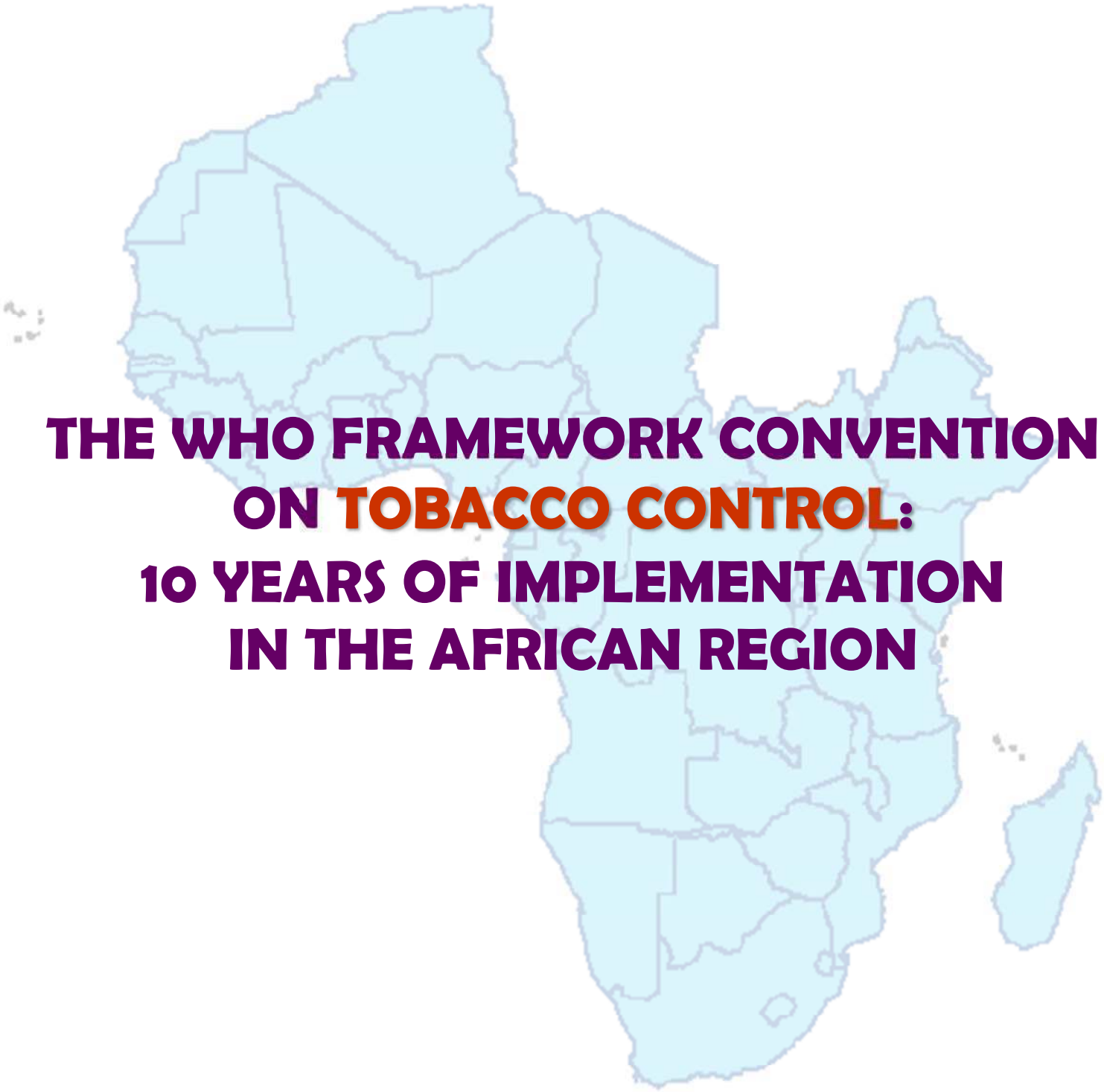
FCTC 10 years 2005–2015

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL



THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL: 10 YEARS OF IMPLEMENTATION IN THE AFRICAN REGION

World Health Organization

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THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL: 10 YEARS OF IMPLEMENTATION IN THE AFRICAN REGION

CONTENTS

Figures

Tables

FOREWORD

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first public health treaty negotiated under the auspices of WHO. It was adopted unanimously by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. To date, 180 countries have ratified the WHO FCTC, including 43 Member States in the African Region.

The WHO Regional Office for Africa has been supporting Member States in implementing the provisions of the Convention through national policies, laws and regulations. Significant progress has been made in the Region, but challenges still remain. During the Sixth session of the Conference of the Parties to the WHO FCTC, held in Moscow, Russian Federation, in October 2014, delegates from the African Region resolved to mark the 10-year milestone since entry into force of the Convention.

Recent years have witnessed significant achievements, innovative approaches and positive trends, which demonstrate the strong commitment of countries in the Region to achieving full implementation of the Convention. Member States are making huge efforts to develop and implement tobacco control policies and programmes, despite the challenges they face. We must ensure, however, that implementation of the Convention is multisectoral and comprehensive. The "whole-of-government" approach remains the best way to realize the full benefits of the WHO FCTC, and thus tobacco control, which is a key element in the prevention and control of noncommunicable diseases.

This report, "The WHO FCTC: 10 years of implementation in the African Region", documents progress and challenges in implementing the Convention in the African Region. As we mark the first decade of the WHO FCTC, I call upon governments, partners, civil society and the private sector to prioritize comprehensive implementation of the WHO FCTC, as a key outcome of the next 10 years. The WHO Regional Office for Africa remains committed to providing the technical leadership that is required to ensure implementation of the Convention.

Let us make the next 10 years the decade of multisectoral action for tobacco control.

Dr Matshidiso Moeti
Regional Director
WHO Regional Office for Africa

1. INTRODUCTION

On 27 February 2005, the WHO Framework Convention on Tobacco Control (WHO FCTC) entered into force and became legally binding for the contracting countries, referred to as the Parties to the Convention. Five of the first 40 countries that ratified the Convention are in the African Region.[1] As of 31 December 2014, 43 of the 47 countries in the African Region had ratified or acceded to the WHO FCTC (38 ratifications[2] and five accessions[3]).

Parties to the WHO FCTC have the obligation to report periodically to the Conference of the Parties on their progress in implementing the Convention. Parties in the African Region are therefore obliged to submit reports to the Conference of the Parties within the reporting cycles. To date, 34 Parties[4] have submitted at least one report on their progress in implementing the Convention.

In 2005, the Fifty-fifth session of the Regional Committee for the African Region reviewed the first report on implementation of the WHO FCTC in the Region[5] and endorsed the proposed actions. The Regional Committee recommended that Member States ratify the WHO FCTC, develop and implement comprehensive tobacco control legislation and adopt national plans of action in accordance with their obligations under the Convention.

In 2013, the Sixty-third session of the Regional Committee for the African Region reviewed and endorsed the second report on implementation of the WHO FCTC in the Region.[6] The Regional Committee recommended that countries accelerate implementation of the Convention by prioritizing enforcement of existing laws, allocating adequate resources proportionate to the burden of tobacco and intensifying South–South collaboration.

This 10-year report highlights the achievements made in the African Region in implementing the WHO FCTC during the period February 2005 to December 2014.

[1] Ghana, Kenya, Madagascar, Mauritius and Seychelles

[2] Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda and the United Republic of Tanzania.

[3] Equatorial Guinea, Guinea Bissau, Sierra Leone, Zambia and Zimbabwe

[4] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritania, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda and the United Republic of Tanzania.

