

The focal points will take the necessary action to prepare for the participation of assessment team members, as approved by the Ministry of Health. They will make sure that invitations are sent in due time, that travel, visa and accommodation arrangements run smoothly, and that all experts are properly briefed on the assessment's terms of reference and on their expected contribution before, during and after the assessment mission. The WFP is in charge of all arrangements for the international part of the assessment team, while the CFP will take similar action for the national experts, as appropriate.

*Accommodation for experts* – the experts will work together as a team and interact frequently for the assessment work, participate in evening debriefing meetings and contribute to the drafting process in a special room at the assessment venue, which will be organized and equipped for this purpose. Therefore all assessment team members should be hosted in the same place (hotel, or sometimes the host Government may provide accommodation in guest houses). Although a final agenda for interviews is usually confirmed before the assessment, late changes may be made in the scheduled interviews, and therefore the assessment team members need to be easily contactable, available and flexible enough to adapt to these changes. Another reason for accommodating the assessment team together is that transportation to and from interviews is more cost-effective when organized from one point, rather than various points dispersed around the city.

At least one international and one national member should be allocated to every group. Some of the experts may be asked to travel to some field sites to conduct interviews and assess the local implementation of tobacco control policies. Overall, the assessment team will need to be divided into smaller groups, each with its own specific agenda of interviews, and the final agenda will reflect the distribution of work for each subteam. It may be agreed with the host Government that field visits are necessary to complete the assessment, and then one or two subteams can be assigned to the field visits. In this case the CFP should make sure that travel and accommodation are arranged in good time for these teams and also that venues are booked for all interviews. It may happen that the field visits include courtesy visits to heads of local authorities, and the team members need to be briefed and instructed in this regard.

## **2) Prepare assessment documents**

The assessment documents include information that is consulted in advance by the members of the assessment team in order to learn as much as possible about the existing problem (tobacco epidemic in the country and its consequences) as well as the solutions currently applied by the country (progress and efforts in tobacco control). Usually the set of background information comprises:

*2(a) relevant national and subnational legislation*

*2(b) statistics and reports*

*2(c) tobacco control country profile (TCCP).*

***2(a) Relevant national and subnational legislation*** (health legislation, but also any relevant legislation from other sectors: agriculture, finance, environment, labour, etc.); these selected laws and regulations should be translated into the agreed working language of the assessment team (usually English, but could also be another United Nations official language; it is essential to have all members of the team speaking fluently in the same language, and one which can also be easily interpreted by local interpreters hired for the interviews and other meetings during the assessment);

**2(b) Statistics and reports** recommended by the Ministry of Health and other Government departments, or nongovernmental partners (if possible, dating back no more than five years); likewise, it is preferable to have these reports available in (if necessary, translated into) the agreed working language of the assessment team;

**2(c) The TCCP**, which is a profile of tobacco use and control in the country, is usually developed specifically for the in-country mission's purposes, so that the assessment team members can quickly learn about the current situation. The two focal points use national data to update information from the various editions of the WHO report on the global tobacco epidemic, but also from WHO FCTC implementation reports or other reports prepared by the Ministry of Health in collaboration with WHO. The TCCP describes the country's characteristics, health system and tobacco control activities, including information on institutions responsible for various components of the tobacco control programme, enforcement, etc. The profile should include sufficient information and analysis to help the assessment team members (particularly the international experts who will be less familiar with the country) to interpret their findings as they study background documents, conduct interviews and make field observations. The profile will include most of the essential data, plus analysis, that the members of the assessment team will validate and expand on as they work. The two focal points will agree on the tobacco control data (e.g. consumption, burden, production, smuggling, key policies, programme structure) which are most important for inclusion in the country profile. It is important to note that development of the profile is not a research project: the profile should be a compilation and analysis of existing data, and should note any important gaps, but it should not attempt to find new data. Box 3 contains guidelines for producing such a profile. Profiles from previous assessments may be used as models (these may be provided by WHO, on request, from [tfi@who.int](mailto:tfi@who.int)). In most cases, national staff will need to be assigned or contracted to prepare the country profile (1–2 persons for 1–2 weeks).

Box 3. Suggested contents of the TCCP

**1. General brief information on the country**

- Population (population size, age and sex, geographical distribution, urban/rural, ethnic groups)
- Economic situation (gross national product (GNP); GNP per capita)
- Political commitment to health by central government
- Health expenditure in absolute numbers, as a proportion of total Government expenditure or proportion of GNP), financing of the health system
- Administrative structure (regions/provinces/districts, etc.)
- Health system structure (public health services, social security, private and corporate system)
- Tobacco industry (national/international, producer/trader, import/export, market share and marketing tactics, etc.)

**2. General information on the health status of the population**

- General health statistics, disease burden, government's main health priorities
- Morbidity and mortality data

**3. Specific information on the tobacco control programme – if existing and available**

- Structure (a chart is useful) with reporting lines, operations and budget of the tobacco control programme
- Main governmental and nongovernmental institutions involved in tobacco control and coordination
- Key Government officials involved in tobacco control, position and roles
- Key civil society groups involved in tobacco control and planned collaboration with partners
- Timeline of key achievements in tobacco control
- States/cities with best progress or with opportunities for tobacco control
- Plans of action – either annual or multiyear
- Steps required to pass tobacco legislation – institutions/departments responsible for setting tax policy.

Box 3. Suggested contents of the TCCP

**4. Specific information related to the policies included in the best-buy/good-buy package**

Monitoring and evaluation of the tobacco epidemic and its response:

- prevalence of tobacco use among adults/adolescents by gender from recent surveys;
- any other available national statistics with data related to tobacco use;
- institutions responsible for monitoring and evaluation related to tobacco.

Protect people from exposure to second-hand tobacco smoke (smoke-free environments):

- brief description of relevant existing smoke free legislation (national, state, provincial, municipal), including enforcement mechanism and responsible institutions;
- published data about the exposure to SHS and also on impact of smoke-free enforcement, if available.

Offering help to people who want to quit in the health system:

- tobacco/smoking cessation services provided by the Government or by professional associations, nongovernmental organizations (quitlines/helplines, availability of cessation therapy, brief advice, etc.);
- brief description of the health system in relation to tobacco cessation (national guidelines, reimbursement of services or therapies etc.).

Warning people about the dangers of tobacco:

- brief description of relevant existing ban on packaging and labelling regulations, including enforcement mechanism and responsible institutions;
- published data about the impact of existing health warnings, if available;
- existing data on public and mass-media campaigns including World No Tobacco Day commemorations.

Enforcing comprehensive bans on advertising, promotion and sponsorship of tobacco products:

- brief description of relevant existing ban on advertising, promotion and sponsorship legislation, including enforcement mechanism and responsible institutions;
- published data on violations and strategies of the tobacco industry to circumvent the law, if available.

Taxes, prices and production of tobacco products, as well as other economic data:

- real price trends of tobacco products; tax levels and structure, tax revenues, earmarked tobacco taxes;
- institutions/departments responsible for setting tax policy.

Other measures/policies considered/implemented by the Government, as appropriate:

- smuggling estimates and Government action to combat illicit trade;
- tobacco growing and alternative livelihoods;
- tobacco industry interference;
- countermeasures against tobacco industry marketing strategies, corporate social responsibility, lobbying, etc.

The TCCP should be circulated to the support team and to the members of the assessment team at least one month before the in-country mission, to ensure that it is clear and correct and that it provides sufficient background information on the country for the external experts. To give time for feedback, the profile should be started as soon as it has been agreed that an assessment will be carried out. Discussion of the proposed content of the profile will help the focal points and the support team to determine the main policy gaps and to agree the main priorities of the assessment. If the assessment was agreed between the Ministry of Health and WHO as a comprehensive exercise, then the TCCP will look at all the aspects listed above, while a selective assessment focuses on those specific strategies in which the Government is interested. However, in the latter case, the first introductory sections and the one related to the national tobacco control programme should still be included in the profile. A comprehensive assessment is usually preferable to a selective one, but a selective assessment may be appropriate in a country which is at a fairly advanced stage of implementation of its tobacco control programme and wishes to evaluate and develop a specific area of interest.

### **3) Prepare final assessment schedule**

The in-country assessment may take 1–2 weeks, depending on the size of the country and the components to be evaluated. The length of the assessment must balance the need to gather sufficient observational data with the cost and availability of the experts. It is important to take into account local festivals, national holidays and other important events, such as elections, that may influence the timing of the assessment. [For a sample assessment schedule, see Section 3.5].

#### **The preparation of the final schedule includes steps such as:**

*3(a) preparing the tentative schedule of the assessment*

*3(b) selecting sites for visits and identifying key informants.*

**3(a) Tentative schedule for the assessment.** The in-country mission is composed of four main elements:

#### **Team preparation**

This is a meeting of all assessment team members that takes place on the first morning of the mission. It is, in effect, a team-building moment and a chance to recall the information shared during the preliminary briefing. The assessment team members will go through the schedule of interviews together with the two focal points, learn about the assessment procedures and briefly revise the country framework. Practical arrangements and logistics are clarified and subteams identified. The two focal points will remind everyone about rules and responsibilities for interviews, field visits and report writing/presentation of the collected data. The national members will brief the internationals on possible cultural sensitiveness and local codes of courtesy.

#### **Data collection**

The data collection during the assessment is mainly achieved through visits to key-informant institutions and organizations. The assessment team is divided into operational subteams, as described previously. They will have a confirmed schedule, prepared by the focal points, that includes contact persons for each key-informant institution. Transportation to and from the visited institution is organized in advance by the focal points, preferably through specialized companies that will guarantee safe transport and security in the field. Data collection tools will be used by the members of the assessment team during the country visit. The use of standardized tools will ensure that information collected by different teams is complete and comparable, and will facilitate consolidation of the data. Examples of some data collection tools are given in Section 3.

#### **Report preparation**

As soon as all interviews and observational visits are completed, all team members return to the main venue (usually the hotel where they are lodged) and start preparing the report. As a first step, they need to meet up again as a full team and present to each other the reports of their findings from the subteam visits, so every member of the team is briefed on the entire set of findings (see Section 3.7 for a sample subteam findings report). They will then discuss these findings and agree on the main aspects that will be included in the executive summary of the report. Another division into subteams, this time based on expertise, and/or preference for a particular policy, will create small drafting teams that will be responsible for drafting one or two sections of the full report. Ministry of Health representatives could contribute to the discussions and drafting process, but most importantly they need to be in the room when the first draft of the executive summary and the various sections of the full report are discussed. After a first round of discussion on the first drafts, the same teams will prepare a second draft, and where possible, the same process should lead to a third draft. A preliminary debriefing and consultations take place between the two focal points and the leading department in the Ministry of Health regarding the executive summary and draft of the full report.

### **Debriefing and dissemination**

Once the assessment team and the Ministry of Health have reached a preliminary agreement about the executive summary and main aspects of the full report, the last day of the in-country assessment is dedicated to debriefing of all key-informant institutions visited and any other interested stakeholders. The assessment findings are reported back to the audience. It is recommended that the debriefing meeting is chaired by the highest possible level of the Ministry of Health (Minister) and WHO (Head of the WHO Country Office). The invited audience should include not only the visited stakeholders, but also any other key high-level senior officials, key senior opinion leaders, decision-makers, Members of Parliament, potential donors, nongovernmental organizations and other relevant organizations.

The purpose of the debriefing is:

- to disseminate the draft assessment findings
- to widen the consultation and increase ownership of the assessment findings and recommendations
- to ensure that the recommendations are fully understood and accepted
- to obtain political commitment
- to agree on a time frame and the responsibility for implementing the recommendations
- to identify the next steps.

It is also recommended that a press briefing (preceded by a press release) is organized on the last day of the assessment, right after the debriefing meeting, in order to disseminate the executive summary conclusions to the public. The press briefing is principally organized by the Ministry of Health. Assessment team members may participate in the press briefing by invitation of the Ministry of Health.

