Landscape of tobacco control in sub-Saharan Africa

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ABSTRACT

Yearly, tobacco use kills about 8 million people globally, 80% of whom live in low/middle-income countries. Given sub-Saharan Africa's (SSA) rapidly increasing and youthful population, growing incomes and the increased presence of the tobacco industry, the number of tobacco users is growing. The region is predicted to face a heavier burden of tobacco-related diseases and deaths in the future. We examined the policy, advocacy, economic and media landscapes of tobacco control as well as tobacco industry interference in SSA. We also highlighted key challenges and priorities for intervention in the region. Their vast financial power has enabled transnational tobacco companies to interfere in tobacco control and slow down policy implementation efforts in SSA. Despite recent gains, inadequate investment in tobacco control has prevented effective tobacco control implementation in SSA. Other challenges include limited locally generated evidence and limited support from mainstream media to back policy and advocacy efforts. Finally, taxation, which is one of the most effective tools for tobacco control, is not yet adequately used in SSA partly due to non-harmonised taxation rates as well as exaggerated and false claims about the potential impacts of increasing taxes, especially that it will increase smuggling. Key priorities to address these challenges include continued strategic funding, capacity building of government and advocacy personnel to strengthen tobacco control governance, regional and institutional cooperation, harmonisation of subregional tax policies, cooperation among international funders, and increased industry monitoring and research in SSA.

INTRODUCTION

Of 8 million tobacco-related deaths annually, 80% occur in low/middle-income countries (LMICs).[1] Sub-Saharan Africa (SSA) has the lowest tobacco use prevalence[1] and the youngest population, but the region has witnessed the largest relative increase in the number of tobacco users than in other regions,[1 2] making it the predicted future tobacco epidemic epicentre.[1]

This paper explores the tobacco control (TC) policy/advocacy, media and economic landscape in SSA, as well as key challenges and priorities.

TOBACCO EPIDEMIC IN SSA

Smoking prevalence in the WHO AFRO region remains the lowest among all WHO regions,[3] but the region is predicted to experience the second lowest real decrease in smoking prevalence of 3.2% due to smaller decline in prevalence.[3] The number of tobacco smokers in the AFRO region was estimated at 52 million in 2000 but increased to 66 million in 2015 and is projected to increase to 84 million in 2025 (there will be a 61.5% relative increase in the number of smokers compared with 2000) making the region one of the only two regions in the world projected to have an increase in the number of tobacco smokers, the second being the Eastern Mediterranean region.[3] SSA remains a viable investment destination for the tobacco industry because of the region's youthful population (the population is predicted to double by 2050).[4 5] Markets in SSA are often unregulated, cigarette prices are low, and TC laws are weak or when strong, not fully implemented and enforced.[6] Limited resources are allocated to healthcare; health infrastructure is poor,[7] industry interference is rife,[8] effective national TC governance and political goodwill to implement tobacco legislation is sometimes lacking[9] creating a possibility of more devastating health effects if the predicted tobacco epidemic occurs in the region.

SSA'S TC POLICY AND ADVOCACY LANDSCAPE

In SSA, 43 of 46 countries have signed, ratified or acceded to the WHO Framework Convention on Tobacco Control (WHO FCTC)[10] (table 1), representing about 25% of all parties to the treaty. However, ratifying or acceding to the FCTC is only the first step towards effective TC. Countries must domesticate the treaty by formulating and implementing comprehensive and effective TC policies to benefit fully.