[5] Implementation of the Framework Convention on Tobacco Control in the African Region: current status and the way forward. Brazzaville: WHO Regional Office for Africa; 2005 (AFR/RC55/13).

[6] Implementation of the WHO Framework Convention on Tobacco Control in the African Region. Brazzaville: WHO Regional Office for Africa; 2013 (AFR/RC63/INF.DOC/4).

2. TOBACCO USE AND HEALTH BURDEN

2.1 Tobacco products

Various types of tobacco products are commonly used in the African Region. These include cigarettes, cigars and pipes; however, more countries are reporting use of smokeless tobacco and waterpipes or *shisha*. The smokeless tobacco products available in the Region include both manufactured products and those produced in small cottage industries, custom-made for personal use or for sale by street vendors (Figure 1). These products are sniffed, chewed, sucked or applied to the gums. Smokeless tobacco products are generally much cheaper than cigarettes and are used mainly by people who are socioeconomically disadvantaged and by older adults. More recently, waterpipes (*shisha*) and electronic cigarettes have become available in some countries in the Region (Figure 2).

Figure 1. Some types of smokeless tobacco products available in the WHO African Region

Figure 2. Some types of smoked tobacco products available in the WHO African Region

2.2 Prevalence of tobacco use

The mean prevalence of tobacco smoking among adults in the African Region is estimated to be 21% for males (94 million people) and 3% for females (13 million people), although some countries have a prevalence of up to 48% for males and 20% for females.[7] Data on the exposure of adults to tobacco smoke show that 17.3–20.4% of adults are exposed in the workplace (Table 1). Young people in the African Region are also exposed to second-hand tobacco smoke, with about 29% exposed at home and 48% in public places (Table 2). Among young people, it is estimated that 18% (21% boys, 13% girls) currently use any kind of tobacco product (Table 3). About 6.5% (9.2% boys, 3.2% girls) currently smoke cigarettes, and 12% (12.8% boys, 10.1% girls) currently use tobacco products other than cigarettes.[8] Recent trends show an increase in the use of tobacco products other than cigarettes in general; and also an increase of tobacco use among girls.

Table 1. Exposure of adults to tobacco smoke in four countries of the African Region

Place of exposure to tobacco smoke (%)		Cameroon	Kenya	Nigeria	Uganda
		2013	2014	2012	2013
At home					
	Men	16.8	16.8	7.7	14.2
	Women	14.3	12	5.6	12
	Total	15.5	14.3	6.6	13.1
At work					
	Men	20.9	23	21.1	26
	Women	16.7	11.5	12	13.7
	Total	19.2	17.6	17.3	20.4
Government buildings					
	Men	15.1	15.2	18.2	6.6
	Women	8.6	7.9	13.9	4.4
	Total	12.8	12.5	16.7	5.7
Health care facilities					
	Men	5.7	10.2	5.8	4.8
	Women	5	7.2	4.9	4.3
	Total	5.3	8.5	5.3	4.5
Public transport					
	Men	26.2	14.1	9.9	9.2
	Women	19.6	10.5	8.9	6.5
	Total	22.9	12.4	9.4	7.8
Restaurants					
	Men	32.8	24.2	29.4	17.3
	Women	29.8	16.8	29.2	13.9
	Total	31.9	21.2	29.3	16

Source: Global Adult Tobacco Survey

[7] Policies for tobacco control in the African Region. Brazzaville: WHO Regional Office for Africa; 2013.
[8] Towards tobacco-free young people in the African Region. Brazzaville: WHO Regional Office for Africa; 2014.

Table 2. Exposure of young people (13–15 years old) in the WHO African Region to tobacco smoke, by country

Country	Year	Coverage	Exposed to tobacco smoke in public places (%)	Exposed to tobacco smoke at home (%)
Algeria	2013	National	55.7	28
Angola	2010	Subnational	26.7	24
Benin	2003	Subnational	38	21.5
Botswana	2008	National	62.1	38.5
Burkina Faso	2009	Subnational	47.5	29.2
Burundi	2008	National	49.3	33.9
Cameroon*	2014	National	42.1	28.5
Cape Verde	2007	National	25.4	13.9
Central African Republic	2008	Subnational	52.4	35.2
Chad	2008	National	55.1	33.9
Comoros	2007	National	58.3	35.2
Congo	2009	National	44.4	22.3
Côte d'Ivoire	2009	National	74.4	33.1
Democratic Republic of the Congo	2008	Subnational	36.8	30.2
Equatorial Guinea	2008	National	61.7	47.5
Eritrea	2006	National	37.3	18.4
Ethiopia	2003	Subnational	41.2	14.9
Gabon*	2014	National	51.1	29.7
Gambia	2008	Subnational	59.2	45.8
Ghana	2009	National	32.3	19.1
Guinea	2008	National	52.3	27.7
Guinea Bissau	2008	Subnational	35.3	31
Kenya	2013	National	44.5	24.8
Lesotho	2008	National	52.6	36.9
Liberia	2008	Subnational	45.5	23.6
Madagascar	2008	National	62.9	49.5
Malawi	2009	National	29.5	19.7
Mali	2008	National	81.4	48.5
Mauritania	2009	National	50.9	37.5
Mauritius	2008	National	73.6	36.1
Mozambique	2013	National	37.4	19.1
Namibia	2008	National	49.9	38.1
Niger	2009	National	54.3	24.1
Nigeria	2008	Subnational	39.7	21.7
Rwanda	2008	National	85.6	19.2
Sao Tome and Principe	2010	National	45.1	18.2
Senegal	2013	National	45.2	27.9
Seychelles	2007	National	57.1	42.3
Sierra Leone	2008	Subnational	56.5	44.2
South Africa	2011	National	39.3	29
South Sudan	. . .	. . .	. . .	. . .
Swaziland	2009	National	55.6	23.3
Togo	2013	National	25.9	20.1
Uganda	2011	National	26.3	21.6
United Republic of Tanzania	2008	Subnational	39.4	19.4
Zambia	2011	National	40.8	30.7
Zimbabwe*	2014	National	48.7	31.8

*Not yet published
Source: Global Youth Tobacco Survey

Table 3. Prevalence of tobacco use among young people (13–15 years old) in the WHO African Region, by country

