Authority in tobacco control in Pacific Small Island Developing States

Tobacco Control

Authority in tobacco control in Pacific small island developing states. A qualitative study of multisectoral tobacco governance in Fiji and Vanuatu

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Complete List of Authors:	Patay, Dori; Australian National University, Menzies School of Health Governance, School of Regulation and Global Governance; The George Institute for Global Health Schram, Ashley; Australian National University, Menzies Centre for Health Governance, School of Regulation and Global Governance Collin, Jeff; University of Edinburgh, Global Health Policy Unit Sell, Susan; Australian National University, Menzies School of Health Governance, School of Regulation and Global Governance Friel, Sharon; Australian National University, Menzies School of Health Governance, School of Regulation and Global Governance
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Authority in tobacco control in Pacific small island developing states

A qualitative study of multisectoral tobacco governance in Fiji and Vanuatu

Authors: Patay, Dori[1;2]; Schram, Ashley[1]; Collin, Jeff[3]; Sell, Susan[1]; Friel, Sharon[1]

Author Affiliations:

[1] School of Regulation and Global Governance, College of Asia and the Pacific, The Australian National University, Canberra, Australia

[2] The George Institute for Global Health, Sydney, Australia

[3] School of Social and Political Science, University of Edinburgh, Edinburgh, United Kingdom

Corresponding author: Dr Dori Patay

E-mail: dori.patay@anu.edu.au

Mobile: +61497895787

Address: School of Regulation and Global Governance, College of the Asia-Pacific, The Australian National University. 8 Fellows Rd, Acton ACT 2601, Australia

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ABSTRACT

Objective: Small island developing states (SIDS) struggle with implementing multisectoral tobacco control measures, and health sector actors often lack capacity to forge multisectoral commitment. This study aims to explore the sources and dynamic of authority that can enable multisectoral collaboration despite the divergence of policy agendas in tobacco control. **Methods:** We applied a qualitative, explorative case study design, with data collection and analysis guided by an analytical framework that identifies sources and dynamics of authority. Seventy interviews were conducted in Fiji and Vanuatu between 2018 and 2019. **Results:** The key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economies, facilitate an economic growth discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance. **Conclusions:** Our results highlight the need for terms of engagement with the tobacco industry to enable governments to implement multisectoral tobacco control measures. Expanding assistance on tobacco control among government and civil society actors and increasing messaging about the impact of economic, trade and agricultural practices on health are essential to help SIDS implement FCTC.

KEY MESSAGES

[What is already known on this subject?]

- Effective tobacco control requires the implementation of comprehensive and coherent multisectoral policies, but Small island developing states (SIDS) struggle with implementing Articles 5.1, 5.2(a) and 5.3 of FCTC.
- There is limited evidence on how health sector actors can enable multisectoral collaboration on tobacco control despite diverging policy agendas in SIDS.

[What this study adds]

- Our study found that health sector actors' authority to compel multisectoral engagement for tobacco control largely depends on their perceived or actual performance, the focus of intersectoral discourse, the extent that the FCTC is realised through domestic regulations, and strategic alliances.
- SIDS vulnerabilities make Fiji and Vanuatu susceptible to the narrow interpretation of economic norms and industry influence, eroding health sector actors' authority to coordinate multisectoral engagement to implement FCTC.

[How this study might affect research, practice or policy]

- The results highlight the importance of Article 5.3 implementation and the need to shift away from the dominant economic discourse to enable the establishment of comprehensive, multisectoral tobacco control measures, even if it is particularly challenging for SIDS.

1. INTRODUCTION

Effective tobacco control requires the implementation of comprehensive and coherent multisectoral policies.[1] Thus, the very first provisions of the Framework Convention on Tobacco Control (FCTC) include developing "*comprehensive multisectoral national tobacco control strategies, plans and programmes*" (Article 5.1), establishing "*a national coordinating mechanism or focal points for tobacco control*" (Article 5.2a), and the protection of public health policy-making from industry interference (Article 5.3).[1] These general obligations are closely linked, as the inclusion of the tobacco industry or the representation of tobacco industry interests in multisectoral governance mechanisms can undermine scope for development and implementation of comprehensive tobacco control measures.[2-4] However, the implementation of Articles 5.1, 5.2a, and 5.3 is lacking in many countries, and the tobacco industry is often perceived to be legitimate among non-health government actors.[5-8] Health sector actors typically lack authority to compel multisectoral commitment for tobacco control across agencies responsible for trade, industry, agriculture, and finance, sectors that in many contexts have mandates and interests that favour supporting the tobacco industry.[2, 5, 9-15]

Through the analysis of actor authority – "*the ability to induce deference in others*" –, this paper explores the ways authority is sourced, exerted and challenged among policy actors with conflicting interests and mandates in multisectoral tobacco governance.[16] In doing so, it aims to expand the evidence on the barriers to multisectoral engagement in tobacco control, in accordance with Articles 5.1, 5.2a, and 5.3. This paper presents part of a larger project exploring how interests, ideas, and institutions shape multisectoral collaboration on tobacco control in Pacific small island developing states (PSIDS).[17]

SIDS constitute 21% of FCTC signatories yet are rarely the subject of tobacco control research.[18-23] SIDS warrant special attention as a group of low- and middle income countries (LMICs) burdened by distinctive vulnerabilities – small land, population, economy and government size, geographical isolation and infrastructural challenges, dependence on the policies of larger countries, and limited ability to shape market conditions.[24] These potentially exacerbate government fragmentation and their vulnerability to tobacco industry influence often reported in PSIDS.[19, 20, 25-29]

Understanding the ways multisectoral engagement can be strengthened in tobacco control is vital for PSIDS. Most PSIDS adopted the Tobacco Free Pacific 2025 Goal, but its achievement seems unlikely, male smoking prevalence reaching as high as 56-74% in some states.[18, 30-35] This study focuses on Pacific Island Countries that are classed as PSIDS, thus have a low- or middle-income economy and are independent from other states. We used Fiji and Vanuatu as case studies.

2. METHODS

A theory-informed, qualitative approach, relying primarily on interviewee data led our exploration of authority in tobacco governance in Fiji and Vanuatu.

2.1. Theoretical perspectives

Table 1 presents the theoretical constructs used during data collection and analysis. We drew on Avant et al.'s theory of authority, which explains how and why actors become accepted authorities.[16] It identifies five sources of authority: expert, institutional, capacity-based, principled, and delegated.[16] Additionally, we adopted the concept of legal authority following Townsend et al., recognising the authority that the FCTC creates at a national level.[36]

Understanding actors' authority can help uncover how health sector actors can enable multisectoral approaches to advancing tobacco control despite conflicting interests and mandates within the

government. This theory was successfully used in prior research at the intersection of trade and health at the national level.[36]

Table 1 The theoretical constructs and example codes used during data analysis

Theoretical constructs		Example quotes
Source of authority	**Expert authority:** actor holds specialised knowledge or information	*"The weakness is in Health [MoH] itself. Health does not have any understanding about trade policies."* (F01, Government)
	Institutional authority: sourced from an official role within on organization	*"[Solicitor General's Office] can just decide to say no to it, and that's it*" (F10, Government),
	Capacity-based authority: based on perceived competence and capacity	*"We have a small committee, headed by BAT from the private sector and it involves some of the key stakeholders in agriculture. […] [BAT] only use that nursery for about three to four months, after that, the nursery is idle for the rest of the year. They have given this facility to the Ministry of Agriculture without any cost to utilise that facility"* [37]
	Legal authority: based on subnational, national, regional, or global legal structures	*"If MoH said, 'we will not accept, there'll be no tobacco production in Vanuatu', and made a policy then that would stop that right".* (V25, Government)
	Principled authority: sourced from serving in a moral, normative, principled, spiritual, or religious role	Not identified in our data on tobacco governance
	Delegated authority: temporarily given from another authority	Not identified in our data on tobacco governance
Dynamic / changes in authority (Mitigating and enhancing factors)	**Performance** (perceived or actual)	*"MoH needs to function first more efficiently and effectively to be able to start to reach out and start coordinating with the other ministries".* (V27, Development partner).
	Relationships between actors (alliances)	*"WHO is here, we have a strong collaboration with them. That makes our work easy."* (F22, Government)
	Multiple authority sources possessed by a single actor	*"You still need to go through the Attorney-General… that is exactly the wall we are facing, because he is pro-trade, he is also the Minister of Economy. He is holding the two big portfolios we need to crack."* (F02, Government)

