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Tobacco Control in Sub-Saharan Africa: Challenges and Recommendations

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Abstract

According to the World Health Organization, more than 80% of the world's current smokers live in low- and middle- income countries. In Sub-Saharan Africa (SSA), the increase in tobacco smoking is facilitated by the fast-growing population, increase in purchasing power of the consumers and massive efforts by the tobacco industry to expand their reach in this region. Until the World Health Organization's Framework Convention on Tobacco Control (FCTC), many countries in SSA had weak or non-existent tobacco control policies, about 44 countries in the region are currently signatories to the treaty. Despite being signatories to the FCTC, many sub-Saharan African countries have not been able to implement and/or enforce comprehensive tobacco control policies. This chapter is intended to share the challenges facing existing public health advocacy and interventions against tobacco smoking in SSA countries and to make recommendations necessary to control tobacco smoking in the SSA countries.

Keywords: tobacco control, sub-Saharan Africa, smoking, FCTC, harm reduction

1. Introduction

Tobacco use poses a major threat to global public health [1]. The number of smokers globally has now risen to 1.3 billion and may reach 1.5 billion by 2025 with low-and-middle-income countries (LMICs) having 80% of the global smoking population [2, 3]. By 2025, the smoking rate in sub-Saharan Africa is estimated to be about 37%, the highest estimated growth among the six World Health Organization (WHO) regions [4].

African countries are therefore positioned on the upward slope of the smoking prevalence curve, denoting a high vulnerability to further penetration of markets by multinational tobacco corporations through advertising, increased competition for sales and large-scale promotion of appealing images of smokers, encouraging

experimental smoking [5–7]. Effective tobacco control is imperative in Africa as it is well-documented in literature that the region is suffering from the double burden of communicable and non-communicable diseases [8].

The answer to the increasing danger of the global tobacco epidemic is often pointed to as the WHO Framework Convention on Tobacco Control (FCTC) by the anti-tobacco advocacy groups, which is the first international treaty on tobacco control [9]. MPOWER is another policy package intended to aid in the country-level implementation of effective interventions to reduce the demand for tobacco, as ratified by WHO FCTC. The six evidence-based components of MPOWER are: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; Raise taxes on tobacco [10].

Looking at the status of legislation on tobacco control in Africa, Sub-Saharan Africa (SSA) countries are still far from the benchmark on implementation of the FCTC stipulations. In countries like South Africa and Kenya, favorable political environments and adequate knowledge provide fertile grounds for the implementation of FCTC and the MPOWER measures while in countries like Nigeria, Malawi and Ghana, prioritization, lack of enforcement of existing tobacco control initiatives, and lack of capacity are factors shown to be major obstacles hindering effective policy implementation [7, 11–13].

Many advocacy groups and governments use the MPOWER policy package and the WHO FCTC as the benchmark for tobacco-related advocacy. To ensure the success of FCTC, a formal agreement of the ratification must be followed by implementation tailored to the particular challenges of SSA countries, putting to use, lessons from schemes that have been proven to work in other environments. There is emerging advocacy for Tobacco Harm Reduction, an option proven to reduce the harm from tobacco consumption with alternative nicotine products such as e-cigarettes and snus, in SSA by some advocacy groups.

2. Case

Many African countries are struggling to implement the recommendations of the treaty in a way that matches the unified action of member countries during the treaty negotiations. Implementation of the FCTC recommendations varies greatly across the SSA countries ranging from 9% in Sierra Leone to 78% in Kenya [14].

South Africa is making strides in tobacco control, putting to use a couple of opportunities presented by the African National Congress [12]. It has successfully put in place, legislation that bans smoking in outdoor locations and has introduced bans on smoking in other public places. It became the first country in the world to have a national ban on smoking in cars where children (≤12 years) are present and also made significant efforts towards a smoke-free world cup in 2010 [12].