Country	Year	Coverage	Current tobacco use (%)			Current cigarette smoking (%)			Current smokeless tobacco use (%)		
			Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Algeria	2013	National	17.4	2.6	9	12.2	0.8	5.7	6.9	0.8	3.5
Angola	2010	Subnational	20.2	18.6	19.8	3.2	0.3	2.3	18	19	18.7
Benin	2003	Subnational	14.6	5.8	11	11.2	1.8	7.2	6.7	4.2	5.6
Botswana	2008	National	23.3	16.2	19.4	12.9	4.6	8.2	16.3	14.3	15.2
Burkina Faso	2009	Subnational	22.6	11.5	16.8	11.9	2	6.5	15.2	10.1	12.6
Burundi	2008	National	20.7	16.8	19.3	5.8	3.2	4.6	17.1	14.3	16.1
Cameroon*	2014	National	13.8	5.7	10.1	8.3	2.5	5.7	5	2.3	3.7
Cape Verde	2007	National	14.7	11.7	13.4	3.7	3.1	3.5	11.6	9.3	10.6
Central African Republic	2008	Subnational	29.5	34.5	32.4	10.4	4.3	8.1	24	31.3	28.2
Chad	2008	National	20.9	13.9	18.9	8.4	4.3	7.5	16.5	11.6	15.1
Comoros	2007	National	21.8	14.8	18.1	13.5	6.9	9.6	12.5	9.9	11.4
Congo	2009	National	27.6	20.4	24.3	11.3	5	8.2	22	17.4	20
Côte d'Ivoire	2009	National	26.3	10.9	19.1	20.9	5.7	13.7	10	6.5	8.3
Democratic Republic of the Congo	2008	Subnational	36.5	29.3	33.6	11.7	3.6	8.2	29.3	27.6	28.9
Equatorial Guinea	2008	National	25.1	17.3	22.1	9.9	3.4	7	19.5	14.8	17.8
Eritrea	2006	National	7.8	4.6	6.6	2	0.6	1.6	6.4	4.2	5.5
Ethiopia	2003	Subnational	9.9	4.9	7.9	2.5	0.7	1.9	8.4	4.4	6.6
Gabon*	2014	National	9.2	8.8	9.2	6.1	4	5.2	1.9	2.9	2.4
Gambia	2008	Subnational	34	36.6	36.1	12.7	8.6	10.8	29.5	34.3	32.7
Ghana	2009	National	14.1	10.6	12.5	4.3	2.9	3.6	11.7	9.2	10.6
Guinea	2008	National	30.8	20	26.1	11.6	1.6	7.1	23.4	18.9	21.6
Guinea Bissau	2008	Subnational	11.5	10.3	10.9	7.2	3	5.1	4.5	7.8	6.1
Kenya	2013	National	12.8	6.7	9.9	7.4	2.6	4.9	4.3	3.3	3.9
Lesotho	2008	National	26.4	21.7	24.8	11.8	7.5	10.1	20.4	17.9	19.5
Liberia	2008	Subnational	14.2	11.8	13.6	2	1.2	2.1	. . .	. . .	. . .
Madagascar	2008	National	33.2	14.3	22.8	30.7	10.2	19.3	8.5	5.8	7
Malawi	2009	National	16.7	11.4	14.2	5.8	1	3.5	14.9	11.2	13.2
Mali	2008	National	23.1	8.8	16.6	17.4	2.5	10.4	10.7	7.2	9
Mauritania	2009	National	27.5	17.7	22.6	14.6	9	11.6	15.9	10.2	13.1
Mauritius	2008	National	. . .	. . .	. . .	20.3	7.7	13.7	. . .	. . .	. . .
Mozambique	2013	National	9.3	8.2	9.1	2.1	2.3	2.3	5	3.3	4.3
Namibia	2008	National	31.9	29.9	31.1	12.3	11.3	11.9	26.7	25.8	26.4
Niger	2009	National	11.8	5.6	8.6	6.8	0.6	3.5	5.9	5	5.4
Nigeria	2008	Subnational	19.2	11.1	15.4	5.6	1.3	3.5	16.9	10.7	13.9
Rwanda	2008	National	13.3	9.5	11.5	3	0.9	1.8	12	8.7	10.5
Sao Tome and Principe	2010	National	30.7	22.7	26.2	6.1	3	4.4	30.1	22.2	25.6
Senegal	2013	National	14.9	6.2	11.2	4.7	3.1	4.5	6.6	1.8	4.3
Seychelles	2007	National	27.1	25.3	26.6	23.2	20	21.5	10.6	9.2	10.5
Sierra Leone	2008	Subnational	20.3	24.1	23.5	6.6	5	5.8	16.7	21.8	20.7
South Africa	2011	National	24.3	19	21.5	15	10.8	12.7	14.4	12.6	13.5
South Sudan	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Swaziland	2009	National	15.8	8.6	11.5	9.2	4.5	6.4	9.5	5.3	7
Togo	2013	National	11.3	4.3	8.4	7.4	1.2	4.8	2.4	1.8	2.1
Uganda	2011	National	19.3	15.8	17.3	5	4.7	4.8	17.8	14.1	15.6
United Republic of Tanzania	2008	Subnational	9.7	5.3	7.6	4.6	0.7	2.6	6.2	4.7	5.7
Zambia	2011	National	24.9	25.8	25.6	6.2	5.7	6.2	23.7	24.2	24
Zimbabwe*	2014	National	22	15.8	20	11.3	8.9	11.2	6.5	4.6	5.6

*Not yet published
Source: Global Youth Tobacco Survey

2.3 Tobacco-related morbidity and mortality

Approximately one person dies due to tobacco every 6 seconds globally, accounting for one in 10 adult deaths. Up to half of current tobacco users will eventually die of a tobacco-related illness.[9] Tobacco use thus accounts for more than 6 million deaths every year, including over 600 000 deaths from exposure to second-hand smoke. Nearly 80% of these deaths occur in low- and middle-income countries, which constitute the vast majority of countries in the African Region.[9] In the Region, 3% of all deaths among adults aged 30 years and over were attributed to tobacco use (Table 4). The proportion of deaths attributable to tobacco is higher among men (5%) than women (1%).

Between 2002 and 2030, tobacco-attributable deaths are projected to decrease in high-income countries but to double in low- and middle-income countries**.** Tobacco use not only reduces the number of years that users live but also shortens the number of healthy years when alive, as tobacco use is a major contributor to noncommunicable diseases, such as lung cancer and heart disease (Figure 3). Additionally, tobacco use involves considerable economic costs, including spending on health care to treat diseases caused by tobacco use and exposure to tobacco smoke, as well as lost productivity and income due to illness and premature death.

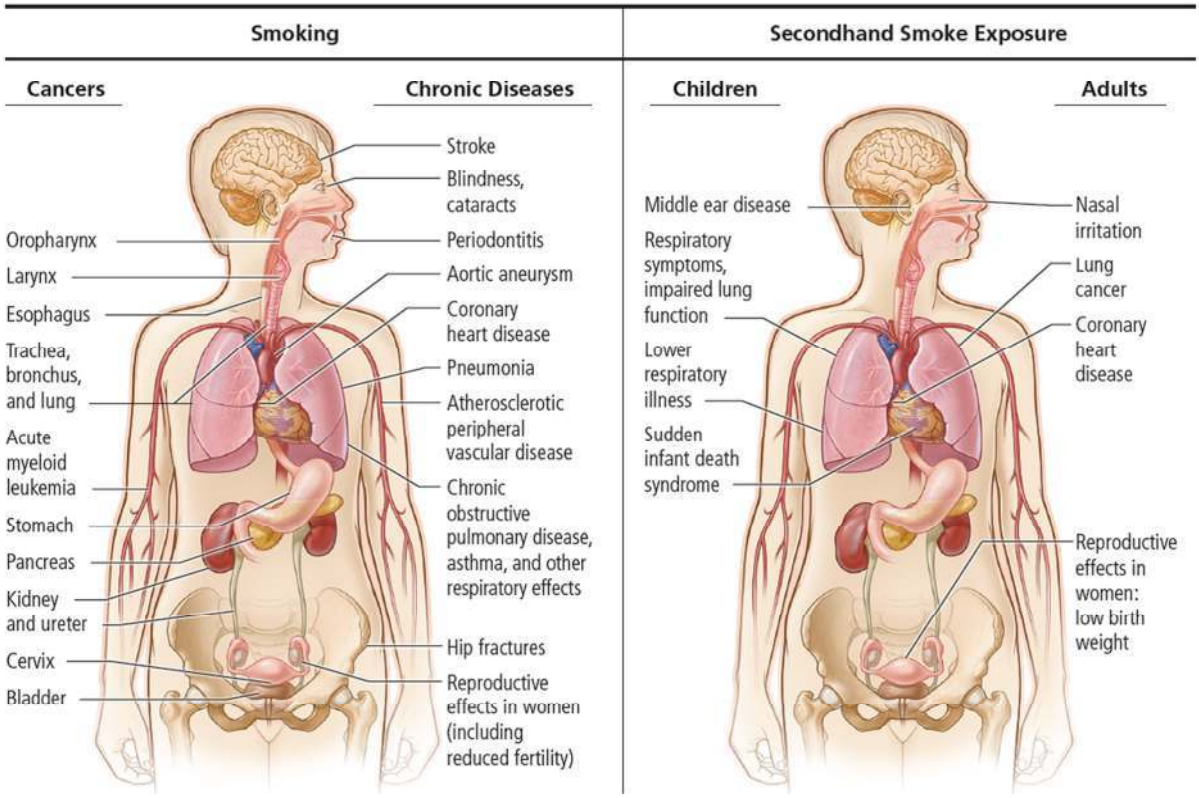
Table 4. Estimated proportions of deaths attributable to tobacco in the WHO African Region

