AGENDA SETTING AND POWER IN POLICY MAKING: A CASE STUDY OF TOBACCO POLICY IN DEVELOPING COUNTRIES

Abdul Mu’eez A. S.¹, Arifah A.R.¹, Azreena M.B.¹, Farahana M.P.¹, Mustafa A.D.¹, Muhamad Hanafiah Juni²*

¹Master in Public Health Candidates, Department of Community Health, Faculty of Medicine, University Putra Malaysia.
²Department of Community Health, Faculty of Medicine, University Putra Malaysia

*Corresponding author: Muhamad Hanafiah Juni
Email: hanafiah_juni@upm.edu.my

ABSTRACT

Background: Agenda-setting is an important component of the policy making process where the roles of power involved influence the resulting agenda. The aim of this paper is to analyse agenda-setting and the roles of power using tobacco control policy in developing countries as a case study.

Materials and Methods: Scoping review method was adopted with articles identified using Scopus, Google Scholar, PubMed and ScienceDirect databases using the keywords “agenda setting”, “power”, “policy making process” and “tobacco control policy”. Only articles published in English within the last 15 years were included. Final 15 articles were reviewed.

Results and Discussion: Prioritization of public health impacts of tobacco control versus its economic contributions is complicated in developing countries. State actors have their own agenda with influence from international actors. Power is exerted by actors in different ways and determines whether problems will be prioritized to become agenda. The decision makers exercise power by authority, coercion and by influencing national, state and non-state actors in decisions made. The power of non-decision-making actors takes the role of influencing and lobbying the decision makers in favour of their own agenda. The agenda-setting phase is important in paving the way for policy formulation. Lessons learned from the case study of tobacco control policy are firstly, leadership of governments hold the power in setting the agenda, secondly, cooperation between tobacco control advocates can ensure success and thirdly, it is important to understand the interfering role of Transnational Tobacco Companies.

Conclusion: Agenda-setting determines issues to be considered by government. The roles of power by various actors can be seen influencing the agenda-setting process of tobacco control policy.

Keywords: “agenda setting”, “power”, “policy making process”, “tobacco control policy”
1.0 Introduction

Tobacco control has increasingly been a global policy concern in most developed as well as developing countries. This is evidently so, due to the disturbing epidemiological pattern of morbidity and mortality from tobacco smoking. Hence, understanding the process of tobacco control policy making will contribute to the improvement of tobacco control in many countries involving various stakeholders. In addition, agenda setting as part of the policy making process and recognition of the roles of power contributes in setting the initial direction of the policy.

1.1 Tobacco Epidemic in Developing Countries

The significant harms of tobacco use in developing countries are usually primarily understood as an alarming crucial health issue. Historically, there were about 100 million deaths from tobacco in the 20th century, most in developed countries. Based on recent smoking patterns, with a global average of about 50% of young men and 10% of young women becoming smokers and relatively few stopping, annual tobacco-attributable deaths are projected to rise from about 5 million in 2010 to more than 10 million in the coming following decades, as young smokers of today reach middle and old age (Jha & Peto, 2014). If current smoking patterns persist, tobacco will kill about 1 billion people this century, mostly in low- and middle-income countries. About half of these deaths will occur before 70 years of age. For the age group 30 to 70 years of age, The World Health Organisation (WHO) has also called for countries worldwide to achieve a 25% decrease between 2008 and 2025 in the probability of dying from non-communicable disease which includes reduction of tobacco smoking (Jha & Peto, 2014).

About 1.3 billion people worldwide now smoke, most in low- and middle-income countries where cessation is uncommon (Jha & Peto, 2014). Two thirds of all smokers live (in descending order of numbers of smokers) in China, India, the European Union (in which central tobacco legislation can influence 28 countries), Indonesia, the United States, Russia, Japan, Brazil, Bangladesh, and Pakistan. In India, manufactured cigarettes are now displacing bidis (Jha & Peto, 2014). Cigarette consumption in China continues to rise sharply and now accounts for more than 2 trillion of a global total of about 6 trillion cigarettes smoked per year (Jha & Peto, 2014). Tobacco already accounts for about 12 to 25% of deaths among men in low- and middle-income countries such as China, India, Bangladesh, and South Africa and given current smoking patterns, these proportions are likely to increase (Jha & Peto, 2014). The shift of tobacco epidemic to the developing world will lead to unprecedented levels of disease and early death in developing countries where population growth and the potential for increased tobacco use are among the highest and where health promotion and prompt services are least available.