### ***3(b) The selection of sites for visits and identifying key informants***

A preliminary agreement on this matter should be reached during the planning visit. A draft list of key-informant institutions is drafted by the two focal points. The purpose of these visits is to gather information from key informants on the structure, process and outcome of tobacco control activities in the country, to interview persons involved in these activities, and to gather the views of associated agencies and partners. Sources of information may include health and social workers, or other relevant staff at all levels of the health sector and other sectors (health promotion units, tobacco control units, smoking cessation services, etc.), tobacco control commissions and committees, cancer patients, health practitioners, other sectors include policy-makers, representatives of trade unions, representatives of employers' associations, tobacco farmers, and so on. The main purpose of the visits is not to gather new quantitative data, which should already be available from the Ministry of Health and elsewhere and should have been collected in advance. Rather, the purpose of the visits is to assess the validity of the data and information provided and to observe the development and implementation of tobacco control interventions.

The draft list includes institutions and organizations from the capital, but also from localities which are potentially of interest for the field visits. It will be impossible to visit all sites or to ensure a representative sample, so some selection will be necessary. The decision about the number of sites to visit should take into account the time needed to travel to and from the sites as well as the time involved in the actual visit. The selection of sites (or states/cities) should involve as many of the support team and partner organizations as possible, and the criteria used for the selection should be shared with the assessment team. The decision may balance the main objective of obtaining information for the assessment with the possibility of using the assessment team's visit to mobilize political commitment for tobacco control in a particular region.

Priority should be given to sites and informants which can provide unique and senior-level strategic perspectives and information, or key missing data, and organizations and individuals whose participation in tobacco control is particularly important. For instance, if a country has a weak tobacco tax policy, meetings with senior tax officials and politicians dealing with financial issues should be seen as critical. In some cases, geographical representation may be important – particularly if a given region has expressed interest in implementing precedent-setting policies, or if tobacco use is concentrated in a particular area, or if opposition to tobacco control in a certain region presents an obstacle to national efforts. In very large countries and those with a federal structure, the national tobacco control coordinating authority must have strong connections with councils, committees or other authorities that coordinate tobacco control at subnational and local levels. Such connections may be in the form of direct representation (so that at least some people on the national council are also on subnational councils or governments) or of working groups or other forums through which various constituencies (e.g. local associations of health professionals or local grassroots organizations) advise the national council or committee. The assessment team will take advantage of opportunities to meet various representatives who are members of more than one structure, thus ensuring that the interviews cover as many levels and structures as possible. In particular, if subjurisdictions have implemented precedent-setting tobacco control policies, team members should make an effort to visit these areas or should invite key representatives from them to travel to meet the team. Box 4 lists potential sites for field visits. In addition to visiting sites for interviews, the assessment team members should also visit specific sites where they can observe the enforcement/implementation of the policies included in the best-buy/good-buy package. In this regard, there are many target areas that can be tracked; a selection is generally needed so that resources can be used efficiently and policy needs met. Target areas may be sites (e.g. points of purchase, restaurants), events (e.g. industry-sponsored concerts and sporting events), populations (e.g. health-care providers, young people), or tobacco products (e.g. cigarette packaging). The targets should be aspects of tobacco control for which change is anticipated. For instance, smoking in hospitals would be an important target area if smoking is still allowed in hospitals, but it is unimportant if hospitals are smoke-free. Attention should be directed at those target areas for which the data will guide policy change and will track the consequences of change (9). Box 4 lists potential sites for observing the application of existing legislation for the key policies. Some interviewees are sometimes only identified after the Assessment missions has started and they should to the extent possible be accommodated in the schedule.

#### Box 4. Examples of potential sites for visits/interviews

##### **National/federal level**

- **Ministry of Health**

- Minister or Secretary of Health, directors of public health/health-care services/prevention services, coordinator of smoking cessation services, designated senior officials in the Ministry;
- Director of health policy and legislation department, directors of budget/planning/human resources, head of pharmaceuticals policy (related to nicotine replacement therapy and treatment of tobacco dependence);
- designated officials dealing with communication, noncommunicable diseases, health promotion and advocacy;
- National committees or commissions.

- **National regulatory agency/department** (may be part of the Ministry of Health but may also be independent agency).

- **Ministry of Finance and Customs/Trade** Minister, Secretary or senior officials in charge of tax policy and tax collection procedures, tobacco smuggling control, tobacco trade and agricultural policies.



#### Box 4. Examples of potential sites for visits/interviews

##### **National/federal level**

- **Other ministries/agencies** potentially involved in developing or implementing tobacco control measures: senior officials of the
  - Ministry of Labour (essential when creating smoke-free environments in workplaces);
  - national authority for consumer protection (senior officials in charge of implementing regulatory requirements on tobacco marketing, advertising, packaging and labelling, tobacco testing, and disclosure of information on tobacco additives and toxic ingredients);
  - Ministry of Justice (assistance on facing legal challenges to tobacco control legislation and on constitutional matters and international treaty obligations, including human rights);
  - Ministry of Communication, Ministry of Transport, Ministry of Agriculture and/or Ministry of Industry (if tobacco is grown or tobacco products are manufactured in the country);
  - Ministry of External Affairs; national authority for monitoring mass-media; Ombudsman; etc.
- **Nongovernmental organizations** involved in tobacco control, and the head of the national coalition of nongovernmental organizations (if any).
- Health and other organizations of professionals (such as lawyers and economists): representatives.
- Medical schools, universities: representatives.
- Private sector and industry (except for the tobacco industry): representatives, managers, etc.
- National trade unions: representatives.
- Other organizations (patients' rights, women's and children's rights, environmental, religious, consumer protection, teachers, parents organizations, human rights): representatives. Tobacco growers organizations (not supported by the tobacco industry).
- Mass media: representatives (ideally editorial boards) of the most important newspapers and radio and television outlets identified as interested in tobacco-related issues.
- Places that should be smoke-free according to the law (e.g. hospitals, Government offices, public transportation, workplaces, restaurants, etc.): managers and also patients (in hospitals), workers in all other public places.

##### **Regional, provincial and district levels**

- Regional and provincial public health and social departments: officials.
- Regional and local nongovernmental organizations, associations of health professionals and trade unions: representatives.
- Smoking cessation services: managers or coordinators and patients.
- Private sector: managers of enterprises that officially implement smoke-free policies.

##### **Others**

- **Public places** covered by smoke-free legislation: (smoke-free) hospitals, workplaces, public administration offices, transportation, cinemas, restaurants, bars, etc.
- **Outdoor and indoor sites** for advertising and marketing: billboards, free offers of tobacco products on the street, any form of outdoor and indoor indirect advertising, etc.
- **Audiovisual media** (monitoring for direct and indirect advertising): main television channels, 2–3 main newspapers, 2–3 magazines aimed at women or other readerships, including electronic media.
- **Retail tobacco shops and other points of sale** (including sales on the streets): to observe the prices of tobacco products, packaging and labelling for 2–3 brands, availability of tobacco products to schoolchildren, etc.
- **Pharmacies:** to observe the availability and prices of treatment for nicotine addiction.

#### **4) Book and prepare the venues**

An important element that needs to be discussed at an early stage during the planning visit is related to the venues which need to be prepared for the assessment. The two focal points will discuss the best options for the following venues:

4(a) *interview venues*

4(b) *debriefing meeting venue*

4(c) *working venue and lodging for the assessment team*

**4(a) Interview venues** – the data collection part of the assessment exercise includes visits to various institutions and organizations (interviews with key informants). When deciding on a specific venue, there are several factors that need to be taken into consideration by the CFP.

- The distance from the lodging hotel and the venue, as well as that between one informant institution and the next, influences the number of interviews that can be conducted by one subteam in one day. Sometimes, in large cities, around one hour needs to be allowed in the tentative agenda for travel from one institution to another. The working hours of public institutions and the availability of the key informants are also important aspects to be explored. It is preferable for venues in reasonable proximity to one another to be selected for the same time slot (morning/afternoon) so that the subteams go from one interview directly to the next one on the schedule. This maximizes the number of interviews that can be scheduled for one day, e.g. one subteam can conduct 2-3 interviews in the morning, followed by 2-3 interviews in the afternoon, totalling 20-25 interviews conducted in one day by all five subteams. With 2.5 days of data collection, the team could plan for a maximum of 50-60 interviews. These practical details need to be discussed at an early stage, as they may influence the overall decision about the number of key informants/institutions to be invited for interview, and therefore will have an impact on the scope of the assessment exercise.
- The interview room is an important element that should reassure the key informants and give them the confidence to share their experience and information with the visiting assessment team. This room should be dedicated to interviews, and accommodate the planned (and confirmed) number of participants. The fewer the participants in the interview, the higher the chances of an effective discussion. If the key-informant institution prefers to make available a larger group of staff, the interview room should enable all participants to have a seat, and everybody in the room to be seen and/or heard. An amphitheatre with people spread around is not an optimum solution, and neither is holding the interview at a desk in a bigger room where other staff are carrying on with their daily tasks. The interview room can either be at the institution or at the hotel, whichever is more appropriate.

Depending on the size of the country, the number of stakeholder institutions and the overall goal of the assessment, the number of interviews may vary from 40 to 200. In any of the selected options, it may not be possible for all interviews to be conducted by the experts as a full interviewing team during the few days dedicated to the data collection phase of the assessment. Moreover, the interviews are not effective if the entire team is present. On the one hand, each assessment team member may be specifically assigned to one or another policy (usually his/her own field of expertise) during the data collection process, so the presence of all members is not absolutely critical to the discussions, and on the other hand the key informants may not be comfortable in the presence of more than 4-5 people during their interview (the TOR in Section 3.4 include details of interviewing rules).

**4(b) Debriefing meeting venue** – this should be a conference room specially prepared for this type of meeting. Usually all key-informant institutions are invited to participate, plus other relevant stakeholders. Apart from the WHO and Ministry of Health high-level representatives who will chair the meeting, it is recommended that the entire assessment team should attend. The debriefing room should thus have a capacity of around 60-70 people and be properly equipped for presentations and interactive discussions; it may be provided by the hotel that hosts the assessment team, or alternatively by another venue usually used by the Ministry of Health for such events. It is also possible that the Ministry of Health or the WHO Country Office can provide a conference room at their own locations, an option that needs to be discussed between the two focal points.

#### **4(c) Working venue and lodging for the assessment team**

*Hotel accommodation* – the entire assessment team should be lodged in the same hotel. This allows close interaction among the members of the team, ensures members' security, and saves on transport costs to and from the interviews. Since the subteams are requested to hold daily subteam debriefing and planning meetings, upon completion of the interviews they may hold these meetings in a dedicated working space provided by the hotel.

*Working space* – the assessment team will work on the assessment report in a special room provided by the hotel that hosts the team. Alternatively, this room may be provided by the Ministry of Health or WHO Country Office, provided that it is close to the hotel. This room will serve as the "headquarters" or "secretariat" of the entire assessment exercise and serves as a workplace for all assessment team members. It will be properly equipped (one or two computers, printer/scanner, Internet connections (preferably wireless, as assessment team members may use their own laptops), etc.). This room will be used for the assessment team briefing on the first day, for the daily debriefing/planning meetings of subteams, and for preparing and presenting the subteams' reports on their findings, holding team discussions and drafting the assessment report.

#### **5) Arrange for interpretation/translation services**

Interpretation (spoken) and translation (written) services may well be crucial to the success of the joint assessment.

**Interpretation:** especially in countries where the key informants or stakeholders may not feel comfortable in engaging in discussions with the international assessment team members in what is, to them, a foreign language. It is desirable to provide interpretation in the following settings.

- **Interviews** – for ensuring correct communication of data and facts on the topics in discussion by avoiding misunderstandings generated by a poor command of the foreign language. Since there should be one interpreter for each interview, this may place a high burden on the overall budget for the assessment. If the available budget does not cover all interpretation services, then the national members of the team should agree to provide interpretation during interviews. In this situation, the scheduled length of the interview should be longer than usual (e.g. 1 hour 30 min. rather than 50 min.).
- **Debriefing meeting** – in order to ensure correct understanding of findings and main recommendations presented at the meeting and to allow participants to engage in discussion that may clarify some points or even add more information to one topic or another (simultaneous interpretation must be provided).
- **Internal working time of the assessment team** – during the discussions around the table on the first and second draft of the full assessment report; as relevant staff from the Ministry of Health usually need to participate in these discussions, one interpreter may also be needed.

**Translation:** Various documents will need to be translated during the preparation time, during the assessment in-country and even afterwards.

