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HEALTH PLANNING THEORIES AND TOBACCO CONTROL PROGRAMMES: A REVIEW

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ABSTRACT

Background: The most common health planning theories described by literature reviews are rationalism, incrementalism, and mixed- scanning. The application of planning theories in health planning is essential to give planners a broader perspective and to ensure the aims of their programmes are achievable. Tobacco control programme is among the health programmes that has been well established at an international level whereby The Framework Convention on Tobacco Control (FCTC) and MPOWER package have served as a guide to the WHO member countries. However, the planning process of tobacco control programmes of each country are made based on further justifications and current situations of the respective countries. Marked differences in health planning theory approaches can be seen among low, middle and high income countries during the planning of tobacco programmes.

Materials and Methods: A scoping review was done using online databases by choosing the most common health planning theories used and mentioned in literature reviews. With the exception of Antarctica, several low, middle and high income countries with comprehensive information on tobacco control programmes were taken as representatives. Search for articles were conducted via four major databases including Scopus, Science Direct, Google Scholar, and PubMed with additional information from guidelines and expert reports from official websites.

Result: The three most common theories used in health planning are rationalism, incrementalism, and mix scanning. Differences in the application of these theories are seen among low, middle and high income countries. Rationalism and mixed scanning theory were mostly applicable in high and middle income countries whereas incrementalism is mostly being used in LIC.

Conclusion: The application of health planning theories in tobacco control program may differ depending on factors that influence the planning process mainly the economic and political factors as well as support from key players.

Keywords: planning theories, planning characteristics, tobacco control program planning

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1.0 Introduction

Increasing demand in the health service sector and the financial burden it faces has made health planning a growing concern (Berry, 1974). In general, health planning can be described as "deciding how the future should be different from the present, what changes are necessary, and how these changes should be brought about" (Lee, 1979). The process involved in the health planning includes the identification of health issues, recognizing the unmet need, examining resources availability, setting the main objectives which are practicable and achievable, and delivering the administrative actions (J.Hogarth ,1975). Different approaches might be used in the planning of various health programs where several aspects related to health services need to be considered namely sufficiency, efficiency and efficacy of the health services as well as the ecological factors, individual and social behavioural factors which act as determinants of a population's health (J.Hogarth ,1975).

The approaches used in health planning can be further explained by different planning theories. The main planning theories that have been frequently used in health planning programmes include rationalism, incrementalism and mixed scanning (Lee, 1979). Rationalism theory emphasizes on detailed information and comprehensive planning. All possible choices are taken into account where the approach starts with the identification of the root problems followed by the determination of objectives and brainstorming on the available alternatives to solve the issues. Lastly, this approach emphasizes on the evaluation of the outcome and ways to overcome the drawbacks from each option (Berry, 1974). Incrementalism theory on the other hand tends to be less comprehensive as this approach focuses on improving the existing policy by making a slight increase or a slight change over the system that has been set in the long run. The elements of goals, values and alternatives will be incorporated together based on previous policies (Lindblom, 1959). The most feasible alternatives will then be chosen by decision-makers as a good policy within a short period of time after considering a few realistic options. In mixed scanning theory, all the available information will be analysed in a comprehensive manner whereby the most practicable approach will be selected (Lee, 1979). It entails the review process, selection procedure and detailed planning as the key components within the spectrum of planning continuum of the rationalism and the incrementalism theory complementing both the previous theories by reducing their shortcomings while using the essential components of both (Etzioni, 1967). Practically, mixed scanning is known to be far more effective than the other two theories. Longer duration and more resources needed in the rationalism approach is usually considered impractical in real situations (Berry, 1974) while in incrementalism, the failure of the approach is usually due to the limitation in choices of goals and less comprehensive knowledge regarding the problem (Bekker et al., 2004)

Initially, the application of health planning was limited to the administrative level, facilities development, flexible health and welfare organizations (Berry, 1974). However, after the recognition of health planning as a good tool to ensure the success of a program, many program planners have started to apply the various theories in planning health programs as well (Berry, 1974). Recognizing the threat posed by tobacco use and exposure, the tobacco control programme has internationally gained participation from most of the member countries of the World Health Organization (WHO). However, the application of theories used by various countries may differ depending on their circumstances.