Cause of death	Age group (years)					
	30-44	45-59	60-69	70-79	≥80	Total
All	1%	4%	5%	3%	2%	3%
Communicable diseases	0	1%	2%	2%	3%	1%
Tuberculosis	3%	4%	4%	2%	3%	3%
Lower respiratory tract infections	5%	4%	4%	3%	4%	4%
Noncommunicable diseases	5%	8%	6%	4%	2%	5%
All malignant neoplasms	4%	9%	9%	6%	6%	7%
Trachea, bronchus, lung cancers	24%	54%	61	57%	59%	55%
All other malignant neoplasms	3%	6%	5%	3%	4%	5%
All cardiovascular diseases	10%	10%	4%	2%	0	4%
Ischaemic heart disease	11%	11%	5%	2%	0	5%
Cerebrovascular disease	9%	9%	4%	2%	0	4%
Other cardiovascular diseases	10%	9%	5%	2%	1%	4%
Respiratory diseases	7%	15%	17%	14%	14%	14%
Chronic obstructive pulmonary disease	19%	31%	30%	23%	25%	26%
Other respiratory diseases	4%	5%	5%	4%	4%	5%

Source: Global report: mortality attributable to tobacco. Geneva: World Health Organization; 2012.

[9] Towards tobacco-free young people in the African Region. Brazzaville: WHO Regional Office for Africa; 2014

Figure 3. Diseases caused by smoking and exposure to second-hand smoke



Source: WHO report on the global tobacco epidemic. Geneva: World Health Organization; 2011.

3. OVERALL PROGRESS IN IMPLEMENTING THE WHO FCTC

3.1 Key achievements

Member States in the African Region have made significant progress in implementing the WHO FCTC. So far, 43 countries[10] in the Region have ratified or acceded to the WHO FCTC, whereas there were only nine in 2005 (Table 5). Despite challenges such as interference from the tobacco industry and lack of adequate resources, countries have continued to strengthen their tobacco control mechanisms, including developing comprehensive legislation and plans of action.

At present, all countries in the Region have national tobacco control focal points, and 41 countries[11] have national programmes on tobacco control, whereas there were only four in 2005. A platform for communication and collaboration among all focal points for tobacco control in governments has been established and is fully functional. Countries have also established or strengthened their national multisectoral coordination mechanisms.

Forty-one countries[12] have adopted measures to protect their peoples from second-hand tobacco smoke in public places, whereas there were only 12 in 2005. Seven of these countries[13] have enacted comprehensive smoke-free legislation. Protection from exposure to tobacco smoke is one of the time-bound measures defined in the guidelines for implementation of the WHO FCTC: each country must comply with this obligation within 5 years after entry into force of the Convention for that country and ensure that indoor workplaces and all other public places are 100% smoke-free, without exception.

Thirty-five countries[14] require health warnings on packages of tobacco products, while three countries[15] require pictorial health warnings. Effective packaging and labelling of tobacco products is also a time-bound measure defined in the WHO FCTC: each country must comply with this obligation within 3 years of entry into force of the Convention. The guidelines for implementation of the WHO FCTC encourage countries to require pictorial health warnings covering at least 50% of the display area of all tobacco product packaging.

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10 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

11 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

12 Algeria, Angola, Benin, Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Togo, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe

13 Burkina Faso, Chad, Congo, Madagascar, Namibia, Seychelles and Zambia

14 Algeria, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Togo, the United Republic of Tanzania, Zambia and Zimbabwe

15 Madagascar, Mauritius and Seychelles

Table 5. Status of ratification of or accession to the WHO FCTC by countries in the WHO African Region (as of 31 December 2014)

No.	Country	Signature date	Ratification or accession date	Entry into force date
1	**Seychelles**	11 Sep 2003	12 Nov 2003	27 Feb 2005
2	**Mauritius**	17 Jun 2003	17 May 2004	27 Feb 2005
3	**Kenya**	25 Jun 2004	25 Jun 2004	27 Feb 2005
4	**Madagascar**	24 Sep 2003	22 Sep 2004	27 Feb 2005
5	**Ghana**	20 Jun 2003	29 Nov 2004	27 Feb 2005
6	**Lesotho**	23 Jun 2004	14 Jan 2005	14 Apr 2005
7	**Senegal**	19 Jun 2003	27 Jan 2005	27 Apr 2005
8	**Botswana**	16 Jun 2003	31 Jan 2005	01 May 2005
9	**South Africa**	16 Jun 2003	19 Apr 2005	18 Jul 2005
10	**Niger**	28 Jun 2004	25 Aug 2005	23 Nov 2005
11	**Equatorial Guinea**	–	17 Sep 2005 (accession)	16 Dec 2005
12	**Cape Verde**	17 Feb 2004	04 Oct 2005	02 Jan 2006
13	**Mali**	23 Sep 2003	19 Oct 2005	17 Jan 2006

No.	Country	Signature date	Ratification or accession date	Entry into force date
14	 **Rwanda**	02 Jun 2004	19 Oct 2005	17 Jan 2006
15	 **Nigeria**	28 Jun 2004	20 Oct 2005	18 Jan 2006
16	 **Democratic Republic of the Congo**	28 Jun 2004	28 Oct 2005	26 Jan 2006
17	 **Mauritania**	24 Jun 2004	28 Oct 2005	26 Jan 2006
18	 **Benin**	18 Jun 2004	03 Nov 2005	01 Feb 2006
19	 **Central African Republic**	29 Dec 2003	07 Nov 2005	05 Feb 2006
20	 **Namibia**	29 Jan 2004	07 Nov 2005	05 Feb 2006
21	 **Togo**	12 May 2004	15 Nov 2005	13 Feb 2006
22	 **Burundi**	16 Jun 2003	22 Nov 2005	20 Feb 2006
23	 **Swaziland**	29 Jun 2004	13 Jan 2006	13 Apr 2006
24	 **Comoros**	27 Feb 2004	24 Jan 2006	24 Apr 2006
25	 **Chad**	22 Jun 2004	30 Jan 2006	30 Apr 2006
26	 **Cameroon**	13 May 2004	3 Feb 2006	04 May 2006
27	 **Sao Tome and Principe**	18 Jun 2004	12 Apr 2006	11 Jul 2006
28	 **Algeria**	20 Jun 2003	30 Jun 2006	28 Sep 2006