- **During preparation** – background information (i.e. relevant legislation, statistics, reports and the TCCP) should be translated from the country language into the agreed working language of the assessment for preliminary reading by the assessment team.
- **During in-country assessment – to the extent possible**, the first and second draft of the full report as well as the executive summary of the report need to be revised by the staff assigned by the Ministry of Health, as explained above.
- **After the in-country assessment** – the final assessment report will be delivered to the Government in both languages (the agreed working language of the assessment and the country language).

## 6) Prepare for dissemination of the assessment report

The impact of the assessment will be increased significantly by ensuring strategic dissemination of the findings and recommendations. The dissemination should be planned and agreed upon during the planning visit. However, given the potential political sensitivity of some of the findings and recommendations, the dissemination plan should be implemented by competent Government agencies and officials, with the full approval and involvement of the Government.

A first step towards dissemination takes place at the debriefing meetings, when stakeholders are informed about the main conclusions of the assessment mission, and also through the press briefing, when the media are informed that a joint WHO/Government mission has taken place and some of the main conclusions are released to the public. However, more effective dissemination includes the distribution of the full assessment report (once it becomes public) to the institutions and organizations that will be responsible for or involved in the implementation of the assessment recommendations. The involvement of the information and communication office of the Ministry of Health or another suitable Government agency should be arranged at an early stage of planning. A link should also be established with WHO early on to facilitate communication and exchange of information. As soon as the full report becomes public, it may be published on the WHO and/or Ministry of Health Web sites, and printed and disseminated as appropriate and agreed. Although the full report may be finalized in the agreed working language of the assessment team (e.g. English), the report needs to be translated into the country language to allow dissemination to relevant stakeholders in the country.

A checklist for logistics and budget may be found in Section 3.3.

## 2.2 In-country assessment

There are three main components of the joint assessment.

### 2.2.1 Conducting the assessment in the host country

### 2.2.2 Finalizing the joint assessment report

### 2.2.3 Making the assessment report public and disseminating it

#### 2.2.1 Conducting the assessment in the host country

There are four main elements of the in-country assessment, from briefing the assessment team members to finalizing the first draft of the main report and disseminating the assessment findings. The two focal points supervise these tasks. Depending on the scope of the assessment and the availability of the key informants, this stage of the capacity assessment normally takes a minimum of five working days, but can be extended to 10 working days, excluding days spent travelling (see also Section 3). The overall schedule for a capacity assessment would be as follows and as described in the previous section.

#### Arrival (travel day)

1. **Team preparation** – one half-day. It is recommended that arrival is organized for the weekend before the in-country mission, so the team briefing meeting can be held on Sunday (morning or afternoon, as the team agrees), and data collection (visits/interviews) can start on Monday morning.
2. **Data collection** – minimum 2.5 days, but can be extended to 3.5 or 4.5 days depending on the scope of the assessment.
3. **Report preparation** – minimum 1.5 days, but can be extended to 2.5 days or 3 days depending on the scope of the assessment.
4. **Debriefing and dissemination** – the last day of the in-country mission (it could be on a Friday morning, or the following Monday morning, or later, depending on the scope of the assessment).

#### Departure (travel day)

A detailed description of work during the assessment mission, plus the specific tools to be used during the mission, are included in the TOR (see Section 3.4).

### **2.2.2 Finalizing the joint assessment report**

A model of the content of the final report is shown in Section 3.8. It may not be possible to finalize the entire report by the end of the assessment. Nevertheless, it is essential that an executive summary and the main recommendations are drafted and presented verbally to the highest decision-makers in the Ministry of Health and to other audiences as appropriate. The executive summary and recommendations will form part of the final assessment report. All the members of the assessment team, not only the international participants, are responsible for the summary and recommendations of the report.

The final joint assessment report is structured in two main sections.

#### **EXECUTIVE SUMMARY**

The executive summary is the section that is presented during the debriefing meeting, so it should be finalized and agreed with the Ministry of Health in good time. It is often the only part of the assessment report that many people in a position to take political decisions will read. Many will not be technical experts in tobacco control, so the language must be adjusted accordingly. The executive summary must be prepared carefully so that the main message of the assessment is stated clearly and unequivocally.

The executive summary usually includes:

- an introductory paragraph listing the objectives and methodology of the assessment;
- a brief assessment of the burden of tobacco in the country;
- a statement regarding the benefits of building up the country's capacity for tobacco control by implementing an effective national tobacco control programme and action plan;
- a summary of the main national achievements and the constraints facing tobacco control efforts;
- the main findings and conclusions regarding the country's capacity for tobacco control, and its achievements and gaps;
- the most significant recommendations of the assessment team (these should be measurable, time-limited and specific; if possible, potential responsible institutions may be identified).

The main recommendations should be limited to those (perhaps 5–6 in number) that will contribute the most to achieving effective tobacco control measures in the short term (12–18 months) – particularly those relating to resource requirements, policy priorities and organization of the tobacco control programme. They should be concrete, measurable and feasible in the short term, should relate to the problems and constraints described in the summary, and provide solutions for the main findings. Other findings/recommendations for the medium- and longer-term agenda may be included in the main text of the report in the appropriate section.

#### **ASSESSMENT REPORT**

##### ***During the assessment***

The assessment report is a joint one, agreed between the Ministry of Health and WHO, but the main authors are the members of the assessment team, with help and support from the Ministry of Health representatives present at the drafting stage, as well as WHO staff assigned to provide support. It is recommended that senior officials are involved in the revision of the executive summary which will be presented at the debriefing meeting, in order to make final corrections and avoid misinterpretations/

translation errors by assessment team members relating to existing structures, legislation, statistics, etc. During the assessment week(s), the assessment team is usually able to draft and discuss 2-3 drafts for each section of the main report, and the final drafts should be handed over to the two focal points before the team leaves the country.

The main report has an *introductory section* that briefly describes the background situation that led the Government to invite WHO to carry out a joint assessment, the scope, the methodology used to assess tobacco control and a brief description of the structure of the following chapters, which are in effect describing tobacco control policies that were assessed in line with the agreed scope of the assessment (see Section 3.8).

A *special chapter* placed immediately after the introductory part will describe the general national/federal efforts for tobacco control in the country, governmental commitments, the national coordination mechanism and current capacity for the implementation of a national tobacco control programme.

Several *chapters* follow describing each assessed policy, each with three sections.

- **Policy status and development** A brief introduction describes the present status and future development of the policy in question, based on a thorough review of all documents made available by the coordinating team from the capacity assessment prior to the country visit (TCCP, *WHO report on the global tobacco epidemic*, legislation in force, results and conclusions of previous studies and reports, etc.) and interviews with key informants.
- **Key findings** A summary providing the most important facts discovered by the assessment team after conducting the visits and interviews. This is based on an analysis of key factors for success in implementing present policies and developing future ones, such as political will, programme management and coordination, partnerships and networks for implementation and provision of funds, human resources.
- **Recommendations** These address the actions required, in the opinion of the assessment team, to improve the design, implementation and enforcement of the policy examined. Each key finding leads to a recommendation.

#### ***Immediately after the assessment***

During the 30 days following the in-country assessment, the two focal points finalize the report. This includes completing and editing the draft and circulating the document electronically to the members of the assessment team for final comments. In addition, the CFP may need to consult specific institutions about the accuracy of some of the information or the references. The report must be circulated rapidly to team members, with a maximum of one week for them to return their comments, which are then incorporated if appropriate. The two focal points are usually responsible for writing the final report, but an agreement on this should be reached at the planning stage. Both coordinators will be responsible for the preparation of the final draft and for the informal consultation with the national authorities. The entire process should preferably not take more than one month. Existing WHO rules and Ministry of Health report clearance and distribution procedures should be followed.

### **2.2.3 Making the assessment report public and disseminating it**

The final assessment report has to be approved by the Ministry of Health and WHO. The two focal points work together to compile the final version from the reports by the assessment team members, and submit their final draft to the Ministry of Health and WHO (at all levels involved). Following comments from the Ministry of Health and WHO, the two focal points will make any final changes and will submit a final copy to WHO for approval. Then the WHO Office (country/regional/headquarters, as appropriate) will formally submit the final draft to the Ministry of Health. In order to ensure further implementation of the recommendations it is important for senior Government officials to endorse the report, therefore the Ministry of Health may wish to revise the final draft together with other relevant members of the Government. Once the final document is approved by the national authorities (Ministry of Health) and by WHO, it can be made public and can be disseminated to other parties, including publication on the WHO Web site. See previous capacity assessment reports on the WHO Web site (10).

## **2.3 Post-assessment (follow-up)**

It is important to ensure that this phase is planned as carefully as the assessment itself, and that deadlines are set. Otherwise, the political commitment generated by the assessment and the momentum gained by increased awareness of the tobacco burden may be lost. There are three main goals of the post-assessment phase.

### **2.3.1 Preparing/refining/revising and approving the national plan of action**

### **2.3.2 Preparing a plan for technical cooperation between WHO and Ministry of Health**

### **2.3.3 Monitoring progress through follow-up visits and revising of plans**

#### **2.3.1 Preparing/refining/revising and approving the national plan of action**

The existing plan will be refined or revised and then approved by the Ministry of Health or, if no action plan existed previously, a plan will be prepared by the Ministry of Health with technical assistance offered by WHO. The assessment should be viewed as a stage in the dynamic process of change. It provides the basis for political decisions and guidance for a medium-term plan of action (3–5 years). This plan should be reviewed periodically and adjusted on the basis of need. The cycle of this process is planning, implementation, monitoring, evaluation and revision of plans. A five-year plan for the development of the national tobacco control programme should take into consideration the necessary policy changes and modifications to the programme. Once this plan is approved by the Government and sufficient resources (internal and external) are mobilized, an annual operational workplan can be prepared and activities implemented accordingly. Policies and achievements can be evaluated periodically through capacity assessments.

Technical assistance to prepare or revise the medium-term plan of action can be provided by WHO and other international organizations in the form of consultants, training, programme observation in other countries and exchanges of information. A one-year workplan to implement tobacco control activities provides a framework to budget for, monitor and adjust interventions to make them more effective. A mechanism for monitoring should be put in place, with well defined and measurable indicators. The system of monitoring and the indicators employed should be consistent with the *WHO report on the global tobacco epidemic*. Periodic and regular evaluation of the programme should lead to annual replanning.

### **2.3.2 Preparing a plan for technical cooperation**

This plan will be designed by WHO and the Ministry of Health in support of the implementation of the recommendations. They will jointly implement this cooperation plan. The plan may include provision of technical assistance by other international partners, as appropriate. The Ministry of Health is responsible for ensuring that the recommendations are implemented in a timely manner. The CFP may be assigned to report to the Ministry of Health management and WHO. The Government will have already expressed its willingness to build national capacity for implementing effective tobacco control policies through its formal invitation to WHO and its direct participation in the assessment process. Usually, the joint assessment report sets out a shortlist of recommendations that may be implemented in the shorter term (12--18 months, as recommended by the assessment team and agreed with the Ministry of Health and WHO). Nevertheless, implementation of the recommendations may be a lengthy process that involves mobilization of social action and resources to achieve the desired changes, as well as a formal mandate for implementing the recommendations. Therefore, the two focal points will work together to ensure that, besides the action plan of the national tobacco control programme, a joint plan for technical cooperation is drawn up by WHO and the Ministry of Health, with realistic timelines, expected outcomes and responsibilities. A technical cooperation plan of this kind is useful in supporting the implementation of the recommendations. It should be submitted for approval to the Ministry of Health and to WHO by the two focal points. Each activity should be specific, achievable and time-limited. Estimates of additional resources required to implement the action plan, plus possible sources of funding, may be needed. The two focal points should periodically evaluate the need for changes to the plan, and they should bring relevant members of the assessment team into the process, as necessary, to contribute to the efforts of the Ministry of Health. Assessment team members should be aware that they may be requested to assist with ongoing monitoring and implementation of the recommendations.

Potential activities to include in a technical cooperation plan include support for:

- revising key policies and operational procedures
- developing a long-term plan for the national tobacco programme
- developing training programmes and workshops
- translating and adapting training packages.

The CFP may need external assistance in implementing some of the recommendations, particularly mobilizing additional resources from donors. Close collaboration between WHO headquarters, Regional Office, Country Office and partners will be necessary to facilitate this. It may also be necessary for the WHO assessment coordinator or other WHO staff or consultants to make further visits to the country to offer technical assistance (according to the technical cooperation plan) and to monitor progress. There may also be further opportunities for reporting on progress, such as international conferences and regional meetings of focal points for tobacco control.