1.1 Problem Statements

Tobacco use is known as an important public health issue which gives rise to numerous non-communicable diseases (NCDs) and was the main cause of premature death in 1990s (Chollat-Traquet, 1996). In 1998, almost 4 million deaths occured due to tobacco use and this data has been projected to increase to at least 10 million deaths per year by 2030 (WHO, 2003). The fight against tobacco is quite challenging as it has been portrayed to bring large contributions to the world's economic situation. However, the extensive research done to establish a causal relationship between tobacco and lung cancer has opened up more collective efforts against tobacco usage (Chollat-Traquet, 1996). To enhance the efforts against tobacco, the Framework Convention for Tobacco Control (FCTC) came into action in 2005. Several measures to combat tobacco have been listed in the framework which include decreasing the demand and supply of tobacco, to gain technical and scientific cooperation, to protect the environment, and to provide the law and legislation related with tobacco (WHO,2003). Besides, WHO introduced the MPOWER package in the year 2008 to help the WHO member countries develop their own tobacco control program which consist of six measures that emphasizes on monitoring tobacco use and policies on prevention, protecting people from tobacco smoke, offering assistance to quit smoking, warning about the dangers of tobacco, enforcing tobacco bans, and raising tobacco taxes (WHO, 2013).

The success of tobacco control activities is reflected by the reducing trend in tobacco smoking and reduction in tobacco related diseases in the years that followed (Chollat-Traquet, 1996). Globally, the estimated tobacco smoking prevalence has seen a reduction from 26.9% in the year 2000 to 20.2% in the year 2015 (WHO, 2018). Based on World Bank classification of countries by income level across the continents, high income countries have reported to have the greatest reductions in tobacco smoking prevalence of 9% from the year 2000 to 2015 whereas in upper middle, lower middle, and low income countries were 6.2%, 5.7%, and 4.5% respectively (WHO,2018). Economic factors could be one of the major challenges to plan for successful tobacco control programs especially in low and middle income countries due to the unavoidable interference from tobacco industries who hold authority in the global economy.

1.2 Importance of Planning Theories in Tobacco Control Programme

Planning tobacco control programmes is a complex process which involves various parties with different key players, interest, and tactical ideas (Portes, Machado, Rubano, Turci, & Figueiredo, 2018). The application of different planning theories while designing the tobacco control program will enable the planner to have a better perspective on interrelated issues with regards to tobacco. However, planning theories used will differ according to circumstances. Historically, the success of tobacco control programmes reported from various countries were strongly dependant on support from the key stakeholders which comprised of individuals, groups, governmental, non-governmental organizations, and international organizations. Besides, the political wills and availability of resources became an important consideration when planning for an effective tobacco control program (Chollat-Traquet, 1996). The application of health planning theories in selected World Bank Income countries group across the continent will be further discussed in this review.

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1.3 Research Question

What are the planning theories used in planning tobacco control programme across continents?

1.4 Aim of Research

To identify and elaborate on the application of planning theories in tobacco control programs within several countries across the continents based on the level of a country's economic development.

2.0 Materials and Methods

Using online databases, a scoping review was done by selecting the three commonly used planning theories which are rational planning theory, incrementalism, planning theory and mixed-scanning theory. Relevant countries that transcended across each of the six continents were selected based on the level of development by WHO namely high income, middle income and low income and countries that showed high and low prevalence on tobacco consumption reported by WHO. Search for articles were conducted via four major databases including Scopus, Science Direct, Google Scholar, and PubMed. Other articles retrieved from grey literature include WHO world report on tobacco control programs, government documents and policies related to tobacco control, Ministry of health guidelines and expert panel report on health planning programmes. Keywords used for this search exercise were “planning theories” and “tobacco control program planning” Aspects of planning tobacco control programmes in a particular country as well as the theory used were explored. Countries with unavailable data were excluded. Only articles written in English and original articles were included in this paper.

