WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
ESCRITÓRIO REGIONAL AFRICANO

REGIONAL COMMITTEE FOR AFRICA **AFR/RC55/13**
17 June 2005

Fifty-fifth session
Maputo, Mozambique, 22–26 August 2005 **ORIGINAL: ENGLISH**

Provisional agenda item 8.7

IMPLEMENTATION OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL IN THE AFRICAN REGION: CURRENT STATUS AND THE WAY FORWARD

Report of the Regional Director

EXECUTIVE SUMMARY

1. On 27 February 2005, the WHO Framework Convention on Tobacco Control entered into force and became legally binding for the first 40 countries—including five African countries—that became Contracting Parties before 30 November 2004.

2. As of 1 March 2005, eight countries of the African Region have ratified the Convention and 31 are taking steps to ratify it. Setting implementation goals and developing plans and strategies for the implementation of the Convention in the African Region are imperative.

3. The tobacco industry continues aggressive expansion into the developing world, obstructing effective tobacco control by influencing sales and corporate social responsibility programmes.

4. Building a national action plan and establishing legal and institutional frameworks to implement the plan are key steps in the implementation of the Convention.

5. The Regional Committee is requested to consider this document and endorse the proposed steps for action.

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INTRODUCTION

1. Tobacco use is the largest cause of preventable death globally, estimated to kill 4.9 million people annually compared to 3 million annual deaths due to HIV/AIDS. By 2020, this death toll will be 10 million, 70% in developing countries.

2. In Africa, tobacco use prevalence was 29% in males and 7% in females in 2000,[1] and there were 200 000 tobacco-related deaths.[2] Studies also indicate that tobacco is an important cause of oral cancer.[3] Smoking increases the risk of infections. Tobacco is a major risk factor for lung cancer and cardiovascular disease. The greatest public health impact of smoking on infection is the increased risk of tuberculosis, a particular problem in Africa. The tobacco epidemic adds to the double burden of disease in the Region. Africa is currently grappling with HIV/AIDS and malaria and needs to counter the entirely preventable tobacco epidemic.

3. The situation is moving from bad to worse as the tobacco industry relocates to the poor south, fleeing harsh regulation in the developed countries. In 1995, the total cigarette consumption was at 131 181 million sticks. This figure rose to 212 788 million in 2000.[4] Results of the Global Youth Tobacco Survey show a prevalence of smoking in 13–15-year-old school youths that ranges from 10% in Mozambique to 33% in Uganda.[5]

4. The economic costs of the tobacco epidemic are devastating for Africa where 10 countries are net tobacco exporters and the rest net importers,[6] trading scarce resources for tobacco products. The pattern is repeated in poor households where money is spent on tobacco instead of basic necessities such as nutrition and education. Tobacco kills people at the height of their productivity, depriving nations of a healthy workforce and furthering the cycle of ill-health, poverty and death. Premature death of a breadwinner often means doom for the surviving family.

5. In tobacco-producing communities, many farmers are trapped in debt, earning barely enough to service the loans for farm input. Tobacco farming also leads to deforestation, soil erosion and polluted water bodies. This environmental degradation results in loss of biodiversity and further aggravates poverty.

6. It is for the above reasons that the World Health Assembly mandated the first public health treaty, the Framework Convention on Tobacco Control.[7] The Convention was adopted in May 2003 and opened for signature from 16 June 2003 to 29 June 2004.

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[1] Guindon E, Boxcar D, Past, current and future trends in tobacco use. HNP Discussion Paper, Economics of Tobacco Control Paper No. 6, Geneva, WHO/World Bank, 2003.

[2] WHO, *The world health report 2002: Reducing risks, promoting health life*, Geneva, World Health Organization, 2002.

[3] Adewole RA, Alcohol, smoking and oral cancer: a 10-year retrospective study at Base Hospital, Yaba, *West African Journal of Medicine*, 21 (2): 142–145, 2002; Pacella-Normal R, Urban MI and Beral V, Risk factors for esophageal, lung, oral and laryngeal cancers in black South Africans, *British Journal of Cancer*, 86(11): 1751–1756, 2002; Macigo FG, Mwaniki DL and Guthua SW, Influence of cigarette filters on the risk of developing oral leukoplakia in a Kenyan population, *Oral Diseases*, 7(2): 101–105, 2001.

[4] Guindon E, Boxcar D, Past, current and future trends in tobacco use. HNP Discussion Paper, Economics of Tobacco Control Paper No. 6, Geneva, WHO/World Bank, 2003.

[5] CDC URL: http://www.cdc.gov/tobacco/global/gyts/factsheets.htm (accessed on 7 December 2004).

[6] FAO Database. URL: http://apps.fao.org/default.jsp (accessed on 7 December 2004).