Figure 1 shows percentage of SSA countries with laws covering three key FCTC articles: 100% smoke-free policy (Article 8), health warning labels (Article 11), bans on tobacco advertisement, promotion and sponsorships (Article 13).[11] Overall, a higher percentage of SSA countries appears to be doing well in banning tobacco advertisement, promotion and sponsorship, followed by health warnings on tobacco packages. However, for all provisions of a 100% smoke-free policy, less than 50% of SSA countries have put in place appropriate legislation.[11]

FCTC implementation requires effective TC governance involving a whole of government approach and intergovernmental cooperation as well as multisectoral implementation of TC.[12] Many countries in SSA now recognise the role of civil society organisations (CSOs) as legitimate representation of the people, for example, in Nigeria, CSOs are members of the National Tobacco Control Committee set up to see to the effective implementation of TC.[13] However, dynamics of TC policymaking are complex—government ministries, especially commerce/trade, finance and agriculture, sometimes work in opposition to health ministries.[14] The industry enlists government officials in opposing FCTC

Table 1 WHO FCTC and protocol to eliminate illicit trade in tobacco products status with retail price and total tax share of the most sold brand of cigarettes, in sub-Saharan Africa

	FCTC status		PEITTP status		Retail price in US$	Excise tax	VAT/sales tax	Import duties	Other taxes	Percentage of total tax
Country	Signature	Ratification*	Signature	Ratification*†						
Angola	29 Jun 2004	20 Sep 2007	-	-	2.34	16.43%	15.38%	0.00%	3.67%	35.47
Benin	18 Jun 2004	3 Nov 2005	24 Sep 2013	6 Jul 2018	1.56	3.93%	2.17%	5.82%	0.19%	12.11
Botswana	16 Jun 2003	31 Jan 2005	1 Oct 2013	-	0.90	7.77%	1.40%	0.00%	0.37%	9.54
Burkina Faso	22 Dec 2003	31 Jul 2006	8 Mar 2013	30 Mar 2016	4.31	35.15%	10.71%	0.00%	6.30%	52.17
Burundi	16 Jun 2003	22 Nov 2005	-	-	1.35	28.25%	15.25%	0.00%	0.00%	43.50
Cabo Verde	17 Feb 2004	4 Oct 2005	-	16 Oct 2019*	1.04	22.00%	15.25%	0.00%	0.00%	37.25
Cameroon	13 May 2004	3 Feb 2006	-	-	2.66	12.92%	2.78%	3.73%	0.05%	19.49
Central African Republic	29 Dec 2003	7 Nov 2005	-	-	1.26	20.51%	16.14%	4.79%	1.75%	43.19
Chad	22 Jun 2004	30 Jan 2006	-	13 Jun 2018*	-		-	-	-	-
Comoros	27 Feb 2004	24 Jan 2006	-	14 Oct 2016*	0.90	32.10%	15.25%	0.00%	4.24%	51.60
Congo	23 Mar 2004	6 Feb 2007	-	14 May 2015	0.96	62.76%	9.09%	0.00%	1.99%	73.84
Côte d'Ivoire	24 Jul 2003	13 Aug 2010	24 Sep 2013	25 May 2016	1.35	10.97%	15.90%	0.00%	0.00%	26.87
Democratic Republic of Congo	28 Jun 2004	28 Oct 2005	9 Dec 2013	-	1.26	16.29%	15.25%	0.00%	3.00%	34.54
Equatorial Guinea	-	17 Sep 2005*	-	-	0.51	38.31%	13.79%	0.00%	0.00%	52.11
Eritrea	-	-	-	-	0.90	8.02%	6.25%	9.62%	0.32%	24.21