3.0 Result and Discussion

The process involved in tobacco planning programs across continents represented by seven high, low and middle income countries namely Australia, Canada, Malaysia, Turkey, Brazil, Sierra Leone and Haiti have been tabulated in Table 1 based on the characteristics of three main planning theories, which are rationalism, incrementalism and mixed-scanning.

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Table 1 - Planning characteristics on tobacco control programme in selected countries

Planning characteristics*	Country						
	AUS	CAN	TUR	BRA	MAS	LEO	HAI
Identification of root problem	x	x	x	x	x		
Determining program objective	x	x	x	x	x		
Considering all alternatives	x	x	x	x			
Evaluation of alternatives	x	x		x	x		
Improve existing policy	x		x		x	x	x
Shorter duration					x	x	x
Longer duration	x	x	x	x			
Realistic policy alternatives						x	x
Situational-based decision	x			x	x	x	
Best approach decision		x					

*based on planning characteristics described by Berry, 1974 and Lee, 1979

Legend:
AUS - Australia
CAN - Canada
TUR - Turkey
BRA - Brazil
MAS - Malaysia
LEO - Sierra Leone
HAI - Haiti

In this article, the application of health planning theories in tobacco control programme across continents will be discussed based on the three dimensions of tobacco control policy adopted by the Brazilian healthcare system, namely power, economic and dimension of social (Portes, 2018). The dimensions of power incorporate the role of players (actors or stakeholders), strategies and institutionalizing policies that was adopted to support the tobacco control policies. Economic dimension concerns the tobacco economy sectors and its industrial environment and social dimension on the other hand refers to health as a right for the population and its health consequences. In exploring the health planning theories and practices, the interaction between these dimensions incorporate the relationship between the country's economic development and its unique capacity, local epidemiology issues and challenges, government policies and priorities, population structure, and effectiveness of the policies (Yogarabindranath, 2016; Banks, 2017).

3.1 Application of Planning Theories

3.1.1 High Income Countries

Tobacco control remains a big challenge for policy and programme development in HIC and has been identified as an unsettled achievement in a public health arena. Canada has no exception in this issue as smoking is still the top preventable cause of premature mortality (WHO TobReg, 2005). About 1 in 5 Canadians (20%) were smokers according to the Canadian Tobacco Use Monitoring Survey 2004 which adds up to around 5 million of them. Since the 1980s, Canada has adopted a more comprehensive approach in implementing the tobacco control programme which incorporates continuous NGOs engagement in the legislation, enforcement, promotions and community participation supported by taxation policies. In 1999, the *National Strategy on Tobacco Control* was adopted by the federal and state governments in collaboration with NGOs. The strategy has since been reviewed in 2001 through the *Federal Tobacco Control Strategy* which emphasized on four mutually reinforcing elements of protection, prevention, cessation and harm reduction. The incremental approach was applied to complement the national strategy which was more specific. In 2004, Canada ratified the WHO FCTC after playing their active role in developing the tobacco policies.

In Australia, the government's initiative to regulate tobacco-related activities started in the early 1970s, by enforcing mandatory health warnings on all cigarette packets. Using rationalism, the government started to upstream its many activities tailored to reducing the rate of tobacco usage for the next 20 years by introducing bans on all cigarette advertising, increasing tobacco excise and also phased-in smoking bans at workplace and public places which led to the enactment of the *Tobacco Advertising Prohibition Act* in 1992 (Department of Health Australia, 2018). Following the FCTC, a main national coordinating mechanism for tobacco control, the National Tobacco Strategy 2004 -2009 was developed outlining priority areas and key strategies.