2.2. Study design, data collection and analysis

We employed an exploratory case study design, combined with within-case analysis and cross-case synthesis.[38-41] Earlier studies on harmful commodity regulation in PSIDS have used a similar approach.[19, 42-44]

To identify positive lessons in the region, we selected two PSIDS with recent improvement in implementing multisectoral tobacco control policies. Since FCTC Implementation reports among PSIDS are infrequently submitted, and at the time of case selection the Pacific Monitoring Alliance for Noncommunicable Disease Action (MANA) reports were often not available, we used MPOWER reports to compare progress.[18, 45] To explore the influence of tobacco industry interests, we selected one PSIDS with an established tobacco industry and another one with emerging interest in tobacco investment. The presence of tobacco production and/or manufacturing was assessed using tobacco-related exports as a percentage of total GDP in PSIDS.[46, 47] A Google search was conducted to scope consideration among PSIDS in foreign direct investment in tobacco. Out of those PSIDS with recent progress in tobacco control, Fiji arose as a case where tobacco industry interests are already present, while Vanuatu appeared under pressure to establish a local commercial tobacco industry.[48, 49]

Table 2 provides recent demographic data, the contribution of agriculture and other industries to GDP, and smoking prevalence in Fiji and Vanuatu. In Fiji, tobacco is not considered a significant agricultural product; however, it is valued by farmers as a cash-crop, and the close relationship of British American Tobacco (BAT) to the local political elite is frequently showcased in the media.[50-56] Vanuatu did not have commercial tobacco production at the time of data collection; however, several companies expressed interest in investing in tobacco, and construction of a tobacco factory commenced in Port Vila in 2019.[57, 58] At the time of case selection in 2017, no

recent information was available on the status of Article 5 implementation in these PSIDS; however, the 2020 FCTC country reports showed that neither country has a dedicated national coordination mechanism or terms of engagement established.[59, 60]

Table 2 Demographic and economic characteristics, and smoking prevalence in Fiji and Vanuatu

	Fiji	Vanuatu
Population[61]	943,737	308,043
Ethnic groups[61]	iTaukei 56.8%, Indo-Fijian 37.5%, other 4.7%	ni-Vanuatu 99.2%, other 0.8%
GDP (US$, 2020 est.) [61]	9.86 billion	850 million
GDP per capita (US$)[61]	11,000	2,800
GDP composition by sector of origin (2017 est.) [61]	agriculture 13.5%, industry 17.4%, services 69.1%	agriculture 27.3%, industry 11.8%, services 60.8%
Labour force by occupation[61]	agriculture 44%, industry 14%, services 42%	agriculture 65%, industry 5%, services 30%
Tobacco-related export, value exported in 2016 (US$, thousands)[61]	1,726,000	0
Tobacco-related export in proportion to GDP in 2016 (% in GDP)	0.04%	0
Smoking prevalence (current smokers, 2011)[62, 63]	Male: 47.0%, female 14.3%	Male: 46.0%, female 4.0%

Key-informant interviews were conducted between April 2018 and August 2019. Participant selection followed a purposive and snowball process, targeting government agencies, development partners (intergovernmental and regional organisations, and governmental agencies of donor countries), civil society organisations (CSOs), local academic institutions, and tobacco industry. Interviews were conducted in person, and in a few cases over Skype, and were characterised by semi-structured and open-ended questions that were designed to explore actor interests, mandates, and influence to identify the sources and dynamics of authority among actors. For example, the questions included "*What authority does your unit hold over tobacco governance?*" or "*What are the challenges of multisectoral coordination?*" Interviews were transcribed, coded against the theoretical constructs and analysed using NVivo. Additionally, parliamentary debates were analysed to triangulate interviewee data.

3. RESULTS

Seventy interviews were conducted in Fiji (N=42) and Vanuatu (N=28); 21 interview requests were rejected, including the tobacco industry. Table 2 presents the distribution of interviews.

Table 3 The distribution of in-depth interviews

Country / type of actor	**Fiji** organizations (interviews)	**Vanuatu** organizations (interviews)
Government agencies	17 (25)	13 (21)
Civil society organisations & academic institutions	3 (3)	1 (1)
Development partners	7 (14)	6 (6)

Our analysis shows that the key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance.

3.1. Expert authority

3.1.1. Fields of expertise

Actors generally hold expert authority in a field in which they are recognised to have knowledge and experience.[16] While the FCTC states that tobacco control is a multisectoral issue, in Fiji and Vanuatu it is often perceived primarily as a health issue. This perception could grant expert authority to the Ministry of Health (MoH) to coordinate multisectoral collaboration; yet, the agency struggles to exert this authority:

> *A lot of time [FCTC] is just translated to MoH policies. It should get it into other sectoral policies and implementation plans.* (V29, Government)

If an actor tries to exert authority in a field not within its scope of expertise, its expert authority is reduced.[16] This is relevant for MoH in both countries, as non-health government agencies tend to discuss noncommunicable diseases (NCDs) and tobacco control in economic and trade terms:

> *Tobacco is a powerhouse for the government to generate revenue. It will not be easy for the government to give this up easily.* (V22, Government)

> *Health is a big part of the government budget. If it's not managed properly, it can affect the government budget significantly.* (F22, Government)

The intersectoral discourse on economic and trade terms reduces MoH's authority because it is perceived to be without expertise on these areas:

> *The weakness is in Health [MoH] itself. Health does not have any understanding about trade policies. (F01, Government)*

In Vanuatu, MoH is not invited to the National Trade Development Committee, where officials from the Ministry of Economy (MoE) and Agriculture (MoA) are present and discuss trade policies related to tobacco. A participant explained why this is so with a shrug that "*there's already lots of people, which can make it difficult at times to have a proper strategic discussion as opposed to just general updates*" (V24, Government).

The economic discourse nominates MoE as the chief expert authority on the economic implications of tobacco control decisions. This is a barrier for tobacco control in Fiji because the Minister for Economy (who is also the Attorney-General) sees the tobacco industry as a partner to improve the country's economy, which is openly declared in the media and Parliament.[53-56, 64]

Although Fiji and Vanuatu committed to protect public health policy-making from the tobacco industry (Article 5.3) when they ratified the FCTC, tobacco companies are seen by key actors as a provider of expertise and capacity – scarce resources in these countries. In Fiji, MoA perceives BAT as having expertise in tobacco farming and agriculture in general, granting expert authority to the company. For example, in 2019, the Chief Executive Officer of BAT was elected as the Permanent Secretary for Agriculture.[56] Our inquiries to MoA on tobacco regulation were referred to BAT, who also leads a public-private committee on agriculture,[37] and assists MoA with

agricultural projects.[65] BAT is perceived as an expert on economic and commercial matters, too, as the Minister for Economy's statement demonstrates:

> *In Fiji we see a huge level of poaching taking place between different agencies. […] Everyone wants the best people. […] We ourselves are doing that. For example, the Head of Procurement in the Ministry of Economy now, is someone who has come from British American Tobacco.*[66]

Limited financial and human capacity make SIDS susceptible to tobacco industry influence. The small education sector in Fiji and Vanuatu offers limited local options, and geographic isolation combined with constrained income make it challenging to study abroad. Consequently, SIDS often rely on tobacco industry expertise, enhancing views of them as a legitimate actor in governance:

> *We had a short meeting with BAT a few weeks ago. […] They calculated the threshold beyond which [tobacco excise tax] won't be sustainable for them. It's something what the government has to take into account. (F22, Government)*

3.1.2. Perceived performance and reputation

Low performance and subsequent poor reputation can also diminish an actor's expert authority.[16] MoH is perceived to be performing poorly based on population health outcomes, diminishing its reputation among other government agencies and decreasing its authority to coordinate multisectoral collaboration:

> *MoH needs to function first more efficiently and effectively to be able to start to reach out and start coordinating with the other ministries.* (V27, Development partner).

Human and financial capacity, performance management and accountability issues, and logistical difficulties of geographic isolation are mentioned by participants as reasons behind MoH's performance issues – issues that are linked to SIDS vulnerabilities.