No.	Country	Signature date	Ratification or accession date	Entry into force date
29	 **Burkina Faso**	22 Dec 2003	31 Jul 2006	29 Oct 2006
30	 **Congo**	23 Mar 2004	06 Feb 2007	07 May 2007
31	 **United Republic of Tanzania**	27 Jan 2004	30 Apr 2007	29 Jul 2007
32	 **Uganda**	5 Mar 2004	20 Jun 2007	18 Sep 2007
33	 **Gambia**	16 Jun 2003	18 Sep 2007	17 Dec 2007
34	 **Angola**	29 Jun 2004	20 Sep 2007	19 Dec 2007
35	 **Guinea**	1 Apr 2004	7 Nov 2007	05 Feb 2008
36	 **Zambia**	_	23 May 2008 (accession)	21 Aug 2008
37	 **Guinea Bissau**	_	7 Nov 2008 (accession)	05 Feb 2009
38	 **Gabon**	22 Aug 2003	20 Feb 2009	21 May 2009
39	 **Sierra Leone**	_	22 May 2009 (accession)	20 Aug 2009
40	 **Liberia**	25 Jun 2004	15 Sep 2009	14 Dec 2009
41	 **Côte d'Ivoire**	24 Jul 2003	13 Aug 2010	11 Nov 2010
42	 **Ethiopia**	25 Feb 2004	25 Mar 2014	23 Jun 2014
43	 **Zimbabwe**	_	04 Dec 2014 (accession)	04 Mar 2015

Thirty-two countries[16] have laws restricting tobacco advertising, promotion and sponsorship, whereas there were only 12 in 2005. Fourteen countries[17] have imposed a comprehensive advertising ban. Banning tobacco advertising, promotion and sponsorship is the third time-bound measure defined in the WHO FCTC: each country must comply with this obligation within 5 years after entry into force the Convention. Countries should completely ban tobacco advertising, promotion and sponsorship at domestic and cross-border levels.

Countries in the African Region are conducting education and public awareness programmes on a tobacco-free lifestyle, mainly through mass media campaigns and activities related to World No Tobacco Day. They include information about the harm of using tobacco and exposure to tobacco smoke and also the adverse health, social, economic and environmental consequences of tobacco consumption and production.

Thirty-two countries[18] are promoting tobacco cessation through education and health promotion programmes in health care facilities, and six countries[19] have prepared national clinical guidelines on tobacco cessation. Twenty-six countries[20] prohibit the sale and free distribution of tobacco products to minors. Prohibition of the sale of tobacco products by minors was reported by 24 countries.[21]

The Centre for Tobacco Control in Africa, hosted by the Makerere School of Public Health in Uganda, was established with support from the Bill & Melinda Gates Foundation. The Centre provides technical support to governments in selected technical areas of tobacco control. The Centre is autonomous and will act as a resource centre for tobacco control in the Region.

Countries in the African Region participated actively at all six sessions of the Conference of the Parties to the WHO FCTC, with daily meetings for coordination and wide consultation during negotiations. The work was divided among various delegations. The Region thus maintained a common position and voice on all matters. Any challenges that were identified were tackled immediately. The African Region is furthermore well represented in all the working groups established by the Conference of the Parties. This common approach has enabled the Region to contribute effectively to tobacco control at the global level.

[16] Algeria, Benin, Botswana, Burkina Faso, Cameroon, Cape Verde, Chad, Comoros, Congo, the Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Togo, the United Republic of Tanzania, Zambia and Zimbabwe

[17] Chad, Eritrea, Ethiopia, the Gambia, Ghana, Guinea, Kenya, Madagascar, Mauritius, Namibia, Niger, Seychelles, Swaziland and Togo

[18] Algeria, Angola, Benin, Botswana, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Congo, the Democratic Republic of the Congo, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mauritius, Mozambique, Namibia, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda, the United Republic of Tanzania and Zambia.

[19] Ethiopia, the Gambia, Ghana, Kenya, Mauritius and the United Republic of Tanzania.

[20] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, Congo, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo and the United Republic of Tanzania

[21] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, Congo, the Democratic Republic of the Congo, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo and the United Republic of Tanzania

3.2 Support provided by WHO to Member States

The WHO Regional Office and country offices continue to provide support to countries in adhering to the WHO FCTC and strengthening tobacco control initiatives. Countries were given support in developing and implementing legislation and regulations compliant with their WHO FCTC obligations and in drawing up national tobacco control strategies and action plans.

Establishment of partnerships for specific interventions resulted in more resources, which translated into better support to countries. This was accomplished by the Tobacco Control Programme at the WHO Regional Office for Africa, which mobilized resources for tobacco control activities in the Region from partners including the Bill & Melinda Gates Foundation, the United States Centers for Disease Control and Prevention (CDC), the CDC Foundation, the McCabe Center for Law and Cancer and the Norwegian Agency for Development Cooperation.

Support was provided to countries to improve surveillance and monitoring of tobacco use, by conducting periodic surveys, monitoring tobacco control policies and documenting the magnitude, determinants and consequences of tobacco use and exposure. Data are currently available for 46 countries,[22] mainly from the Global Youth Tobacco Survey and the Global Adult Tobacco Survey. Data on trends among young people are available for 26 countries.[23] Accurate data on use of tobacco by adults are also available from household surveys (Table 6). The data are used to monitor implementation of the WHO FCTC and as advocacy for the introduction of new laws and regulations that are compliant with the Convention.

In collaboration with the Convention Secretariat, 17 countries[24] in the Region were supported in assessing their needs and capacity to identify the priorities to be addressed, the resources available to the country for addressing those priorities and any gaps in the required resources. The results of these assessments were also used to develop or strengthen national tobacco control programmes so as to meet obligations under the Convention and to promote and accelerate access to the resources required for implementation of the WHO FCTC. There is now better understanding of the needs of individual countries, their priorities and the resources required to fill the identified gaps.

A number of publications related to the WHO FCTC were produced and disseminated to countries in the African Region.[25] These publications contain key information, describe best practices and include success stories with regard to various measures outlined in the Convention. The information in these documents will increase awareness and provide practical guidance to policy-makers, governments and tobacco control advocates in the African Region. They provide evidence for advocating for policy to prevent people from starting to use tobacco, help current tobacco users to quit and protect people from exposure to second-hand smoke.

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[22] Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe

[23] Algeria, Botswana, Burkina Faso, Cameroon, Congo, Côte d'Ivoire, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

[24] Angola, Botswana, Burkina Faso, Burundi, Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Mauritania, Mauritius, Senegal, Sierra Leone, South Africa, Togo and Uganda

[25] *Towards tobacco-free young people in the African Region*, 2014; *Tobacco tax as a public health tool*, 2014; *Policies for tobacco control in the African Region*, 2013; *Bans on tobacco advertising, promotion and sponsorship in the African Region*, 2013; *Facts on tobacco use in the African Region*, 2012; *Global Adult Tobacco Survey in Nigeria, a success story in the African Region*, 2012; *Mauritius' health warnings, a best practice from the African Region*, 2011; *Packaging and labelling of tobacco products*, 2011; *Report cards on the implementation of the WHO FCTC*, 2010; *Fact sheets on the Global Youth Tobacco Survey*, 2009.