The tobacco control programme in Canada has commenced and is being practiced since the late 1980s by the introduction of the US Family Smoking Prevention and Tobacco Control Act, prior to the FCTC initiated by WHO (Lenchucha, 2018). This initiative adopted the components of the rationalism during its development which incorporate the situational analysis of the current tobacco issues, problems and consequences of all available options identified from multi-stakeholder, and selecting the optimum rational decision. Since 1986, a more comprehensive approach was adopted through implementing a series of tobacco control strategies encompassing policy development, legislation and regulations, enforcement, mass media campaigns, community action, capacity building and public education, supported by robust taxation policies. In line with the WHO FCTC initiated in 2003, these strategies were then revised, improved and implemented by the federal and state governments, in collaboration with non-governmental organizations (NGOs) (WHO, 2005). Subsequently, the act was revised and improved in line with the dynamic issues of prevalence trending, population dynamics, resource scarcity and revenue generation, Bill C-32 has been introduced in 2009 to amend the tobacco act and it was the first legislation in the world to control flavoured tobacco products. It provides an important case to examine the factors and circumstances that helped propel flavoured tobacco products onto the policy agenda and ultimately led to the adoption of legislation to control these products.

Apart from historical policies and legislation development, economic dimension of planning theories was interpreted by the level of effectiveness or policy outcome. The effectiveness of tobacco control policies is influenced by these four main factors: (a) the development of tobacco control policies due to poor law enforcement, (b) the failure of retailers to comply with the law, (c) the social availability of cigarettes to teenagers, and (d) easy availability of cheap, smuggled cigarettes (Tohid, 2012). As expected from HIC such as Australia and Canada, better policy outcome was observed. In a highly populated country, about 24.5 million populations in Australia and 36.7 million populations in Canada, low tobacco prevalence were reported in both countries, estimated at 16.7% and 17.6% respectively (WHO GHO, 2015; The World Bank 2018). This achievement reflected the effective tobacco control policies, compared to other lower income countries, due to better resource capacity to carry out MPOWER measures outlined by WHO FCTC mostly from the promotion activities, comprehensive advertisement, taxation and price policy enforcement (Anderson, 2016). The evolution of the tobacco control programmes and practices within Canada demonstrated the application of the planning continuum by which the different planning characteristics utilized from the period from 1980s until 2009.

In terms of country's specific capacity, both Canada and Australia have higher government expenditure on health, estimated at 8.8-10.4% of GDP per capita spent on the health sector from 2013 to 2015. Compared to other lower income countries, higher commitment was illustrated from the government to combat the health issues and improve the population health status in general (Anderson, 2016). With regards to the government structure and political decision, Canada practiced the consolidated central government that adopted more comprehensive and multisectoral approach in the policy and programme development (The World Bank, 2018; WHO TobReg 2005), and similar structure was observed in Australia.

In summary, both Canada and Australia applied a comprehensive planning approach in developing policies for tobacco control programmes. The planning components incorporated problem identification and agenda setting through multi stakeholders input, from all possible alternatives with its consequences, and set up the best option for the country. The rationalism theory was observed during programme development in these countries, however the incrementalism theory could be seen as a better option alongside the country's development to counteract the potential policy issues such as local epidemiological transition, shifting perception among the public, shift in power distribution and political involvement. On top of that, mixed-scanning theory is the way forward to overcome each other's shortcomings by combining higher-order with fundamental policy-making processes with incremental ones.

