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An overview of tobacco control and prevention policy status in Africa

Muhammad Jami Husain [a,*], Lorna McLeod English [a], Nivo Ramanandraibe [b]

[a] Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, GA, United States
[b] Regional Office for Africa, World Health Organization, Brazzaville, Congo

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ABSTRACT

Tobacco smoking prevalence remains low in many African countries. However, growing economies and the increased presence of multinational tobacco companies in the African Region have the potential to contribute to increasing tobacco use rates in the future. This paper used data from the 2014 Global Progress Report on implementation of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), as well as the 2015 WHO report on the global tobacco epidemic, to describe the status of tobacco control and prevention efforts in countries in the WHO African Region relative to the provisions of the WHO FCTC and MPOWER package. Among the 23 countries in the African Region analyzed, there are large variations in the overall WHO FCTC implementation rates, ranging from 9% in Sierra Leone to 78% in Kenya. The analysis of MPOWER implementation status indicates that opportunities exist for the African countries to enhance compliance with WHO recommended best practices for monitoring tobacco use, protecting people from tobacco smoke, offering help to quit tobacco use, warning about the dangers of tobacco, enforcing bans on tobacco advertising and promotion, and raising taxes on tobacco products. If tobacco control interventions are successfully implemented, African nations could avert a tobacco-related epidemic, including premature death, disability, and the associated economic, development, and societal costs.

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1. Introduction

Tobacco use is the leading cause of preventable deaths in the world (World Health Organization, 2008). During the 20th century, the tobacco epidemic contributed to an estimated 100 million deaths worldwide (World Health Organization, 2008). Tobacco use continues to kill nearly 6 million persons each year, including approximately 600,000 from secondhand smoke (World Health Organization, 2008; Eriksen et al., 2012). If the current trend persists, it is projected that tobacco use will kill over 8 million people per year by 2030, with 80% of these deaths occurring in low or middle-income countries (World Health Organization, 2008; Eriksen et al., 2012). Cigarette smoking has declined significantly in developed countries; however, it is increasing in low and middle income countries (Drope, 2011). Many countries in the African Region have relatively low cigarette smoking prevalence as compared with other World Health Organization (WHO) Regions (Eriksen et al., 2012). However, economic growth outlook in the Region, combined with increased presence of multinational tobacco companies and product marketing, has the potential to increase tobacco use and tobacco-related disease and death (Doku, 2010).

In response to the global tobacco epidemic, most countries have pledged to comply with the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC). The WHO FCTC, which came into force in 2005, is the first global evidence-based public health treaty to protect people from the negative consequences of tobacco use (World Health Organization, 2003; World Health Organization, 2015a). In the decade since WHO FCTC was introduced, steady progress on implementing WHO FCTC provisions has been achieved in many countries, including increasing tobacco taxes, expanding protections from tobacco smoke through smoke-free policies, regulating additives in tobacco products, prohibiting tobacco displays at points of sale, introducing large health warnings on packages, and using mobile and internet technologies for promoting smoking cessation (World Health Organization, 2014).

Subsequently, in 2008, WHO introduced the MPOWER measures, which assist in the country-level implementation of effective interventions to reduce the demand for tobacco that are contained in the WHO FCTC (World Health Organization, 2015b). The policy package consists of the following measures: **M:** monitor tobacco use; **P:** protect people from tobacco smoke; **O:** offer help to quit tobacco use; **W:** warn about the dangers of tobacco; **E:** enforce bans on tobacco advertising and promotion; **R:** raise taxes on tobacco products. The **MPOWER** package of tobacco control policies and interventions has been used effectively by

* Corresponding author at: Global Tobacco Control Branch, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway N.E., Mailstop F-79, Atlanta, GA 30341-3717, United States.
E-mail address: MHusain@cdc.gov (M.J. Husain).

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countries to plan, build, and evaluate progress toward implementing the WHO FCTC's provisions (World Health Organization, 2015b).

We used data from the 2014 Global Progress Report on implementation of the WHO FCTC, as well as the 2015 WHO report on the global tobacco epidemic, to describe the status of tobacco control and prevention efforts in countries in the WHO African Region relative to the provisions of 16 substantive Articles of the WHO FCTC and the MPOWER package. A comparison of the WHO FCTC implementation status between the African Region and the remaining five WHO Regions is also presented.[1] Given some of the challenges that the African Region faces in the fight against tobacco use, this paper highlights the importance of proactive interventions, in compliance with WHO FCTC and MPOWER provisions, to prevent and control tobacco use.

2. Method

2.1. WHO FCTC implementation status

As of June, 2015, 38 of the 47 countries in the WHO African Region had ratified the WHO FCTC, and 5 countries are in accession status. Mozambique has signed but not ratified the Treaty, and Eritrea, Malawi, and South Sudan have neither signed nor ratified it (United Nations, 2015). Parties that have ratified the WHO FCTC have reporting obligations, and are required to submit standardized progress reports to the Convention Secretariat in each reporting cycle by filling out a standardized questionnaire. The Convention Secretariat maintains the global progress reports and the implementation database to track the achievements, as well as the areas in which more progress is warranted (World Health Organization, 2015a, 2014). In the 2014 reporting cycle, 73% of Parties (i.e. 130 in 177 countries) submitted their implementation reports to the Convention Secretariat. In the WHO African Region, 23 of the 43 Parties (i.e. countries in ratification or accession status) submitted the report.