Eswatini	29 Jun 2004	13 Jan 2006	-	21 Sep 2016*	-	…	-	-	-	-
Ethiopia	25 Feb 2004	25 Mar 2014	-	-	1.15	40.78%	10.39%	0.00%	0.00%	51.16
Gabon	22 Aug 2003	20 Feb 2009	10 Jan 2013	1 Oct 2014†	1.81	8.44%	4.94%	7.79%	0.38%	21.55
Gambia	16 Jun 2003	18 Sep 2007	-	26 Sep 2016*	1.35	35.71%	6.92%	1.74%	4.38%	48.75
Ghana	20 Jun 2003	29 Nov 2004	24 Sep 2013	-	0.88	16.51%	14.89%	0.00%	0.35%	31.75
Guinea	1 Apr 2004	7 Nov 2007	-	9 May 2017*	0.52	3.89%	2.87%	2.60%	0.36%	9.71
Guinea-Bissau	-	7 Nov 2008*	24 Sep 2013		-		-	-	-	-
Kenya	25 Jun 2004	25 Jun 2004	29 May 2013	4 May 2020	2.32	25.26%	13.79%	0.00%	0.00%	39.05
Lesotho	23 Jun 2004	14 Jan 2005	-	-	2.77	37.54%	13.04%	0.00%	0.00%	50.58
Liberia	25 Jun 2004	15 Sep 2009	-	-	1.41	46.52%	9.09%	1.07%	0.11%	56.78
Madagascar	24 Sep 2003	22 Sep 2004	25 Sep 2013	21 Sep 2017	1.05	63.61%	16.67%	0.00%	0.15%	**80.43**
Malawi	-	-	-	-	0.71	42.16%	14.16%	0.00%	0.00%	56.32
Mali	23 Sep 2003	19 Oct 2005	8 Jan 2014	17 Jun 2016	1.44	11.18%	9.19%	6.51%	0.81%	27.69
Mauritania	24 Jun 2004	28 Oct 2005			1.07	1.99%	1.66%	1.37%	0.89%	5.91
Mauritius	17 Jun 2003	17 May 2004	-	26 Jun 2018*	3.75	68.15%	13.04%	0.00%	0.00%	**81.19**
Mozambique	18 Jun 2003	14 Jul 2017	-	-	0.85	14.00%	14.53%	0.00%	0.00%	28.53
Namibia	29 Jan 2004	7 Nov 2005	-	-	3.58	29.00%	13.04%	0.00%	0.00%	42.04
Niger	28 Jun 2004	25 Aug 2005	-	12 Jul 2017*	0.90	14.96%	15.97%	0.00%	0.89%	31.82
Nigeria	28 Jun 2004	20 Oct 2005	-	8 Mar 2019*	1.05	30.00%	6.98%	0.00%	0.00%	36.98
Rwanda	2 Jun 2004	19 Oct 2005	-	-	1.06	49.00%	15.25%	0.00%	0.00%	64.25
Sao Tome & Principe	18 Jun 2004	12 Apr 2006	-	-	1.42	29.15%	0.00%	4.54%	0.00%	33.69
Senegal	19 Jun 2003	27 Jan 2005	-	31 Aug 2016*	1.26	22.99%	15.25%	0.00%	0.00%	38.24
Seychelles	11 Sep 2003	12 Nov 2003	-	7 Jan 2020*	7.12	56.46%	13.04%	0.00%	0.00%	69.51
Sierra Leone	-	22 May 2009*	-	-	0.62	4.29%	13.04%	5.01%	0.21%	22.56
South Africa	16 Jun 2003	19 Apr 2005	10 Jan 2013	-	2.62	39.69%	13.04%	0.00%	0.00%	52.73
South Sudan	-	-	-	-	2.44	33.90%	15.25%	0.00%	16.95%	66.10
Togo	12 May 2004	15 Nov 2005	9 Jan 2014	31 Jan 2018	2.57	40.47%	13.04%	0.00%	0.00%	53.51
Uganda	5 Mar 2004	20 Jun 2007			1.26	25.46%	15.25%	0.00%	0.65%	41.37
United Republic of Tanzania	27 Jan 2004	30 Apr 2007	24 Sep 2013	-	1.09	27.50%	7.08%	0.00%	0.00%	34.58
Zambia	-	23 May 2008*	-	-	1.74	14.71%	15.25%	0.00%	0.00%	29.97
Zimbabwe	-	4 Dec 2014*	-	-	1.16	25.00%	13.79%	0.00%	0.00%	38.79

Data source for FCTC and PEITTP status: United Nations Treaties.[10 66] Price and tax share data source: 2021 WHO Global Tobacco Control Report.[39]
Values in bod are the ones which are above the threshold of 75% as required by the WHO FCTC.
*Accession.
†Acceptance.
FCTC, Framework Convention on Tobacco Control; PEITTP, Protocol to Eliminate Illicit Trade in Tobacco Products.