1.2 Tobacco Control Policy

The latest WHO report on the global tobacco epidemic published in 2017 finds that more countries have implemented tobacco control policies, ranging from graphic pack warnings and advertising bans to no smoking areas. About 63% of the world’s population (4.7 billion people) are covered by at least one comprehensive tobacco control measure, which has quadrupled since 2007 when only 15% of the world’s population were covered.
Implementations of such policies have saved millions of people from early death (WHO, 2017).

Tobacco control is a development issue and its success relies on the work of other sectors such as commerce, trade, finance, justice and education. Consequently, in respond to the multisector factor mentioned, the international community agreed to include the implementation of the WHO FCTC in the UN’s new Sustainable Development Goals 2030 (SDGs) (WHO, 2018). The Agenda includes targets to strengthen national implementation of the WHO FCTC and a one third reduction in premature deaths from NCDs, including heart and lung diseases, cancer and diabetes. This is especially so since tobacco use is a leading common risk factor for NCDs which kill 40 million people each year, equivalent to 70% of all deaths globally, including 15 million people aged between 30 and 69 years. Over 80% of these "premature" deaths occur in low- and middle-income countries (WHO, 2017).

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first treaty negotiated under the auspices of the World Health Organization. The WHO FCTC opened for signature on 16 June to 22 June 2003 in Geneva, and thereafter at the United Nations Headquarters in New York, the Depositary of the treaty, from 30 June 2003 to 29 June 2004. The treaty, which is now closed for signature, has 168 Signatories, including the European Community, which makes it one of the most widely embraced treaties in UN history (WHO, 2017a). The Convention entered into force on 27 February 2005 which was 90 days after it had been consented to be ratified, accepted, or approved by 40 States (WHO, 2017).

The establishment of MPOWER package in 2008 was later introduced to assist in implementation of the WHO FCTC at the level of countries. Each measure reflects one or more of the demand reduction provisions of the WHO FCTC. Governmental action on tobacco control strategies are assisted, in-line with the WHO FCTC to monitor tobacco use and prevention policies. MPOWER measures include protecting people from tobacco smoke, offering help to quit tobacco use, warning people about the dangers of tobacco, enforcing bans on tobacco advertising, promotion and sponsorship and raising taxes on tobacco (WHO, 2017). Nearly two thirds of countries (121 of 194) comprising 63% of the world’s populations have introduced at least one MPOWER measure at the highest level of achievement (WHO, 2017).

1.3 Agenda Setting and Power in Policy Making

The development of any policy, including tobacco control policy, generally goes through a cycle of policy making process. There are 3 phases in policy making process which is agenda phase, decision phase and implementation phase. Under policy process, it starts with problem identification, policy formulation, followed by policy implementation and policy evaluation.

Multiple issues can be arising by initiators either from government, individual, politician, interest groups, pressure groups or Non-Governmental Organizations (NGOs). Issues also can be identified through publicized demands for government action. These issues will be discussed and debated through multiple processes such as lobbying, negotiation and advocacy. Once issues get the attention of government official, the policy issue will become a policy agenda and subsequently will go through sequence of policy formulation process. Under policy framework, policy formulation has primary linkage with constituency building.
and resource mobilization before the policy can be implemented and finally to be evaluated. Constituency-building refers to activities aimed at strengthening the involvement of those most affected by the issue and leadership of advocacy to build their knowledge, capacity and agency so that they can effectively participate in the policy making.