### **2.3.3 Monitoring progress through follow-up visits and revising of plans**

The first follow-up visit should be conducted at least one year after the in-country assessment mission. Its schedule and meetings should be carefully planned and prepared by the two focal points. Examples of schedule of meetings for this follow-up visit are included in Section 3.9. A sample follow-up questionnaire is shown in Section 3.10.



## Tools for conducting the assessment

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This section is based on the step-by-step approach described in Section 2. It describes the logical sequence from planning and preparation to completion of the final report. It offers a range of organizational tools and an analytical framework that is designed to identify a country's tobacco control policies and programme and to explore its capacity to engage the whole community in confronting the tobacco epidemic. It includes planning and managerial tools needed by the WFP and CFP in preparing the various phases and activities of the capacity assessment.

The tools offered in this section will be used by the two capacity assessment focal points together with the members of the support team. Depending on the size of the country and the practicality of arranging interviews with key informants in a limited time, the two coordinators may need to modify the interview schedule (see Section 2.1.3. and Section 3.5) and agree on the most appropriate time frame in each case.

Members of the assessment team will collect information relevant to the topic areas of each section. Then, on the basis of this information, they will analyse current practices in delivering the “five Ps”.

This section concludes with a template for the final report of the assessment team (Section 3.8).

## 3.1 Planner – assessing national capacity for tobacco control

### A. PRE-ASSESSMENT

#### 1. Engagement

#### 2. Planning

- (1) Assignment of assessment focal points
- (2) Proposal of overall scope and objectives of the assessment
- (3) Planning visit

#### 3. Preparation

- (1) Preparing the assessment team
- (2) Preparing assessment documents
- (3) Preparing final assessment schedule
- (4) Preparing and securing venues
- (5) Arranging for interpretation/translation services
- (6) Preparing for dissemination of the assessment report

### B. ASSESSMENT

#### 1. Conducting the joint assessment in the host country

- (1) Team preparation
- (2) Data collection
- (3) Draft report preparation
- (4) Debriefing and first dissemination

#### 2. Finalizing the joint assessment report

#### 3. Making the assessment report public and disseminating it

### C. POST-ASSESSMENT

#### 1. Preparing/refining/revising and approving the national plan of action

#### 2. Preparing a plan for technical cooperation

#### 3. Monitoring progress through follow-up visits

Engagement and planning steps during the pre-assessment phase (A above), from the invitation letter to the end of the planning visit, usually take 2-3 months. The preparation during the pre-assessment phase (A), dedicated to the detailed preparation of the in-country assessment, may take 2-3 months, although this is an indicative time frame and not prescriptive, since experiences and the time frame may differ from one country to another. The in-country assessment (B) may last one or two weeks, depending on the scope of the assessment (comprehensive or selective). The post-assessment phase (C), which includes the follow-up visit, may be a long period, lasting at least two or three years. A new assessment exercise (to evaluate progress between one assessment and the next) should be planned and organized by the Government only when some time has been allowed for implementation of the previously recommended measures.

		TIME (months/weeks)																										
PHASES		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25		
A.	1.	1																										
	2.		1																									
	3.			1	2	3																						
	B.	1.																										
2.																												
3.																												
4.																												
C.	1.																											
	2.																											
	3.																											

## 3.2 Planning visit

The *planning visit* (see Section 2.1.2.2) should be conducted at an early stage, no later than 2-3 months after the engagement step has been taken. It usually lasts for 2-3 days. Main participants are the two focal points (WHO and Ministry of Health) as well as other relevant representatives of both the Ministry of Health and WHO. The visit will include a meeting with stakeholders relevant for tobacco control (from Government institutions/agencies and nongovernmental organizations at national/regional level).

### Objectives

- Raising awareness and securing support from the relevant country authorities, other than the Ministry of Health (which is already aware and engaged), for the upcoming capacity assessment mission.
- Reaching preliminary agreement on preparatory activities between the Ministry of Health and WHO teams.
- Planning the entire preparatory process for the capacity assessment mission, reaching agreement on a detailed plan of action.

### Several meetings may be held during the planning visit.

1. **Inception meeting** – participants: WHO and Ministry of Health focal points plus any other appropriate WHO and Ministry of Health staff as planned (brief get-together meeting before any other meetings of the visit, 30 minutes–1 hour, for last-minute revisions to the agenda of the planning visit).
2. **WHO courtesy meeting** – participants: the Head of the WHO Country Office, the two focal points. This meeting is conducted, preferably, early on the morning of the first day, it is brief (usually 30 minutes), and it aims to introduce the two focal points and other WHO staff assigned to this visit, as appropriate, to the Head of the WHO Country Office, who is briefed on the progress of the overall mission.
3. **Ministry of Health high-level meeting** – participants: the Minister of Health, the two focal points, and any other WHO and Ministry of Health senior officials assigned as part of the planning visit (the Head of the WHO Country Office, the senior official of the Ministry of Health, directors of public health, noncommunicable diseases and/or any Government agency that has a coordinating role in the national tobacco control programme). Representative(s) from the Presidential Cabinet and the Ombudsman may attend if the Ministry of Health thinks it appropriate. This meeting is also brief (usually not longer than 30 minutes) and is preferably held at the beginning, on the morning of the first day of the visit, or according to the availability of the Minister of Health.
4. **Stakeholders' meeting** – The two focal points and all other Ministry of Health and WHO representatives meet relevant stakeholders from governmental institutions/agencies and non-governmental organizations at national and regional level. This meeting has the purpose of introducing the capacity assessment mission to the stakeholders, presenting the WHO FCTC and the MPOWER package, learning from the participating stakeholders about their tobacco control priorities and their views on immediate needs for tobacco control in the country; recording their interest in being further involved in the assessment process; and agreeing on and drawing up an agenda for the upcoming mission (visits, meetings, interviews). Such a meeting has a critical role, not only in securing the stakeholders' interest and participation in the in-country assessment exercise, but also in the follow-up stages, namely the implementation of the assessment recommendations, including monitoring and evaluation. Usually, this is a meeting lasting several hours, and it is preferable (as far as possible) to have both the decision-making and the implementation levels present at the discussions. An example of the agenda for this meeting might be:

- opening remarks (WHO and Ministry of Health);
  - introduction of the capacity assessment mission (WHO);
  - presentation (PowerPoint if possible) of methodology for preparing and conducting the joint assessment;
  - brief presentation on the national context, the country's tobacco control policy priorities and agenda of the hosting Government (Ministry of Health – possible PowerPoint presentation), followed by discussions focusing on the stakeholders' perceived needs for the planned assessment – if time permits, a brief SWOT (strengths/weaknesses/opportunities/threats) analysis for the current tobacco control momentum in the country could be conducted;
  - discussions on possible dates for the main mission and the places/regions/institutions to be visited (work with participants on selecting potential key-informant institutions and sites for field visits);<sup>6</sup>
  - wrap-up and next steps.
5. **Planning meeting(s)** – participants: WHO team (as appropriate WHO headquarters, Regional Office, Country Office), Ministry of Health team (support team, if appropriate).
6. **Wrap-up meeting** – Usually, at the end of all planning work, the WHO (headquarters/Regional Office/Country Office) and the Ministry of Health focal points meet with officials at the highest level available at the Ministry of Health and the WHO Country Office to inform them of the final preparation plan and secure support for putting it into practice.

**The discussions for planning include:**

- consolidation of information regarding the assessment methodology;
- final agreement on the capacity assessment objectives, in line with the results of the Ministry of Health high-level and stakeholders' meetings (based on the country context and existing momentum for tobacco control);
- discussion and preliminary agreement on:
  - roles and concrete responsibilities for the WHO and Ministry of Health focal points and possibly for the support team<sup>7</sup> for each category of activities, according to provenance of funds;
  - composition of the assessment team (international/regional/national experts) and modalities of contracting the work of these experts;
  - selection of key-informant institutions/relevant departments/individuals to be visited during the assessment – draft list;
  - selection of field visits (regions, cities, states, districts according to administrative and territorial distribution in the country) – draft list;
  - tentative schedule for the mission (the schedule will be finalized over the following few months through direct dialogue with the relevant key informants);
  - plan for dissemination of the assessment findings;
  - plan of preparatory work, with activities that may include:
    - ▣ roles and time frames for the development and/or selection of background documents and information in order to make them available to the assessment team at least one month before the mission:
      - ◆ TCCP (see Section 2) – time frame and roles (contracting and coordinating authority, editing and translation into English);

<sup>6</sup> For practical reasons, it is recommended that the focal team for the assessment (WHO and Ministry of Health) discusses in advance the possible dates and assessment visits (list of institutions in the capital and in the field, selection of provincial/regional/municipal governments to be visited), and prepares several options ready to be proposed during the stakeholders' meeting.

<sup>7</sup> The Ministry of Health team may or may not have Ministry of Health employees at its central level. The Minister of Health takes the decision about the health staff assigned to the preparation of the assessment mission; it could be staff from an institute involved in the coordination of the tobacco control programme (i.e. from Ministry of Health departments or from a Ministry of Health subordinated agency, such as a public health institute, etc.). WHO is usually informed about this assignment through an exchange of engagement letters (Ministry of Health invitation).

- ◆ selection of current relevant legislation, including its translation into English;
- ◆ other products, as appropriate (country reports, surveys, epidemiological data, etc.).
- ▣ roles and time frames for contracting interpretation for assessment interviews and other meetings (e.g. final debriefing) and for translation of assessment documents into the country language (executive summary; draft and final assessment reports);
- ▣ roles and time frames for arranging logistics (e.g. transportation, accommodation, meeting rooms, daily work room equipped for the assessment team, secretarial support for negotiating and confirming interview times, sending invitations, etc.);
- ▣ communication channels during the preparation period (letters, e-mail messages, telephone calls, etc.) and their regularity (e.g. every first and third Monday of the month in the first two months and every Monday in the last 1-2 months for conference calls and whenever needed for e-mail messages, etc.).

### **3.3 Checklist for logistics and budget**

#### **Logistics**

Transportation, accommodation and other logistical arrangements for the assessment should be discussed during the planning visit. It will be necessary to designate a person to act as logistics officer during the assessment in order to coordinate transport, maintain contact with all teams, and reprogramme interviews and visits if required. The CFP is responsible for local arrangements in consultation with the WHO Country Office. The logistics to be taken into consideration by the Country Focal Point include:

- invitations to national members of the assessment team (directly or through their institutions);
- payment or allowance and expenses (per diem) for national members of the assessment team and support staff;
- internal transport costs and arrangements (air/bus/rail tickets and vehicles);
- hotel reservations (preferably in the same hotel as the meetings, or in a very accessible location);
- meeting rooms for briefing, debriefing and report preparation;
- refreshments during meetings when appropriate;
- office accommodation for administration and computer and Internet facilities;
- secretarial and operational support;
- administrative support (computers, printing, photocopying facilities, PowerPoint projector and probably a mobile phone for each team, as this can be useful for coordinating visits);
- equipment and supplies (paper, pens, computer disks, individual name labels);
- communications (telephone, fax, e-mail);
- coordination with and transport to locations chosen for site visit(s);
- monitoring of visits and last-minute changes if necessary.

The WFP will usually make arrangements for international travel, payment or allowance and expenses for the international members of the assessment team. The logistics to be taken into consideration by the WFP include:

- Government agreement for the assessment;
- information for and consultation with all levels of WHO and collaborating institutions;

- invitations to international members of the assessment team (directly or through their institutions);
- payment or allowance and expenses (per diem) for international members of the assessment team/ air tickets for international members of the assessment team/ visas (usually the responsibility of the individual team member);
- notification of the press and other news media, if necessary.

### Budget

The two focal points should jointly prepare a proposed budget for the assessment. Expenses for the various components of the assessment should be outlined and funding sources clearly identified and explained. Funds readily available should be listed separately from potential sources that will require resource mobilization by either the coordinators or the support team.