Government officials, outside MOH, commonly emphasise the responsibility of individuals to lead a healthy lifestyle in reducing the NCD burden:

> *Fijians are in dire need of being steered away from their usual norms and should be educated tirelessly on the perils of unhealthy lifestyle habits.*[67]

This emphasis on individual behaviour disregards the structural drivers of health that sit outside the health sector and is closely aligned with dominant neoliberal ideologies. Without recognising the role of the wider determinants of health, MoH is perceived to be the only agency responsible for tobacco control and solving the NCD crisis, mainly through health education and treatment. However, since MoH is unable to fulfil the (unreasonable) expectation of tackling the NCD crisis with a single-sector approach, many government officials believe that it is not performing well:

> *If MoH does not do well with educating the public, the families in the household, then that can be a burden for the government in the years to come. (F22, Government)*

3.1.3. Strategic alliances

An actor's expert authority can be strengthened by strategic alliances.[16] WHO's support of MoH increases the ministry's authority in both countries. WHO holds expert authority because it is seen by governments and other development partners as having extensive knowledge on tobacco control.

> *WHO is here, we have a strong collaboration with them. That makes our work easy. We do not work with others on tobacco.* (F22, Government)

WHO's expert authority is expanded through its synergistic relationship with the United Nations Development Programme (UNDP) and the Secretariat of the Pacific Community (SPC). WHO's mandate allows it to engage directly only with MoH; however, UNDP and SPC have mandates over several policy fields, allowing them to reach out to non-health ministries, for example, conducting awareness raising activities among government officials about the impact of trade policies on NCDs.

> *We support WHO and other health specialised agencies because we can open doors that they not necessarily can. Because our direct counterpart is the Ministry of Economy, Trade, Environment, Agriculture, Planning, Finance; for WHO it is only MoH.* (F28, Development partner).

While the alliances may morph based on the issue at hand, the synergistic relationship of WHO to UNDP and SPC increases its authority and mitigates its singular access to MoH.

CSOs have been important to the global progress of tobacco control;[68] however, in Fiji and Vanuatu, no CSOs are active on this field. CSOs in general show little expert-based authority in these states:

> *Civil society capacity for analysis and policy development needs to be strengthened.* (F29, Development partner)

Participants suggested that the limited resources common in PSIDS are the reason behind the limited CSO expertise.

3.2. Institutional authority

Institutional authority emerged as highly important in Fiji in tobacco control; in Vanuatu such evidence was not identified. In Fiji, the Attorney-General (AG), who is also the Minister for Economy, Civil Service, and Communication, represents a case when one actor holds several sources of institutional authority, multiplying their influence.[69] They also control the Solicitor General's Office which vets every bill before presented to Parliament, thus *"it can just decide to say no to it, and that's it"* (F10, Government), the bill will not reach the Cabinet. The AG (alongside the Prime Minister) controls the Public Service Committee, the agency nominating Permanent Secretaries. As the AG tends to view the tobacco industry as a partner rather than an actor to be regulated, MoH's authority is being circumscribed:

> *You still need to go through the Attorney-General… that is exactly the wall we are facing, because he is pro-trade, he is also the Minister of Economy. He is holding the two big portfolios we need to crack. (F02, Government)*

3.3. Capacity-based authority

Capacity-based authority often appeared alongside expert capacity, particularly in the case of non-state actors, such as WHO, tobacco industry, and CSOs.

WHO wields capacity-based authority due to its provision of considerable resources. In both countries WHO provided significant assistance to MoH on tobacco control.

The capacity-based authority of tobacco industry was frequently demonstrated in the data:

> *We have a small committee, headed by BAT from the private sector and it involves some of the key stakeholders in agriculture. […] [BAT] only use that nursery for about three to four months, after that, the nursery is idle for the rest*

> *of the year. They have given this facility to the Ministry of Agriculture without any cost to utilise that facility.*[37]

> *With tobacco, [BAT] bring the seeds and fertilisers to the [farmers] home. […] The tobacco industry just brings them everything. (F02, Government)*

Reflecting on BAT's capacity-based and expert authority, MoA and MoT officials in Fiji are reluctant to implement FCTC Article 17 to shift tobacco farming to viable alternatives.

CSOs have little capacity-based authority in Fiji and Vanuatu. Limited resources common in SIDS are likely a major reason behind this.

> *Not only in tobacco, but they do not have any CSOs which are looking into NCDs. […] They said that they do not have any support or funding.* (F27, Development partner)

3.4. Legal authority

The Tobacco Control Act in both states mandates MoH to implement FCTC measures, thus increasing the agency's legal authority:

> *We have a lot of opposition from tobacco [industry], but one of our strengths is that we can say 'look, we signed this Convention and the government has to follow it'. (F02, Government)*

In Vanuatu, MoH's legal authority is challenged by MoA and MoT, agencies working towards establishing commercial tobacco production, instead of implementing Article 17. Interviewees suggest that the authority in tobacco governance had been fairly evenly distributed among

government agencies, until MoA strengthened its legal authority by creating a legal base for tobacco farming:

> *We have a new legislation that's been passed in the Parliament on the newly introduced crops, and we will have a policy on regulating tobacco farming in Vanuatu.* (V02, Government)

These legal instruments appear to be the deciding factor between the agencies, as MoH policies currently do not cover tobacco farming provisions.

> *It's good for Vanuatu, but for the health it's not good, but we do not have any regulation which would ban the tobacco industry in Vanuatu. (V16, Government)*

> *If MoH said, 'we will not accept, there'll be no tobacco production in Vanuatu', and made a policy then that would stop that right. (V25, Government)*

This shows that MoH in Vanuatu could have gained the necessary legal authority to block tobacco investment in the country by adopting relevant policies; however, in 2019 and 2020 the Minister for Health endorsed the establishment of a tobacco factory instead.[58]

4. DISCUSSION

This study offers an in-depth analysis of the ways authority is sourced, shaped and challenged by state and non-state actors in tobacco control in two PSIDS – Fiji and Vanuatu – and the way this impacts the implementation of FCTC Articles 5.1 and 5.2(a) in particular. While health sector actors' weakness to enable multisectoral tobacco governance is often reported in tobacco control

studies, this study presents new insights about the factors that may increase or decrease their influence on actors with divergent policy agendas.[2, 6, 7, 12, 14]

The exploration of sources and dynamics of authority showed that health sector actors actively working for tobacco control (MoH and WHO) in Fiji and Vanuatu can source authority based on their knowledge in health (expert authority), legislation, such as the Tobacco Control Act (legal authority), and their technical and human resources (capacity-based authority). However, the amount of authority they gain from these sources depend on their performance (perceived or real), which is viewed in light of the dominant discourse around tobacco, the legal tools supporting their authority (FCTC and the ways it is executed in national legislation), and their strategic alliances. This authority is contested by state and non-state actors that tend to prioritise tobacco industry interests (MoE, MoA, MoT and tobacco industry) through exerting their own institutional, expert, capacity-based and legal authority. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance.

To date, no other published study has assessed authority among both state and non-state actors in tobacco control, though other conceptualisations of power and influence have been explored. The structural and agentic power of the tobacco industry was analysed by Holden and Lee; however, their study does not cover state actor influence.[7] Our study of authority expanded the evidence on the reasons health sector actors are disempowered to implement Articles 5.1 and 5.2(a) in SIDS. Moreover, it explains why SIDS are susceptible for tobacco industry influence, highlighting the need for Article 5.3 implementation.

MoH does not have enough expert authority to coordinate multisectoral tobacco governance in Fiji and Vanuatu, despite its strategic alliance with WHO, because the economic and commercial focus

of intersectoral discourse over tobacco control grants MoE and MoT the expert authority. Our findings confirm previous research reporting that the discourse over tobacco control in LMICs is often conducted on economic terms.[8, 29] Lencucha et al. found that "pro-tobacco discourses" are dominant among non-health sector actors in Kenya, Malawi and Zambia and deeply influence tobacco governance, highlighting the need to shift away from the "narrow conceptualisation of international economic norms".[8] A report on Caribbean SIDS describes a "structural reliance on key commercial actors" as a result of SIDS vulnerabilities.[29] While such reliance on industry actors is reported in multiple LMICs, SIDS are increasingly incentivised to seek foreign investment due to their vulnerabilities.[29]

Prior research suggests that the dominance of economic discourse enables the tobacco industry to be perceived as a legitimate actor in governance.[70, 71] Our study expands this understanding by explaining how this discourse lowers MoH's expert authority, and by revealing the connection between SIDS vulnerabilities and capacity-based and expert authority of state and non-state actors.