**Figure 1.0: Policy Agenda in Policy Framework**

Agenda setting is a process of identifying policy issues or problems, which requires the attention of a legislator. It is a process which certain issues come onto the policy agenda from the much larger number of issues potentially worthy of attention by policy makers. The setting of the policy agenda allows a legislator to become sensitized to some of the critical policy requirements that affect society. Public problem will reach political agenda when it is converted into political issue. Prioritization in public health policy usually will be conducted at central level and local issues sometimes tend to be ignored. Global priorities such as the Millennium Development Goals or the WHO FCT, for example, often take precedence even over national determination or need.

During policy making process, power manifest in various way. Power is defined as the ability to influence, and in particular to control resources. Power is also described as those who make and implement the policy. Three main sources of power can be divided into three major components including government, technical aspect such as expertise, evidence and technologies and also funding resources. Government primarily play major roles in policy making process. Government has the capability to influence local, state and national policy legislation. Communities including NGOs will influence through engagement in community activities such as environmental care groups, child care group and many more.

The policy making process is an ongoing, frequent process that all countries go through at the global and international level. Agenda setting is a very important component that is part of the policy making process where the roles of power goes into play to influence the decision of an
agenda. The aim of this paper is to analyse agenda setting and power in policy making process using tobacco control policy in few developing countries as a case study.

### 2.0 Methodology

The methodological approach taken for this study involves a scoping review of articles according to several specified keywords. Four databases, PubMed, Google Scholar, Scopus and Science Direct, were utilised to determine relevant articles to be reviewed.

The keywords chosen “agenda setting”, “power”, “policy making process” and “tobacco control policy” were entered individually for each database. The criteria of articles included were original articles that were written only in English, written and published within the last 15 years and those related to agenda setting in tobacco control policy with roles of power explained.

Identification from initial database search generated a total of 108 articles. Duplicates of the same article which amounted to 18 articles were removed. From the 90 articles left, abstracts were reviewed for initial screening to check for the relevancy of the articles. From here, another 60 articles were removed. Then, full-text articles were carefully assessed for eligibility.

Subsequently, after reading the full-texts of the remaining 30 articles, only 15 articles were included in this review. The PRISMA diagram of the review as shown in Figure 1 explains the scoping review methodology and the numbers of resulting articles identified.

The remaining 15 articles subsequently were reviewed using a framework base on the categories of power that is power as decision making via authority and coercion and power as non-decision making. The countries that emerged were discussed according to this framework so as to get a richer and structured understanding of agenda-setting and roles of power in tobacco control policy making in developing countries.
Figure 1: PRISMA Diagram of the ‘Agenda Setting and Power in Policy Making: A Case Study of Tobacco Policy’ Scoping Review, adapted from Moher, Tetzlaff & Altman, The PRISMA Group (2009)
3.0 Results and Discussion

Agenda-setting and power are closely linked together in initiating the process of policy-making. For an issue to become an agenda that will be taken up by policy-makers, power plays a big part is pushing it forward at this stage. The roles of power played can often be the reason why an issue is taken up as an agenda. Understanding how issues are prioritised and the roles of power in the process is therefore crucial.

3.1 Issues and Prioritisation of Issues in Agenda Setting

Although the contemporary global health literature has increasingly recognized the role and influence of networked forms of health advocacy and policy-making, the 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. It is so important to understand these network and its effect positively or negatively on the tobacco control policy in the developing countries which are more prone to these effects (Gneiting, 2016).

Tobacco industry led an argument that the tobacco control policy is a developed countries issue, and it is not a developing countries problem, the industry claimed: “The first world, Anglo-Saxon and English speaking political economies, ... are fuelling the debate and in many cases driving the political agenda within the WHO. Most third world countries have other priorities but are not able to resist the pace, drive and political dynamics which are moving the FCTC forward.” To counter this statement, the Tobacco Free Initiative (TFI) tried to push developing countries to take a lead in the regional groups like Turkey, South Africa, India, and Iran. This led to increasing the tobacco-free activity within the developing countries (Lee, Chagas, & Novotny, 2010).