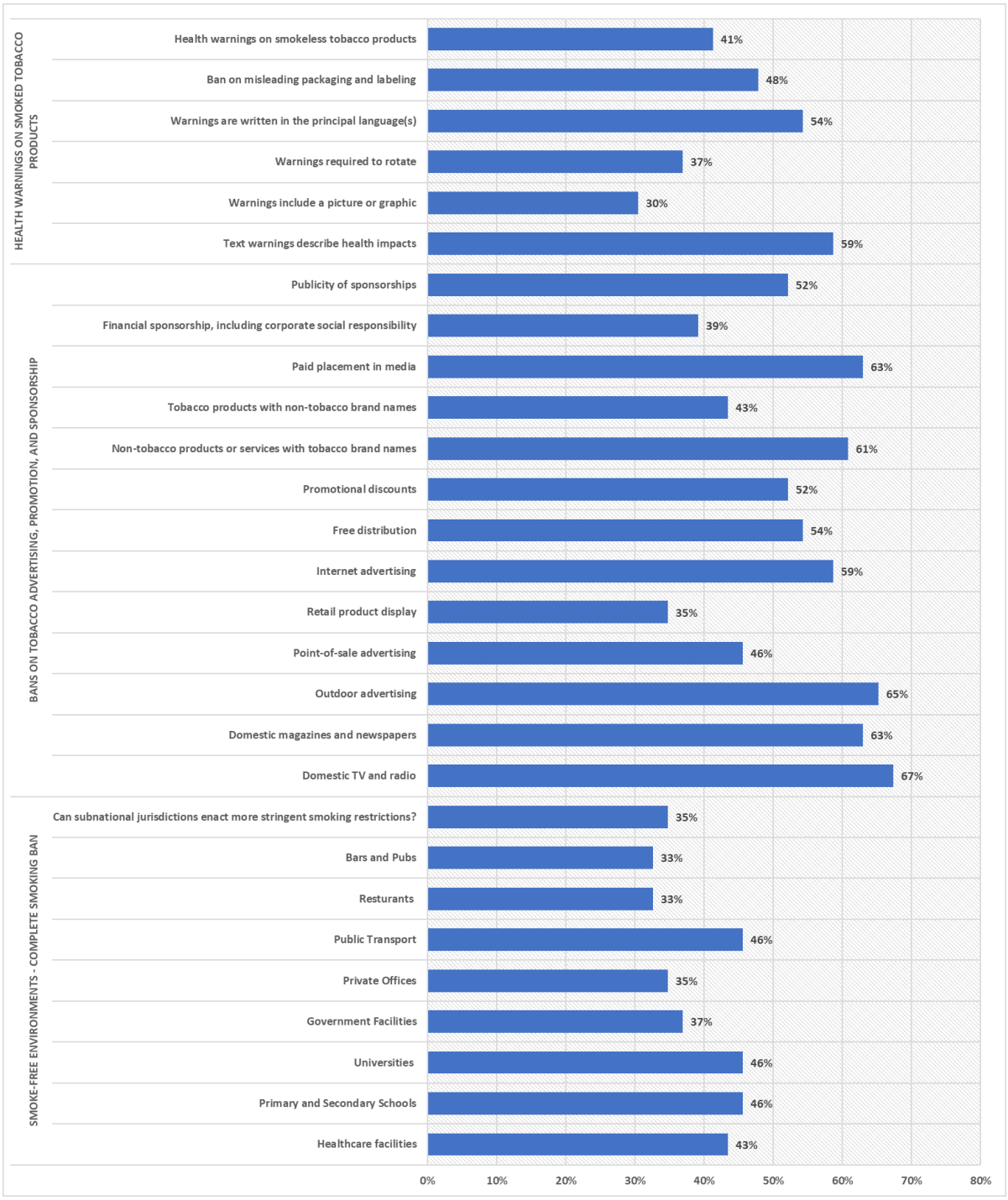

Figure 1 Percentage of SSA countries with comprehensive tobacco policies in three key areas (data source: Campaign for Tobacco Free Kids Policy Factsheets). Reference: Campaign for Tobacco Free Kids. Tobacco Control Laws: Policy Factsheets. 2021; https://wwwtobaccocontrollawsorg/legislation/factsheet/. Accessed 20 April 2021. SSA, sub-Saharan Africa.