Table 6. Most recent surveys of adult tobacco use in the WHO African Region, by country

Country	Type of survey	Year	Coverage	Age group (years)	Indicator	Prevalence(%) Men	Women
Algeria	Tobacco survey	2010	National	15-74	Current tobacco smoking	27.1	1.7
Angola	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Benin	DHS	2012	National	15-49	Current cigarette smoking	8.1	0.2
Botswana	STEPS	2007	National	25-64	Current tobacco smoking	32.8	7.8
Burkina Faso	DHS MICS	2010	National	15-49	Current cigarette smoking	20.6	0.1
Burundi	DHS	2010	National	15-49	Current cigarette smoking	12	0.7
Cameroon	GATS	2013	National	15+	Current tobacco smoking	13.9	4.3
Cape Verde	STEPS	2007	National	25-64	Current tobacco smoking	15.9	4
Central African Republic	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Chad	STEPS	2008	Subnational	25-64	Current tobacco smoking	20.2	1.2
Comoros	STEPS	2011	National	25-64	Current tobacco smoking	23.8	2
Congo	DHS	2012	National	15-49	Current cigarette smoking	19.8	0.5
Côte d'Ivoire	DHS	2012	National	15-49	Current tobacco smoking	26.2	1.7
Democratic Republic of the Congo	STEPS	2005	Subnational	15-64	Current tobacco smoking	14.1	1.4
Equatorial Guinea	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Eritrea	STEPS	2004	National	15-64	Daily tobacco smoking	12.4	0.7
Ethiopia	DHS	2011	National	15-49	Current cigarette smoking	6.5	0.2
Gabon	DHS	2012	National	15-49	Current cigarette smoking	22.3	2.9
Gambia	STEPS	2010	National	25-64	Current tobacco smoking	31.3	1
Ghana	DHS	2008	National	15-49	Current tobacco smoking	6.2	0.4
Guinea	STEPS	2009	Subnational	15-64	Current tobacco smoking	23.2	2
Guinea-Bissau	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Kenya	GATS	2014	National	15+	Current tobacco smoking	15.1	0.8
Lesotho	STEPS	2012	National	25-64	Current tobacco smoking	48.7	0.7
Liberia	STEPS	2011	National	25-64	Current tobacco smoking	17.2	2.8
Madagascar	DHS	2009	National	15-49	Current cigarette smoking	27.7	1.5
Malawi	DHS	2010	National	15-49	Current cigarette smoking	17.6	0.4
Mali	STEPS	2007	Subnational	15-64	Current tobacco smoking	30.6	2.8
Mauritania	STEPS	2006	Subnational	15-64	Current tobacco smoking	34.2	5.7
Mauritius	NCD	2009	National	19+	Current tobacco smoking	40.3	3.7
Mozambique	DHS	2011	National	15-49	Current cigarette smoking	19.9	1.4
Namibia	DHS	2007	National	15-49	Current tobacco smoking	24	8
Niger	DHS MICS	2012	National	15-49	Current tobacco use	14	2.4
Nigeria	GATS	2012	National	15+	Current tobacco smoking	7.3	0.4
Rwanda	DHS	2010	National	15-49	Current cigarette smoking	12	0.4
Sao Tome and Principe	STEPS	2009	National	25-64	Current tobacco smoking	9.7	1.7
Senegal	DHS MICS	2011	National	15-49	Current tobacco smoking	17.7	0.2
Seychelles	NCD	2014	National	25-64	Current cigarette smoking	34.1	7.7
Sierra Leone	STEPS	2009	National	25-64	Current tobacco smoking	43.1	10.5
South Africa	Health Nutrition	2012	National	15+	Current tobacco smoking	27.8	7.2
South Sudan	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Swaziland	STEPS	2007	National	25-64	Current tobacco smoking	12.9	2.2
Togo	STEPS	2011	National	15-64	Current tobacco smoking	12.4	1.8
Uganda	GATS	2013	National	15+	Current tobacco smoking	10.3	1.8
United Republic of Tanzania	STEPS	2012	National	25-64	Current tobacco smoking	26	2.9
Zambia	DHS	2007	National	15-49	Current cigarette smoking	23.2	0.7
Zimbabwe	DHS	2011	National	15-49	Current cigarette smoking	21.2	0.2

DHS, demographic and health survey; GATS, global adult tobacco survey; MICS, multiple indicator cluster survey; NCD, noncommunicable disease survey; STEPS, stepwise approach to surveillance

3.3 Emerging areas in tobacco control

Countries in the Region have also begun to tackle emerging areas of tobacco control in collaboration with regional economic communities. Agreements and joint work plans have been developed to address tobacco taxation, eliminate illicit trade in tobacco products and provide alternative livelihoods for tobacco growers. Collaboration is under way with three regional economic blocs, namely the West African Economic and Monetary Union, the East African Community and the Southern Africa Customs Union.

All countries in the Region levy taxes on tobacco products, at rates ranging from 11% to 76% of the retail price; five countries[26] have earmarked a proportion of this tax for health promotion, young people or sport. Technical assistance to effect policy change in tobacco taxation was provided to 20 countries[27] and to the secretariats of the West African Economic and Monetary Union and the East African Community. Twelve countries[28] have increased taxes on tobacco products with the objective of reducing demand.

The Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to the WHO FCTC, was adopted by the Conference of the Parties on 12 November 2012. It was developed in response to the growing international illicit trade in tobacco products, which poses a serious threat to public health. The objective of the Protocol is the elimination of all forms of illicit trade in tobacco products, in accordance with the terms of Article 15 of the WHO FCTC. The Protocol supplements the WHO FCTC by providing comprehensive means for countering and eventually eliminating illicit trade in tobacco products and strengthening the legal dimensions of international health cooperation. To date, 14 countries[29] in the African Region have signed the Protocol; only Gabon has ratified it, and the Protocol is therefore not yet in force. To prepare for effective implementation of the Protocol, capacity was built in five countries[30] and two economic blocs[31].

Thirteen countries[32] are promoting environmental protection and providing alternatives for tobacco workers, growers and sellers. The key role of international trade and investment laws in effective implementation of the Convention is recognized. Misconceptions about the link between these laws and the WHO FCTC are being clarified, and capacity-building in this area was conducted in 12 countries.[33] These approaches, which are not classical public health measures, are critical to achieving full implementation of the Convention.

[26] Algeria, Kenya, Lesotho, Madagascar and Namibia

[27] Angola, Benin, Burkina Faso, Burundi, Cote d'Ivoire, Ethiopia, the Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Rwanda, Senegal, Togo, Uganda, the United Republic of Tanzania and Zambia

[28] Benin, Burkina Faso, Côte d'Ivoire, the Gambia, Ghana, Guinea-Bissau, Kenya, Mali, Mauritania, Niger, Senegal and Togo

[29] Benin, Botswana, Burkina Faso, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, Ghana, Guinea-Bissau, Kenya, Madagascar, Mali, South Africa, Togo and the United Republic of Tanzania

[30] Ethiopia, the Gambia, Ghana, Kenya and Uganda

[31] East African Community and Southern Africa Customs Union

[32] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, Gabon, Ghana, Kenya, Mali, Nigeria, Senegal and Uganda

[33] Botswana, Ethiopia, Ghana, Kenya, Lesotho, Namibia, Nigeria, Senegal, South Africa, Swaziland, Togo and Uganda