In most of the cases in the developing countries, the initiator of the changes which is the real pusher for tobacco control policy is WHO and a framework convention on tobacco control especially (FCTC). Developing countries want to prove their profile so the leaders with the public health scholar will push toward tobacco policy control. One of these examples is Turkey which has a great success in tobacco control policy, the country's desire for European Union accession pushed towards creating a political environment prone to control and against tobacco. Different but connected groups work together with help from regional friends and support of highest political leaders of the country led to a success story. This shows that the global-agenda setting activities is a cornerstone of political priority development (Hoe, Rodriguez, Üzümcüoğlu, & Hyder, 2016).

India has a larger number of smokers with involvement of complicated actors. In India there are more than 250 million tobacco product users making India the second biggest market for tobacco products. Around 16% use local cigarettes and 26% of the users use bidi which is a low quality very cheap local tobacco cigarette produced by both large and small companies. The last proportion is 58% who use smokeless tobacco. Bidi is a small cigarette or mini-cigar packed with tobacco flake and usually wrapped in a leaf of certain tree attached with a string or adhesive at one end. It arises from India. Due to its composition, there is a chance that it has more bad effects on health compared with other tobacco products. More than 25% of tobacco product users in India are using bidi which produced by a mixture of big companies and home industry manufacturing (Sankaran & Hiilamo, 2016).
The conflict in India was among several parties, the tobacco companies’ international and local, small and large. All tobacco product companies’ cigarettes, bidi, and smokeless tobacco from one side, and on the other side is the health group, scholars, and government. The conflict was about graphical health warning labels (GHWL). The friction between the cigarette and bidi (beedi) industries started with the GHWLs. The bidi companies pressured the Indian government aggressively to exclude bidis from the new laws being formulated concerning GHWLs, so they will be able sell their products more freely. On the other hand, cigarette industry pressed the Indian government to put GHWLs on bidis and smokeless tobacco products too. So, after the cigarette companies, accepting the fact that they will have to add GHWLs to their products; they interestingly started lobbying the government so that the bidis and smokeless tobacco have to follow the same regulations. This helps the NGOs because they push for the same direction adding the GHWLs to all tobacco product (Sankaran & Hiiilamo, 2016).

The complex interplay was between the government and the cigarette and bidi industries, who have shared as well as conflicting interests. Joint lobbying by national-level tobacco companies and local producers of other forms of tobacco blocked GHWLs for decades and delayed the implementation of effective GHWLs after they were mandated in 2007. Tobacco control activists used public interest lawsuits and the Right to Information Act to win government implementation of GHWLs on cigarette, bidi and smokeless tobacco packs in May 2009 and rotating GHWLs in December 2011 (Sankaran & Hiiilamo, 2016). One of the important lessons from India is the presence of bidi and cigarettes together leads to complex agenda setting environment. As a developing country with high rates of other forms of tobacco use establish and enforce graphical health warning labels (GHWL) laws, the tobacco control advocacy community can use pressure on the multinational cigarette industry as an indirect tool to power the policy and regulations to be used as agenda setting on other forms of tobacco (Sankaran & Hiiilamo, 2016).

Generally, three main tobacco industry arguments used against all forms of tobacco control policy; firstly, it will stand up for small businesses and defend those employed in the tobacco sector. Secondly, tobacco control measures will result in a rise in the illicit trade of tobacco. Lastly, tobacco control measures are/will be ineffective. By these arguments, they try to push the tobacco policy out of agenda setting by trying to affect the media, the policy maker, and other actors. These legal ways to support their own benefits will not always stay legal especially in developing counties which have less transparency (Lencucha, Drope, & Labonte, 2016).