3.1.2 Middle Income Countries (MIC)

In this section, the application of planning theories in tobacco control programme among three MIC countries which are Malaysia, Turkey and Brazil are entailed. In Malaysia, the tobacco programme planning started with the identification of the root problem. In 1970's, the tobacco control initiative was preceded by the first study done on prevalence of smoking among Malaysia's subpopulation (Institute for Public Health [IPH], 2011). By identifying all the alternatives to reduce smoking prevalence, the tobacco control program being carried out in stages. Starting in the 1970s, the banning of free tobacco, sponsorship, smoking in movies and smoking in health facilities, the establishment of tobacco advertisement health warning

on cigarette package, health promotion, and several other programmes were introduced in stages in following years until 1990s (IPH,2011). A less comprehensive planning which was done in shorter duration has led to lack of enforcement and poor implementation of the policies (Assunta & Chapman, 2004). However, after the ratification of Malaysia in FCTC, the existing policies have been improved and strengthened with support from various stakeholders (IPH,2011).

In Turkey, tobacco issues became more serious following the influx of tobacco products from outside countries as result of free market economy in the 1980s. This problem lead to the first prevalence study on tobacco use by Ministry of Health. Turkey had initiated their tobacco control program by identifying the root problems and proceeded with a comprehensive planning after gaining participation from various stakeholders which included the Ministry of Health, academicians, other governmental agencies, private sectors, media and interest groups (Bilir, 2017). Longer time taken was taken to implement the tobacco control programme in Turkey as laws on preventing harms of tobacco products had to be approved by their president in 1997 before being able to carry out smoking bans (Bilir, 2017). The process gained support from multiple agencies and involved comprehensive planning considering all factors which could contribute to the success and failure of the program. The effectiveness of tobacco control programme in Turkey has become an example for other countries at international level as it was the only country that was able to accomplish the highest performance for the six best buy measures proposed by WHO for tobacco control which are monitoring, smoke free policies, cessation program, warnings, advertising bans and taxation (MPOWER) in the year 2015. (WHO, 2015).

In Brazil, tobacco control program was initiated much earlier in the 1960s and evolved through the years driven mostly by continuous public policy analyses and involvement of political economics (Portes et al., 2018). The establishment of the national smoking program, national conference to fight tobacco and the advisory group for tobacco control has enabled Brazil to strengthen their tobacco control program since 1986. Various national bodies have been created to enhance support towards the tobacco control program in Brazil such as National Tobacco Control Committee (NTCC) and National Health Surveillance Agency. The ratification of Brazil in FCTC has enabled the tobacco control measures to be taken into higher levels with the establishment of National Tobacco Control Policy (NTCP) in 2006. Tobacco control remained a strong point of the national health policy throughout the second half of the 21st century in Brazil. The “Strategic Action Plan to Combat Chronic Non-Communicable Diseases in Brazil, 2011-2022” includes reducing the number of smokers as one of its targets, with measures that include surveillance, research and health promotion related to tobacco use (Portes et al., 2018). Generally, the tobacco control programmes in Brazil were quite comprehensive with involvement of various stakeholders, considering various alternatives with existence of national bodies for surveillance, emphasize on research and also ongoing health education besides improving the existing policies over time.

Generally, the applications of planning theories in MIC varies depending mainly on the economic and political support. Middle income countries (MIC) have been targeted by the tobacco industries as a platform to expand their business (Gilmore, Fooks, Drope, Bialous, &

Jackson, 2016). The economic and political manipulation by the tobacco industries are considered unavoidable where third parties might be used to interrupt the planning process of tobacco control programs. However, some MIC have shown great performance by being able to carry out tobacco control programmes successfully even before being ratified in FCTC, as shown by Turkey and Brazil.

Malaysia's population in 2015 was almost 31 million with gross domestic product (GDP) of 297 billion whereby 4% was dedicated for health expenditure (The World Bank, 2019). In comparison, Brazil's population was close to 210 million in 2016 with almost 2 trillion USD GDP having 8.7 % allocated for health expenditure. Turkey population was close to 80 million, a GDP of 860 billion with 4.1% allocated for health expenditure in the year 2015 (The World Bank, 2019). Brazil and Turkey has a larger population and stronger economics in term of GDP as compared to Malaysia. In terms of tobacco programmes, all three countries had carried out most of the MPOWER measures. Looking at the trend of current smoking among person aged 15 years old and above, Brazil showed reduction from 24% in 2000 to 14.9% in 2015 as well as Turkey which was 59.6% in 2000 and reduced to 42.7% in 2015 (WHO,2018). However, in Malaysia, due to poor surveillance system, the data available was not accurate enough to be compared with both the countries as different age classification was used in their survey.