provision and implementation in many SSA countries. In Nigeria, some policymakers were enlisted to stall legislative procedure on the National Tobacco Control Act 2015.[15] In South Africa, some officials of the 'Hawks' (special anti-corruption unit within the police service), the South African Police Service, the South African Revenue Services and other government parastatals were implicated in a case of 'advancing the interest of commercial enterprises' including the tobacco industry.[16] In some East African countries, policymakers were reported to have collected bribes to advance the position of the tobacco industry both at country and international levels.[17]

Lack of capacity also challenges policy formulation and implementation. Most SSA health ministries have a TC focal point[18] but these are not exclusively dedicated to TC activities. Health ministries may need more negotiation and diplomacy skills

to bring together other government departments/agencies to discuss and agree on common TC approaches.[19 20]

A key barrier to effective policy implementation in most African countries is the limited government investment in TC. With limited health budgets in most SSA countries and falling behind the widely recommended 5% of Gross Domestic Product earmarked for the health sector,[21] or the allocation of 15% of budget for health financing pledged in the Abuja Declaration,[7 22] it is not a surprise that most countries do not adequately fund TC.[23] Very little is known of the amount of money spent by African governments on TC and of the seven countries with data, government spending on tobacco control amounts to US$337 000, or about US$0.006 per capita,[23] compared with US$4.08 per capita for HIV/AIDs spending.[24] Available data show that 11 SSA countries impose special levies or taxes on tobacco products but only six (Botswana, Cote d'Ivoire, Gabon, Kenya, Madagascar and Mauritius) use some of these funds for TC.[25] The lack of government funding creates a gap which to some extent has been filled by international funders coordinated by the WHO.[23] Such funders include International Development Research Centre, The Union, Bloomberg initiatives through the Campaign for Tobacco Free Kids, and the Bill and Melinda Gates Foundation.[23] CSOs and non-governmental organisations[15 26] have been vocal and visible in the SSA political space, contributing to awareness creation and the advancement of the adoption of TC legislation in the region.[27] However, many CSOs involved in advocacy are relatively young, lacking experience and sustainable means beyond donor funding.[28] Governments must invest in national TC programmes, with donor agencies supporting advocacy to complement government's initiatives. For example, Gates Foundation (through the Centre for Tobacco Control in Africa) provides support to some African countries (including government and other stakeholders).[29 30]

Limited locally generated data underpin TC efforts in SSA,[31] given insufficient national and international research funding to inform TC policy and advocacy. Mamudu and colleagues investigating tobacco-related published research in SSA over 50 years found that over half of the publications were from South Africa and Nigeria.[31] International funding of TC in SSA is mostly channelled into policy engagement and advocacy, with less support for local research except for a few cases like the more recent funding support through the African Capacity Building Foundation for industry monitoring capacity building by the Africa Centre for Tobacco Industry Monitoring and Policy Research at Sefako Makgatho Health Sciences University and Research Unit on the Economics of Excisable Products at University of Cape Town, both based in South Africa. Limited local funding allows international funders to set the TC research agenda in SSA, where there are few core TC researchers, compounded by a brain drain as researchers seek better opportunities outside the region.[31]