In Thailand, the effect of a small group of people and how their commitments, their organizing work, and advocacy against the tobacco were the reason for putting the tobacco control policy on the agenda. They mobilized the media and social support, defined the rules of engagement and pushed persistently for a stronger legislation to be the priority in the agenda setting. The transnational tobacco companies (TTCs) refusal to let them engage the tobacco policy control and fighting back was clear-eyed understanding for them. The transnational tobacco companies were willing to use and methods to get their objectives, this group of actor noticed that the TTCs used bribery, fraud, slander, harassment, and beside the legal actions and legal interference (Charoenca et al., 2012).
The following two examples, Vietnam and China, are unique in nature because they are from countries with one-party dominated political system. In Vietnam, the key players in tobacco control policy are the Ministry of Health, Ministry of Finance, and The Ministry of Trade and Industry. They have competing interests over health macro-economy and revenue. However, the high official of the Communist Party and National Assembly members take a relaxed position against tobacco. These relax positions show the low political stakes-placed on tobacco problems since the state tobacco industry is an important contributor to government revenue and GDP. Here the political system of one-party regime put his print, the MOH showed reluctant towards the tobacco control programs and revealing mixture attitudes. In conclusion, the government-ownership of tobacco industry raises a big controversy within the state. The paradox is that the government benefits from producing of tobacco and at the same time responsible for controlling tobacco consumption. The focus on the short-term economic benefits and reluctance to face the health issue means that the tobacco control failed to secure itself a position on priority policy agenda (Higashi, Khuong, Ngo, & Hill, 2011).

The second example is from China, a one party dominated political country too. With 1.2 million people dying from smoking annually, the People's Republic of China is the world's largest consumer and producer of tobacco (Stone & Zhou, 2016). The tobacco control is slowed by the circumstance that the tobacco industry is a strong government-owned monopoly that contributes, via its membership of key government bodies, in overseeing the implementation of tobacco control policies. The conflict between the government's two responsibilities for both the production of tobacco and responsibility to implement the tobacco control brings internal contradictions and bias within the government body. This conflict is clear even in the official government newspaper People’s Daily framing and agenda setting. Framing for tobacco-related subjects is positive toward tobacco industry and tobacco control but negative toward tobacco smoking in China. While the policy-oriented newspaper system indicates that the reports on tobacco-related issues will follow the will of the central government and be authoritarian (Lin, 2014).

As a major global power, there are other factors that play major roles in China scenario and complicate the scene. As a major power in the globe, it is important to be seen as a responsible power, sovereignty-related issue, and the domestic political economy. These are sets of factors that shape Chine’s agenda-setting and negation of tobacco control on an international level. While sovereignty interests will remain a major aspect of China’s engagement in future international health negotiations about tobacco control, national economic policy issues have powerful potential to decide the path and discourse of such controversy (Huang, 2014).

It is clear that every country has its own agenda setting and prioritization. The conflict between the positive impact of the tobacco industry on the economy and long-run effects on health was the main issue that affects the agenda setting. However, economic development to international acceptance and relationship to sovereignty interests all is factors that affect the prioritization and how to arrange agenda settings. The effect of globalization is clear in this arena of tobacco control in both positive and negative effects, but the positive impact of globalization has more influence in tobacco control arena. In the success of Turkey, the country’s leadership had used the three categories of power well (authority, coercion and non-decision making) which led to the huge success in the agenda setting arena. While in India.
the case was who has more power to gain the struggle with less space for non-decision-making power, the authority power of winning the law suit changed the roles and enabled the pass the GHWLs. Lastly, in the unique political system of China, the coercion is the most prominent power in the arena which is used in agenda setting. The use of all categories of power (authority, coercion, and non-decision making) makes tobacco control policy more effective and help to make it as a priority in agenda setting.

3.2 Power and the Roles of Power in Agenda Setting

Decision making in the process of establishing tobacco control policy at the national level involved input of actor and stakeholders in favour of their personal interest or political process. It encompasses multiple stages of actors from international committee, national, state and non-government organization which act as lobbyist, pressure group or interest group. International actor is headed by World Health Organization through the introduction of Framework Convention on Tobacco Control (FCTC) (WHO, 2003). It’s the world’s first global health evidence base treaty. The signatories of this treaty would be legally bound to address tobacco used.

