From global agenda-setting to domestic implementation: successes and challenges of the global health network on tobacco control

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Global policy attention to tobacco control has increased significantly since the 1990s and culminated in the first international treaty negotiated under the auspices of the World Health Organization—the Framework Convention on Tobacco Control (FCTC). Although the political process that led to the creation of the FCTC has been extensively researched, the FCTC’s progression from an aspirational treaty towards a global health governance framework with tangible policy effects within FCTC member countries has not been well-understood to date. This article analyses the role of the global health network of tobacco control advocates and scientists, which formed during the FCTC negotiations during the late 1990s, in translating countries’ commitment to the FCTC into domestic policy change. By comparing the network’s influence around two central tobacco control interventions (smoke-free environments and taxation), the study identifies several scope conditions, which have shaped the network’s effectiveness around the FCTC’s implementation: the complexity of the policy issue and the relative importance of non-health expertise, the required scope of domestic political buy-in, the role of the general public as network allies, and the strength of policy opposition. These political factors had a greater influence on the network’s success than the evidence base for the effectiveness of tobacco control interventions. The network’s variable success points to a trade-off faced by global health networks between maintaining internal cohesion and their ability to form alliances with actors in their social environment.

Keywords Advocacy, FCTC, global health policy, governance, networks, public health, tobacco control

KEY MESSAGES

- A global health network of tobacco control scientists and advocates, which formed around the creation of the Framework Convention on Tobacco Control (FCTC), successfully extended its life cycle into promoting the domestic implementation of the FCTC.

- The network’s effectiveness in promoting the implementation of the FCTC has varied across policy issues highlighting the role of domestic political factors in shaping tobacco control policy-making.

- The case of global tobacco control highlights the trade-off faced by global health networks between maintaining internal cohesion and forming alliances with actors in their social environment.
Introduction

The global health governance landscape is increasingly fragmented and politicized as states and inter-governmental organizations no longer hold the monopoly over global health policy-making and implementation (McInnes and Lee 2012). Scholars have recognized that within this global health arena attention to issues is not solely based on the existence of scientific evidence and cost-effective interventions but also attributable to networked forms of advocacy and policy-making, in which members collectively frame an issue and lobby for its attention (Shiffman 2009). Although the contemporary global health literature has increasingly recognized the role and influence of networked forms of health advocacy and policy-making, our understanding of how global policy and advocacy networks extend their influence beyond the tasks of global-level agenda setting and policy formulation has remained more limited.

This article fills this research gap by analysing the evolving role and influence of the global health network on tobacco control. Tobacco use represents a central risk factor within the emerging global health agenda on non-communicable diseases (NCDs) as it is the world’s leading cause of preventable death killing more people than acquired immune deficiency syndrome (AIDS), legal and illegal drugs, road accidents, murder and suicide combined (World Health Organization (WHO) 2008b). It is the only product that kills about one-third to one-half of its regular users. Tobacco use has become a truly global epidemic with ~80% of tobacco-related deaths living in developing countries (WHO 2011). The globalization of tobacco consumption has heightened the need for global governance solutions to tobacco control (Yach and Betchter 2000).

Existing research has highlighted the networked element of global tobacco control policy-making by analysing the contours of what has been labelled the ‘global anti-tobacco advocacy network’ (Farquharson 2003) or ‘global tobacco control epistemic community’ (Mamudu et al. 2011). Other publications have moved beyond descriptive analyses of the global tobacco control network and have assessed the network’s contribution in elevating tobacco control on the global health agenda through the utilization of evidence-based advocacy strategies (Collin et al. 2002; Mackay 2003; Collin 2004; Roemer et al. 2005; Wilkenfeld 2005; Mamudu and Glantz 2009).

These studies overall reach fairly optimistic conclusions regarding the network’s effectiveness based on the network’s success in diffusing a public health frame for global tobacco control, expose the industry’s efforts in derailing the World Health Organization’s (WHO’s) policy efforts, and ultimately helping to move tobacco control from a fringe issue in global health to the first international treaty negotiated under the auspices of the WHO—the Framework Convention on Tobacco Control (FCTC).

This study takes the creation of a global policy framework for tobacco control (i.e. the FCTC) as starting point and adds to an emerging literature (Drope 2010; Crosbie et al. 2011; Cairney et al. 2012), which focuses on the mechanisms that translate states’ commitment to tobacco control at the global level to domestic policy change. There are two primary justifications for analysing the global tobacco control network’s role and influence around the FCTC’s implementations. First, civil society organizations as main nodes of the tobacco control network have been ascribed a central role in promoting the effective implementation of the FCTC framework by becoming integrated into the formal FCTC governance structure through paragraph 4.7 of the treaty (Sparks 2010; Cairney et al. 2012). Tobacco control experts also have emphasized the importance of tobacco control advocacy in pushing forward the implementation of the FCTC (Sparks 2010; WHO 2011). Second, the role of tobacco control advocacy has represented a cross-cutting finding within the emergent research field on FCTC implementation, which has largely focused on country case studies, not on more global-level assessments of the network’s contributions (Griffith et al. 2008; Champagne et al. 2010; Drope 2010; Croie et al. 2011; Tumwine 2011).

The study’s findings qualify assumptions regarding the influence of tobacco control advocacy on the FCTC’s implementation. On the one hand, the global tobacco control network successfully prevented a ‘voltage drop’ (Eisenberg and Power 2000) in the form of a decrease in network membership and collective agency post-FCTC adoption despite being faced with the challenge of (re-) defining its structure and strategy post-FCTC adoption. The network built on its success during the FCTC negotiations and took advantage of new funding opportunities and institutionalized its network activity through the creation of formal network organizations at the global and regional level. Although the study highlights how network members have been involved in a wide array of domestic-level tobacco control advocacy and policy initiatives, it also illustrates the network’s challenge to effectively scale up its realm of influence into domestic implementation contexts. The ability of network members to initiate and/or shape tobacco control policy processes has varied across political contexts and tobacco control interventions. This argument is supported by a comparison of two central FCTC policy interventions with varying global implementation rates: smoke-free environments and tobacco taxation.