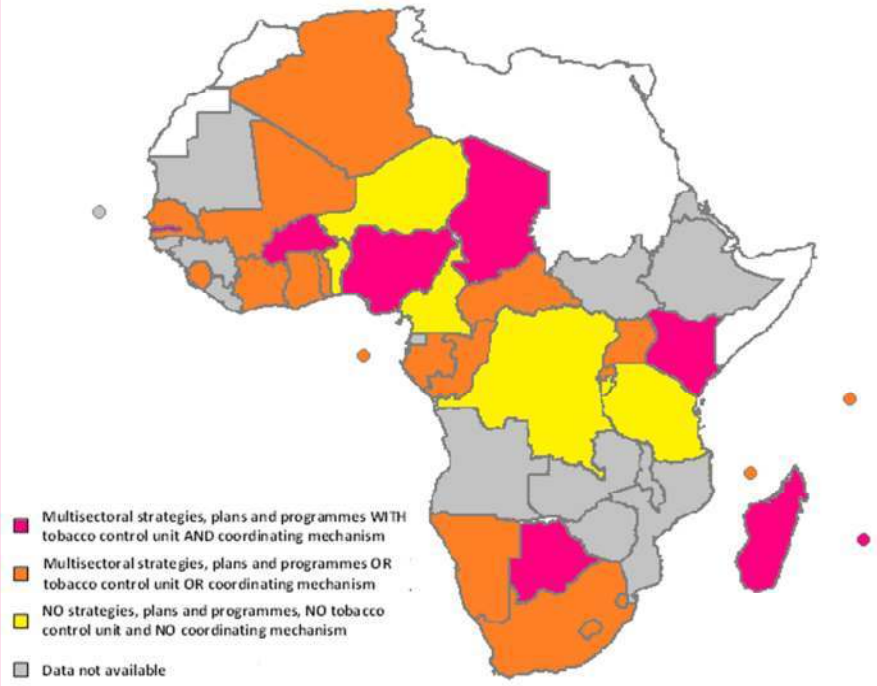
4. CURRENT STATUS OF IMPLEMENTATION OF THE WHO FCTC

4.1 Article 5 on *General obligations*

Article 5.1 of the WHO FCTC requires countries to develop, implement, update and review comprehensive multisectoral national tobacco control strategies, plans and programmes. Article 5.2 requires countries to establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control.

In the African Region, 30 countries[34] reported that they had prepared and implemented national strategies, plans and programmes on tobacco control. Furthermore, 17 countries[35] have established or reinforced and financed a tobacco control unit, while 22 countries[36] have established or reinforced and financed a national coordinating mechanism for tobacco control (Figure 4). Staffing levels and funding allocations remain low, however, and countries report lack of human and financial resources as the main obstacles to effective implementation of tobacco control activities.

Figure 4: Status of implementation of key measures under Article 5 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[34] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda and United Republic of Tanzania

[35] Algeria, Botswana, Burkina Faso, Chad, Comoros, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mauritius, Namibia, Nigeria, Seychelles, South Africa and Uganda

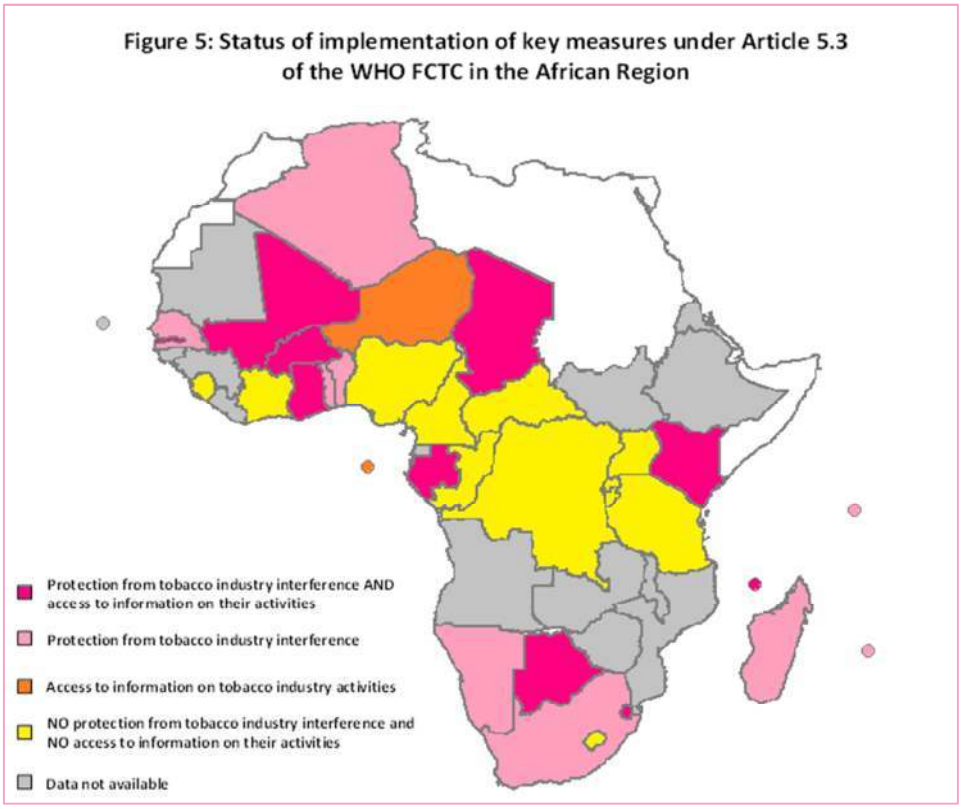
[36] Botswana, Burkina Faso, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Nigeria, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, Togo and Uganda

4.2 Article 5.3 on *Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry*

Article 5.3 of the WHO FCTC requires that in setting and implementing their public health policies with respect to tobacco control countries shall act to protect those policies from commercial and other vested interests of the tobacco industry in accordance with national law. It is recognized that there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health.

In the African Region, 19 countries[37] reported that they had protected their public health policies for tobacco control from commercial and other vested interests of the tobacco industry. Another 12 countries[38] reported that their populations had access to a wide range of information on tobacco industry activities relevant to the objectives of the Convention (Figure 5). In implementing these measures, countries stated that no person or individual affiliated with the tobacco industry in any manner whatsoever is allowed to participate in the development of tobacco control policies. Nevertheless, countries reported that the tobacco industry has a negative influence once the draft legislation is open for public consultation before its adoption.

Figure 5: Status of implementation of key measures under Article 5.3 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[37] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Senegal, Seychelles, South Africa, Swaziland and Togo

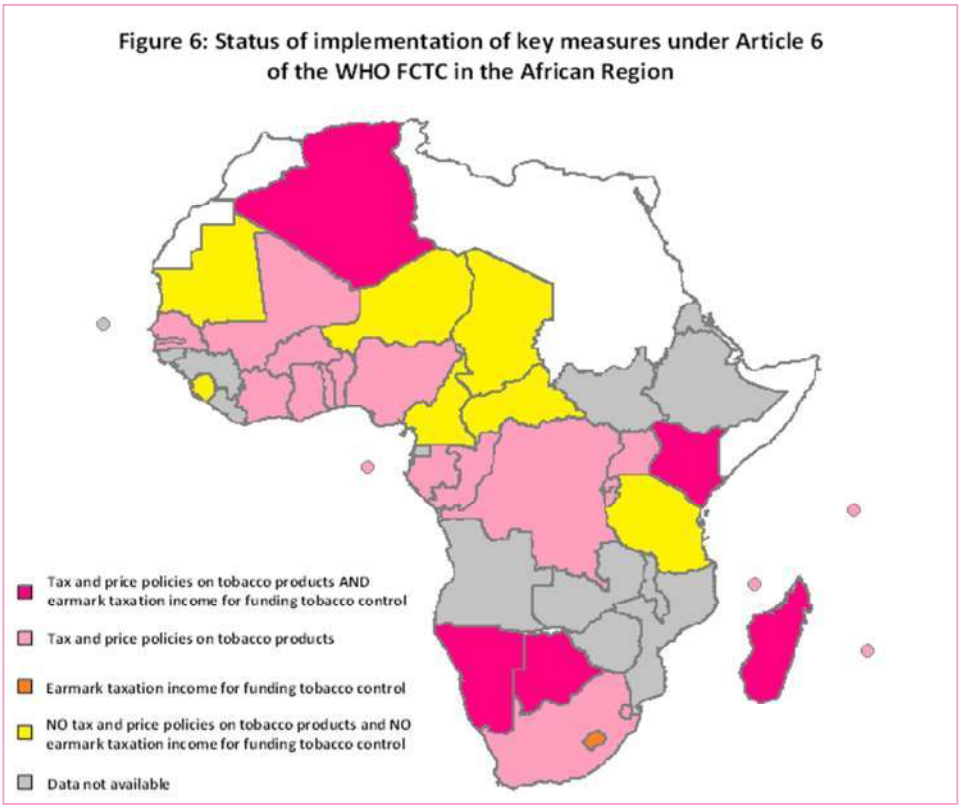
[38] Botswana, Burkina Faso, Chad, Comoros, Gabon, the Gambia, Ghana, Kenya, Mali, Niger, Sao Tome and Principe and Swaziland