The reporting instrument contains information on ~230 indicators relevant to a list of WHO FCTC Articles, from which a select 148 indicators are used to assess the current status of implementation of select WHO FCTC Articles (World Health Organization, 2014). The 2014 Global Progress Report provides information, for each country, on the number of indicators considered under a particular Article, as well as the maximum number (or score) which a Party (country) can be given for complying with the requirements of that Article. Compliance or implementation of a particular indicator mainly refers to whether the reporting countries recorded affirmative or negative response for that indicator (World Health Organization, 2014). For this study, the implementation rate for each WHO FCTC Article in each country was calculated as the ratio of implemented indicators to the total number of indicators considered under that Article. The average implementation rate for each Article refers to the average (i.e. mean) of the implementation rates for countries in the Region.

Table 1 provides further details on each Article assessed in this study. Out of the total 38 Articles in the WHO FCTC, 16 Articles are identified as substantive Articles in the 2014 Global Progress Report: Article 5 lays out the general obligations for the party to develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programs; Articles 6, 8–14 contain the core demand reduction provisions; Articles 15–17 contain the core supply reduction measures; Article 18 contains the provisions pertaining to the protection of the environment; Article 19 lays out the liability provisions; Article 20 calls on parties to develop and promote research, surveillance and exchange of information; and Article 22 lays out the obligations about cooperation in the scientific, technical, and legal fields, and the provision of related expertise (World Health Organization, 2003).

2.2. MPOWER implementation status

We used data from the 2015 WHO report on the global tobacco epidemic to summarize the MPOWER implementation status in 47 countries in the WHO African Region (World Health Organization, 2015c). The implementation status of MPOWER tracks country progress on select indicators, unlike the WHO FCTC global progress report where a comprehensive list of 148 indicators pertaining to 16 selected Articles are considered. The MPOWER report measures the extent of enforcement on specific indicators corresponding to each of the MPOWER components.

The status of the 'M' component is measured by the extent to which countries have survey data on tobacco use among adults and youths that are recent and representative. The status of the 'P' component is measured by assessing country specific legislation to determine the extent to which smoke-free laws are implemented that prohibit smoking in indoor environment at all times in eight different types of location (World Health Organization, 2015c). The 'O' component is tracked by assessing achievement in treatment for tobacco dependence, which is based on whether the country has available nicotine replacement therapy (NRT), non-NRT tobacco dependence treatment, reimbursement for either, and a national toll-free quit line (World Health Organization, 2015c). Implementation status of the 'W' is assessed by two main sub-components: attributes of warning labels on tobacco packaging, and the frequency and characteristics of the anti-tobacco mass media campaigns by the respective countries (World Health Organization, 2015c). The 'E' component describes the country level achievements in banning tobacco advertising, promotion, and sponsorship, and was assessed by whether the bans covered various forms of direct advertising, including television, radio, print media, billboards and outdoor advertising, and point of sale; additionally, various forms of indirect advertising were assessed, including promotions, discounts, coupons, free distribution of tobacco products, brand stretching, sharing, and placement activities, and sponsorship including corporate social responsibility programs (World Health Organization, 2015c). To gauge the status of the 'R' component, countries are classified according to the percentage contribution of all taxes to the retail price of tobacco products (World Health Organization, 2015c).

3. Results

3.1. Implementation status of WHO FCTC provisions in the African Region

Fig. 1 shows the average implementation rates of selected WHO FCTC Articles, comparing the African Region with the remaining five WHO Regions. The articles reporting the highest implementation rates across the 23 African countries included in the analysis are: Article 12 (66%; Education, communication, training and public awareness), Article 8 (63%; Protection from exposure to tobacco smoke), Article 11 (62%; Packaging and labeling of tobacco products), and Article 5 (61%; General obligations). The articles for which the implementation rates were moderate were: Article 16 (55%; Sales to and by minors), Article 13 (53%; Tobacco advertising, promotion and sponsorship), Article 15 (50%; Illicit trade in tobacco products), Article 6 (49%; Price and tax measures to reduce the demand for tobacco), Article 10 (46%; Regulation of tobacco product disclosures), Article 22 (45%; Cooperation in the scientific, technical and legal fields and provision of related expertise), and Article 20 (33%; Research, surveillance and exchange of information). The articles reporting the lowest implementation rates were: Article 9 (30%; Regulation of the contents of tobacco products), Article 14 (28%; Demand reduction measures concerning tobacco dependence and cessation), Article 18 (23%; Protection of the environment and the health of persons), Article 19 (11%; Liability), and Article 17 (9%; Provision of support for economically viable alternative activities).

Fig. 1 also shows the average implementation rates by 107 countries in the remaining five WHO Regions. The overall implementation rate, calculated based on the implementation rates by article as shown in Fig. 1, was 43% for the African Region, as compared to 53% by the countries in the remaining WHO Regions. By Article, significant differences in implementation rates for the African Region vs. other Regions were observed for: Article 14 (28% vs. 57%, $p = 0.000$); Article 16 (55% vs. 77%, $p = 0.000$); Article 20 (33% vs. 55%, $p = 0.002$); Article 9 (30% vs. 52%; $p = 0.019$); Article 6 (49% vs. 64%; $p = 0.066$); and Article 11 (62% vs. 76%; $p = 0.055$).[2]

Table 2 shows the status of implementation of select Articles by the Parties in the WHO African Region. Among the 23 countries in the

[1] The six WHO Regions are used in the analysis: African Region, Region of the Americas, South-East Asia Region, European Region, Eastern Mediterranean Region, and Western Pacific Region. The sub-Saharan Africa and some of the North African countries are included in the WHO African Region, while most of the North African countries are included in the Eastern Mediterranean Region.

[2] The reported p-values are from t-tests. Chi-square tests and Wilcoxon rank-sum tests produced similar results.

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