According to official FCTC progress data, which is based on states’ self-reporting on the implementation of key provisions of the FCTC articles, smoke-free policies have an average implementation rate of 83% across FCTC parties compared with 46% for taxation (WHO 2012a). The discrepancy in implementation between the two policy areas cannot be easily accounted for by correlating strengths of the two interventions’ evidence bases as tobacco taxes are considered to be one of the most effective tobacco control interventions (WHO 2010). Similarly, smokefree policies and tobacco taxation both represent two central tobacco control policies based on the agendas of the WHO and major global funders, such as the Bloomberg Initiative (WHO 2008b). Instead, explaining the discrepancy in translating global attention into domestic policy change requires attention to scope conditions related to the tobacco network’s policy environment (global and domestic) and characteristics of the issue, which have shaped the network’s ability to promote domestic-level tobacco control policy diffusion. These factors include the existence of binding policy prescriptions at the global level, the relative importance of non-health expertise and buy-in for effective policy-making, the role of the general public as network allies, and the strength of policy opposition. These political factors are found to have a greater influence on the
network’s success than the evidence base for the effectiveness of tobacco control interventions. These contingencies regarding the network’s effectiveness point to broader trade-offs faced by global health networks between maintaining their internal cohesion and extending their influence by forming alliances with external actors.

Conceptual framework

This study is part of the Global Health Advocacy and Policy Project (GHAPP), a research initiative examining networks that have mobilized to address six global health problems: tuberculosis, pneumonia, tobacco use, alcohol harm neonatal mortality and maternal mortality. Its aim is to understand why networks appear surrounding some issues but not others, and why some are better able to influence policy and public health outcomes. GHAPP studies draw on a common conceptual framework grounded in theory on collective action from political science, sociology and economics (Snow et al. 1986; Stone 1989; Powell 1990; Kingdon 1984; Finnmore and Sikkink 1998; Keck and Sikkink 1998; Marsh and Smith 2000; McAdam et al. 2001; Kahler 2009). The introductory article to this supplement presents the framework in detail (see Shiffman et al., 2016).

The GHAPP studies examine network outputs, policy consequences and impact. Outputs are the immediate products of network activity, such as guidance on intervention strategy, research and international meetings. Policy consequences pertain to the global policy process, including international resolutions, funding, national policy adoption and the scale-up of interventions. Impact refers to the ultimate objective of improvement in population health.

The framework consists of three categories of factors (Shiffman et al. 2016). The first category, network and actor features, concerns factors internal to the network involving strategy and structure, and attributes of the actors that constitute the network or are involved in creating it. This category pertains to how networks and the individuals and organizations that create and comprise them exercise agency. A second category, the policy environment, concerns factors external to the network that shape both its nature and the effects the network hopes to produce. The third category, issue characteristics, concerns features of the problem the network seeks to address. The idea is that issues vary on a number of dimensions that make them more or less difficult to tackle. GHAPP studies begin with the presumption that no single category of factors is determinative: rather factors in each of the three interact with one another to shape policy and public health effects.

Network and actor features

Among network and actor features, the existence of effective ‘leaders’ (factor 1) may be one reason networks crystallize in the first place, and why, once they appear, they are able to achieve their objectives. The quality of ‘governance’ (factor 2) may also matter: the effectiveness of the institutions network members set up to steer themselves towards collective goals (Buse and Walt 2000). A third factor is ‘composition’ (factor 3). Diverse networks that link scientists, advocates, policy-makers and others from both high- and low-income countries may achieve better outcomes than uniform ones because diversity improves collective understanding and problem solving (Hong and Page 2004; Page 2007). On the other hand, heterogeneity may hamper cohesion and increase the likelihood that networks disagree on objectives. The fourth factor is ‘framing strategy’ (factor 4; Snow et al. 1986; McInnes and Lee 2012): how network actors publicly position an issue in order to attract attention and resources. Networks may differ in their capacities to discover frames that work.

In the case of global tobacco control, network members include tobacco control scientists, civil society groups and individual tobacco control advocates, and individual policymakers and bureaucrats within the WHO and national governments, which fulfill complementary functions of research, advocacy and policy-making. The network thus combines characteristics of an epistemic community (Farquharson 2003) and an advocacy network (Mamudu et al. 2011). Despite the members’ diversity, the network has exhibited a high level of cohesion regarding its framing, including tobacco as a public health issue, the tobacco industry as vector of disease and population-based tobacco control policies based on an international treaty (Wilkenfeld 2005; Mamudu and Glantz, 2009). In addition to being informally linked through conferences and online communication, network members are more formally linked through network organizations, such as the Framework Convention Alliance (FCA), which formed in the context of the FCTC negotiations.

Policy environment

Several factors in the policy environment may be particularly influential. Among these are ‘potential allies and opponents’ (factor 5). If there are many groups whose interests align with a network’s goals, that network is more likely to expand and be effective than one that faces a dearth of potential allies. Opponents, such as the tobacco industry, may both hinder and facilitate network outcomes: they may seek to discredit the network, but may also inspire mobilization. Substantial ‘funding’ (factor 6) may enable a network to flourish; however, a network set up at the behest of donors may be perceived as less legitimate than those that emerge from grassroots activism. ‘Norms’ (factor 7)—standards of appropriate behaviour for a particular group of actors—may also be influential. The starkest examples of influential norms in global health are those that the health-related Millennium Development Goals advance (Fukuda-Parr and Hulme 2011). These goals have raised expectations that states, international organizations and other global actors act to reduce burden from that subset of global health problems selected for inclusion.

The policy environment of global tobacco control has historically been marked primarily by a transnational industry whose interests stand in conflict to the objectives and motivations of members of the global tobacco control policy and advocacy network (Novotny and Mamudu 2008; Lee et al. 2012) and governments as the political authority to pass and enforce tobacco control policies and legislation. The FCTC process altered the global policy environment for the network as it marginalized the tobacco industry within the global tobacco control policy space and mainstreamed the network’s framing.
studies unfolded. The study protocol was cleared through the institutional review boards of American University and Syracuse University, which granted the study exempt status, as it focused on public policy and was deemed to pose minimal risk to informants.

Data collection for this case study entailed two main research strategies: expert interviews and document review. Thirty-six semi-structured interviews were conducted in-person, over the phone or via Skype. The interviews were recorded after obtaining permission by the interviewee and subsequently transcribed. Initial interview partners were selected based on their authorship of relevant publications or their documented involvement in global tobacco control (e.g. during the FCTC negotiations). Following this initial set of interviews, which centred on outlining the contours of the global tobacco control network, snowball sampling was used to expand the sample to other network participants that could adequately describe the network’s efforts around the FCTC’s implementation. Interviewees included academics and medical professionals, managers of transnational and domestic tobacco control nongovernmental organizations (NGOs), members of regional tobacco control alliances, international organizations and government representatives. Organizational affiliations of interviewees include the Tobacco-Free Initiative of the WHO, the Action on Smoking and Health (ASH), FCA, the Campaign for Tobacco-Free Kids, the Southeast Asia Tobacco Control Alliance (SEATCA), the Tobacco Epidemic Research Center and the African Tobacco Control Alliance (ATCA), and some national-level tobacco control groups. Interview partners were selected from different geographical regions in order to gain insights into regional variation of tobacco control advocacy and policy processes. Interviews focused on the individual’s personal engagement in tobacco control, the framing of tobacco control, organizational activities and strategies, inter-organizational linkages and their evolution over time, network achievements and obstacles, and the role of the tobacco industry.