Malaysia depends very much on the ministry of health as its main key player (IPH,2011) in carrying out tobacco control programs whilst struggling to gain more political involvement. Turkey and Brazil on the other hand were able to get collective support especially from politicians to ensure the success of their programmes. Besides, a stronger economic built, additional integrity among politicians and support from various stakeholders in the latter can prevent interference from tobacco industries (Bilir, 2017) leading to a more comprehensive approach being applied during planning of tobacco control programmes. In Malaysia, strong influence from tobacco industries has led to ineffective and failure of the programme (Assunta & Chapman, 2004). Limitations in certain areas especially economic and political will preventes more detailed planning leading to weak policy implementation.

3.1.3 Low Income Countries (LIC)

Globally, 80% out of the 1 billion smokers estimated in 2015, were living in low and middle income countries (WHO, 2015). In LIC, planning, development and implementation of tobacco control activities are difficult as a result of limited resource capacity, little access to education, prevention and assistance (Anderson, 2016; Hipple, 2018). Due to these given reasons, Haiti, as one of the LIC within the continent of North America, has not signed the WHO FCTC and is progressing at a very slow pace in planning for tobacco-related issues. In contrast, Sierra Leone, as part of the African continent with similar level of economic development, has allocated a substantial amount of GDP towards health (18.3%). However, due to different priorities the funding has been channeled towards communicable disease. Although they adopted the WHO FCTC in 2009, no policies or programmes were in place

until of recent in 2018 where they developed the National Tobacco Control Strategic Plan 2018-2022.

With an estimated population of 10.9 million (World Bank, 2018), the tobacco control program remains a great challenge for Haiti, characterized by small country resources with 6-7% of GDP spending per capita on health (WHO 2017), with moderate to high prevalence of tobacco consumption trend latest reported at 22.1% among males aged 15 years and older in the country (WHO 2015). The tobacco control efforts in the Caribbean Community (CARICOM) are progressing at a very slow pace even so for Haiti being the only CARICOM not party of the WHO Framework Convention on Tobacco Control (FCTC) (PAHO, 2018). From 2009 to 2011, CARICOM through its regional meeting issued a statement specifically affirming their commitment to addressing the burden of NCDs including initiatives to discourage tobacco use, and urged the community's commitment to pursuing an agenda that placed emphasis on the NCDs and the risk factors in terms of tobacco use, diet, physical inactivity and inappropriate alcohol use. From 2016 to 2017, they acknowledged that the progress made was variable and agreed to adopt a more holistic approach. They pledged to address issues such as the banning of smoking in public places. According to the WHO report on the global tobacco epidemic 2017, Haiti has no specific government objectives in tobacco control with very limited capacity in terms of manpower, even though the national agency or technical unit for tobacco control was established (WHO, 2017). In relation with the MPOWER structure, Haiti focused only on the component of tax implementation which is 35.1% of retail price of tobacco products, apart from others (Tobacco Atlas, 2019). However, there was no explicit retrievable evidence on the planning components in term of monitoring process, policies on smoke-free environments, tobacco cessation programme, mass media campaigns and promotion or advertisement.

In line with the increasing trend of tobacco prevalence which is about 60% out of overall population, better strategies were observed in Sierra Leone. The government has specific objective towards tobacco control in the country, by which it has incrementally set up a National Tobacco Control Strategic Plan 2018-2022 that is approved by the Ministry of Health and ran warning about the dangers of tobacco to the population at large, following the comprehensive approach set by the WHO FCTC. Apart from tobacco regulations, the government allocated better resources to promote health prevention including tobacco related activities (WHO GHO, 2015).