Nigeria's first attempt to control tobacco consumption in furtherance of public health was in the form of the Tobacco (Control) decree in 1990 [12]. A National Tobacco Control Act (NTCA), 2015 was signed into law after the presidency had earlier refused to assent to an earlier Tobacco Control bill that was passed in the senate and house of representatives in 2011 [13]. The NTCA as it is, contains significant loopholes that loosen its ultimate control over the production, sale, and distribution of tobacco in the country.

A National Tobacco Control Committee (NATOCC) was created to advise the Federal Ministry of Health (FMoH) on the implementation of tobacco control policies. The NATOCC however, includes representatives of the Manufacturers Association of Nigeria (MAN) (which includes the tobacco industry), in violation of Article 5.3 of the WHO FCTC, providing an avenue for the tobacco industry to influence the implementation of the tobacco control policies [13]. The act also requires that regulations proposed by the Federal Ministry of Health (FMoH) be approved by both houses of the National Assembly, reducing the independence of the FMoH and allowing the industry ample opportunity to influence tobacco control by lobbying with legislators. The Standards Organization of Nigeria (SON), developed the Nigerian Industrial Standards (NIS) for cigarettes, responsible for the control of the constituents and emissions of cigarettes, and with the backing of the laws governing the organization, involved the tobacco industry and excluded the FMoH in the development of the NIS [13].

Kenya passed its first tobacco Control Bill in 1998 and made history by being the second country in the world to ratify and sign the WHO FCTC on the same day in 2014. Kenya also passed its first post-FCTC control bill in 2007 [12]. Strong local evidence on the economic effects of tobacco use, coupled with political factors provided the required impetus for the development and implementation of strategies by Kenya to control the production, sale, and distribution of tobacco in Kenya. The Tobacco Control Act (TCA)←←←← of 2007 developed to implement the WHO FCTC policies remains the main tobacco control policy document in Kenya. The provisions of the TCA have been implemented in Kenya although there is room for improvement [7]. The Finance Act in Kenya has stipulated an increase in the excise duty of tobacco products at 35% (which however remains lower than the 70% recommended by the WHO) [7]. Tobacco smoking has now been banned in all public places with enforcement in most areas. Although, signs and billboards can still be found in certain parts of the country [15], advertisement, promotion, and sponsorship has been completely banned in the country by the TCA [12].

Malawi, despite having five documents on tobacco and tobacco smoking is not a signatory to WHO FCTC [12]. Besides this, the Malawian economy is largely reliant on tobacco farming and implementation of some articles of the WHO FCTC according to key players, is feared by the government and has received resistance from farmers and the tobacco industry [12]. With the belief that ratifying parts of the FCTC to limit exposure to tobacco smoke will lead to the implementation of all aspects of the FCTC, including Articles 17 and 18, which discourage support for tobacco farming and will have an untoward impact on the national economy due to their reliance on tobacco farming as their cash crop in Malawi [12, 16]. Foundation for Smoke-free World has been working with national authorities, partners, and tobacco farmers to help smallholder tobacco farmers transit to alternative livelihoods.

A paradoxical observation made during the study of the global rate of reduction in tobacco smoking to observe changes in the rate after 2003 was that while there was no significant difference in the rates of reduction of tobacco smoking -before and after 2003- globally, stratified analyses showed that European and other high income countries have seen increased rates of reductions in tobacco smoking while low-and-middle-income countries and Asian countries have seen a reversal in the reducing rate of tobacco smoking after the adoption of FCTC in 2003 in such a way that LMICs as well as Asian countries are consuming in excess of what they used to, enough cigarettes to make up for the reduction in consumption in their high income and European counterparts [17]. A possible explanation would be that implementation

of FCTC provisions in high income and European countries have facilitated the shift in focus of the tobacco industry to LMICs and Asian countries where governmental control is not as stringent [9].

Therefore, the role the tobacco industry plays in the effectiveness of FCTC in SSA countries cannot be overestimated. Ranging from allegedly sponsoring "researches" and analyses that debunk the WHO claims about the health hazards of tobacco smoking, to mongering the notion among stakeholders in SSA countries that relates reduction in tobacco cultivation with malignant economic trends, the tobacco industry is indeed clawing back at the initiatives put forward to curb tobacco smoking in the grand stages of policy making and nuances of implementation.