Document review started with a search in PubMed and Google Scholar and a review of WHO publications. Also, the websites of prominent advocacy groups involved in global tobacco control, such as FCA (www.fctc.org), the Southeast Asia Tobacco Control Alliance (www.seatca.org) and the Campaign for Tobacco-Free Kids (www.tobaccofreekids.org), were searched for relevant reports and position statements. The first part of the document review included a historical analysis of the events that led to the creation of the FCTC based on existing scholarly publications, WHO reports, media releases and NGO statements. A second part focused on the analysis of global and regional progress reports, donor reports, NGO project and programme evaluations, and published country-level case studies regarding the implementation of the FCTC.

The primary limitation of this study is its inability to draw generalized conclusions about tobacco control advocacy and policy processes in low- and middle-income countries due to the scarcity of readily available information and the relatively small sample size of interviewees compared with the overall size and the breadth of the network. Interviews with regional experts with insights into regional dynamics of tobacco control and the triangulation of their statements with existing country-level case studies and global progress reports was the main strategy to enhance the validity of the case study findings.

**Issue characteristics**

Among issue characteristics, ‘severity’ (factor 8), ‘tractability’ (factor 9) and the nature of ‘affected groups’ (factor 10) may be particularly influential. Robust networks may be more likely to emerge when problems lead to high mortality and morbidity or social disruption—or are perceived to do so. Also, individuals and organizations may be more likely to act on problems perceived to be soluble (Stone 1989). In addition, affected populations that inspire sympathy, such as children, may be more likely to inspire network mobilization (Stone 1989) than those that do not. Also, positive network results may be more likely if affected populations are able to mobilize on their own behalf, as people living with human immunodeficiency virus (HIV/AIDS) have done.

In the case of global tobacco control, relevant issue characteristics include its addictive nature, the disproportional harm of tobacco use on low-income groups and low- and middle-income countries, the social harm of tobacco use through second-hand smoke and a strong scientific evidence base regarding the link between tobacco use and negative health effects (i.e. cancer, lung and heart disease). At the policy implementation level, additional considerations include the evidence base for tobacco control interventions’ effectiveness and the technical and political resources necessary for policy design, adoption and implementation.

This case study expands the analysis of global health networks’ role and influence by focusing on the network’s efforts to translate FCTC member countries’ commitments into domestic policy change. Similar to other international treaties, FCTC ratification does not imply the automatic translation of this commitment into domestic policy change. Instead, states’ commitment to the FCTC through ratification can prove inconsequential for domestic conditions as the FCTC (like most treaties) lacks enforcement mechanisms. By focusing on the role of the global health network on tobacco control in promoting FCTC implementation, this project follows scholars who have argued that states’ compliance within international treaties can be affected by the agency of domestic and transnational advocacy networks through their influence on policy agendas within domestic political structures (Risse et al. 1999; Simmons 2009).

**Methodology**

This study followed a case study approach and used a process-tracing methodology involving in-depth examination of social and political processes in order to uncover causal mechanisms that led to the policy and public health outcomes being investigated (Yin 2003; Bennett 2010). The aim was to trace in detail the role of networks, environments, issue characteristics and other factors in shaping agenda-setting, policy formulation, policy implementation and mortality and morbidity change. GHAPP researchers used the same methodology, began with the same basic set of questions and were in frequent communication in order to share insights as the studies unfolded. The study protocol was cleared through the Institutional Review Boards of American University and Syracuse University, which granted the study exempt status.
Nevertheless, this study does not aim to make all-encompassing claims about the effectiveness of the global network in domestic policy processes but to identify regular patterns that characterize this interaction.

Results

The global tobacco control network and the FCTC process

For much of the second half of the twentieth century, tobacco control was largely a scientific endeavor and primarily concerned with building an evidence base regarding the negative health impact of tobacco use in developed countries. A more coordinated and mobilized global health network emerged in the context of the FCTC negotiations during the late 1990s. Although individual tobacco control advocates had been critical in triggering the FCTC process (Mackay 2003), it was not until the World Health Assembly’s decision to sponsor a treaty on tobacco control in 1996 that a broader and more formal network of tobacco control advocates and scientists formed on global tobacco control (Wilkenfeld 2005). The FCTC negotiation represented a turning point for networked activity around global tobacco control as it created a focal point to co-ordinate advocacy activities and provided a more permanent collaborative space. Prior to the FCTC negotiations, network members were primarily connected through inter-personal relationships, sporadic meetings at international conferences and interactive communication linkages, such as GLOBALINK, a web-based network that facilitated information exchange between tobacco control advocates and scientists around the world. The institutional support by the WHO, which had provided resources to help create a civil society alliance that would co-ordinate NGO participation at the FCTC negotiations (Collin et al. 2002), facilitated the creation of a coalition of non-governmental organizations and advocates working on tobacco control in the context of the global treaty process: FCA.

The creation of FCA facilitated the formation of an increasingly expansive global network as it allowed its northern NGO members, such as Action on Smoking and Health (ASH), the American Cancer Society (ACS) and the Campaign for Tobacco-Free Kids, to expand its efforts of recruiting and supporting tobacco control allies from low- and middle-income countries. Over the course of the FCTC negotiations the civil society network represented by the FCA grew from 25 NGOs during the first negotiating session (intergovernmental negotiating body (INB) 1 in 2000) to 195 at its last session (INB 6 in 2003) (Mamudu 2005). Despite its ad hoc and informal nature, the FCA helped to deepen North-South and South-South relationships between advocates, enabled the exchange of knowledge and information pertinent to the FCTC negotiations among FCA members and government representatives, and strengthened the capacity of NGOs and delegates from low- and middle-income countries (Collin 2004; Mehl et al. 2005; WHO 2009).