ECONOMIC LANDSCAPE OF SSA TC

The tobacco industry increasingly uses narratives on economic prosperity (mostly unvalidated) to slow TC progress in SSA.[32–34] The industry routinely argues that increasing tobacco excise tax will reduce licit tobacco demand sharply, decreasing government tax revenue[35] and expanding the illicit cigarette market. Empirical evidence, however, shows that raising taxes is the most effective way to reduce tobacco use and results in higher tax revenue,[36 37] validating the FCTC's recommendation of a minimum 75% tax share of the retail price of tobacco.[38] However, only Madagascar's and Mauritius' tax shares are above the recommended level (table 1).[39] Policymakers in some countries hesitate to raise taxes due to misinformation and industry interference, especially in economic, trade and finance ministries, for example, in Kenya.[40] Also, SSA countries belong to multiple regional trading and customs blocks, so harmonisation of tobacco excise taxes in the region is essential to decrease incentives for cross-border bootlegging and illicit trade due to price differences between countries.[41–43] Some countries are members of more than one trading and customs blocks, for example, the Economic Community of West African State and Members of the West African Economic and Monetary Union. These blocks which have some mutual members impose minimum tax policies that could be levied by member countries but these policies are often not uniform as seen in 2017 tobacco tax directives by these bodies.[43]

To improve tobacco tax collection and curb illicit trade, cost-effective technology such as Kenya's track-and-trace system and significant financial penalties can be adopted.[37] This is in addition to being party to the Protocol for the Elimination of Illicit Trade in Tobacco Products (20 SSA countries are already parties, table 1).[10] The track-and-trace system helps determine whether a product was legally produced or imported into the country to confirm taxes have been paid. This is done through marking tobacco products with secure and unique markings (tax stamp) for tracking purposes. The impact of this system can be observed by the significant reduction of illicit trade from 15% of total consumption at the time of installation of the system in 2013 to 5% as of 2015.[44] Another factor affecting TC in SSA is increased investment in leaf production, partly fuelled by lower production costs in SSA and stringent TC measures in high-income countries.[45] Tobacco leaf export value exceeded 1% of GDP in only four countries globally and three of these were countries in SSA (Malawi, 8.45%; Zimbabwe, 3.43% and Mozambique, 1.77%).[45] Some governments (likely influenced by the tobacco industry) believe tobacco plays an important role in improving economic fortunes through employment creation and foreign earnings.[32 46] Empirical results from research on tobacco farming suggest that these economic prosperity narratives are exaggerated: fewer farmers grow tobacco than reported by industry proponents; the true cost of tobacco farming is very high.[47] Most tobacco farmers are forced into contract farming, paying higher prices for inputs than other farmers in the same geographical locations, incurring higher labour costs for this labour-intensive crop, making little or no profit,[46 48 49] and exposing families, including children, to the health hazards associated with tobacco harvesting.[47]

TC MEDIA LANDSCAPE IN SSA

News media set the agenda in public health by framing and shaping public opinion, but TC has not benefited adequately from the media.[50] There is competition to use the media to push for or against TC: the media in SSA are the future battlefield for TC and this has become quite prominent especially in South Africa where the industry has launched several media campaigns to protest against TC regulations, for example, #handsoffmychoices against South Africa's tobacco control bill, #Notjustjobs[51] and #takebackthetax against tax increases under the guise of fighting illicit trade which they have been found to be part of[52 53] and recently during the COVID-19 lockdown tobacco sales ban in South Africa on various social media platforms.[54] News media in SSA often tacitly portray the industry positively, allowing subtle advertising while reporting on the industry's

corporate social responsibility activities.[15 50] Media practitioners may be largely unaware of tobacco industry tactics due to how the industry ties their campaigns to issues that are of importance to a vast majority of the population like jobs and human rights. New media (social media and digital platforms) enable the industry to contravene country policies banning advertising, sponsorship and promotion:[55 56] the industry recruits social media influencers to promote their products and entice young people (the main consumers of new media content).[57] Acknowledging the potential of media to drive TC agenda, some TC organisations, for example, in Nigeria,[15] deliberately build relationships and media capacity to engage in TC in a timely, analytical and factual manner. The advent of new media has enabled advocates and governments to create their own 'spaces' to advance TC messaging to the populations in a timely and cost-friendly manner,[58] for example, the #ProtectOurNext campaign in South Africa[59] and Smoke Free Uganda project.[60] However, traditional and new media need to be more strategically used as TC resources in SSA.