The application of the tobacco control program in both countries followed the incrementalisme theory. Haiti only adopted part of the MPOWER measures, which was enforcement on tax regulation, as resource limitation was an obstacle. In Sierra Leone, the program is constructed based on the WHO's comprehensive plan that has been laid out for member countries to follow but however the application is done stepwise depending on the priorities set by the country and the feasibility in terms of manpower, finance and strong political will. Based on the available data on planning practices towards tobacco control programme practiced by most CARICOM countries, the rationalism and mixed-scanning approach were demonstrated, according to the WHO FCTC framework, excluding Haiti. The incrementalism approach was observed in Haiti due to limited country capacity to adopt the WHO FCTC framework and different health priorities towards public health intervention.

4.0 Conclusion and Recommendation

As the use of tobacco has declined in high-income countries, the tobacco industry has increasingly turned to low- and middle-income countries, particularly in Africa, Asia, and Eastern Europe, to recruit new users. Dependent upon the market for allocation and distribution of health resources leads to limited experience of the health industry in health programme planning. Planning theorist usually highlight the inadequacies of other theories and present his as the best. Instead of dismissing a particular theory, it is better to explore the potential of adapting the strategy rather than hiding behind its inadequacies. The application of health planning theories in tobacco control program may differ depending on the internal and external factors that influence the planning process mainly the economic factors, political factors and support from key players.

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Author's Contribution

Authors 1 – 3: Data collection and manuscript preparation

Author 4 : Initiation of idea and final manuscript editing

References

Anderson, C. L., Becher, H., & Winkler, V. (2016). Tobacco Control Progress in Low and Middle Income Countries in Comparison to High Income Countries. *International journal of environmental research and public health*, *13*(10), 1039. doi:10.3390/ijerph13101039

Assunta, M. (2004, 12). The tobacco industry's accounts of refining indirect tobacco advertising in Malaysia. *Tobacco Control*,*13*(Suppl_2), Ii63-Ii70. doi:10.1136/tc.2004.008987

Australian Council on smoking and health, (2018). Autralian tobacco control legislation https://www.acosh.org/law-policy/australian-tobacco-control-legislation/

Banks, C., Rawaf, S., & Hassounah, S. (2017). Factors influencing the tobacco control policy process in Egypt and Iran: a scoping review. *Global health research and policy*, *2*, 19. doi:10.1186/s41256-017-0039-6

Bekker, M. P. M., Putters, K., & Van Der Grinten, T. E. D. (2004). Exploring the relation between evidence and decision-making: A political-administrative approach to health impact assessment. Environmental Impact Assessment Review, 24(2), 139–149. https://doi.org/10.1016/j.eiar.2003.10.004

Berry,David. (1974). The Transfer of Planning Theories to Health Planning Practice, *5*, 343–361.

Bilir, N. (2017, 11). Successes and Challenges in Tobacco Control–Turkish Experience of 20 Years. *Eurasian Journal of Pulmonology*,*19*(3), 119-123. doi:10.5152/ejp.2017.75047

Chollat-Traquet, C. (1996) Evaluating Tobacco Control Activities: Experience and Guiding Principles. World Health Organisation, Geneva

Etzioni, A. (1967). "Mixed-Scanning: A 'Third' Approach to Decision-Making," Public Administration Review, 27(5).

Gilmore, A. B., Fooks, G., Drope, J., Bialous, S. A., & Jackson, R. R. (2016). Exposing and addressing tobacco industry in low and middle income countries, *385*(9972), 1029–1043. https://doi.org/10.1016/S0140-6736(15)60312-

Hipple Walters, B., Petrea, I., & Lando, H. (2018). Tobacco Control in Low- and Middle-Income Countries: Changing the Present to Help the Future. Journal of Smoking Cessation, 13(4), 187–188. https://doi.org/10.1017/jsc.2018.4

Hogarth J.(1975). Glossary of health care terminology. Copenhagen, World Health Organization, Regional Office for Europe,http://whqlibdoc.who.int/publications/9290201231.pdf

Institute for Public Health [IPH].(2011). Report of the Global Adult Tobacco Survey (GATS) Malaysia, Ministry of Health Malaysia, 2012.