Budget items will include:

- payment or allowances and expenses of international experts and travel to/from the country by international experts;
- payment or allowance and expenses of national participants;
- transport costs during the assessment;
- hotel costs/rental of meeting rooms/refreshments;
- secretarial/translation costs;
- communication costs (telephone, fax, Web access);
- photocopying and printing costs/other equipment and supplies (computers, stationery, etc.);
- refreshments for briefing and debriefing meetings;
- materials for press briefing, if necessary;
- preparation of press releases / press kits, if necessary.

### MODEL DRAFT TEMPLATE ACTIVITIES/RESPONSIBILITY/DEADLINES

**Location:** Mainly in the capital of the country.....  
with..... field visits to.....

**Preparation time:** from.....date.....

**HOLIDAY BREAKS:** from.....date.....

**Date:** from.....

		Deadline
1.	<b>Confirmation of international members of the assessment team (including WHO staff and international partners): WHO and MOH</b>	
	a) finalize the participants' list – <b>WHO (all) and MOH</b>	
	b) first contact and confirmation of interest – <b>WHO/HQ</b>	
	c) send details and answer expert's questions – <b>WHO/HQ</b>	
	d) firm confirmation of expert's commitment to the mission – <b>WHO/HQ</b>	
	e) agreement on distribution of international members in subteams (for the field visits) – <b>WHO (all) and MOH</b>	
	f) prepare TAs and communicate with expert about travel details (flight ticket plus per diem; visa requirements; others, e.g. vaccination requirements, etc.) – <b>WHO/HQ</b>	
	<b>N.B.:</b> international partners will be invited to participate in the mission by nominating an expert/representative; participation costs will usually be covered by the expert's own organization	

2.	<b>Confirmation of national members of the assessment team: WHO and MOH</b>	<b>Deadline</b>
	a) TOR for national experts – <b>WHO and MOH</b>	
	b) RO, HQ – send to CO the suggestions for national experts (if any) that might come from international experts – <b>WHO/HQ</b>	
	c) finalize the list – <b>MOH/WHO</b>	
	d) first contact and confirmation of interest – <b>WHO/CO and MOH</b>	
	e) send details and answer expert's questions – <b>WHO/CO and MOH</b>	
	f) firm confirmation of expert's commitment to the mission – <b>WHO/CO and MOH</b>	
	g) agreement on distribution of national members in subteams (for the field visits) – <b>WHO/CO and MOH</b>	
	h) prepare TAs and communicate with expert for travel details (flight/train ticket plus per diem, for the main mission and for the preliminary “awareness-building” meeting, others as appropriate) – <b>WHO/CO and MOH</b>	
	<b>NB:</b> It was agreed that a preliminary briefing meeting with national experts will be organized, and the field focal persons may be invited to participate as well.	
<b>3.</b>	<b>Development of list of background documents and selection of legislation – MOH plus WHO/CO</b>	
<b>4.</b>	<b>Selection of expert for TCCP – MOH plus WHO/CO</b>	
<b>5.</b>	<b>Development of TCCP (final draft) – MOH</b>	
<b>6.</b>	<b>Contract (APW) for copy-editing of TCCP – MOH plus WHO</b>	
<b>7.</b>	<b>Copy-edit of TCCP and release of final TCCP – WHO editor hired by WHO (HQ could do this)</b>	
<b>8.</b>	<b>Electronic distribution of TCCP to assessment team members together with other background docs – WHO (HQ could do this, if so agreed)</b>	
<b>9.</b>	<b>Selection of admin. support – MOH/WHO CO</b>	
<b>10.</b>	<b>Contract for the admin. support staff (APW/short-term contract) – MOH/WHO CO</b>	
<b>11.</b>	<b>Booking internal travel tickets (including local transportation) and hotel accommodation for all participants (CO/RO/HQ, experts) in the country, capital and field – MOH/WHO CO</b>	
	a) booking flight tickets to/from capital – for WHO (RO/CO/HQ) and international/national members – <b>MOH/WHO CO</b>	
	b) booking internal transportation to/from meetings and visits in capital (if necessary renting appropriate vehicles) – <b>MOH/WHO CO</b>	
	c) booking hotel accommodation in capital plus field – <b>MOH/WHO CO</b>	
	d) organizing briefing meeting for all national experts plus/minus the counterparts from..... provinces – <b>MOH/WHO CO</b>	



12.	<b>Booking work/meeting rooms – MOH/WHO CO</b>	<b>Deadline</b>
	a) team's main "assessment office" in the same hotel that was booked for accommodation (from ...to...) fully equipped for experts' work – computer, printer, appropriate Internet access (either wireless or, if cable, with sufficient number of terminals for the assessment team members), video projector, flipchart, tables and chairs, etc.) – <b>MOH/WHO CO</b>	
	b) room for debriefing with MOH and stakeholders (half a day) – can be MOH room or other room appropriate for the number of participants) – date ..... – <b>MOH/WHO CO</b>	
	c) room for press conference (1-1.5 hrs) – as preferred by the MOH Communication Department - .....date..... – <b>MOH/WHO CO</b>	
13.	<b>Sending invitations – MOH/WHO CO (as agreed between them)</b>	
	a) for participation in the CA main mission by accepting the visit of the team of experts assigned to the organization concerned (including the entire correspondence and negotiation for setting the agenda for the visits/interviews) – <b>MOH/WHO CO (as agreed between them)</b>	
	b) for the debriefing (...date...) (could be in the same letter as above) – <b>MOH/WHO CO (as agreed between them)</b>	
	c) for the press conference (.date..) – <b>MOH (possibly MOH PR dept.)/WHO CO (as agreed between them)</b>	
14.	<b>Translation services – MOH/WHO CO (as agreed between them)</b>	
	a) hiring translators into country language for methodology, TCCP (if originally written in English) or into English (if originally written in country language); executive summary draft made available for MOH on the .....date..., final report, and any other document as appropriate (e.g. national/federal/local legislation) – <b>MOH/WHO CO (as agreed between them)</b>	
	b) hiring interpreters (if agreed as appropriate) – <b>MOH/WHO CO (as agreed between them)</b>	
	c) coordinating interpretation/translation services – <b>MOH/WHO CO (as agreed between them)</b> <ul style="list-style-type: none"> <li>• for "preparatory documents" (legislation, TCCP, reports, etc.), translation should be completed by ..... date.....</li> <li>• for "executive summary", translation should be carried out simultaneously with drafting work during the second week of CA (.....date.....)</li> <li>• for "final report", translation should be carried out as soon as final report is finalized in English (first month after the end of CA)</li> </ul>	
	d) coordinating interpretation (if agreed as appropriate) – <b>MOH/WHO CO (as agreed between them)</b> <ul style="list-style-type: none"> <li>• debriefing meeting/press event (...date...)</li> <li>• visits/interviews (one interpreter per day and per team): <ul style="list-style-type: none"> <li>– one interpreter for each team, every day, with interviews scheduled during the first week (...days) (in all capital and field visits)</li> <li>– two interpreters for unexpected meetings on ...date....</li> </ul> </li> </ul>	
15.	<b>Contract for printing and distributing the report (bilingual) MOH/WHO CO (as agreed between them)</b>	
	<ul style="list-style-type: none"> <li>• country language/English</li> </ul>	
16.	<b>Printing and distributing the final joint report – MOH/WHO CO (as agreed between them)</b>	
	<ul style="list-style-type: none"> <li>• country language/English</li> </ul>	

APW: Agreement for Performance of Work; CA: capacity assessment; CO: Country Office; HQ: WHO headquarters; MOH: Ministry of Health; PR: public relations; RO: WHO Regional Office; TA: travel authorization; TOR: terms of reference.

### **3.4 Model template – terms of reference (tor) for assessment team members/ international and national experts<sup>8</sup>**

The capacity assessment team is in charge of conducting the assessment. The team collects the necessary information to assess the country's capacity to implement effective tobacco control policies, prepares reports and briefing notes, discusses the findings, and draws up a summary of findings and preliminary recommendations.

The team is made up of international and national experts. While international experts bring specific international expertise, knowledge of evidence and best practice, international recommendations and experience from various countries and new perspectives on local problems, the national team members provide local experience, and understanding of the local situation and history as well as the social and political context of the country. They should be prepared to provide background information for international experts.

The assessment team members' key roles are:

- to learn and analyse the information available (country profile and other documents) on tobacco use, control strategies and programme organization;
- to check through observation and interviews whether the information provided is consistent with reality and is sufficient for deciding policy and interventions;
- to contribute to the discussions of the assessment team internally, identify areas for improvement, propose priorities for action, propose issues for operational research and directly contribute to specific sections of the final joint assessment report.

The international and national consultants will each sign a Declaration of Interests, specifying their past and present, paid or unpaid involvement with the tobacco or pharmaceutical industries and any other commercial interests.

There are several major tasks involved in conducting the assessment during the in-country mission, based on the overall schedule for the capacity assessment.

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<sup>8</sup> These sample TOR describes the roles and expected work of assessment team members during a one-week assessment mission (starting on Sunday and ending on the following Friday). However, according to the agreement between WHO and the Ministry of Health, the time frame of the assessment may be different, longer or shorter, starting on a different day of the week, etc. Based on the above model, the TOR for a particular mission will be prepared to reflect the schedule of the assessment concerned.

## I. TASKS DURING THE IN-COUNTRY MISSION

		Days	Activity
1	Team preparation	Sunday afternoon (...exact date...)	<b>Team building and final briefing of assessment team members</b> on assessment procedures and brief revision of country framework: introduction of assessment team members, objectives of the assessment and planned programme of activities; questions and answers; practical arrangements; identification of subteams; rules and responsibilities for interviews, field visits and report-writing; presentation of data collection tools; brief discussion based on tobacco control country profile.
2	Data collection	Monday full day Tuesday full day Wednesday morning	<b>Conducting visits and data collection</b> (split into five operational teams – T1, T2, T3, T4, T5) agenda based on confirmed appointments from institutions and organizations located in .....(capital city) and, in the confirmed regions for field visits (...).
3	Report preparation	Wednesday afternoon Thursday full day Friday morning	Small operational teams rejoin full assessment team for <b>presentation and discussion of findings and visit reports. Preparation of the assessment report</b> – assessment team together with MOH: Selection of key recommendations – full assessment team; preparation of first and second draft of full report (with development of summary of all findings and recommendations) – subteams dedicated to sections in report/policies; <b>preparation of executive summary</b> (with key findings and key recommendations) together with MOH; informal briefing for MOH and agreement on executive summary (Friday morning).
4	Debriefing and dissemination	Friday afternoon (...exact date...)	<b>Debriefing meeting</b> (to report on assessment findings and recommendations) with high-level officials of MOH, other ministries and public agencies involved in the tobacco control programme, donors (current and potential), nongovernmental organizations and other relevant organizations (co-chaired by high-level MOH and WHO). <b>Press briefing</b>

MOH: Ministry of Health

### 1. Team preparation

All team members will be briefed in good time before the assessment regarding their key roles, time frames and expected deliverables of their work. The internationals will be briefed remotely by the WFP, while the nationals will be briefed locally by the WHO/MOH focal team. Around one month in advance, they will receive by e-mail documents with information relevant to the assessment, which include information about the tobacco control efforts in the country (TCCP, assessment operational manual, relevant legislation, studies/surveys/reports). This background information will give them a preliminary understanding of the current status of tobacco use and control in the country. In this regard, the team members will be informed that they are expected to be available for all meetings/activities that require their participation during the scheduled in-country assessment (team briefing, interviews for data collection, teamwork for developing the final report and stakeholders' debriefing), and also to become familiar with the background information that was provided to them in advance. All the team members will also be briefed on the first day of the assessment mission (Monday morning) as part of a team-building process. The objective of the team-briefing meeting includes, apart from informing participants about the final logistics and practical details, a brief discussion among team members on queries that might have arisen from their review of the background information and the tobacco control profile of the country, and also a common understanding of the framework that will further guide the interviews and facilitate interpretation of the findings. Most of the background data will be included in the country profile, but the briefing will give members of the assessment team an opportunity to ask questions for clarification, and also get to know one another and supplement the information they have already acquired.

## 2. Data collection and interviews

The team members should be fully aware of the country's tobacco control policies, as well as WHO's recommendations and international best practices in tobacco control, before attending the interviews scheduled during the assessment. Team members should be aware that their field visits may be viewed with suspicion, as they may be seen as outsiders coming in to "report on" the people and programmes being visited. They should therefore make every effort to put the interviewees at their ease, to be respectful, to ask questions in an interested and factual manner, and not to appear judgemental. They should introduce themselves and should explain that the purpose of their visit is to find out more about what is happening in tobacco control in the country, with an eye to improving the effectiveness of efforts, and to note case-studies and experiences that may be useful to others.