The lack of CSO presence in tobacco control in Fiji and Vanuatu is troubling because their principled authority could support health sector actors balance out pro-tobacco interests. While a whole-of-society approach is often recommended to tackle the NCD crisis, PSIDS are unlikely to achieve this goal, if the only representation of "society" is the tobacco industry .[72] SIDS vulnerabilities enable non-state actors to gain capacity-based authority if they provide resources for the government. Earlier studies in tobacco and food policy in PSIDS describe the impact of resource-low settings on policy implementation and enforcement but do not analyse how capacity issues shape actor's influence on tobacco control.[19, 21, 43, 44, 73-75] Our findings are aligned with a prior report on Caribbean SIDS that showed that SIDS vulnerabilities exacerbate the susceptibility of these governments to tobacco industry influence.[29]

Our results suggest that FCTC ratification, without translating into specific regulations, does not carry enough legal authority to stop non-health government agencies from supporting the tobacco industry. This aligns with Lencucha et al.'s findings on the legal weight of FCTC in the Philippines.[2] However, the execution of FCTC through domestic regulations potentially provides enough legal authority for MoH to stop new investment in tobacco.

4.1. Limitations

While studying SIDS where the health sector managed to compel multisectoral commitment to tobacco control would have been optimal, this study was successful in exploring how actor authority affects multisectoral tobacco control. As a doctoral project, funding restrictions precluded the inclusion of local Fijian or ni-Vanuatu researchers; the limitations inherent in this structure were mitigated by substantial guidance from diverse government officials in MoH in both countries. These restrictions allowed the inclusion of only two case studies, negatively impacting the generalisability of the findings but enabling the initial exploration of relevant conditions influencing authority in tobacco control in SIDS. Additionally, by not explicitly enquiring about each type of authority in the interviews, it is possible that interviewees discussed the most obvious forms of authority to them, and thus we might have missed others. Due to cultural and linguistic limitations, we have not adopted an iTaukei or Ni-Vanuatu version of the authority constructs, which might have limited our findings.

5. CONCLUSIONS

This study contributes to the tobacco control literature by expanding evidence on why SIDS struggle to implement Articles 5.1 and 5.2(a), through the analysis of authority among state and non-state actors. Our findings elucidate the ways performance (perceived or real), the discourse around tobacco control, legal tools, and strategic alliances shape authority in tobacco governance,

and they show how SIDS vulnerabilities make Fiji and Vanuatu susceptible to the narrow interpretation of economic norms and industry influence, eroding health sector actors' authority to coordinate multisectoral engagement to implement FCTC.

These results highlight the importance of Article 5.3 implementation to enable governments to establish multisectoral tobacco control. Moreover, the need to shift away from the dominant economic discourse is vital, even if it is particularly challenging for SIDS. These countries are likely to rely on the tobacco industry as long as they do not have other sources of capacity and expertise. More development partner support should be focused on preventing NCDs and targeting civil society. Increased messaging on the impact of economic, trade and agricultural practices on public health is essential to help SIDS implement FCTC.

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Authors' contributions: DP: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Validation; Visualization; Roles/Writing - original draft. **SF:** Supervision; Writing - review & editing. **AS:** Supervision; Writing - review & editing. **SS:** Supervision; Writing - review & editing. **JC:** Supervision; Writing - review & editing. All authors read and approved the final manuscript.

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29/06/2022

Dr Mark Joseph Cubelo
Editor
Tobacco Control

Dear Dr Cubelo,

Thank you for your email of 2 June 2022, providing feedback on our submission tobaccocontrol-2022-057404: "*Authority in tobacco control in Pacific small island developing states. A qualitative study of multisectoral tobacco governance in Fiji and Vanuatu*". We value the insightful comments from the reviewers. Most importantly, we have made major changes throughout the manuscript to clarify the methods, key findings and the contributions of the paper to the tobacco control scholarship, decreased the word count, added details of the ethics approvals granted by the Fijian and Vanuatu authorities, and made several other amendments as suggested by the reviewers.

The prior publication in *Regulation and Governance* gave an overview of this doctoral research project, situated it within the regulation and governance scholarship, introduced the key findings and focused on discussing the interlinkages between the interests-based, ideational and institutional conditions relevant in multisectoral tobacco governance in the case study countries, while the key conclusions were framed to inform regulation and governance scholars. By contrast, the current manuscript submitted to *Tobacco Control* provides a detailed analysis of authority that is distinctive from the prior paper and which we feel can make an important contribution to tobacco control policy debates. The paper also differs significantly in terms of the interview data on which it draws, and places the results, analysis, and discussion into the specific context of tobacco control (as opposed to the discipline of regulation and governance), reflects in more detail on Article 5 of FCTC and relevant tobacco control studies. As a result, this paper provides new evidence, and new and additional insights that we believe are of interest for the readership of *Tobacco Control*.

Please find attached a table presenting point-by-point responses to all comments and queries and noting where changes have been made to the manuscript.

Kind regards,

The Authors

Reviewers' comments/feedback	Authors' response	Change in manuscript or other action
Editor		
While we understand that qualitative articles sometimes require additional words, please try to keep the word count to no more than 4000.	We have revised the manuscript and decreased the word count to 4023.	
It is noted that the study only received ethics approval from the ANU HREC. Please outline why ethics approval was not sought from appropriate committees in Fiji and Vanuatu. Please also pay particular attention to question 4 by reviewer 3 regarding the involvement of local researcher(s) from each country.	Ethics approval was obtained from both Fiji and Vanuatu prior commencing the study. We have added these approvals to the Acknowledgement section.	Lines 342-346 were amended as follows: "Research Ethics approval was granted for this study by the Fiji National Health Research and Ethics Review Committee, the Vanuatu Cultural Centre, and the Australian National University Human Research Ethics Committee (protocol number: 2017/945)."
Regarding comments from reviewers 2 and 3 about the similarity with previous publications from this study, please provide a clear outline of the new contribution of this paper after revisions and how it is differentiated from the already published work. (It is noted that the prior publications were not disclosed in the cover letter accompanying the original submission which is the usual expectation).	The prior publication in *Regulation and Governance* gave an overview of this doctoral research project, situated it within the regulation and governance scholarship, introduced the key findings and focused on discussing the interlinkages between the interests-based, ideational and institutional conditions relevant in multisectoral tobacco governance in the case study countries, while the key conclusions were framed to inform regulation and governance scholars. By contrast, the current manuscript submitted to *Tobacco Control* provides a detailed analysis of authority that is distinctive from the prior paper and which we feel can make an important contribution to tobacco control policy debates. The paper also differs significantly in terms of the interview data on which it draws, and places the results, analysis, and discussion into the specific context of tobacco control (as opposed to the discipline of regulation and governance), reflects in more detail on Article 5 of FCTC and relevant tobacco control studies. As a result, this paper provides new evidence, and new and additional insights that we believe are of interest for the readership of *Tobacco Control*.	

Reviewer 1		
WHO is not the only authority in the region as stated (Conclusions) on tobacco control measures because regional organisations (SPC and the Forum Secretariat) exert considerable influence in both the context (social, cultural, political and economic). SPC has significant influence on health policy and practice (in some cases more than WHO). This conclusion is erroneous and misleading.	We have removed the indicated statement from the Conclusions. We would like to note that while SPC and other regional organisations have influence over health and trade policy, WHO was the only organisation reported by interviewees as providing technical assistance in tobacco control. (Please see quote in lines 179-180.) We have made some amendments to the lines before the quote to make it clearer that we relied on the interviewee perceptions as reported in our data.	We have removed the indicated statement from the Conclusions. We have amended the text in lines 176-178: "WHO holds expert authority because it is seen by governments and other development partners as having extensive knowledge on tobacco control."
Reviewer 2		
I think the introduction would benefit from a clearer description of the relationship between Articles 5.1, 5.2, and 5.3. The authors chose to address all three. However, the relationship between the three is left implicit. What is the relationship between 'industry interference' and multisectoral coordination? In what ways does 5.3 have bearing on 5.2? Certainly the formal inclusion of industry representatives on a multisectoral coordinating mechanism/body is detrimental to efforts to strengthen tobacco control as is seen in the case of the Philippines (as the authors cited in Lencucha et al., 2015). There is also implications of having tobacco interests represented in such a body (not just industry) as seen in Brazil: Lencucha, R., Drope, J., Bialous, S. A., Richter, A. P., & Silva, V. L. D. C. (2017). Institutions and the implementation of tobacco control in Brazil. Cadernos de Saúde Pública, 33. This to say that the linkages need to be made more explicit.	We have added a sentence to the indicated section to briefly clarify the relationship between the three articles, have added the suggested and another reference to the text.	The following sentence was added to lines 7-10: "*These general obligations are closely linked, and the inclusion of the tobacco industry or the representation tobacco industry interests in multisectoral governance mechanisms can undermine scope for development and implementation of comprehensive tobacco control measures.*" The following reference was added to the end of this sentence: Barry, R. A., Abdullah, S. M., Chugh, A., Hirpa, S., Kumar, P., Male, D., ... & Collin, J. (2022). Advancing whole-of-government approaches to tobacco control: Article 5.3 and the challenge of policy coordination in Bangladesh, Ethiopia, India and Uganda. Tobacco Control, 31(Suppl 1), s46-s52. The following reference was added to line 12: Lencucha, R., Drope, J., Bialous, S. A., Richter, A. P., & Silva, V. L. D. C. (2017). Institutions and the implementation of tobacco control in Brazil. Cadernos de Saúde Pública, 33.