Lee, K. (1979). HEALTH Planning , policies , and incentives, 482–490.

Lindblom, Charles E. (1968) The Policy-Making Process, Englewood Cliffs, New Jersey: Prentice Hall.Lindblom, Charles E., "The Science of Muddling Through," Public Administration Review (Spring 1959), pp. 79-88.

Opening windows and closing gaps: a case analysis of Canada's 2009 tobacco additives ban and its policy lessons. (2018). Lenchucha et al., BMC Public Health, 18:1321. https://doi.org/10.1186/s12889-018-6157-3

Portes, Leonardo Henriques, Machado, Cristiani Vieira, Turci, Silvana Rubano Barretto, Figueiredo, Valeska Carvalho, Cavalcante, Tânia Maria, & Silva, Vera Luiza da Costa

e. (2018). Tobacco Control Policies in Brazil: a 30-year assessment. *Ciência & Saúde Coletiva*, *23*(6), 1837-1848. https://dx.doi.org/10.1590/1413-81232018236.05202018

Portes, L. H., Machado, C. V., Turci, S. R., Figueiredo, V. C., Cavalcante, T. M., & Vera Luiza Da Costa E Silva. (2018, 06). A Política de Controle do Tabaco no Brasil: Um balanço de 30 anos. *Ciência & Saúde Coletiva*, *23*(6), 1837-1848. doi:10.1590/1413-81232018236.05202018

Swarna Nantha, Yogarabindranath. (2016). A Review of Smoking Research In Malaysia. The Medical journal of Malaysia. 71. 29-41.

The World Bank Group. (2019). *Data Malaysia*. Retrieved from https://data.worldbank.org/country/malaysia

The World Bank Group. (2019). *Data Turkey*. Retrieved from https://data.worldbank.org/country/turkey?view=chart

Tohid H, Ishak NM, Muhammad NA, Ahmad FNM, Aziz AEA, Omar K. Perceived effects of the Malaysian national tobacco control programme on adolescent smoking cessation: A qualitative study. Malaysian J Med Sci 2012; 19(4): 35-47.

Wipfli, H., Stillman, F., Tamplin, S., Luiza, V., Yach, D., & Samet, J. (2004). Achieving the Framework Convention on Tobacco Control' s potential by investing in national capacity, 433–437. https://doi.org/10.1136/tc.2003.006106

World Health Organization [WHO].(2003) WHO Framework Convention on Tobacco Control. Geneva: WHO

World Health Organization. (2013). *MPOWER in Action: Defeating the global tobacco epidemic*. Retrieved from https://www.who.int/tobacco/mpower/publications/mpower_2013.pdf?ua=1

World Health Organizations [WHO],(2015). Tobacco Free Initiative: Tobacco Control in Turkey. Retrieved from https://www.who.int/tobacco/about/partners/bloomberg/tur/en/

World Health Organizations. (2018). WHO global report on trends in prevalence of tobacco smoking 2000-2025. 2nd Edition. Geneva: the World Health Organization.

World Health Organizations [WHO](2018). Advancing Implementation of the WHO FCTC in the Caribbean Community, (August), 1–6.

World Health Organizations [WHO] (2018). FCTC progress report.https://untobaccocontrol.org/impldb/australia/

World Health Organizations [WHO],(2018). Tobacco Free Initiative: WHO global report on trends in prevalence of tobacco smoking 2000-2025. Retrieved from https://www.who.int/tobacco/publications/surveillance/WHO-global-report-trends-prevalence-tobacco-smoking-annex-2.pdf?ua=1