In complement with the FCTC, Tobacco Harm Reduction (THR) provides another option worth exploring. It involves the use of less harmful nicotine products, e.g., snus and e-cigarettes as a substitute for tobacco smoking. Many tobacco control advocacy groups such as the Nigeria Tobacco Control Alliance, the Environmental Rights Action/Friends of the Earth Nigeria and Campaign for Tobacco-Free Kids among others strongly resist the concept of THR because of misconceptions surrounding the use of these products, e.g., exaggerated health impacts of nicotine and normalization of the use of these products among others.

Nonetheless, the use of these products is increasing globally and SSA will not be an exception. Additionally, there is an increase in a number of tobacco harm reduction advocacy groups in SSA, e.g., Tobacco Harm Reduction Nigeria, Tobacco Harm Reduction Kenya, Tobacco Harm Reduction Malawi, Tobacco Harm Reduction Uganda and Campaign for Safer Alternatives among others. Moreover, the first tobacco harm reduction forum by Campaign for Safer Alternatives is scheduled to hold in Nairobi, Kenya but was canceled because of the unprecedented novel coronavirus pandemic.

3. Discussion

Being a pacesetter, the FCTC was undoubtedly a much-needed stride in the control of the global tobacco epidemic. However, it requires adaptation to overcome the significant challenges it faces in the developing world. It is, therefore, necessary to incorporate some concepts not covered in FCTC and MPOWER if the public health implications of tobacco smoking in SSA are to be checked.

The status quo dictates that current smokers have only two options, complete cessation and abstinence from tobacco or continued use in the face of overwhelming evidence of the harmful effects of tobacco smoking on the health of the user, bystanders, and on the environment [18, 19]. A lot of smokers are unable, or unwilling to stop smoking, and the majority of those who quit, relapse within months. This necessitates the introduction of a third option that caters for those that are unable to quit smoking while producing less harm than that produced from traditional tobacco smoking; Tobacco Harm Reduction [18].

Despite being relatively new in SSA, the concept of THR is not new in the western part of the world, having had its fair share of controversies and debates. It has also proven efficacious in the reduction of the prevalence of tobacco smoking as observed in Sweden and Norway with the THR product, Snus [18, 20]. A THR product that is garnering support is the e-cigarette which due to its appearance and mode of use, is touted to imitate the social cues of smoking traditional cigarettes and therefore, provide better help with components of addiction to tobacco smoking not directly related to the addictive component, nicotine.

There is not enough evidence to prove that THR products are absolutely safe when used as intended as e-cigarette vapor for instance contain potentially toxic compounds [18, 19] . However, they are much safer alternatives, devoid of the contaminants and toxic combustion products of cigarettes. They have toxicity profiles, comparable with the FDA-approved pharmaceutically-formulated smoking-cessation aids [18]. THR advocacy groups continue to advocate the inclusion of "ED" to MPOWER policy package so it can become MPOWERED, where E is Encourage Safer Alternatives and D is Deliver accurate & honest information regarding THR.

Successful reduction of the public health risk of tobacco smoking in SSA will require that policymakers at all levels deploy schemes and policies that allow for better acceptance and market flow of THR products while keeping stringent measures on tobacco smoking. Extensive research will also be required to keep tabs on the socio-economic effects of substituting THR products for traditional cigarettes, as well as on public health and the prevailing perspective and practice of healthcare providers.

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Conflict of interest

Aishat Jumoke Alaran and Yusuff Adebayo Adebisi are both beneficiaries of the Tobacco Harm Reduction Scholarship Programme by Knowledge-Action-Change, London. Aishat Jumoke Alaran is a 2020 beneficiary while Yusuff Adebayo Adebisi is a 2019 beneficiary. Both authors are advocates of Tobacco Harm Reduction.