[7] Resolution WHA48.11, An international strategy for tobacco control. In: *Forty-eighth World Health Assembly, Geneva, 1-12 May 1995. Volume III: Handbook of resolutions.* Geneva, World Health Organization, 1995 (WHA48/1995/REC/1).

7. The objective of the Convention is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure. It provides a framework for tobacco control measures to be implemented by Parties at the national, regional and international levels in order to substantially and continually reduce the prevalence of tobacco use and exposure to tobacco smoke.

8. This document describes the current status of the Convention and proposes steps for implementation in the African Region at national level, encouraging non-parties to accept, approve, ratify or accede to the treaty.

CURRENT STATUS

9. Following adoption of the Framework Convention on Tobacco Control, 39 of 46 Member States in the WHO African Region signed the treaty, and nine countries[8] ratified it as of 1 July 2005. The Treaty became binding international law for the first 40 Parties on 27 February 2005, 90 days following the fortieth ratification by Peru on 30 November 2004; this includes five countries from the African Region. The Treaty will legally bind subsequent Parties on the ninetieth day following the deposit of instrument of ratification, approval, acceptance or accession.

10. Countries can become Parties to the Convention through ratification, acceptance, approval or accession. Ratification is an act that indicates to the international community a country's commitment to undertake the obligations under the WHO Framework Convention on Tobacco Control. The ratification process must be preceded by signature, the deadline for which was 29 June 2004.

11. Acceptance and approval have the same legal effect as ratification. Signature subject to acceptance or approval was recently introduced to the treaty practice to provide a country with further opportunity to examine a treaty but not necessarily be obliged to submit it to a particular constitutional procedure. Like ratification, the instrument needs to be lodged with the United Nations Treaty Section in New York.

12. Non-signatories to the Convention can become Parties to it through the process of accession. Accession has the same legal effect as ratification. However, accession requires only one step, the deposit of an instrument of accession at the United Nations Treaty Section in New York.

13. African countries were strongly represented throughout the negotiations and provided solid leadership in building a comprehensive treaty. The Convention process has created a new wave of consciousness and political commitment to address the tobacco epidemic in the Region. Nongovernmental organizations also played a prominent role in shaping the regional position on the Convention, and they continue to drive the implementation process.

14. The African Region is making notable progress in the efforts to implement the Convention. Currently, 12 countries are at various stages of reviewing tobacco legislation, including banning advertisements and exposure to tobacco smoke; four countries are developing national plans of action.

[8] Botswana, Ghana, Kenya, Lesotho, Madagascar, Mauritius, Senegal, Seychelles and South Africa.

CHALLENGES AND OPPORTUNITIES

15. Major challenges include:

(a) protecting public health policies from the commercial interests of the tobacco industry and ensuring effective interventions to counter the social effects of persuasive and misleading advertising;

(b) strengthening capacity of health personnel to prevent and reduce tobacco consumption; improving financial and human resources to support comprehensive tobacco control programmes; and encouraging the involvement of non-health sectors in tobacco control;

(c) ensuring that tobacco control is included on national development agendas and investing in feasible and sustainable alternative sources of economic income for countries heavily dependent on tobacco revenues.

16. Various opportunities exist for implementation of the Convention in countries. Implementation begins with application of strategies that have already been adopted by the Region to foster action towards tobacco control.[9] Integration of tobacco control into established national HIV/AIDS, malaria and tuberculosis programmes is necessary as tobacco is an important risk factor in tuberculosis and also interferes with the immune system.

17. The strong stand of the development community, notably the World Bank and the European Union, on tobacco control and the recent resolution of the Economic and Social Council[10] offer further opportunities for countries to accept the challenge of tobacco control as well as enhance their capacity to achieve the Millennium Development Goals pertaining to poverty reduction and better health.

18. Tobacco surveys focusing on school youths, school personnel and health professionals have been developed to provide evidence for policy and programme development. The recently published WHO handbook, *Building blocks for tobacco control*, provides practical guidelines for setting up tobacco control programmes at country level.

19. Despite the wealth and inventiveness of the tobacco industry, the tide is now turning against it as dramatically illustrated by the recent court victories in the United States. Celebration of World No Tobacco Day continues to enhance advocacy for tobacco control.

THE WAY FORWARD

Roles of countries

20. Member States should take advantage of the recognized link between tobacco control, poverty alleviation and the achievement of the Millennium Development Goals and should work actively for

[9] WHO, *Health promotion: A strategy for the African Region*, Brazzaville, World Health Organization, Regional Office for Africa, 2003 (AFR/RC51/12 Rev.1); WHO, *Adolescent Health: A strategy for the African Region*, Brazzaville, World Health Organization, Regional Office for Africa, 2001 (AFR/RC51/10 Rev.1); WHO, *Regional strategy for mental health 2000–2010*, Brazzaville, World Health Organization, Regional Office for Africa, 1999 (AFR/RC49/9).