The visits give the assessment team members the opportunity to obtain information on the "five Ps" (policy, programme, partnerships, people and provision of funds) according to the items outlined in the matrix below (the "five Ps" matrix will be attached to the TOR).

The information can be obtained by:

- reviewing the reference materials and documents provided by key informants
- interviewing key informants
- observing the tobacco control interventions and their enforcement during the one-week assessment.

All the information gathered should be checked for consistency and, to do this, it is important to take notes on the data and references reported during the interviews. Team members should observe existing mechanisms for implementing, monitoring and evaluating tobacco control interventions, as reported by different key informants. They should check for consistency between the data provided and the data reported through the routine reporting system of the national tobacco control programme (if any) or through international surveillance systems. Team members should attempt to verify information obtained from the briefing materials, background documents, key informants and other data sources. They should confirm their observations and findings, and check the credibility of the data provided. In collecting information, team members should record their findings, identify the strengths and weaknesses of the programme, analyse the reasons for these weaknesses, and propose solutions. The assessment team members will normally divide into subteams. Each subteam (composed of both national and international experts) will be assigned to observe and report on specific components of the assessment, and will visit certain institution(s) (or a region, if it has been agreed to assess at regional level), according to the expertise and specialization of the team members. Although each subteam will have specific components to report on, all teams should observe and gather information on all components. Field visits should be completed in parallel in order to shorten the total time for this stage of the assessment. Planned interviews may be postponed or cancelled due to unforeseen circumstances, or new appointments may be necessary in view of the information received. The subteams should be flexible in order to make the best use of the time available, and the coordinators and the logistics focal point will be ready to rearrange visits and provide a revised printout of the schedule. If additional visits are considered necessary by the subteams as a result of the information obtained, the country coordinator should be informed so that he/she can organize the new appointments. Emphasis should be placed on the presence of the tobacco industry, lobbying and interference.

During the data collection days, each subteam will divide its daily work into four phases: preparation, collection, analysis and reporting.

**Preparation** For each interview or field visit, members of the subteam must come prepared. This means that each team member must have a clear understanding of the reason for the visit and the information/perspectives to be gathered. The team will be informed in advance about the identity and responsibilities of the person(s) to be interviewed. It should be clear who will be taking notes and recording necessary information, such as names and titles of persons interviewed (spelling mistakes can be avoided by asking people for their business cards or asking them to write down their names and positions). Each team should have a copy of the matrix and should be familiar with the key questions to be asked. Team members should come with flexible and alert minds, ready to ask supplementary questions to clarify issues or to probe into important issues not anticipated by the standard matrix.

**Collection** The teams should use the data collection tools prepared for the assessment to record their findings. These will facilitate the development of the analysis and the report, as well as the final recommendations, in a complete and consistent manner. One team member should be given specific responsibility for recording observations during each visit. In addition, specific team members should be given responsibility for extracting data from the documents that are provided by the key informants and for recording names of places visited and names/positions of the persons interviewed. Interviews will usually follow a specific pattern.

- The visiting team members will be introduced, the objectives of the assessment and of the visit will be described, and the expected outcomes will be explained.
- The person(s) to be interviewed will be asked to describe their functions and position, the department/institution's role in tobacco control, its resources (budget, staffing), its main achievements, current activities and plans and any contacts with the tobacco industry.
- Specific questions will be asked about the person's area of responsibility in tobacco control. One team member should take the lead, and others should check that important questions are not missed.
- The person interviewed will be asked for his/her general views on priorities in tobacco control that could be addressed by the mission and for his/her suggestions for other sources of information.

**Debriefing and analysis** At the end of each day of visits, members of each subteam should gather to review and summarize their observations and conclusions and to plan for the following day's activities, making changes to the agenda as necessary. This debriefing can take place on return from the visits or over dinner, depending on the availability of the participants. It should be as short as possible (no more than 45 minutes) to allow time for the team to draft the visit reports and prepare for the next day. The discussion and notes should also cover suggestions for the final report's findings and recommendations. Notes on the findings of the field visits should be fairly extensive, as they will be the basis for preparing the various chapters of the final report on the assessment, while conclusions and recommendations can be brief.

**Reporting** After the discussion, team members should take time to organize their notes and write them up in electronic format.

### Carrying out the interviews

Action	Comments
1. Introduction of team members and explanation of the objectives of the mission and of the visit.	One team member should collect data (names, position, telephone numbers, e-mail addresses) for the report of the interview. An exchange of business cards is useful.
2. Ask for a brief description of: <ul style="list-style-type: none"> <li>• the role in tobacco control of the person(s) interviewed and of the institution/department;</li> <li>• resources (budget, staffing), main achievements, current activities and plans;</li> <li>• links and coordination with the national tobacco control programme and with other institutions in the programme.</li> </ul>	Brief questions can guide the presentation of the person being interviewed. The objective is to understand the organizational structure and the capacity of the department or institution for tobacco control (i.e. the five Ps). The information received should be recorded in notes and will contribute to the text of the assessment report. Copies of supporting documents (hard-copy or electronic) should be collected if considered useful for preparation of the assessment report. If the key informants are willing to provide reports, publications, electronic documents, etc. relevant to the subject, the members of the respective subteam should accept them and circulate the information further to all other team members.
3. Ask specific questions, if not yet covered, on the area of responsibility for tobacco control (e.g. taxation, legislation, enforcement, cessation, training, public information and education, etc.). (See Five Ps matrix, Section 3.6.)	One team member should take the lead while the others check that important questions are not missed. The objective is to obtain information, to check the validity of the data reported in the background documents (particularly the country profile), and to assess the feasibility of interventions that might be recommended.

Action	Comments
4. Ask the person being interviewed for views on priorities in tobacco control that could be addressed by the mission, and ask for suggestions for other sources of information.	The team may decide to follow up on other sources and may request the logistics coordinator to arrange additional interviews. Ask how interaction with the tobacco industry takes place, if ever, and about mechanisms to avoid undue interference, including code of ethics, etc.
5. Thank those who have been interviewed for their collaboration.	The assessment team will assure the key informants that no specific quotes will be included in the report. No tape recording or other means of recording the interview will be used.

### 3. Report preparation

When the visits and interviews are completed, the subteams meet to discuss their reports. Each subteam prepares a brief report on the findings of the visits, including observations, interpretation, analysis, conclusions and recommendations. The visit reports should be organized by topic (programme organization and each of the assessed policies agreed during the engagement visit) to facilitate discussion and to consolidate the observations of different groups. Quantitative data and lists of places visited and people met should be included in an annex to each report. Ideally, each team will prepare its report on computer (each using the same word processing program) and will give a copy in electronic format to the coordinators. A model of this report will be made available to all team members. Each subteam then makes a verbal summary presentation to the other assessment team members, preferably using PowerPoint. A template for the Power Point will be provided in good time. The chairperson of these presentations should ensure that discussion focuses on interpretation of the findings, with specific attention to achievements and constraints, as well as to possible causes of and solutions for any problems detected. The findings and recommendations from the final report will be prioritized to increase the effectiveness of the country's tobacco control capacity. A fairly advanced draft of the final report should be ready before members of the capacity assessment mission leave. The final report provides information on which technical and political decisions for improving the tobacco programme can be based, and includes recommendations for a national action plan for the immediate future.

### 4. Debriefing and dissemination

Once the executive summary of the final report has been finalized in collaboration with the Ministry of Health, the recommendations will be presented to other decision-makers in the relevant Government agencies during the debriefing meeting on the last day of the assessment, or to the public during a press event organized by the Ministry. The assessment coordinators will introduce the assessment team members to the audience, and present the executive summary and main recommendations, noting that it is a draft document that is still in progress. The debriefing will include time for questions, so the assessment team members should be prepared to answer questions related to the assessment.

## II. TASKS AFTER THE ASSESSMENT MISSION

### Finalizing the assessment report

Immediately after the assessment mission, the focal teams from WHO and the Ministry of Health will finalize the report. This includes completing and editing the draft and circulating the electronic document to the members of the assessment team for final comments. The report must be circulated rapidly to team members, with a maximum of one week for them to return their comments, which are then incorporated.

### 3.5 Assessment schedule – sample

#### JOINT MISSION FOR ASSESSMENT OF NATIONAL CAPACITY FOR IMPLEMENTING TOBACCO CONTROL POLICIES<sup>9</sup>

**Venue:** .....the capital.....; and .....the locations of field visits.....

**Dates:** .....(inclusive of travel)

	Activity	Days
Team briefing	<b>Arrival</b> of international/national assessment team members Meeting between CFP and WFP to finalize arrangements for the assessment and to make final preparations for the next day's briefing meeting	<b>Saturday/ Sunday</b>
	<b>Briefing</b> of assessment team members on assessment procedures and short revision of country framework (agenda will be produced) <ul style="list-style-type: none"> <li>• Introduction of assessment team members</li> <li>• Objectives of the assessment and schedule</li> <li>• Practical arrangements (per diem, local transportation, accommodation, etc.)</li> <li>• Identification of subteams; rules and responsibilities for interviews, field visits, drafting report; presentation of data collection tools</li> <li>• Brief discussion based on TCCP</li> <li>• Q&amp;As</li> </ul>	<b>Sunday</b> 13:00 – 17:00
Data collection	<b>Courtesy visit</b> to senior officials in the Ministry of Health (very brief – 30 min.)	<b>Monday</b> 08:30 – 09:00
	<b>Conducting visits and data collection</b> (split into five operational teams/subteams – T1-T5) based on confirmed appointments in capital city and in other localities (field visits) <ul style="list-style-type: none"> <li>• T1, T2, T3, T4 – Mon &amp; Tue – capital</li> <li>• T5 – Mon – ..... (travel to/from .....)</li> <li>• T5 – Tue – ..... (travel to/from .....)</li> <li>• T1, T2, T3, T4, T5 – Wed – capital</li> </ul>	<b>Monday</b> 10:00 – 17:00 <b>Tuesday</b> 08:30 – 17:00 <b>Wednesday</b> 08:30 – 12:00
	<b>Subteams' presentation of findings and visit reports</b> – each subteam <b>Team discussions on findings/recommendations</b> – full assessment team	<b>Wednesday</b> 14:00 – 17:30
	<b>Preparation of the assessment report</b> <ul style="list-style-type: none"> <li>• Selection of key recommendations – full assessment team</li> <li>• Preparation of first and second draft of main report chapters – subteams allocated to various chapters/policies</li> <li>• Preparation of executive summary (1-2 selected team members)</li> </ul>	<b>Thursday</b> 08:00 – 17:30 <b>Friday</b> 08:00 – 12:00
Debriefing and dissemination	<b>Preliminary (de)briefing MOH – informal</b> <ul style="list-style-type: none"> <li>• Informal briefing on draft executive summary and recommendations with senior Ministry of Health officials and WHO Representative</li> <li>• Revision of executive summary/second draft based on final comments from MOH</li> </ul>	<b>Friday</b> 08:00 – 12:00
	<b>Debriefing meeting</b> (to report on assessment findings and recommendations) with high-officials in the Ministry of Health, other ministries and public agencies involved in the tobacco control programme, donors (current and potential), nongovernmental organizations and other relevant organizations (co-chaired by high-level Ministry of Health and WHO)	<b>Friday</b> 14:00 – 15:30
	<b>Press briefing</b>	<b>Friday</b> 15:30 – 16:00
	<b>Departure</b> of international/national assessment team members	<b>Saturday</b>

MOH: Ministry of Health; Q&A: questions and answers

<sup>9</sup> This sample schedule is for a **one-week assessment mission** (starting on Sunday and ending on the following Saturday). However, according to the agreement between WHO and the Ministry of Health, the time frame for the assessment may be different, longer or shorter, starting on a different day of the week, etc. Based on the above model, the schedule for a particular assessment will be prepared to reflect the agreed time frame.