Tobacco industry interference

Industry interference remains one of the biggest challenges faced by TC in SSA.[9] With the advantage of big capital to lobby governments officials[16 17] and pay social influencers, the industry's promotional and political activities may be the single most significant vector of the tobacco epidemic in the region.[61] This situation is not peculiar to SSA,[61] but weak TC governance and political will to make and implement comprehensive TC policies make this a bigger challenge in this region. The industry has become innovative in their strategies to expand the SSA market by introducing new tobacco and nicotine products to bypass current laws like the oral nicotine pouches introduced in some SSA countries like Kenya and Tanzania,[62 63] bribing government officials[16 17] and leveraging on the COVID-19 pandemic to present themselves as positive contributors to society,[8] making tobacco control advocates struggle to catch up with their tactics.

KEY PRIORITIES FOR TC IN SSA

Given the challenges of TC in SSA, we highlight some key priorities for the region.

1. *Tobacco industry monitoring and countering:* industry monitoring must be stepped up to proactively counter industry activities to undermine TC in the region. Awareness raising on the harms of tobacco and nicotine products should be combined with informing the public about the industry's role in promoting nicotine addiction and their attempt to divert attention from prevention to 'harm reduction' in a region still at an early stage of the tobacco epidemic.[64]
2. *Regional and institutional cooperation:* more cooperation between subregional bodies to harmonise subregional tax policies, and between government, research institutions and CSOs in the region would enhance knowledge sharing and transfer, judicious use of scarce resources and prevent duplication of efforts. This is in line with the harmonisation of policies, including taxes and strategies on issues such as education, investment treaties, etc both at the African Union and within the African Continental Free Trade agreement, and would help create a win-win scenario for all countries and the region. International funders should also consider requiring some level of regional cooperation and knowledge transfer as a key performance area in their grants to countries, institutions and CSOs. This would meet the recommendations of the WHO FCTC Articles 20 and 22 on international cooperation/collaboration.
3. *Cooperation among international funders:* international funders would use resources more effectively and efficiently with better cooperation rather than competition between organisations working in SSA. Some of the international funders work simultaneously in several of the same countries. While there is already some cooperation between international funders, more cooperation and better synergy among funders would ensure wider coverage of countries and better use of limited resources.

LIMITATIONS

SSA is comprised of countries which are different in tobacco use prevalence and advancement in TC. In this paper, we have attempted to paint a picture of TC in SSA. In doing this, we acknowledge that it is practically impossible to write a paper which would capture all the details of TC, including key data needs by country within the region. Also, despite the progress recorded in some countries in the region, research and publications to document these successes are lacking. While research needs for LMICs that are applicable for the implementation of the WHO FCTC in SSA can be found elsewhere,[65] this paper gives a general description of the landscape of TC and makes recommendations which we believe are applicable, and would be beneficial to all countries if implemented irrespective of their progress in TC over the years.

CONCLUSION

Despite substantial TC progress in SSA in the last 15 years, more must still be done to avert a tobacco epidemic in the region. Stakeholders' efforts in and outside SSA need synergy to achieve the desired effects and cover more bases in SSA.

What this paper adds

- Sub-Saharan Africa (SSA) has the lowest smoking prevalence globally, but aggressive marketing activities by the tobacco industry, youthful population growth and weak political will to effectively implement comprehensive policies contribute to the projected highest relative increase in tobacco use by 2025.
- Commitment from government, better use of the media (traditional/new), regional cooperation, funding to generate local data through research, as well as more cooperation among international funding agencies and civil society organisations are needed to boost tobacco control in SSA.
- Harmonisation of subregional tax policies must be implemented to remove tax limits and maximise taxation as a Tobacco Control tool in SSA.

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