The adoption and ratification of the FCTC by WHO member countries established global tobacco control policy within an inter-governmental governance structure (Lo 2006). Despite the state-centric nature of the FCTC implementation regime, in which policy-making and implementation fall into the responsibility of states, the global health network on tobacco control did not experience a decrease in membership and collective agency post-FCTC adoption. At the global level, a group of FCA members promoted the coalition’s evolution from an ad hoc network to an incorporated membership organization that would ensure and co-ordinate global interaction among network members and facilitate resource acquisition for the network (Interview 25). Although the FCA became characterized by a more formal organizational structure, the organization continued to base its networking activity on its founding principles, including free membership, consensus-based decision-making processes regarding its policy positions and the exclusion of members with ties to the tobacco industry. Over the following years, the FCA continued to increase and diversify its membership base over time from 195 members in 2003 to 306 in 2008 to close to 500 organizations in 2014 (Wilkenfeld 2005; Mamudu and Glantz 2009; http://www.fctc.org/about-fca).

As the global tobacco control policy process moved towards the implementation of the FCTC, the network started to expand its reach and influence towards domestic policy contexts. The network’s expanding reach was made possible by changes in the policy environment for tobacco control at the global level. First, the creation of the FCTC had validated and institutionalized the network’s framing of tobacco control as a public health issue and the ascribed role of the tobacco industry as vector of disease (WHO 2003). The existence of the FCTC framework as an emerging global regulatory standard for effective tobacco control provided tobacco control advocates with an important leverage tool. ‘Finally, we had an international instrument that enabled us to campaign’ as one advocate articulated the effect of having a global standard for tobacco control on national-level advocacy (Interview 35). Furthermore, as the broad-based adoption by low- and middle-income countries had led to high levels of demand for implementation assistance by member countries, the WHO encouraged NGOs’ participation around FCTC implementation processes (Wipfl et al. 2004; Sparks 2010).

Second, the network’s growth was facilitated by an increase in global funding for tobacco control due to the engagement of private donors, such as the Bloomberg Initiative and the Gates Foundation, which together have contributed >$600 million to global tobacco control (Bloomberg Philanthropies 2012; Bill & Melinda Gates Foundation 2013). Previously, the FCA had been dependent on the contributions of individual members, such as the American Lung Association, which alone contributed one-third of the FCA’s operating budget during the network’s early years (Interview 3). Following the FCA’s formal incorporation, some of the FCA’s primary funders, such as the American Lung Association or the American Heart Association, scaled back their financial commitment to the FCA. ‘They felt like they could pull back without destroying what they had built’, as one FCA leader explained (Interview 3).

The increase in available funding represented a significant change within the network’s external environment as it expanded the network’s boundaries and increased its capacity. As one tobacco control advocate described this change,

“There is money now for tobacco control. So this is a big difference. There are a lot of new organizations, a lot of new advocates, a lot of people […] So I think it has changed dramatically in terms of the
number of people that has the knowledge of tobacco control” (Interview 14).

Additional funding not only allowed the network to institutionalize its network structure at the international level through the FCA but also facilitated the network’s expansion beyond the FCA as its primary coordinating structure for global-level tobacco control advocacy. On the one hand, greater resource availability led to the creation of new, funding-specific network structures, such as the organizational network funded under the Bloomberg initiative. The network is co-ordinated by tobacco control NGOs, such as the Campaign for Tobacco-Free Kids, which expanded its investment in international tobacco control activities from $1 million in 2006 to >$9 million in 2010 (Campaign for Tobacco-Free Kids 2007; Campaign for Tobacco-Free Kids 2011) and created an International Legal Consortium to support advocacy around adoption and implementation of effective laws and policies in FCTC member countries.1

On the other hand, the increased availability of funding for tobacco control advocacy facilitated the institutionalization of regional-level network structures, such as ATCA or SEATCA, which had the goal to provide support and strengthen the capacity of domestic tobacco control advocates. Given its limited capacity to effectively strengthen the capacity of low- and middle-income country tobacco control groups, the FCA actively supported the formation of regional network clusters given its limited organizational and regional networks. Over time, regional tobacco control alliances, such as SEATCA and ATCA, developed region-specific approaches to tobacco control networking, policy and advocacy. These organizations have really become the go to NGOs in their regions, and this was also by design, as an FCA leader described (Interview 3). A division of labour emerged, in which the FCA network coordinates efforts around international tobacco control policy processes and regional networks focus on supporting national-level FCTC implementation processes.

The network’s expanding structure and reach allowed the network to position itself as a relevant actor in the context of FCTC implementation processes around the world. At the same time, the network’s expanding structure and reach led to new challenges to the network’s cohesion as the FCTC’s utility as shared basis for network action became more limited on several fronts. First, it increased the diversity of network members as the network over time included civil society groups with varying ties to public health issues (e.g. tobacco control NGOs, doctors and nurses organizations, development NGOs, consumer rights groups and human rights organizations). For instance, only about half of the FCA members are tobacco control advocates (Interview 3). Second, the transition from global-level to national-level policy-making elevated country contexts as the primary policy environment for tobacco control advocacy post-FCTC adoption, which required the development of contextualized tobacco control advocacy and policy approaches (Interviews 11, 20, 32, 33). Third, the availability of resources augmented the influence of funders in shaping tobacco control agendas of domestic advocates, which was based on but not always congruent with the contents of the FCTC (Interviews 3, 6, 19, 20).

Successes and limitations of tobacco control advocacy around FCTC implementation

Its growing membership and organizational capacity (particularly of network members in low- and middle-income countries) allowed the network to significantly expand its activity level beyond the adoption of the FCTC. Network members have been involved in a wide array of tobacco control advocacy and policy initiatives around the world by conducting research, lobbying policy-makers, drafting model legislations, educating the public, and providing background information and feedback on effective policy-making around policy and legislative proposals. Their linkages with global and regional network structures has augmented the ability of domestic tobacco control advocates to promote the FCTC’s implementation as network organizations have provided local tobacco control advocates with financial and technical resources, supplied them with information regarding advocacy and policy processes in other countries and helped with the recruitment of international experts (American Cancer Society [ACS] 2007; African Tobacco Control Alliance 2010; InterAmerican Heart Foundation 2010; Southeast Asia Tobacco Control Alliance [SEATCA] 2012). Three types of network contribution can be distinguished: capacity-building, advocacy support and research.