### 3.6 The “five Ps” matrix – checklist and measuring instrument for the assessment interviews

“FIVE P <sub>s</sub> ” MATRIX FOR THE ASSESSMENT INTERVIEWS		POLICIES/WHO FCTC PROVISIONS		PROGRAMME MANAGEMENT		PEOPLE (HUMAN RESOURCES)		PROVISION OF FUNDS		PARTNERSHIPS		
		P <sub>1</sub>	P <sub>2</sub>	P <sub>3</sub>	P <sub>4</sub>	P <sub>5</sub>						
<b>OVERALL NATIONAL/FEDERAL TOBACCO CONTROL EFFORTS</b>		<ul style="list-style-type: none"> <li>National commitment to tobacco control/status – WHO FCTC</li> <li>National committee for the implementation of the WHO FCTC</li> <li>Existing tobacco control priorities on the Government agenda</li> <li>Action taken for prevention of tobacco industry interference (cross-cutting) – WHO FCTC Art. 5.3.</li> <li>Policies to counteract tobacco industry marketing strategies</li> </ul>		<ul style="list-style-type: none"> <li>Formal mandate and commitment for national tobacco control programme</li> <li>Existing focal governmental structure for tobacco control, authority and responsibilities</li> <li>Specific written Government objectives, strategic plans, national action plan</li> <li>Mechanism for coordination and management</li> </ul>		<ul style="list-style-type: none"> <li>Existing human resources for tobacco control activities and national coordination</li> <li>Existing Government/nongovernmental efforts for training of tobacco control human resources</li> <li>Academic education in tobacco control</li> </ul>		<ul style="list-style-type: none"> <li>Existing funding for tobacco control efforts from Government sources</li> <li>Existing funding for tobacco control efforts from nongovernmental and other sources</li> </ul>		<ul style="list-style-type: none"> <li>Intrasectoral cooperation (among Government institutions)</li> <li>Intersectoral cooperation (among Governmental and nongovernmental organizations and other stakeholders)</li> </ul>		
		<ul style="list-style-type: none"> <li>Current policy status and development</li> <li>Leadership and commitment to development and implementation of the policy</li> <li>Legislation and regulations for the specific policy; enforcement and litigation</li> <li>Monitoring of implementation and research for the policy</li> <li>Lobbying and advocacy</li> <li>Tobacco industry interference, marketing, lobbying</li> </ul>		<ul style="list-style-type: none"> <li>Management/coordination and organization of services responsible for implementing the specific policy, including reporting mechanism (among institutions and to the public)</li> <li>Existing structures for the development/ introduction/enforcement/ monitoring of the assessed policy (including offices, equipment)</li> <li>Distribution and location of responsibilities (institutions for data collection, reporting, monitoring, evaluation, communication, etc.)</li> </ul>		<ul style="list-style-type: none"> <li>Existing human resources for the specific policy development and implementation</li> <li>Existing Government/nongovernmental efforts for training for the specific policy assessed (including enforcement agents)</li> <li>Academic education for tobacco control</li> </ul>		<ul style="list-style-type: none"> <li>Existing funding for tobacco control efforts from Government sources for the specific policy assessed</li> <li>Existing funding for tobacco control efforts from nongovernmental sources for the specific policy assessed</li> </ul>		<ul style="list-style-type: none"> <li>Intrasectoral cooperation (among Government institutions) for the specific assessed policy</li> <li>Intersectoral cooperation (among Governmental and nongovernmental organizations and other stakeholders) for the specific assessed policy</li> </ul>		
		<b>M</b>	Monitoring the epidemic and the response to it – <b>Arts. 20/21</b>									
		<b>P</b>	Protecting people from tobacco smoke (smoke-free environments) – <b>Arts. 8</b>									
		<b>O</b>	Offering help to people who want to quit tobacco – <b>Art. 14</b>									
		<b>W</b>	Warning people about the dangers of tobacco (health warnings & media campaigns) – <b>Arts. 11/12</b>									
		<b>E</b>	Enforcing bans on tobacco advertising, promotion and sponsorship of tobacco products – <b>Art. 13</b>									
<b>R</b>	Raising tobacco taxes – <b>Art. 6</b>											
	<b>Other national priorities</b> (illicit trade, economically viable alternative livelihoods, product regulation, etc.) – <b>Arts. 15, 17, 9/10</b>											
		<b>P<sub>1</sub></b>		<b>P<sub>2</sub></b>		<b>P<sub>3</sub></b>		<b>P<sub>4</sub></b>		<b>P<sub>5</sub></b>		



### 3.7 Model of subteams' findings reports

At the beginning of each interview, the assessment subteams will hand out a template prepared in advance for recording the names and positions of the key informants present at that interview:

Place (national level, state, city):

Subteam members:

Date	Institution/department	Person(s) interviewed and position	Telephone, e-mail and Web addresses

As a matter of courtesy and acknowledgement, the names of all key informants will be included in an annex of the joint assessment report, so it is important that all subteams remember to ask the key informants to add their names into the table.

When gathering information during the visits, the five basic questions (the “five Ps” matrix) can be used as a guide for exploring the various topics relating to capacity. The visiting team should then organize its findings and conclusions in a format that is suitable for presentation to (e.g. PowerPoint) and discussion by the full assessment team and can also be used in preparing the final assessment report. The visiting team should review its findings and conclusions in the light of the background documents, interviews and observations, as if this were the only information available. Consolidation with the reports of other groups will produce the final assessment report. An example of the contents of a field visit report is as follows:

- **Subteam number and members:.....**
- **Number of key informants and number of institutions visited.....**
- **National tobacco control efforts/national tobacco control programme (WHO FCTC Art. 5)**
  - **Policy status** – national commitment to tobacco control/status – WHO FCTC; national committee for the implementation of the WHO FCTC; national committee for monitoring and preventing tobacco industry interference; existing tobacco control priorities on the governmental agenda.
  - **Programme management** – formal mandate and commitment to national tobacco control programme, existing focal governmental structure for tobacco control, authority and responsibilities; specific written Government objectives, strategic plans, national action plan; mechanism for inter-sectoral coordination and management; communication and reporting between institutions and to the public, mechanisms to cope with tobacco industry interference, etc.
  - **People** – existing human resources for tobacco control activities and for national coordination; existing Government/nongovernmental efforts in training of human resources for tobacco control and for management of national programme; professional motivation and incentives for human resources in tobacco control; academic education for tobacco control, etc.; code of conduct and ethics.

- **Provision of funds** – existing funding for tobacco control efforts from Government sources and from nongovernmental sources; dedicated budget; competitive or regular grants, etc.
  - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations, etc.
- ***M – monitoring the epidemic and the response to it (WHO FCTC Arts. 20 and 21)***
    - **Policy status** – past and current surveillance efforts; institutions responsible for surveillance and monitoring tobacco control policies.
    - **Programme management** – existing infrastructure for surveillance and for monitoring tobacco control policies; equipment and offices; leadership and commitment to development and implementation of surveillance; implementation responsibilities – data collection/ data reporting/ data interpretation/ translating data into action.
    - **People** – current human resources for surveillance and monitoring of tobacco control policies; existing Government/nongovernmental efforts in training of surveillance staff, etc.
    - **Provision of funds** – existing funding for tobacco control efforts from Government sources and from nongovernmental sources for regular surveys and for monitoring tobacco control policies; internal/ international funding.
    - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations for surveillance and monitoring tobacco control, etc.
  - ***Protecting people from tobacco smoke – smoke-free environments (WHO FCTC Art. 8)***
    - **Policy status** – existing legislation and regulations for creating smoke-free environments; institutions that are responsible for protection from exposure to second-hand tobacco smoke (SHS); existing data for exposure of population to SHS; existing opinion polls related to a possible 100% smoke-free law; existing information on strategies of the tobacco industry to prevent the creation of smoke-free places.
    - **Programme management** – existing infrastructure for creating smoke-free environments and enforcing and mobilizing public support; leadership and commitment to development and implementation of the policy; existing infrastructure in relation to Art. 8 Guidelines on enforcement strategies; institutional duties; signage, fines, inspection protocols, powers of inspection, monitoring of compliance, reporting to other institutions and to the public.
    - **People** – existing human resources for developing the policy and for enforcing it; inspectors, complaint-line operators, nongovernmental organizations active in mobilizing public vigilance and community support; existing efforts for training of enforcement agents; existing efforts and human resources for litigation.
    - **Provision of funds** – existing internal/international funding for tobacco control efforts from Government sources and from nongovernmental sources for the development and enforcement of the policy, etc.
    - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations for the development and enforcement of the policy, etc.

- **Offering help to people who want to quit tobacco (WHO FCTC Art. 14)**
  - **Policy status** – existing legislation and regulations for offering support for tobacco cessation; institutions that are responsible for a tobacco cessation system, etc.
  - **Programme management** – leadership and commitment to development and implementation of guidelines for tobacco cessation; existing infrastructure for tobacco cessation; Government and nongovernmental services/clinics; national quitline; national essential medicines list; integration of brief advice into primary health care services, etc.; monitoring new drugs and new products with harm-reduction claims which are intended to replace tobacco products.
  - **People** – human resources for developing a tobacco cessation system, guidelines and mechanisms for data collection and reporting; existing training for health professionals in dispensing brief advice; specialized support; training of quitline operators, etc.
  - **Provision of funds** – existing internal/international funding for tobacco cessation; reimbursement of services and medicines; availability of nicotine replacement therapy, etc.
  - **Partnerships** – cooperation inside the Government and between Government and civil society, academia, professional associations which offer help to quit smoking; partnership between “cessation” focal team and “health warnings” focal team in order to place quitline number on tobacco packs; etc.
  
- **Warning people about the dangers of tobacco use (WHO FCTC Arts. 11 and 12)**
  - **Policy status** – existing legislation and regulations for 1) packaging and labelling and 2) mass-media campaigns; whether there is a mandate for regulatory institutions, for pretesting and evaluation of impact and for enforcement; etc.
  - **Programme management** – leadership and commitment to development and implementation of pictorial warnings and other packaging and labelling regulations; existing infrastructure for development of policy and for enforcement mechanisms; inspection responsibilities and protocols, monitoring compliance; fines and punishment; licensing for trade in tobacco; complaint line; existing infrastructure for public and mass-media campaigns, etc.; preparedness to observe commemorative dates such as World No Tobacco Day, national health days; existing information on strategies of the tobacco industry to prevent the deployment of health warnings and plain packaging policies.
  - **People** – existing human resources for developing and enforcing the policy, pretesting and evaluation of impact, inspection, mobilizing community support; existing human resources for campaigns; existing training for development and implementation of warnings, for inspection; existing human resources involved in public/media campaigns, etc.
  - **Provision of funds** – existing internal/international funding for development and enforcement of warnings; conducting regular media campaigns; etc.
  - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations for the development and the enforcement of health warnings, for media campaigns etc.
  
- **Enforcing bans on tobacco advertising, promotion and sponsorship (WHO FCTC Art. 13)**
  - **Policy status** – existing legislation and regulations for bans on tobacco advertising, promotion and sponsorship; whether there is a mandate for regulatory institutions, enforcement, etc.; existing information on strategies of the tobacco industry to circumvent bans on advertising, promotion and sponsorship.

- **Programme management** – leadership and commitment to development and implementation of ban on advertising, promotion and sponsorship; infrastructure for development of policy and for the enforcement mechanism; inspection responsibilities and protocols, monitoring compliance; fines, complaint line; penalties; etc.
  - **People** – existing human resources for developing and enforcing the policy, inspection, mobilizing community support; existing training for inspection, etc.
  - **Provision of funds** – existing national/international funding for development and enforcement of policy, etc.
  - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations for the development and enforcement policy, etc.
- **Raising tobacco taxes (WHO FCTC Art. 6) and illicit trade (WHO FCTC Art. 15)**
    - **Policy status** – existing legislation and regulations for taxes, institutions for collection; institutions for trade inspection, enforcement, etc.; existing information on strategies of the tobacco industry to prevent tax and price increases.
    - **Programme management** – leadership and commitment to development and implementation of tobacco tax policy; institutions responsible for combating illicit trade; antimuggling infrastructures and strategies; equipment; etc.
    - **People** – existing human resources for developing and enforcing the policy, illicit trade inspection, mobilizing community support; existing training for inspection; etc.
    - **Provision of funds** – national/international funding for policy development and enforcement; etc.
    - **Partnerships** – cooperation inside the Government and between Government and nongovernmental organizations, civil society, academia, professional associations for the development and enforcement policy; partnerships with neighbouring countries against illicit trade; etc.
  - **Other policies** – subsequently, following a similar approach, any relevant findings will be presented for other measures or policies considered or already implemented by the Government (sales to and by minors – WHO FCTC Art. 16; provision of support for economically viable alternative activities – WHO FCTC Art 17; regulation of the contents of tobacco products; regulation of tobacco product disclosures – WHO FCTC Arts. 9 and 10; etc.).
  - **Key conclusions and recommendations for each measure** – if appropriate, one or two conclusions may be drawn and recommendations made. These will then be considered for inclusion among the main recommendations of the mission. If supported by the plenary, subteam recommendations will be included in the body of the document. Only those recommendations that are most important for political decisions will be included in the executive summary. It is possible that the observations of a particular group during fieldwork may not result in a major conclusion or recommendation.