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References

[1] Alfred L, Jnr D, Fabyan M, Dei LA Jr. The threats of globalization on global public health with specific reference to tobacco control. Public Health Research. 2016;**6**:132

[2] World Heath Organization. Global action plan for the prevention and control of noncommunicable diseases. Geneva Switzerland: World Health Organization 2013-2020; 2013

[3] Jha P, Peto R. Global effects of smoking, of quitting, and of taxing tobacco. The New England Journal of Medicine. 2014;**370**:60

[4] Bilano V, Gilmour S, Moffiet T, D'Espaignet ET, Stevens GA, Commar A, et al. Global trends and projections for tobacco use, 1990-2025: An analysis of smoking indicators from the WHO Comprehensive information Systems for Tobacco Control. Lancet. 2015;**385**:966-976

[5] Pampel F. Tobacco use in sub-Sahara Africa: Estimates from the demographic health surveys. Social Science & Medicine. 2008;**66**:1772

[6] Siddiqi K. Tobacco use in sub-Saharan Africa: The risks and challenges. Nicotine & Tobacco Research. Oxford University Press. 2019;**21**:999

[7] Magitta NF. Epidemiology of tobacco use and dependence in Sub-Saharan Africa: A systematic review. Journal of Pulmonology and Clinical Research. 2018;**2**(1):9-15

[8] Lucero-Prisno DE, Adebisi YA, Lin X. Current efforts and challenges facing responses to 2019-NCoV in Africa. Global Health Research and Policy. 2020;**5**:21

[9] Hoffman SJ, Poirier MJP, Rogers Van Katwyk S, Baral P, Sritharan L. Impact of the WHO framework convention on tobacco control on global cigarette consumption: Quasi-experimental evaluations using interrupted time series analysis and in-sample forecast event modelling. British Medical Journal. 2019;**365**:1

[10] World Heath Organization. WHO Report on the Global Tobacco Epidemic 2019. Offer Help to Quit Tobacco Use; 2019

[11] Owusu-Dabo E, McNeill A, Lewis S, Gilmore A, Britton J. Status of implementation of framework convention on tobacco control (FCTC) in Ghana: A qualitative study. BMC Public Health. 2010;**10**:1

[12] Wisdom JP, Juma P, Mwagomba B, Ndinda C, Mapa-Tassou C, Assah F, et al. Influence of the WHO framework convention on tobacco control on tobacco legislation and policies in sub-Saharan Africa. BMC Public Health. 2018;**18**:954-965

[13] Egbe CO, Bialous SA, Glantz S. Framework convention on tobacco control implementation in Nigeria: Lessons for low- a Nd middle-income countries. Nicotine & Tobacco Research. 2019;**21**:1122

[14] Brathwaite R, Addo J, Smeeth L, Lock K. A systematic review of tobacco smoking prevalence and description of tobacco control strategies in sub-Saharan African countries; 2007 to 2014. 2015;**1**

[15] Shoba J. Best practices in implementation of article 13 of the WHO FCTC case study: Kenya, 2013. 2013;**13**

[16] Otañez MG, Mamudu HM, Glantz SA. Tobacco companies' use of developing countries' economic reliance on tobacco to lobby against global tobacco control: The case of Malawi. American Journal of Public Health. 2009;**99**:1759

[17] Eriksen M, Mackay J, Ross H. The Tobacco Atlas. 4th ed. Atlanta, GA: World Lung Foundation. Available from: http://Tobaccoatlas.Org/; World Med. Heal. Policy 5, 2742013

[18] Polosa R, Rodu B, Caponnetto P, Maglia M, Raciti C. A fresh look at tobacco harm reduction: The case for the electronic cigarette. Harm Reduction Journal. 2013;**10**:1

[19] Nansseu JRN, Bigna JJR. Electronic cigarettes for curbing the tobacco-induced burden of noncommunicable diseases: Evidence revisited with emphasis on challenges in sub-Saharan Africa. Pulmonary Medicine. 2016;**2016**

[20] Ramström L, Borland R, Wikmans T. Patterns of smoking and SNUS use in Sweden: Implications for public health. International Journal of Environmental Research and Public Health. 2016;**13**:1