A first contribution of the network on FCTC implementation concerns the facilitation of information exchange and mutual learning among network members. By serving as a vehicle to access information, expertise and resources, network structures such as the FCA, ATCA, SEATCA or the network supported by the Bloomberg Initiative, enabled domestic tobacco control advocates to draw on information and expertise beyond the available resources at the domestic level. For instance, domestic civil society groups in Peru with the support of the Campaign for Tobacco-Free Kids ensured stringent language of smoke-free policy proposals by supplying policy-makers with information from effective smoke-free regulation within the region (Interview 33).

Cross-national networks have not been limited to civil society linkages but also enabled the exchange of information between pro-tobacco control fractions within governments as countries started to share their policy-making experiences with other interested policy-makers in their region (Interview 33; SEATCA 2012). Due to the need to build the capacity of tobacco control advocates and policy-makers alike, a variety of resource hubs have emerged that aim to strengthen the capacity of advocates for tobacco control around the different policy areas included in the FCTC framework. Regional network structures, such as SEATCA and ATCA, have devoted much of their web presence as an information source for tobacco control advocates. International NGOs have created platforms for tobacco control-related resources (e.g. tools, guidelines, research and expertise). For instance, the Campaign for Tobacco-Free Kids established an online-based International Tobacco Control Resource Center in 2006 (Campaign for Tobacco-Free Kids 2007). The Johns Hopkins School of Health (another Bloomberg partner) has established a Global Tobacco Control Online Training site.2 The World Lung Foundation has established five Tobacco Control Resource Centers in Beijing, Mexico City, Moscow, Delhi and Cairo.
A second contribution concerns the network’s support of domestic-level advocacy strategies and campaigns. The ability of domestic tobacco control groups to contribute to policy processes has been augmented by their ability to draw on external network support for their advocacy work, including financial and technical support for policy advocacy, access to information from advocacy and policy processes in other countries and the recruitment of international experts. A related advocacy role concerns the mobilization of public support for tobacco control initiatives in an effort to raise public awareness of the negative effects of tobacco consumption, increase the political weight of tobacco control advocacy campaigns and to prevent the influence of anti-tobacco control groups on public sentiments. Regional alliances, such as ATCA and SEATCA, as well as individual NGOs, such as the Campaign for Tobacco-Free Kids and ACS, have supported national-level media campaigns by training journalists and providing advocates with media advocacy trainings (American Cancer Society (ACS) 2007; 2008) (Interviews 27, 29, 32). For instance, the African Tobacco Control Consortium has advocated at the regional level for the inclusion of tobacco control into national development plans and for increasing taxation of tobacco products (Interview 29). SEATCA has engaged in regional-level advocacy activities around industry interference, taxation, advertising bans, smoke-free policies and warning labels (SEATCA 2012).

A third network contribution concerns its efforts to fill research gaps and monitor countries’ FCTC performance. The progression towards implementing the FCTC has evoked a wide variety of new research needs within the field of global tobacco control. Because most of the scientific evidence informing the FCTC negotiations stemmed from high-income country contexts, FCTC implementation required the expansion of research relevant to low- and middle-income countries (Leischow et al. 2013). Regional alliances and international NGOs have provided research support to their domestic counterparts in an effort to equip domestic advocates with stronger evidence regarding the negative health effects of tobacco consumption, the effectiveness of tobacco control interventions and the tobacco industry’s actions to derail tobacco control policy processes. For instance, the Campaign for Tobacco-Free Kids has funded research studies to promote smoke-free policies, such as public opinion polls to demonstrate public support for the policy and air quality studies highlighting the difference in outcome between comprehensive and weaker policies (Interview 32). SEATCA has provided technical assistance to domestic research teams and has helped to create linkages between research institutions in the US with local research teams in the Association of Southeast Asian Nations (ASEAN) region (SEATCA 2012). Other domestic groups have used research to accompany and monitor domestic policy processes. For instance, Centro de Investigación para la Epидemia del Tabaquismo (CIET) in Uruguay has carried out a series of research projects on the implementation of smoke-free policies (i.e. compliance rates, air quality) and tobacco consumption (see e.g. Bianco et al. 2009).

A related research function is the role of network members as monitoring agents who pool information on individual countries’ performance into shadow reports on implementation progress of the FCTC. The FCA has published a couple of reports ‘shadowing’ the official progress reports published by the FCTC and highlighting discrepancies between FCTC members’ commitments and their policy actions and reporting practices. In the absence of independent assessment and enforcement mechanisms on the part of the FCTC, the reports aim to ‘shame’ members towards compliance by diffusing report findings at Conference of the Parties (COP) meetings and through national-level press releases. In addition, the FCA has provided grants to members for the development of national-level monitoring reports (Framework Convention Alliance 2010) and has supported the publication of regional-level reports [see e.g. African Tobacco Control Consortium (ATCC) 2013]. SEATCA has also published score cards on ASEAN countries’ performance on different aspects of tobacco control (e.g. tax policy, smoke-free policies) (SEATCA 2012; 2013). These cards are not necessarily used to shame governments but also serve as educational instruments in order to communicate states’ performance relative to their peers (Interview 28).

The next section analyses and compares the network’s experience around two tobacco control interventions included in the FCTC that target the reduction of demand for tobacco products and have been promoted as central steps to countering the tobacco epidemic by powerful global tobacco control actors, such as the WHO and the Bloomberg Initiative (WHO 2008b): smoke-free environments and tobacco taxation.

Smoke-free environments

Within the FCTC’s comprehensive set of demand-oriented policy prescriptions, smoke-free policies have represented the policy area that evoked the highest level of advocacy momentum and policy traction (WHO 2012a). The worldwide progress in legislating smoke-free environments around the world is particularly noteworthy as comprehensive smoke bans were an exception only 20 years ago. The inclusion of this policy issue into the FCTC negotiation was controversial even among advocates who considered the requirement of entire countries to go smoke-free as too demanding (FCA 2012; Interviews 3, 19). Government delegations also exhibited significant resistance against a total smoking ban despite the strong evidence base regarding the harmful health effects of second-hand smoke (Warner 2008).

A decade after the passage of the FCTC, Article 8 and the ensuing policy momentum on smoke-free environments has become a global initiative (Hyland et al. 2012) providing the most pronounced instance of the global tobacco control policy process’ progression from global agenda setting to national-level implementation. Between 2008 and 2010 alone, the number of people protected by comprehensive smoke-free laws doubled to ~787 million (Eriksen et al. 2012). As of 2012, 120 member countries reported to have implemented measures to protect their citizens from exposure to tobacco smoke (WHO 2012a). It also represents the only FCTC article around which a policy-specific tobacco control advocacy alliance has formed through the creation of the Global Smoke-Free Partnership, a multi-stakeholder initiative providing campaign support for smoke-free advocates around the world.3

Existing studies analysing country-level smoke-free policy processes have highlighted the critical role of domestic tobacco
control advocates with ties to regional and global network structures to develop and maintain momentum for smoke-free policy processes across a diverse selection of country contexts (Griffith et al. 2008; Champagne et al. 2010; Drope 2010; Crosbie et al. 2011; Tumwine 2011). These assessments align with the perspective of NGO members of the Bloomberg-funded network, who have argued that smoke-free advocacy campaigns have represented the policy area with the highest level of civil society demand for assistance (Interviews 32, 33).