### 3.8 Structure of the final report of the assessment

Section	Main areas	Pages
<b>Front page</b>	Title and logo(s)	1
<b>Table of contents</b>		1
<b>Executive summary (with key recommendations)</b>	<ul style="list-style-type: none"> <li>• Brief account of tobacco burden and predictions for the future (consumption, prevalence, morbidity and mortality, etc.)</li> <li>• Brief tobacco control profile (achievements, challenges, etc.)</li> <li>• Key findings (main findings and conclusions regarding the country's capacity for tobacco control)</li> <li>• 5 – 6 key recommendations (most significant recommendations that are measurable, time-limited and specific; if possible, with responsible institutions)</li> </ul>	2 – 3
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Brief tobacco country profile and tobacco control country profile (as in summary)</li> <li>• Objectives, activities, participants of the capacity assessment and brief presentation of report structure</li> <li>• Tobacco control timeline</li> <li>• Acknowledgements</li> </ul>	2 – 3
<b>National/federal tobacco control coordination</b>	<ul style="list-style-type: none"> <li>• <b>Policy status and development:</b> <ul style="list-style-type: none"> <li>– Status of country in relation to the WHO FCTC, and participation in the reporting mechanism</li> <li>– Government policy priorities for tobacco control</li> <li>– Structure of the national tobacco control programme</li> <li>– Organization and management, resources (staffing and funding), partnerships and linkages (coordination within and outside the Government)</li> <li>– Relevant information on tobacco industry</li> </ul> </li> <li>• <b>Key findings</b> (major weaknesses, threats, perceived gaps in policy implementation compared with the WHO FCTC)</li> <li>• <b>Recommendations</b> (technical and operational; for each identified key finding)</li> </ul> <p>Any relevant maps, charts, graphs may be included</p>	3 – 4
<b>Chapters</b> dedicated to each of the tobacco control best buys/good buys and any other tobacco control measures identified as a priority of the Government:	For each of the chapters/policies	
<ul style="list-style-type: none"> <li>• <b>Monitoring successes and challenges</b></li> <li>• <b>Protecting people from tobacco smoke</b></li> <li>• <b>Offering help to people who want to quit</b></li> <li>• <b>Warning people about the dangers of tobacco</b></li> <li>• <b>Enforcing bans on tobacco advertising, promotion &amp; sponsorship</b></li> <li>• <b>Raising tobacco taxes and prices</b></li> <li>• <b>Any other policies that are considered as Government priorities</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Policy status and development</b> (existing legislation, achievements, current status)</li> <li>• <b>Key findings</b> (perceived gaps in policy and enforcement)</li> <li>• <b>Recommendations</b> (technical and operational; for each identified key finding)</li> </ul>	2 – 3 for each policy chapter
<b>Annexes</b>	<ul style="list-style-type: none"> <li>• List of key informants (places visited and people met) and participants in assessment meetings (e.g. debriefing)</li> <li>• List of assessment team members</li> <li>• References</li> <li>• Abbreviations/acronyms (may be at the front of the report)</li> <li>• List of all recommendations of the full report</li> </ul>	

### 3.9 Follow-up visit

The follow-up visit is organized jointly by the Government and WHO, usually lasting 2-3 days.

#### Participants

- Ministry of Health representatives – the focal point who was previously assigned by the Ministry of Health to prepare the assessment and collaborate with WHO on the joint report; the current country tobacco control coordinator; any staff relevant to the assessment and to the implementation of recommendations.
- Representatives of relevant stakeholders from Government institutions and nongovernmental organizations at national (federal)/subnational level – for participation in 1–2 session(s), as appropriate.
- WHO staff – if possible, the focal point(s) previously involved in preparing/conducting the assessment, and writing the final joint report; other staff relevant to the implementation of recommendations assigned for the mission from WHO headquarters, Regional Office and Country Office, as appropriate.
- Experts assigned by WHO's international partners, preferably members of the assessment team.

#### Objectives

- Assess the degree of implementation of the capacity assessment recommendations.
- Explore the obstacles and challenges encountered by the Government in implementing the recommended measures and the need to adjust the existing plan of action and revise and prioritize recommendations.
- Agree on a technical cooperation plan to assist in the implementation of the revised recommendations.

#### The schedule for the follow-up visit usually comprises several types of meeting<sup>10</sup>

**Inception meeting** – participants: Ministry of Health and WHO (headquarters/ Regional Office/ Country Office) focal points for the capacity assessment – brief meeting, not more than 1-2 hours.

**Stakeholders' follow-up meeting** – participants: Ministry of Health focal point and other relevant staff; WHO team; relevant stakeholders from Government institutions and nongovernmental organizations at national (federal)/subnational level; experts from WHO's international partners. This meeting aims to discuss the results of a questionnaire, sent by WHO to the Ministry of Health focal point in advance, before the visit. The questionnaire aims at a basic evaluation of the way the implementation of the recommended measures has evolved.<sup>11</sup> Obstacles and challenges to the implementation of the action plan and immediate needs for technical assistance from WHO and support from other WHO international partners are discussed. The meeting can be conducted as a one-day meeting (split into two half-day sessions); in case of specific time constraints, it may be shortened, but preferably not shorter than 4-5 hours. Main points on the agenda of this meeting could be:

- presentation by Government on implementation of capacity assessment recommendations (around 30 min.);
- presentation by civil society on implementation of capacity assessment recommendations (around 30 min.);
- individual assessment questionnaire – discussion of analysis based on previously collected responses, followed by a reassessment on the basis of presentations (around 1-2 hours);
- prioritizing of recommendations for review and operationalization (30 min.–1 hour)
- SWOT analysis for selected revised recommendations (1–1.5 hours);
- plan of action to implement revised recommendations, and discussion on technical cooperation to implement plan of action (around 1–2 hours).

<sup>10</sup> This general description of the agenda may be adjusted according to local circumstances and in agreement with the Ministry of Health

<sup>11</sup> For this action the WHO and MOH focal points need to collaborate closely. WHO sends the questionnaire to MOH at least one month before the visit; the MOH focal point disseminates the questionnaire immediately and then collects responses from relevant informants in around 2-3 weeks; in the last week before the visit the WHO/Ministry focal points draft a brief analysis of the collected responses.

### Debriefing meeting(s)

- **with authorities (high-level meeting) and stakeholders** – participants: Minister of Health or senior official(s) relevant to the coordination of the national tobacco control programme; WHO and Ministry of Health focal points; other high-level representatives of Government stakeholders involved in the implementation of the WHO FCTC;
- **with WHO** – participants: WHO visiting staff with Head of WHO Country Office – very brief, meeting, pending availabilities, usually not more than 30 min.–1 hour (optional, according to availability);
- **wrap-up meeting** (discussion and agreement on conclusions and outline of a brief follow-up report that includes conclusions and next steps) – participants: Ministry of Health focal point and other relevant Ministry of Health staff, as appropriate; WHO team; experts from WHO’s international partners – 2-3 hours (subject to availability).

### 3.10 Follow-up questionnaire

In 20XX, the Government of .....invited a group of national, international and World Health Organization (WHO) experts to jointly assess the country's tobacco control efforts. WHO, through its Country Office in .....and the WHO Regional Office for ....., worked together with the Ministry of Health to organize and conduct a capacity assessment for implementing tobacco control policies, between ...and ... The assessment team reviewed the existing data and held interviews with individuals from the central Government and ..... The team found a number of challenges to continued progress towards tobacco control in .... The tobacco control measures that were recommended to address these challenges are included in column I of the table below. The implementation of recommendations pertaining to the topics/policies typed with bold fonts have been identified as critical and as having the best potential for success in the short term. Therefore they were included in the executive summary of the joint report as key recommendations. Please fill in the columns II, III and IV of this table with the response that you find appropriate.

Also, please check the squares that are most appropriate to your personal profile:

<input type="checkbox"/> Government department	<input type="checkbox"/> live in the country	<input type="checkbox"/> participated as team member in the capacity assessment
<input type="checkbox"/> nongovernmental organization	<input type="checkbox"/> do not live in the country	<input type="checkbox"/> did not participate as team member in the capacity assessment
<input type="checkbox"/> other		

Thank you very much for your contribution!

I	II			III	IV		
	Achieved implementation					Which organizations/institutions have been involved or could be further involved in the implementation of the specific recommendation?	Other comments, suggestions, or relevant information related to the specific recommended tobacco control measure
CAPACITY ASSESSMENT RECOMMENDATIONS	Yes	Partially	No	Don't know	Already involved	Could be further involved	Don't know
<b>I. COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>II. MONITORING AND EVALUATION</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>III. PROTECT PEOPLE FROM TOBACCO SMOKE – SMOKE-FREE ENVIRONMENTS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>IV. OFFER HELP TO QUIT TOBACCO USE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>V. WARN PEOPLE ABOUT THE DANGERS OF TOBACCO</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>1. PACKAGING AND LABELLING</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>2. PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>VI. ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>VII. RAISE TOBACCO TAXES AND PRICES</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			



# References

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1. World Health Organization. Guidelines for conducting a review of a national tuberculosis programme (document WHO/TB/98.240). Geneva, 1998.
2. World Health Organization. Joint national capacity assessment on the implementation of effective tobacco control policies in Brazil, May 2008. Geneva.
3. World Health Organization. Joint national capacity assessment on the implementation of effective tobacco control policies in Thailand, November 2008. Geneva, 2011 ([http://www.who.int/tobacco/publications/building\\_capacity/en/index.html](http://www.who.int/tobacco/publications/building_capacity/en/index.html), accessed 31 January 2013)
5. World Economic Forum/WHO. "From burden to "best buys": Reducing the economic impact of non-communicable diseases in low- and middle-income countries. Geneva, World Economic Forum, 2011 ([http://www.who.int/nmh/publications/best\\_buys\\_summary/en/index.html](http://www.who.int/nmh/publications/best_buys_summary/en/index.html), accessed 14 January 2013).
6. World Health Organization. WHO report on the global tobacco epidemic 2008 – The MPOWER package. Geneva, 2008 (<http://www.who.int/tobacco/mpower/2008/en/index.html>, accessed 14 January 2013).
7. World Health Organization. WHO report on the global tobacco epidemic, 2009: Implementing smoke-free environments. Geneva, 2009 (<http://www.who.int/tobacco/mpower/2009/en/index.html>, accessed 14 January 2013).
8. World Health Organization. WHO report on the global tobacco epidemic, 2011: Warning about the dangers of tobacco. Geneva, 2011 ([http://www.who.int/tobacco/global\\_report/2011/en/index.html](http://www.who.int/tobacco/global_report/2011/en/index.html), accessed 14 January 2013).
9. Tobacco control tracking tools. Baltimore, MD, Johns Hopkins University Bloomberg School of Public Health, Institute for Global Tobacco Control (<http://www.jhsph.edu>, accessed 14 January 2013).
10. World Health Organization Tobacco Free Initiative. Capacity assessments. Geneva ([http://www.who.int/tobacco/control/capacity\\_building/assessments/en/index.html](http://www.who.int/tobacco/control/capacity_building/assessments/en/index.html), accessed 14 January 2013).



**World Health  
Organization**

Tobacco Free Initiative (TFI)  
20, Avenue Appia  
1211 Geneva 27  
Switzerland

Tel.: +41 22 791 21 11  
Fax: +41 22 791 48 32  
Email: [tfi@who.int](mailto:tfi@who.int)  
<http://www.who.int/tobacco/en>

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