The national level involved policy makers to adhere to WHO legislation with influence of others ministries and NGO’s who acted as lobbyist, interest group and pressure group. For example, 1). 2011. India illustrates how joint lobbying by multinational tobacco companies and producers of local forms of tobacco blocked the implementation of Graphical Health warning Labels (GHWLs) for years, and how tobacco control advocates finally overcame this obstruction through court jurisdiction and the Public right to Information Act (Sankaran & Hiilamo, 2016). The process of regulating tobacco began in 1975 by suggesting the implementation of text warning labels on pack of cigarette but during that time, the government is more interest with tax revenue. In February 2004, India ratified the Framework Convention on Tobacco Control26 (FCTC), which committed India to implementing GHWLs by February 2008 whereby in article 11 specified the characteristic of GHWL (WHO, 2003). On 27 September 2012 8 years after FCTC rectification slowly GHWL can be seen appearing in the cigarette box. Using the same excuse of more time needed to be ready for implementing GHWL, the implication of unsuitable graphical display and economy disruption to lower society of tobacco workers seem legit to lobby the decision maker to delay the implementation. Furthermore, every major political party, including the ruling Congress Party and the major opposition party has been said to accepted money from ITC, totalling at least rupees 124 million ($2.2 million) between 2005 and 2011, and several members of the ITC board of directors held or had held government office (Sankaran & Hiilamo, 2016).

In Turkey, the first anti-tobacco legislation was brought and accepted by Grand National Assembly in 1991 after a countrywide prevalence study by Turkey’s Ministry of Health revealed that almost half of its population smoked. This staggering increment was regard as national crisis and awakened the tobacco control advocates. However, the elected president Turgut Ozal rejected the implementation through veto power as he argued that such restriction will violate free trade. This decision has then initiated the formation of national Coalition on Tobacco Control (SSUK) which consist physicians and academics who were highly educated, aware of international best practices, and possessed connections to the Turkish media and the global community of anti-tobacco advocates (Bilir, Çakır, Dağlı, Ergüder, & Önder, 2009).
Then SSUK became a formidable force against tobacco, which they also influence the ruling government in implementing anti-tobacco control agenda (Gneiting, 2016). During transformation of political stream in 2002, with the support of the newly elected President Tayyib Edorgan and Health Minister Dr Recep Adag who shows high interest in the issue, Turkey rectified FCTC in 2004 which make them among the earliest country to sign the treaty.

Meanwhile in China the idea of having a framework convention protocol for tobacco control originated from a group of academics and anti-tobacco activists. The movement did not gain momentum until receiving strong support from WHO Director- General Gro Harlem Brundtland in 1998. In May 1999, the World Health Assembly, WHO passed a resolution to establish an intergovernmental negotiating body (INB) to draft and negotiate a framework convention on tobacco control (WHA52.18). China was initially ambivalent to multilateral negotiation treaty limiting tobacco use since China is the world’s largest tobacco producer. But since 1990’s China wished to be redefine as a responsible power that is active in international affairs. On the other hand, China was concerned that the FCTC negotiation might undermine its sovereignty. Internally, because the tobacco industry was considered an important contributor to the state economy (Huang, 2014) but China’s deep aspirations and concerns underscored the importance for it to engage actively in the treaty-making process, so it participated in all six (INB) session.

China’s representatives to the intergovernmental negotiating body (INB) meetings consist mainly of MOH officials and representative from China’s STMA. Unlike its regulatory counterparts in other countries, STMA shares its management staff with the China National Tobacco Corporation (CNTC), a state-owned manufacturer of tobacco products and the world’s largest cigarette maker. This unique governance arrangement made STMA the de facto representative of China’s giant tobacco industry (Huang, 2014). The involvement of multiple agencies with differing functions made consensus building difficult for tobacco control policy making. STMA’s opinion which appears to be against tobacco control carried significant weight for Chinese delegation deliberation for the FCTC treaty. Eventually, the lack of solid Chinese support led to a less robust and more generic FCTC policy. The economic clout of the STMA/ CNTC have placed it in a strong position to lobby and influence policy in China. In 2002, the tobacco industry generated 8% of China’s annual fiscal revenue through taxation; in Yunan Province, the share was as high as 49%. In view of its important, STMA/CNTC was included as representative in INB as a representative of tobacco Company (Huang, 2014).