Several factors related to the network, its policy environment, and the policy issue of smoke-free environments help to account for the network’s comparatively high level of take-up and advocacy success around smoke-free environments. The first factor concerns the existence of global-level implementation guidelines for smoke-free policies and the ability of domestic tobacco control advocates to utilize this framework as a resource to influence domestic policy-making (InterAmerican Heart Foundation 2010). Following the FCTC’s adoption, the FCA and its members continued to ‘cheerlead’ country delegations into the initiation of individual guideline formulation processes. In preparation of the second COP meeting in 2007, the Global Smoke-free Partnership initiated the Global Voices Campaign to build support among delegates for guidelines on Article 8 (Bornhäuser and Welch 2007). The implementation guidelines, which were passed at the FCTC’s 2007 COP meeting, assisted member countries in implementing their obligations by providing guidance on best practices and defining elements of effective smoke-free policies (e.g. 100% smoke-free) (WHO 2007). The implementation guidelines were seen as critical by tobacco control advocates accompanying the negotiations as they added specificity regarding countries’ obligation and provided a blueprint for effective policy solutions (Interviews 3, 7, 11).

A second characteristic of tobacco control advocacy around smoke-free policies concerns the central role of public engagement. Tobacco control advocates can derive their political power from linking policy processes with broader audiences through the campaign and public outreach activities of individual members. Smoke-free policies are suitable to utilize public pressure for political influence due to their strong public engagement component. As smoke-free policies primarily affect non-smokers (Hyland 2011), advocacy campaigns have been able to target a broader audience, because smoke-free policies are generally supported by smokers and non-smokers alike (see e.g. Li 2010; Mons et al. 2012). As a result, network members have engaged in a variety of public engagement strategies around smoke-free policy campaigns, including grassroots mobilization, public education and media advocacy in an effort to raise public awareness of the negative effects of tobacco consumption, increase the political weight of tobacco control advocacy campaigns and to prevent the influence of anti-tobacco control groups on public sentiments and the policy process (Griffith et al. 2008; Sebrič and Glantz 2010; Ha-iaconis et al. 2011). These domestic-level campaigns have been supported by global and regional network members, such as ATCA and SEATCA, as well as individual tobacco control NGOs, such as the Campaign for Tobacco-Free Kids and ACS, which have contributed resources, shared information regarding scientific evidence and policy experiences from other countries, and provided local advocates with media advocacy trainings (ACS 2007) (Interviews 27, 29, 32). Based on existing research, these network-supported public campaigns around smoke-free policies have proven effective in helping to create the popular support necessary for incipient policy initiatives around smoke-free environments to move forward. For instance, in Mexico a series of advertising and media campaigns by tobacco control NGOs helped to ensure public support for a comprehensive smoking ban in Mexico City (Crosbie et al. 2011). In Uruguay, the National Alliance for Tobacco Control, a multi-stakeholder initiative including public and private members, implemented two media campaigns in order to gain public support for the government’s smoke-free initiative.4

Third, for tobacco control advocacy to effectively promote countries’ implementation of the FCTC, network members are required to extend their influence into policy-making and legislative processes by gaining the buy-in and support of political authorities (Interviews 30, 36). The FCTC negotiations had extended the boundaries of the global health network on tobacco control and had established relationships between tobacco control scientists and advocates and government delegates supportive of tobacco control, particularly from countries’ Ministries of Health. As one African NGO representative described their relationship: ‘They are our allies. […] We don’t need to continue to discuss so much time with the Minister of Health because they are with us’ (Interview 30). As a result, government health officials gradually constituted the primary vehicles for the network’s extension into domestic policy spheres. Because smoke-free policy processes in many countries can be triggered and shaped by health agencies and ministries, this policy area represented a favourable environment for the network’s domestic-level advocacy activities as it allowed tobacco control advocates to operate within their network’s boundaries (i.e. without requiring the buy-in by non-health experts).

A fourth factor affecting the network’s ability to advocate around smoke-free policies concerns the role of external opponents to tobacco control policy proposals, particularly the ability of the tobacco industry to hinder and obstruct tobacco control processes. The tobacco industry’s strategic agency around the FCTC’s implementation has included a wide array of tactics, including promoting partnership agreements with governments, advancing voluntary regulation, refuting evidence regarding tobacco’s health effects and projected tobacco control policy outcomes, activating front groups to simulate broader support, and taking advantage of their access to policy-makers (e.g. finance ministries) (WHO 2008a; Brandt 2012; Lee et al. 2012). The network’s limitation to curb industry-led policy opposition has become even more pronounced as the tobacco industry has explored more confrontational tactics, particularly the use of global, regional and bilateral trade and investment agreements, as strategic avenues to combat tobacco control policy diffusion (WHO 2012b). As a result, from the perspective of many network members, industry interference around FCTC implementation continues to represent the greatest obstacle to the diffusion of tobacco control policies around the world (Interviews 11, 16, 21, 24).

Although smoke-free policies can be passed without directly targeting the practices of the tobacco industry (Interview 18),
industry opposition has represented an obstacle for the initiation or implementation of smoke-free policy processes across FCTC member countries (Global Smokefree Partnership 2012). Faced by lobbying efforts by the tobacco industry and its industry allies (e.g. hospitality sectors), tobacco control advocates have on more than one occasion managed to transfer their advocacy demands to more favourable policy environments and target institutions as smoke-free policies can be implemented at the national, regional or local level and through varying legislative and policy measures (Drope 2010). On the empirical-scientific level, smoke-free policies have represented a policy area favourable to refute arguments brought forward by the tobacco industry and its allies, such as the negative consequences of smoke-free policies on the hospitality sector, the lack of public support for smoke-free environments and proposals for alternative policy tools (e.g. ventilation systems) as all of these arguments can be and have been disproven by empirical research (Hyland et al. 2012).