[10] ECOSOC resolution—Tobacco control, New York, United Nations Economic and Social Council, 2004.

the inclusion of noncommunicable diseases and tobacco control during the 2005 mid-term review of the Millennium Development Goals.

21. Regarding the Convention, countries of the African Region currently fall into three categories: signatories with ratification, signatories without ratification and non-signatories. Countries that are not Parties to the Convention should make this their central goal and are encouraged to take steps toward ratification and accession. Hence, effective partnership with local nongovernmental agencies working in tobacco control is necessary to step up advocacy for accession, approval, acceptance or ratification. Given that Member States have varying experiences with tobacco control, various steps are suggested to facilitate implementation of the Convention at country level.

22. Step 1 in the process of implementing the Convention is to develop the necessary legal and institutional framework or adapt an existing framework to the requirements of the Convention.

23. Step 2 is to develop a national action plan which outlines how a country intends to deal with the tobacco epidemic. The plan should include a timeline, budget and target date for completion. For facilitation, countries should establish a full-time national coordinating mechanism and designate a national focal point within the health sector. Countries should legitimize the national action plan through official adoption.

24. A national multisectoral steering committee should be created to ensure that the action plan is linked with other relevant committees, nongovernmental organizations and coordinating bodies in the health sector. Broad consultation is crucial to establish ownership among implementing and enforcing parties. Roles and responsibilities must be defined clearly and agreed upon for each sector involved. To ensure sustainability, the health aspect of tobacco control must be integrated into national primary health care services. The primary focus of the steering committee is the promotion of public health through tobacco control. Membership, therefore, should not include representatives of the tobacco industry.

25. Step 3 is a situation analysis. Each country should determine its needs and resources for tobacco control. Necessary information includes the current status of tobacco use prevalence by sex and age group, consumption rate per annum, volume of import and production per annum, and tobacco control practices. Data are also needed on morbidity and mortality attributed to tobacco; health and economic impact of tobacco use; effectiveness of various tobacco control interventions; political environment in relation to tobacco control, existing entry points of integration in health services and interdepartmental activities; public knowledge, beliefs and attitudes; tobacco industry activities. Existing instruments such as the Global Youth Tobacco Survey should be used wherever possible.

26. Step 4 is to promote communication and public awareness. The plan of action should be launched and widely publicized to inform the public about government intentions. This can be done using press conferences, press releases and other appropriate communication channels and media events. Communicating accurate information and raising awareness of the public and of parliamentarians is important to increase support for tobacco control.

27. Effective partnerships should be established with health professional associations, the education sector and the media to encourage behaviour change and increase support for cessation programmes.

28. Step 5 includes monitoring, surveillance, evaluation and reporting. Surveillance should report changes in tobacco use prevalence; tobacco-related mortality and morbidity; knowledge, attitudes and opinions; number and kind of policy measures; economic outcomes, such as costs of medical care; and effectiveness of tobacco control activities. Countries should establish systems for monitoring and evaluating tobacco control policies as well as tobacco industry activities.

29. Step 6 is to explore economic measures and funding initiatives. Countries should explore economic measures to fund and mobilize resources to support initiatives with the participation of other stakeholders, including nongovernmental organizations and the private sector.

Roles of WHO and other partners

30. WHO should continue to provide technical support to countries. More specifically, WHO will support:

(a) countries, technically and materially, to develop policy and legislation;

(b) capacity building for planning and implementing proposed research and actions;

(c) mobilization of resources for national tobacco control programmes;

(d) advocacy to sensitize the network of African parliamentarians;

(e) establishment of tobacco control collaboration centres.

31. Collaboration should be strengthened to ensure that Member States receive appropriate support when developing, implementing, monitoring and evaluating tobacco control programmes. This should involve stakeholders such as the African Union, World Bank, New Partnership for Africa's Development, relevant regional and subregional organizations, international and national nongovernmental organizations, academic institutions and global initiatives such as the tobacco surveys.

CONCLUSION

32. The countries that have ratified now need to proceed with implementation of the Convention in order to reduce tobacco use in their populations. Countries that have signed but not ratified should accelerate the process of ratification. Countries that have not signed the Convention should advance the process of accession to the Treaty. In all the 46 Member States of the African Region, the importance of public health should outweigh any economic importance of tobacco. Implementation of the Convention in countries would contribute to reaching the United Nations Millennium Development Goals through improving health.

33. All countries that have not ratified or signed should take all necessary measures to be Contracting Parties in order to participate fully in the First Conference of the Parties.

34. The Regional Committee is requested to review and endorse the proposed action steps for implementing the Convention.