In developing tobacco control policy, the authority and power of decision making are on the shoulder of policy maker, in this case the “government” or “ruling party”. Through political system, the government convey the input from the citizen in form of arising issues and Public Health importance to implementation of tobacco policy as output. In developing country like China, Turkey, Brazil and India the government are responsible in decision making of adopting and implementing the FCTC framework, the decision making also influence by others who will benefit or affected by the implementation of the FCTC. The speed of adopting and implementing FCTC initiative are driven by their resources, priorities and in some situation “obligation”, for example accession countries in EU (European Union) increased their policies enactment through having to adhere to the acquisition of the EU as well as

through other processes. This “coercive policy transfer” of the accession process apparently acts to speed up policy learning, implementation and outcomes in accession countries (Studlar, Christensen, & Frisbee, 2009).

**Table 1:** Examples of Actors involved in Tobacco Control Policy in three developing countries

<table>
<thead>
<tr>
<th>Actors</th>
<th>India</th>
<th>Turkey</th>
<th>China</th>
</tr>
</thead>
<tbody>
<tr>
<td>International</td>
<td>WHO (FCTC)</td>
<td>1)Framework Convention Alliance (FCA)</td>
<td>WHO (FCTC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2)Bloomberg Philanthropies</td>
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<td></td>
<td></td>
<td>3)WHO Country Office</td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>1)The DUMA (parliament)</td>
<td>1)The President (Tayyip Erdogan)</td>
<td>1)Government (Central Committee of the Communist Party of China (CPC)</td>
</tr>
<tr>
<td></td>
<td>2)India Ministry of Health</td>
<td>2)Health Minister (Dr Recep Adag)</td>
<td>2)China MOH</td>
</tr>
<tr>
<td></td>
<td>3)India Ministry of Commerce</td>
<td>3)Head of Health Commission to Parliament (Dr. Cevdet Erdol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4)Ministry of External Affairs and Economic Development.</td>
<td>4)Justice and Development Party (AKP)</td>
<td></td>
</tr>
<tr>
<td>NGO</td>
<td>Pressure group: Voluntary Health Association of India (VHAI) National organization for Tobacco Eradication (NOTE) Lobbyist 1)India local bidies company 2)National institute of tobacco 3)Transnational tobacco company</td>
<td>Pressure group: 1)National Coalition on Tobacco Control (SSUK) 2) NGO Green Crescent “Yesilay”</td>
<td>Lobbyist: China’s STMA (State Tobacco Monopoly Administration)</td>
</tr>
</tbody>
</table>


It can be seen that power exert in many ways to influence anti-tobacco control policy. The decision makers exercise power by authority for example having control of resources and leadership like turkey, coercion by obligation to follow certain regulatory within the union in developing European country and influencing national, state and non-state actors in decisions made that hold the utmost benefit to all stakeholders. And the power of “non-decision-making actors” take the role of influencing and lobbying the decision makers in favour of their agenda as the role off TTC in many developing countries in influencing the implementation of tobacco control policy.

**3.3 From Agenda Setting to Policy Formulation**

Policy formulation is the growth of productive and acceptable action for conveying what has been stated on the policy agenda as well as involving the proposal of solutions to agenda issues. Senior managers will usually prepare policy recommendations which later given to higher authorities for further validation. It will still depend on the higher authorities to accept or decline any decisions related to policy recommendations though the decision made can be discussed again for further clarification (Fischer et al., 2007).
In the case of tobacco control, it can be seen that a lot of factors come into play and interact during the agenda setting phase and when an opportunity comes where all the factors come together the policy formulation then goes into decisional phase. For example, in Turkey, tobacco control became a political priority in Turkey as a result of the development and conjunction of multiple factors (Hoe et al., 2016). Firstly, the plight of smoking was brought into light by the WHO report in 2008 on the Global Tobacco Epidemic which revealed that Turkey along with nine other countries contributed to two-thirds of the world’s tobacco consumption. Adding to that is solutions brought forth by various tobacco control advocate groups in the country backed by evidence and eventually supported by a strong political will of its President Recep Tayyip Erdogan.