**Tobacco taxation**

Contrary to the momentum around smoke-free policies, FCTC Article 6 on tobacco price and tax measures has represented one of the FCTC policy areas with the lowest level of policy traction measured by average implementation rates (46% compared with 86% for smoke-free policies) (WHO 2012a). Article 6 of the FCTC obliges member countries to implement tax policies, such as levy excise taxes on tobacco products and prohibit sales of tax- and duty-free tobacco products (WHO 2003). Slower implementation progress has been mirrored by a lack of domestic network members’ engagement as highlighted by lower levels of assistance demand by domestic civil society groups from global funders, such as the Bloomberg Initiative, and from regional and global tobacco control network organizations, such as the FCA or SEATCA (Interviews 3, 32, 35).

From a public health perspective, the limited progress around tobacco taxation is puzzling considering that raising taxes represents one of the most effective interventions to curb demand for tobacco products (Chaloupka et al. 2012). Considering the challenges faced by tobacco control advocates in translating FCTC member countries’ commitment around tobacco taxation helps to identify alternative factors for the network’s variable effectiveness in promoting tobacco control policies. A first distinction concerns the lack of available implementation guidelines for Article 6 at the international level. The complex domestic policy environment for tobacco taxation has hindered the development of global policy prescriptions as the variation between countries’ level and structure of tobacco taxes combined with the existence of varying evaluative criteria (i.e. tax level vs price increase vs affordability) has made global level attempts of harmonizing policy prescriptions for effective tobacco taxation policies a complex task (Warner 2008; Chaloupka et al. 2012). As a result, implementation guidelines for FCTC Article 6 (tobacco) were not adopted until 2014 as their content was debated at the meetings of the FCTC’s governance body.

Second, advocacy around tobacco taxation offers limited opportunities for public campaigning. Instead, policy processes generally take place within government bureaucracies where tobacco control advocates are placed in direct competition with industry interests for political influence. As one tobacco control academic summarized his experience:

“I’m a little bit concerned or skeptical about the actual impact we can have in developing countries because of [...] the extent of control of the discourse or the influence of tobacco companies over government—because they, I think, undermine that landscape where good tobacco control groups can actually do effective work in their countries or in their regions” (Interview 13).

In the absence of implementation guidelines, policy advocacy for tobacco taxes to date has represented a higher entry barrier for tobacco control advocates as it required the support by non-traditional network allies (e.g. finance ministries), higher levels of policy customization and non-health expertise. Network members have acknowledged the obstacles for tobacco control advocates to effectively advocate around tobacco control policies that require technical expertise in non-health areas, such as taxation, due to the public health expertise of many network members (Interviews 16, 22). As one of SEATCA’s co-ordinating members explained:

“When SEATCA started to do work on tobacco control they did not start with tax increase although the tax increase as I mentioned is the most effective. We started with the ad bans, smoke free public places [...] we started with other things which seem to be more achievable and for which we had capacity. Because tax increase is a complex issue” (Interview 35).

Gaining external network support beyond health ministries and agencies has represented a key strategic task and challenge for effective tobacco control advocacy around tobacco taxation and other policy areas of the FCTC. These policy processes bring a different set of actors and political agendas to the negotiating table, which are less likely to be persuaded by public health arguments and generally more sympathetic to economic arguments and commercial interests (Interviews 11, 20, 21). As a one tobacco control advocate explained:

“We didn’t go to school with them. They aren’t our colleagues and friends. They don’t speak our language, so to reach out and to speak to them in a language that feels comfortable to them [...] requires us to staff differently” (Interview 32).

The need to lobby actors external to the network’s boundaries has been observed by network members as a central challenge (Interviews 9, 14, 20, 22). As one advocate summarized, “It’s a good group. It’s been good in doing advocacy work. [...] but because it is a narrow bandwidth network, it does not take into consideration the non-health multi-factorial nature of tobacco’ (Interview 22). This challenge has also affected the network’s ability to successfully employ evidence-based advocacy strategies around tobacco taxation. Similar to smoke-free environments, industry-supported arguments against taxation, such as the argument that tobacco taxes place a disproportionate burden on economically disadvantaged people, can exacerbate illicit activities, such as contraband, and potentially decrease government revenue, have been successfully refuted by empirical research on the global level (Chaloupka et al. 2012).
However, the political power of evidence-based advocacy around the health benefits of tobacco taxation has been hampered due to the factors outlined above (i.e. the absence of global level policy prescriptions, the lack of public involvement in tax-related policies, and the political influence of the tobacco industry on key decision makers).

Despite these obstacles, the global health network on tobacco control more recently has augmented its efforts around tobacco taxation by funding advocacy campaigns, supporting research and recruiting fiscal policy experts (SEATCA 2013; African Tobacco Control Consortium 2013; World Lung Foundation n.d.), thus continuing to contribute to the progressive implementation of the FCTC, which is estimated to have averted >7 million smoking-attributable deaths to date (Levy et al. 2013). At the same time, the achievements of global tobacco control advocacy and policy efforts with regards to reducing smoking prevalence have been offset by global population growth, which has led to the continuing rise of the overall number of smokers worldwide (Ng et al. 2014). The challenge of translating the FCTC into a global reduction of prevalence rates highlights broader limitations to the contemporary global advocacy and policy process around global tobacco control. Although this challenge is partly rooted in the lack of implementation of effective tobacco control measures, such as taxation (Munzer 2013), the gap between FCTC implementation and health impact is also rooted in the restricted policy focus on demand-oriented measures while neglecting supply related issues, including the application of a harm reduction approach to tobacco control policy (e.g. e-cigarettes), which has remained a contested issue within the global health network on tobacco control (Interviews 11, 13, 25) (Yach and Sweanor 2013).

Discussion
The FCTC’s progression from an aspirational treaty towards a global health governance framework with tangible policy effects within FCTC member countries represents a puzzling outcome given the cultural embeddedness of tobacco use, the politicized nature of tobacco control as a policy issue, widely divergent economic interests and a powerful opposition group in the form of the tobacco industry. This case study advances understanding of the evolving contributions of the global tobacco control network as the global policy process on tobacco control progressed towards treaty implementation. More specifically, the study results serve to (1) analyse why the global health network on tobacco control did not experience a voltage drop post-FCTC adoption and (2) identify scope conditions for the network’s effectiveness around domestic tobacco control policy-making. To explain the network’s evolution and contribution, the case study (along with the other contributions in this issue) applied a three-pronged framework that aims to capture the bi-directional and dynamic interaction between issue characteristics, policy environment and network structure and strategy to account for the political dimensions of global health policy processes and outcomes.