For information about 5.2 on the continent of Africa see: *link* This report provides a bit more nuance to the extent of which 5.2 has been implemented.	We have added the indicated reference to line 12.	The following reference was added to line 12: Drope J, Lencucha R, Magati P, Small R. Tobacco Control Governance in Sub-Saharan Africa. New York: United Nations Development Programme (UNDP) and the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) Secretariat; 2016.
p. 3, para 1 – The last sentence seems like a bit of a leap. The assumption that the health sector should compel action on tobacco control makes sense, but the political economy of tobacco indicates that this assumption is not warranted in most cases. This is a small point, but I think the discourse in the tobacco control literature needs to more deeply recognize that the health sector often does not have the power to compel multisectoral commitment. There is extensive evidence to support this point. I suggest rephrasing to say that the health sector often lacks the authority to compel multisectoral commitment and then explain why based on existing literature on the political economy of tobacco. It is important to present more of this existing literature to frame this study on authority.	We have rephrased the indicated sentence as suggested and added another sentence to present existing literature on the political economy of tobacco.	We have rewritten the text in lines 12-15 as follows: "Health sector actors typically lack authority to compel multisectoral commitment for tobacco control across agencies responsible for trade, industry, agriculture, and finance, sectors that in many contexts have mandates and interests that favour supporting the tobacco industry."
p. 6 – Could the authors please provide a bit of clarity in column 2 of Table 1. Based on the source of authority I find the dynamic is not clearly associated in column 2. For example, how does performance apply to expert authority and not capacity-based authority if the authority is derived from a type of expertise or capability. Another way to say this is that I don't understand what 'performance' means and I don't understand how some sources of authority pertain to one dynamic and not another. I think a third column with a more detailed description would be beneficial.	We thank the reviewer for highlighting that Table 1 is confusing in its current structure. The two columns are not meant to correlate with each other. We have reorganised the table to clarify this.	We have amended Table 1 as follows: we have moved the contents of column 2 under column 1, and highlighted the lines of the table to indicate that the two group of constructs are not interrelated.
p. 7, para 2 – I think the case rationale could be strengthened. Could more be said about the interests present in the two countries? I know the word limit is a	We have expanded the explanation on the case selection process, and added a Table (line 76) and a paragraph (lines 66-75) to introduce the country context.	We added a Table to line 76. We have expanded the text at lines 66-75 in the following way:

constraint, but I still would like to know more about the country contexts.		"To identify positive lessons in the region, we selected two PSIDS with recent improvement in implementing multisectoral tobacco control policies. Since FCTC Implementation reports among PSIDS are infrequently submitted, and at the time of case selection the Pacific Monitoring Alliance for Noncommunicable Disease Action (MANA) reports were often not available, we used MPOWER reports to compare progress. To explore the influence of tobacco industry interests, we selected one PSIDS with an established tobacco industry and another one with emerging interest in tobacco investment. The presence of tobacco production and/or manufacturing was assessed using tobacco-related exports as a percentage of total GDP in PSIDS. A Google search was conducted to scope consideration among PSIDS in foreign direct investment in tobacco. Out of those PSIDS with recent progress in tobacco control, Fiji arose as a case where tobacco industry interests are already present, while Vanuatu appeared under pressure to establish a local commercial tobacco industry. Table 2 provides recent demographic data, the contribution of agriculture and other industries to GDP, and smoking prevalence in Fiji and Vanuatu. In Fiji, tobacco is not considered a significant agricultural product; however, it is valued by farmers as a cash-crop, and the close relationship of British American Tobacco (BAT) to the local political elite is frequently showcased in the media. Vanuatu did not have commercial tobacco production at the time of data collection; however, several companies expressed interest in investing in tobacco, and construction of a tobacco factory commenced in Port Vila in 2019. At the time of case selection in 2017, no recent information was available on the status of Article 5 implementation in these PSIDS; however, the 2020 FCTC country reports showed that neither country has a dedicated national

		coordination mechanism or terms of engagement established."
p. 7 – I struggle a bit with the concepts of authority and how they were applied for this study. For example, the question posed to informants 'what authority does your unit hold over tobacco governance?' seems too narrow given that the theoretical approach utilizes different types of authority. How were these different notions of authority applied in this study?	As noted by Reviewer 3, in order to ensure that participants do not need to grapple with abstract concepts, that might be difficult to interpret due to cultural and linguistic limitations, such as different types of authority, the interview questions were designed and paraphrased to provide a general direction on interests, mandates, influence and authority that allowed for the identification of sources and dynamic authority among actors. For example, participants were asked about the major actors in tobacco governance, and then asked about how these actors aim to influence policy making. When a participant would say that a particular actor has a lot of power over tobacco control policy making, the researcher asked why this is the case. However, noting the Reviewer 2's point, now we have added this as a limitation to the manuscript, and added further clarification to the Methods section. The collected data was deductively coded against the theoretical constructs to ensure that the notions of authority are applied to the data. For example, when the participants talked about the Attorney-General being the most powerful because they wear the hat of the multiple ministerial positions, the data was coded as relevant for institutional authority. Similarly, when the participants described the FCTC as an important legal reference that allowed them to argue for tighter tobacco control measures, the data was coded as relevant for legal authority. As the third example, when the interviewees discussed the ways WHO works together with UNDP to advance pro-tobacco control interests, the data was coded as relevant for relationships between actors. We have added an extra column to Table 1 to provide examples quotes to demonstrate the ways the different notions of authority ware interpreted during analysis.	We have amended the text in lines 82-87 as follows: "Interviews were conducted in person, and in a few cases over Skype, and were characterised by semi-structured and open-ended questions that were designed to explore actor interests, mandates, and influence to identify the sources and dynamics of authority among actors. For example, the questions included "What authority does your unit hold over tobacco governance?" or "What are the challenges of multisectoral coordination?" Interviews were transcribed, coded against the theoretical constructs and analysed using NVivo." The following was added to lines 321-325: "Additionally, by not explicitly enquiring about each type of authority in the interviews, it is possible that interviewees discussed the most obvious forms of authority to them, and thus we might have missed others." We have added a column to Table 2, containing example quotes.