If the agenda-setting phase is not as positive as seen in the case of Turkey, the policy formulation that follows will may not be as successful. In China for example, due to the presence of conflicting interests of the government and actors from the TTC, the tobacco control policy formulation in China faced multiple hiccups which resulted in poor eventual implementation (Huang, 2014). Hence, the message conveyed here is the importance of the agenda-setting phase in paving the way for policy formulation especially in the case of tobacco control policy.

3.4 Lessons Learned

The most important lesson learned from the case of tobacco control policy-making process is understanding how leadership of governments in developing countries hold the power in setting the agenda of the policy. Power can be exercised in various ways to influence the outcome of the policy. It is important that responsibilities of the government in ensuring the goal of public health in tobacco control are not conflicted with any other interest of short-term economic benefits from the tobacco industry. Any averseness to tackle tobacco health related issues will result in the failure of tobacco control to take a priority on the policy agenda. This can be seen in the case of China (Huang, 2014) and Russia (Lunze et al., 2013) where both of these countries have a conflicting interest between tobacco control and tobacco trade which affected the speed of the resulting tobacco control policy-making phase. On the other hand, Turkey’s strong leadership paved the way to the success of the tobacco control policy in Turkey (Hoe, Rodriguez, Üzümcüoğlu, & Hyder, 2016).

Secondly, it is important for tobacco control advocates to form strong coalition of network to work together and assemble social support while gathering strong evidence against tobacco industries. Principles of engagement should be defined clearly, and strong legislation should be made part of the agenda. A case in point was what happened in Turkey (Hoe, Rodriguez, Üzümcüoğlu, & Hyder, 2016), where a revelation by Turkey’s Ministry of Health countrywide prevalence study that almost half of its population smoked pushed for the acceptance of its first anti-tobacco legislation nationally. The cooperation within the network of advocates eventually pushed for the success of the tobacco control policy in Turkey.

Another lesson learned which is as important is understanding the role of Transnational Tobacco Company (TTC) and its interference in the policy-making process to pursue its own economic self-interest. In many developing countries, TTC have shown how far they are willing to go ensure that their interest is protected and backed including using illegal means of making sure their profit-making goals are achieved at the expanse of the health of the public.
(Charoenca et al., 2012). Hence, policy-makers should be aware of the power that other actors such as TTC have in order to mitigate the affect and ensure that the policy can be implemented.

4.0 Conclusion

The process of agenda-setting often plays the critical role of determining what issues and alternatives are to be considered by any government to be further formulated and implemented. In the case of tobacco control policy, power of the actors involved in the policy making process plays a very huge part in influencing the direction of the policy whether it will be adopted or not. Actors can generally be seen in the context of international and national stakeholders seek to influence the creation and implementation of these public policy solutions. The roles of power can be seen influencing the agenda-setting process of tobacco control policy-making.

Acknowledgement

This manuscript is to fulfil the requirement of Health Policy and Health Planning Course in the Master of Public Health Programme, Department of Community Health, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia. We would like to extend our sincerest appreciation to the staff of the Department of Community Health, Faculty of Medicine of Universiti Putra Malaysia for the support during the completion of this manuscript.

Declaration

Authors declare that this manuscript has never been published in any other journal.

Authors’ contribution

Author 1: Information gathering, preparation and editing of manuscript
Author 2: Information gathering, preparation and editing of manuscript
Author 3: Information gathering, preparation and editing of manuscript
Author 4: Information gathering, preparation and editing of manuscript
Author 5: Information gathering, preparation and editing of manuscript
Author 6: Initiation of idea, review of manuscript and final editing
References