Transitioning from influencing global-level to national-level policy-making processes requires global networks to move from functioning as network actors (i.e. accumulating and unifying network voices within centralized policy-making spaces) to network structures (i.e. diffusing information and resources to a decentralized set of domestic advocacy spaces). The empirical analysis highlights three factors that facilitated the network’s transition and continuing agency beyond setting the global agenda on tobacco control and negotiating the FCTC. First, the creation of the FCTC as institutional framework for tobacco control legitimated network members as participants in global tobacco control by validating their evidence and framing (i.e. negative health effects of tobacco use, tobacco control as a public health issue and the industry as vector of disease). The emergence of a global norm for effective tobacco control through the FCTC and its implementation guidelines helped to unite global and local network members from diverse backgrounds behind a common normative base for action (factor 7—norms). Second, the network’s institutionalization through the FCA and decentralization through the creation of regional network structures, such as ATCA or SEATCA, helped the network to more effectively acquire external funding, expand the network’s reach within domestic policy contexts, and maintain information exchange between the growing number of network members (factor 2—network governance). Third, the availability of new funding sources that could respond to the network’s increase in resource needs around FCTC implementation facilitated the network’s scale-up across countries (factor 6—funding).

The second contribution of this study concerns the question of actual network influence on FCTC implementation processes. Despite the empirical limitations of this study, the comparison between smoke-free and tobacco taxation as two areas of network engagement allows for the identification of a set of hypotheses regarding global health networks’ effectiveness around domestic-level policy implementation processes. At the network level, the extension of network boundaries to include individuals within government agencies with decision-making power represents one scope condition that affects networks’ ability to gain access to and buy-in within domestic political contexts (factor 3—network composition). In the case of global tobacco control, the network’s linkages to national health ministries and agencies facilitated the network’s extension into domestic policy-making processes around smoke-free environments. Although the network’s framing of tobacco control as a public health issue and the industry as vector of disease has represented a binding criterion during the network’s extension, its identity as a public health network has limited the network’s ability to acquire support and develop partnerships with key decision makers in non-health policy areas, such as trade or finance, where public health arguments have shown to be insufficient.

With regards to the network’s environment, two findings stand out. First, the existence of global-level implementation frameworks that can be instrumentalized by networks in their domestic-level advocacy are likely to enhance networks’ effectiveness. In the case of global tobacco control, the elaboration of the FCTC into policy prescriptions through the development of implementation guidelines facilitated domestic-level advocacy efforts around smoke-free policies as the guidelines specified standards for compliant behaviour for FCTC member countries. However, as the level of specificity (e.g. policy design, level of obligation) of global-level policy prescriptions varies across
articles, the ability of domestic health advocates to draw on global FCTC norms in their domestic advocacy efforts fluctuates accordingly (e.g. the case of tobacco taxation).

A second relevant factor within the network’s environment concerns the role of network allies and opposition within domestic policy contexts in affecting networks’ advocacy success (factor 5—allies and opponents). With regards to allies, the tobacco control network’s ability to evoke public support from both smokers and non-smokers augmented the political power of advocacy campaigns around smoke-free environments. With regards to opposition, the tobacco industry has remained the primary oppositional force for tobacco control advocates in the context of FCTC implementation. The political influence of the tobacco industry and its allies continues to represent a major obstacle to the network’s effectiveness as the public health arguments of its members have been countered by the industry’s use of other power resources, such as economic and legal arguments. As a result, non-health aspects of tobacco control policy-making have moved to the foreground in the context of FCTC implementation. Overcoming industry opposition has been more feasible around smoke-free policies compared with other tobacco control policy areas, which lack a significant public engagement component, require a higher level of non-health information and expertise, entail the buy-in of a broader set of political constituents, and are marked by greater traction of counter-frames and arguments advanced by the tobacco industry and its allies.

Conclusion

The case of global tobacco control demonstrates the relevance of global health networks around the health policy field of NCDs. Network members’ shared concern for the negative health effects of tobacco use, their ability to effectively utilize the argumentative force of scientific evidence, their cohesion around a public health frame, their unanimous support of an international treaty, and their confrontational stance towards the industry have represented key sources of the network’s sustained cohesion and collective agency. Instead of constituting an end point of network engagement, the creation of the FCTC represented an additional motivational source for the network as it changed the network’s relationship to its global policy environment by adding validity to the network’s claims, creating new demand for network support, and leading to the emergence of new funding sources. Although these global-level factors have facilitated network’s success in extending its lifecycle, the network’s effectiveness in promoting the FCTC’s implementation has been largely contingent on its domestic-level influence capacity (i.e. its ability to contribute expertise, build coalitions, mobilize the public and overcome opposition), which has varied across policy issues.

The network’s evolving role and strategy in moving global tobacco control forward highlights the dynamic nature of the NCD policy field, in which discursive frames, global norms, institutional arrangements, policy solutions and funding mechanisms are still in the process of developing. Compared with more established global health issues and networks, which have formed around communicable diseases, such as HIV and malaria, the network on global tobacco control is still in its infancy with regards to its institutional linkages, leadership, funding and the organizational capacity of network members in low- and middle-income countries. As the network is maturing, it has been challenged along several of its core dimensions including the need to broaden its framing beyond public health, the rise of new research needs regarding policy effectiveness (not harm), the emergence of tobacco control issues not addressed by the FCTC (e.g. trade) and unresolved questions regarding its stance towards product-related issues and harm reduction (e.g. e-cigarettes).

With these issues looming over the network’s future, maintaining its internal cohesion, which has been a key factor in ensuring the network’s collective agency to date, will likely be marked by trade-offs. Although broadening its discourse and membership could increase the network’s capacity and influence towards non-health aspects of tobacco control and form broader alliances with actors in related fields, such as global development, global finance, or trade, increasing the network’s diversity will likely complicate its ability to reach a consensus regarding some of the most pressing strategic decisions and is likely to exacerbate network members’ already conflicting positions regarding the end goal of their agency around global tobacco control (i.e. prevention of all forms of tobacco use vs harm reduction). The network’s challenge of how to most effectively respond to its contemporary limitations and obstacles highlights a broader dilemma for global health networks as they are forced to balance their internal cohesion with the need to expand and adapt to changing environments and strategic tasks (Kahler 2009).

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Notes

1 http://www.tobaccocontrollaws.org/learn-more/about-us/
2 See http://globaltobaccocontrol.org/home
4 http://www.globalsmokefreepartnership.org/success-stories-uruguay/

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