Also, how do the notions of authority incorporate the tangible tools or mechanisms of authority. For example, a formal mandate to enhance investment in the tobacco sector seems like an overt aspect of authority. I wonder how these aspects of authority like information, knowledge, capacity, formal rules, norms, and others are differentiated and incorporated in the analysis, if at all? For example on page 16 in the section on institutional authority there is reference to the attorney general and their friendly perspective on the tobacco industry. Is this something that is tied to the personal perspective of the AG or is this embedded in some rule that says the AG must treat all legal entities as a legitimate stakeholder?	Given the exploratory nature of this study, the analytical framework focuses on the sources of authority and does not explicitly investigate the tools or mechanisms of authority. However, information and knowledge are incorporated into the framework as the sources of expert authority, capacity is connected to capacity-based authority, formal rules and mandates are connected to institutional authority, while norms are under principled authority. We have amended Table 1 to clarify this further and added a column to list example quotes to show how the constructs were used during analysis The data does not reveal any evidence whether the Attorney-General's pro-tobacco industry stance would be tied to personal perspective nor that a legal rule is the reason for his high regard of the tobacco industry. What the data reveals, is that the Attorney General believes that the tobacco industry as an actor that has expertise and capacity that is perceived to be valuable for the Fijian economy. (Hence our analysis suggest that the tobacco industry bears expert and capacity-based authority in tobacco governance in Fiji.) We have added more references to line 145 to clarify this point.	The content of Table 1, under Sources of Authority, was amended as follows (new text in italic): "Expert authority: actor holds specialised knowledge *or information – example codes: Experience, expertise/skill, technical knowledge, information* Institutional authority: sourced from an official role within on organization – *example codes: Multiple government positions, high government office, Attorney-General, Prime Minister* Capacity-based authority: based on perceived competence and capacity – *example codes:* Lot of resources, capacity, competence, providing resources Legal authority: based on subnational, national, regional, or global legal structures – *example codes: Laws, regulation, global legal tools, FCTC* Principled authority: sourced from serving in a moral, *normative*, principled, spiritual, or religious role – *example codes: Church, customary leaders* Delegated authority: temporarily given from another authority – *example codes: Church, customary leaders"*
p. 10 – The section on expert authority is interesting and illustrates the divide that we see in other countries between health and economic ministries**. I wonder though whether this can be captured within the category of (lack of) expertise?** Is the MoH not invited because they are not an expert on trade or because their mandate is clearly contradictory to the trade ministry and the trade ministry knows that health would oppose any discussion on tobacco as an important economic commodity. This seems more to do with mandates and policy preferences than expertise.	This is a possibility; however, it wasn't borne out of our data. The data we have (e.g., see quote in lines 119-120), show that MoH's lack of expertise in economy or trade is seen as a reason why the agency is unable to propel multisectoral action forward or why it is not invited to multisectoral meetings. We have added another quote on the case of the National Trade Development Committee in Vanuatu to lines 146-150. The data did not indicate that considerations about policy preferences would be the reason that MoH is not invited to the National Trade Development Committee.	The following was added to line 123-125: "A participant explained why this is so with a shrug that "there's already lots of people, which can make it difficult at times to have a proper strategic discussion as opposed to just general updates" (V24, Government)."

p. 14-15 – I think there are a few issues that need to be treated as different policy agendas but are treated as one 'economic' issue. When the authors discuss the WHO's relationship with UNDP and SPC, the positive aspect of this relationship in terms of facilitating connection to economic ministries is tied to tobacco taxation. However, tobacco tax is a demand reduction measure. The issue of trade or agriculture is tied to supply. These are very different issues. Tobacco tax is often appealing to finance ministries because it is a revenue generator and to health ministries because it is an important tobacco control measure. So the alliance itself may not be the factor that contributes to these connections as much as the challenge of the policy issue. I think this is an important point that needs to be addressed in the analysis. Does the WHO alliance with the MoH impact the relationship with trade, agriculture, or other similar agencies that are tied to tobacco supply?	The discussion that Reviewer indicates was meant to illustrate that WHO maintains strategic alliances. The quote which mentions tobacco taxation was meant to demonstrate that MoH perceives WHO as an important ally who are useful because of their expertise. This section does not try to indicate that because of WHO's strategic alliances, MoH was able to get the Ministry of Economy (MoE) to raise tobacco taxes. We have removed this quote to avoid confusion. Due to the exploratory nature of this study, the analysis presented in this paper is limited to understand the ways authority is shaped and distributed among actors in tobacco governance; at this stage, it does not extend to the analysis of in what extent and how exactly the different notions around authority contributed to certain policy gains in tobacco control. In connection to the Reviewer's point, we note that although some progress has been made in increasing tobacco taxes in Fiji and Vanuatu, despite the good economic incentive of raising revenues, it continues to be far below the recommended WHO rates in both states. Although it's not presented in detail in this paper, our data shows that even though taxation is tied to demand, the tobacco industry in Fiji has applied a lot of pressure on MoE to not increase the taxes. This shows that tobacco taxation is a challenging policy issue in Fiji, despite being a demand site measure. To answer the Reviewer's question (Does the WHO alliance with the MoH impact the relationship with trade, agriculture, or other similar agencies that are tied to tobacco supply?): our data indicated that SPC and UNDP supports WHO by conducting awareness raising activities to government officials (including those from MoE, MoA, MoT, and Members of Parliament) about the impact of trade policies on health (particularly on the rise of noncommunicable diseases). We have added a sentence to line 184-186 to present this in the manuscript. To note the Reviewer's point, we added a	We have added the following to lines 184-186: "for example, conducting awareness raising activities among government officials about the impact of trade policies on NCDs." We have amended lines 191-192 as follows: "While the alliances may morph based on the issue at hand, the synergistic relationship of WHO to UNDP and SPC increases its authority and mitigates its singular access to MoH." We have removed the problematic quote from Section 3.1.3.

	sentence to lines 191-192 reflecting that alliances may morph based on the issues at hand.	
Overall, I find the article quite interesting and has potential to contribute to the literature on tobacco governance. While I agree the emphasis on authority is novel, I find that the analysis comes across as not as a new set of insights, but rather a new way of packaging these insights as 'authority' issues. My suggestion is to temper the point about the novelty of the analysis as being tied to the frame, and more about what we can learn from these two cases. We do not often see analysis from small island states.	We have amended the first paragraph of the Discussion section and the first sentence of the Conclusions section to highlight the contribution on SIDS. In addition, we have amended the Abstract and lines 258-275 in the Discussion to make the contribution on the new insights clearer. While the weakness of MoH to influence tobacco control is often reported in tobacco control studies, we are unaware of any studies that report on the ways performance (perceived or real) and the discourse around tobacco control shape state and non-state actor's influence on tobacco governance. In addition, we amended the Abstract, the text in the Introduction (lines 16-20) and Methods sections (lines 51-54) to better explain the value of our approach to expand evidence on tobacco control.	We have amended lines 16-20 as follows: "Through the analysis of actor authority – "the ability to induce deference in others" –, this paper *explores the ways authority is sourced, exerted and challenged among policy actors with conflicting interests and mandates in multisectoral tobacco governance. In doing so it aims to expand the evidence on the barriers to multisectoral engagement in tobacco control, in accordance with Articles 5.1, 5.2a, and 5.3.*" We have amended the text in lines 44-47 as follows: "Understanding actors' authority can help uncover *how* health sector actors *can enable multisectoral* approaches to advancing tobacco control *despite conflicting interests and mandates within the government*." We have amended the text in lines 258-275 as follows: "This study offers an in-depth analysis of the ways authority is sourced, shaped and challenged by state and non-state actors in tobacco control in two PSIDS – Fiji and Vanuatu – and the way this impacts the implementation of FCTC Articles 5.1 and 5.2(a) in particular. While health sector actors' weakness to enable multisectoral tobacco governance is often reported in tobacco control studies,2, 6, 7, 12, 14 this study presents new insights about the factors that may increase or decrease their influence on actors with divergent policy agendas. The exploration of sources and dynamics of authority showed that health sector actors actively working for tobacco control (MoH and WHO) in Fiji and Vanuatu can source authority based on their knowledge in health (expert authority), legislation, such as the Tobacco Control Act (legal authority), and their technical and human

		resources (capacity-based authority). However, the amount of authority they gain from these sources depend on their performance (perceived or real), which is viewed in light of the dominant discourse around tobacco, the legal tools supporting their authority (FCTC and the ways it is executed in national legislation), and their strategic alliances. This authority is contested by state and non-state actors that tend to prioritise tobacco industry interests (MoE, MoA, MoT and tobacco industry) through exerting their own institutional, expert, capacity-based and legal authority. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." We have amended lines 343-349 as follows: "This study contributes to the tobacco control literature by expanding evidence on why SIDS struggle to implement Articles 5.1 and 5.2(a), through the analysis of authority among state and non-state actors. Our findings elucidate the ways performance (perceived or real), the discourse around tobacco control, legal tools, and strategic alliances shape authority in tobacco governance, and they show how SIDS vulnerabilities make Fiji and Vanuatu susceptible to the narrow interpretation of economic norms and industry influence, eroding health sector actors' authority to coordinate multisectoral engagement to implement FCTC."
At the same time, I think the results section could be restructured. I think the presentation of the findings linked to each category of authority is a bit disjointed. Is there a story that can tie the findings together? Can this story integrate the types of authority according to the key findings?	The presentation of the findings in the Results section follows our theoretical framework; we have dedicated the Discussion section to connect, elevate and discuss the key findings. To support the Results section in its current form, we have added several amendments to the Abstract, Introduction, Results, Discussion and Conclusions.	We have revised the results section in the **Abstract** as follows: "The key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources

		was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economies, facilitate an economic growth discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." We have revised the first paragraph of the **Results** section as follows: "Our analysis shows that the key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." In addition, we have amended the first two paragraphs of the **Discussion** as follows: "This study offers an in-depth analysis of the ways authority is sourced, shaped and challenged by state and non-state actors in tobacco control in two PSIDS – Fiji and Vanuatu – and the way this impacts the implementation of FCTC Articles 5.1 and 5.2(a) in particular. While health sector actors' weakness to enable multisectoral tobacco governance is often reported in tobacco control studies, this study presents new insights about the factors that may

		increase or decrease their influence on actors with divergent policy agendas. The exploration of sources and dynamics of authority showed that health sector actors actively working for tobacco control (MoH and WHO) in Fiji and Vanuatu can source authority based on their knowledge in health (expert authority), legislation, such as the Tobacco Control Act (legal authority), and their technical and human resources (capacity-based authority). However, the amount of authority they gain from these sources depend on their performance (perceived or real), which is viewed in light of the dominant discourse around tobacco, the legal tools supporting their authority (FCTC and the ways it is executed in national legislation), and their strategic alliances. This authority is contested by state and non-state actors that tend to prioritise tobacco industry interests (MoE, MoA, MoT and tobacco industry) through exerting their own institutional, expert, capacity-based and legal authority. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance."We have amended the first paragraph of the **Conclusions** as follows: "This study contributes to the tobacco control literature by expanding evidence on why SIDS struggle to implement Articles 5.1 and 5.2(a), through the analysis of authority among state and non-state actors. Our findings elucidate the ways performance (perceived or real), the discourse around tobacco control, legal tools, and strategic alliances shape authority in tobacco governance, and they show how SIDS vulnerabilities make Fiji and Vanuatu susceptible to the narrow interpretation of economic norms and industry influence, eroding health sector actors' authority

		to coordinate multisectoral engagement to implement FCTC."
I'm also not convinced that notions of expertise are the key feature shaping multisectoral coordination. I think the authors need to provide more justification for this interpretation over an interpretation that foregrounds conflicting mandates, agendas, and preferences as well as the interests involved.	We have revised the first paragraph of the Results section to clarify and elevate the key findings. This now should clearly present that expertise is only one of the features, not the sole feature shaping authority in tobacco governance. More specifically, performance (perceived or real), the focus of the discourse around tobacco control (in these cases on economic impact), legal tools, and strategic alliances shape an actor's influence on tobacco governance. We have made these key insights clearer in the Abstract, Discussion and Conclusions sections as well. The important role of conflicting interests and mandates are not contested by our paper; rather, this is the starting point of our analysis: what can enable health sector actors to drive multisectoral collaboration, despite the existence of conflicting interests and mandates in tobacco governance. We have clarified this is the Abstract, Introduction and the Methods sections. Moreover, we have added further details in the Results and Discussion section to illustrate that health sectors' actors authority is contested by actors that tend to prioritise tobacco industry interests due to the alignment of their sectoral interests or mandate.	We have revised the objectives and results section in the Abstract as follows: "This study aims to explore the sources and dynamic of authority that can enable multisectoral collaboration *despite the divergence of policy agendas in tobacco control*." "The key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economies, facilitate an economic growth discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." We have revised the text in lines 12-20: "Health sector actors typically lack authority to compel multisectoral commitment for tobacco control across agencies responsible for trade, industry, agriculture, and finance, sectors that in many contexts have mandates and interests that favour supporting the tobacco industry. Through the analysis of actor authority – "the ability to induce deference in others" –, this paper explores the ways authority is sourced, exerted and challenged among policy actors with conflicting interests and mandates in multisectoral tobacco governance."

		We have revised lines 44-46 as follows: "Understanding actors' authority can help uncover how health sector actors can enable multisectoral approaches to advancing tobacco control despite conflicting interests and mandates within the government." We have revised the first paragraph of the **Results** section as follows: "Our analysis shows that the key features shaping multisectoral coordination for tobacco control in Fiji and Vanuatu are the expert, institutional, capacity-based and legal authority that state and non-state actors have in tobacco governance. The amount of authority actors can secure from these sources was shown to be influenced by their performance (perceived or real), the discourse around tobacco control, the existing legal tools, and their strategic alliances. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." In addition, we have amended the first two paragraphs of the Discussion as follows: "This study offers an in-depth analysis of the ways authority is sourced, shaped and challenged by state and non-state actors in tobacco control in two PSIDS – Fiji and Vanuatu – and the way this impacts the implementation of FCTC Articles 5.1 and 5.2(a) in particular. While health sector actors' weakness to enable multisectoral tobacco governance is often reported in tobacco control studies, this study presents new insights about the factors that may increase or decrease their influence on actors with divergent policy agendas. The exploration of sources and dynamics of authority showed that health sector actors actively working for

		tobacco control (MoH and WHO) in Fiji and Vanuatu can source authority based on their knowledge in health (expert authority), legislation, such as the Tobacco Control Act (legal authority), and their technical and human resources (capacity-based authority). However, the amount of authority they gain from these sources depend on their performance (perceived or real), which is viewed in light of the dominant discourse around tobacco, the legal tools supporting their authority (FCTC and the ways it is executed in national legislation), and their strategic alliances. This authority is contested by state and non-state actors that tend to prioritise tobacco industry interests (MoE, MoA, MoT and tobacco industry) through exerting their own institutional, expert, capacity-based and legal authority. SIDS vulnerabilities, arising from small size, isolation, and developing economy, facilitate an economic discourse that reduces health sector actors' authority and empowers pro-tobacco actors to drive tobacco governance." We have amended the first paragraph of the Conclusions section as follows: "This study contributes to the tobacco control literature by expanding evidence on why SIDS struggle to implement Articles 5.1 and 5.2(a), through the analysis of authority among state and non-state actors. Our findings elucidate the ways performance (perceived or real), the discourse around tobacco control, legal tools, and strategic alliances shape authority in tobacco governance, and they show how SIDS vulnerabilities make Fiji and Vanuatu susceptible to the narrow interpretation of economic norms and industry influence, eroding health sector actors' authority to coordinate multisectoral engagement to implement FCTC."

I am also a bit concerned that this paper re-presents using a different framing similar findings to the study by the authors published in Regulation and Governance.	The prior publication in *Regulation and Governance* gave an overview of this doctoral research project, situated it within the regulation and governance scholarship, introduced the key findings and focused on discussing the interlinkages between the interests-based, ideational and institutional conditions relevant in multisectoral tobacco governance in the case study countries, while the key conclusions were framed to inform regulation and governance scholars. By contrast, the current manuscript submitted to *Tobacco Control* provides a detailed analysis of authority that is distinctive from the prior paper and which we feel can make an important contribution to tobacco control policy debates. The paper also differs significantly in terms of the interview data on which it draws, and places the results, analysis, and discussion into the specific context of tobacco control (as opposed to the discipline of regulation and governance), reflects in more detail on Article 5 of FCTC and relevant tobacco control studies. As a result, this paper provides new evidence, and new and additional insights that we believe are of interest for the readership of *Tobacco Control*.	*No changes are needed.*
Reviewer 3		
This manuscript makes a valuable contribution to the field of tobacco trades multinational corporation and policy space. It is very closely aligned to the author's previous work earlier work on policy on ideas and governments published in 2021. This current study clearly it is a subset of that former or larger body of work most likely a thesis overall, though the paper is well written and really well organized. It addresses an issue that is not often covered in tobacco control particularly in in the Pacific islands region that being the differences or different versions of authority in the tobacco control space in Pacific islands. In this being multi qualitative study gives some fresh new insights into the unique and specific challenges these actors play in	Thank you for your interest in this work. The prior publication in *Regulation and Governance* gave an overview of this doctoral research project, situated it within the regulation and governance scholarship, introduced the key findings and focused on discussing the interlinkages between the interests-based, ideational and institutional conditions relevant in multisectoral tobacco governance in the case study countries, while the key conclusions were framed to inform regulation and governance scholars. By contrast, the current manuscript submitted to *Tobacco Control* provides a detailed analysis of authority that is distinctive from the prior paper and which we feel can make	*No changes are needed.*

various roles. the selection of two countries to work with in a case study type format Fiji and Vanuatu was well explained and makes good sense the authors may not have connections to or be closely aligned with Pacific government or civil society groups but have done an exemplary job at conducting the in-depth interviews to extract really useful rich data on the challenges various actors play in these important roles. this is more than just a study of tobacco interference it is particularly full of focuses on WHO FCTC 5.1, 5.2 (and to a lesser extent. 5.3).	an important contribution to tobacco control policy debates. The paper also differs significantly in terms of the interview data on which it draws, and places the results, analysis, and discussion into the specific context of tobacco control (as opposed to the discipline of regulation and governance), reflects in more detail on Article 5 of FCTC and relevant tobacco control studies. As a result, this paper provides new evidence, and new and additional insights that we believe are of interest for the readership of *Tobacco Control*.	
1. The methods used to collect the data. Sample selection was based on wanting to discover "positive lessons' which led the authors to select Vanuatu and Fiji. This paragraph (page 8, line 59-67) is vague on the selection criteria.	We have expanded the explanation on the selection criteria and the way it was applied on PSIDS.	We have amended the text in lines 54-65 as follows: "To identify positive lessons in the region, we selected two PSIDS with recent improvement in implementing multisectoral tobacco control policies. Since FCTC Implementation reports among PSIDS are infrequently submitted, and at the time of case selection the Pacific Monitoring Alliance for Noncommunicable Disease Action (MANA) reports were often not available, we used MPOWER reports to compare progress. To explore the influence of tobacco industry interests, we selected one PSIDS with an established tobacco industry and another one with emerging interest in tobacco investment. The presence of tobacco production and/or manufacturing was assessed using tobacco-related exports as a percentage of total GDP in PSIDS. A Google search was conducted to scope consideration among PSIDS in foreign direct investment in tobacco. Out of those PSIDS with recent progress in tobacco control, Fiji arose as a case where tobacco industry interests are already present, while Vanuatu appeared under pressure to establish a local commercial tobacco industry."
2. The Pacific Monitoring Alliance for NCD Action (MANA) Dashboard may have been useful in this process, if indeed it was available at time, for sample selection.	Indeed, we would have ideally used the MANA reports for case selection; however, in 2017 (during the planning and preparation phase for data collection) these reports were not	The following was added to lines 56-57 (new text in italic): "Since FCTC Implementation reports among PSIDS are infrequently submitted*, and at the time of case selection the Pacific Monitoring Alliance for Noncommunicable*

	available for many PSIDS. We have added a sentence to line 56-57 to explain this.	*Disease Action (MANA) reports were often not available*, we used MPOWER reports to compare progress."
3. A brief explanation of the term "small islands developing states" would be useful. The term SIDS or PSIDS could be explained (briefly) - why this term and not Pacific Islands Countries (PICS) or Pacific Islands Countries and Territories (PICTS)?	We have added a brief explanation on the term SIDS to line 31 and added another sentence to lines 36-38 to explain why not the term PICs or PICTs are used.	The following amendments were made in lines 23-34: "SIDS constitute 21% of FCTC signatories yet are rarely the subject of tobacco control research. SIDS warrant special attention as a group of low- and middle income countries (LMICs) burdened by distinctive vulnerabilities – small land, population, economy and government size, geographical isolation and infrastructural challenges, dependence on the policies of larger countries, and limited ability to shape market conditions. These potentially exacerbate government fragmentation and their vulnerability to tobacco industry influence often reported in PSIDS. Understanding the ways multisectoral engagement can be strengthened in tobacco control is vital for PSIDS. Most PSIDS adopted the Tobacco Free Pacific 2025 Goal but its achievement seems unlikely, male smoking prevalence reaching as high as 56-74% in some states. This study focuses on Pacific Island Countries that are classed as PSIDS, thus have a low- or middle income economy and are independent from other states."
4. Were any local researchers involved in this study? Was this a limitation?	Due to the nature of this study being a doctoral research, the first author was responsible for planning and implementing data collection and analysis, with oversight from the co-authors. Although no local researchers were included in her supervisory panel, she has received substantial guidance during her fieldwork and analysis from high-level government officials at the Ministry of Health in both Fiji and Vanuatu. We have added this point to the limitations and added to our Acknowledgements	The following was added to lines 316-319: "As a doctoral project, funding restrictions precluded the inclusion of local Fijian or ni-Vanuatu researchers; the limitations inherent in this structure were mitigated by substantial guidance from diverse government officials in MoH in both countries." We added the following to the Acknowledgments: "We thank the government officials in the Ministry of Health of Vanuatu and the Ministry of Health and Medical Services of Fiji for their guidance in this project."
5. The concept of actor authority is interesting in respect to the various forms and ways it is expressed. Is a cultural	We found Deborah Rhodes work ('Capacity Across Cultures' and 'Facilitating Change Across Cultures') on the unique	The following was added to lines 323-325:

dimension or consideration of how these constructs are being played out or not, in the Pacific context? Was there a local iTaukei or Ni-Vanuatu version of this concept or term?	cultural contexts of Pacific SIDS particularly useful during this study. Due to linguistic and cultural limitations, we have not adopted an iTaukei or Ni-Vanuatu version of this concept. We added this point to our limitations.	"Due to cultural and linguistic limitations, we have not adopted an iTaukei or Ni-Vanuatu version of the authority constructs, which might have limited our findings."
6. How did the theoretical constructs as prescribed fit the context (given they may well have been developed and tested against European or non-Pacific or SIDS/ PSIDS contexts)?	We found that the theory of authority was applicable to the Pacific context, although we acknowledge that due to cultural and linguistic limitations, we have not adopted an iTaukei or Ni-Vanuatu version of the authority constructs, thus we might have missed some insights. We have added this to our limitations. Although we have found evidence of the existence of only 4 types of authority specific to tobacco governance, the participant data highlighted that in other areas of governance a 5th (principled authority) is likely to be relevant as well. For example, traditional iTaukei leaders and religious leaders tend to hold significant principled authority – it is only that they don't tend to be getting involved in matters of tobacco according to the participants.	The following was added to lines 323-325: "Due to cultural and linguistic limitations, we have not adopted an iTaukei or Ni-Vanuatu version of the authority constructs, which might have limited our findings."
7. What was the process of data collection – were these conducted on site or via Zoom / Skype?	We have added a sentence to line 93 to provide information on this point.	The following was added to line 82: "*Interviews were conducted in person, and in a few cases over Skype…"*
8. In terms of the data analysis – were the interviews conducted around the theoretical constructs or were these 'applied' to the data after the interviews were conducted.	We have amended the methods section at line 84 to clarify the way the theoretical constructs informed the interview questions and that the coding of the data was conducted according to the theoretical constructs. Moreover, we have added a column to Table 1 to provide examples of quotes to demonstrate how we interpreted the data based on the theoretical constructs.	We have amended the text in lines 82-88 as follows: "Interviews were conducted in person, and in a few cases over Skype, and were characterised by semi-structured and open-ended questions that were designed to explore actor interests, mandates, and influence to identify the sources and dynamics of authority among actors. For example, the questions included "What authority does your unit hold over tobacco governance?" or "What are the challenges of multisectoral coordination?" Interviews were transcribed, coded against the theoretical constructs and analysed using NVivo."

9. The example questions included are quite technical – were these paraphrased or adapted accordingly? Given the capacity challenges would it be expected that all interviewees would be familiar with the concepts?	Indeed, the interview questions were paraphrased to support the ease of the conversation with participants. We have amended lines 93-96 to clarify our approach. (Also, please see our response to Reviewer 2 on this point.)	We have amended the text in lines 82-88 as follows: "Interviews were conducted in person, and in a few cases over Skype, and were characterised by semi-structured and open-ended questions that were designed to explore actor interests, mandates, and influence to identify the sources and dynamics of authority among actors. For example, the questions included "What authority does your unit hold over tobacco governance?" or "What are the challenges of multisectoral coordination?" Interviews were transcribed, coded against the theoretical constructs and analysed using NVivo."