4.3 Article 6 on *Price and tax measures to reduce the demand for tobacco*

Article 6 of the WHO FCTC affirms that price and tax measures are effective, important means of reducing the tobacco consumption of certain segments of the population. The Article requires countries to implement tax and price policies on tobacco products in order to contribute to the health objectives of reducing tobacco consumption. When taxes on tobacco products go up, their prices also go up, and tobacco consumption subsequently goes down, because fewer people use tobacco, the people who continue to use tobacco consume less, the people who have quit are less likely to start again, and the young are less likely to start using tobacco.

Most countries in the African Region levy an excise tax on cigarettes, and six countries[39] earmark a percentage of taxation income for funding tobacco control (Figure 6). Of the 26 countries[40] that reported having tax and price policies on tobacco products, 12[41] have increased taxes on tobacco products in order to reduce the demand. Seven countries[42] prohibit or restrict sales to international travellers of tax- and duty-free tobacco products, while another eight[43] reported prohibiting or restricting imports by international travellers of tax- and duty-free tobacco products. Price and tax measures have been shown to be very effective in reducing the demand for tobacco products.

Figure 6: Status of implementation of key measures under Article 6 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[39] Algeria, Botswana, Kenya, Lesotho, Madagascar and Namibia

[40] Algeria, Benin, Botswana, Burkina Faso, Burundi, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo and Uganda

[41] Benin, Burkina Faso, Côte d'Ivoire, the Gambia, Ghana, Guinea Bissau, Kenya, Mali, Mauritania, Niger, Senegal and Togo

[42] Gabon, Kenya, Mauritius, Nigeria, Seychelles, Swaziland and Togo

[43] Algeria, Burkina Faso, Gabon, Kenya, Mauritius, Nigeria, South Africa and Swaziland

4.4 Article 8 on *Protection from exposure to tobacco smoke*

Article 8 of the WHO FCTC requires countries to adopt and implement effective measures to protect their people from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. Each Party to the Convention should provide comprehensive protection within 5 years of entry into force of the WHO FCTC for that Party.

In the African Region, of the countries that have adopted measures to protect people from tobacco smoke in public places, 22[44] have a complete ban on smoking in government buildings, and 24[45] have a complete ban on smoking in health care and educational facilities (Figure 7). Twenty-seven countries[46] also have a complete ban on smoking in ground public transport, and 20[47] have complete bans on smoking in cultural facilities. Furthermore, 15 countries[48] reported that they have complete smoking ban in restaurants. Approaches other than 100% smoke-free environments, including ventilation, air filtration and the use of designated smoking areas (with or without separate ventilation systems) are ineffective; only a complete ban is effective.

Figure 7: Status of implementation of key measures under Article 8 of the WHO FCTC in the African Region

Source: Country reports on implementation of the WHO FCTC

[44] Benin, Botswana, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo and Uganda

[45] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Madagascar, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo, Uganda and the United Republic of Tanzania

[46] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda and the United Republic of Tanzania

[47] Algeria, Benin, Botswana, Burkina Faso, Comoros, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland and Togo

[48] Botswana, Burkina Faso, Comoros, Congo, Côte d'Ivoire, Ghana, Kenya, Madagascar, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Seychelles, Swaziland and Togo.

Example of Seychelles

Seychelles implements smoke-free environments in public places.

Smoke-free signs in public places in Seychelles

Seychelles was the first country in the African Region to ratify the WHO FCTC, on 12 November 2003, with entry into force for the country on 27 February 2005. The ban on smoking in public places in Seychelles is mandated by the Tobacco Control Act, 2009, adopted on 19 August 2009.

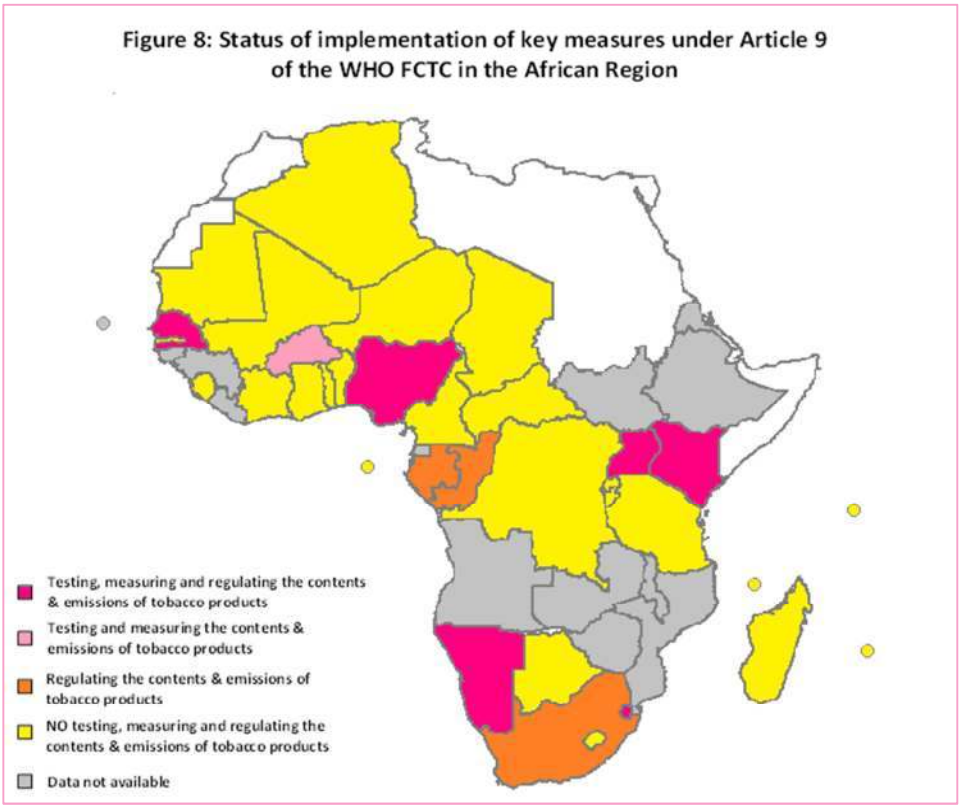
Implementing 100% smoke-free environments is the only effective way to protect the population from the harmful effects of exposure to second-hand tobacco smoke.

4.5 Article 9 on *Regulation of the contents of tobacco products*

Article 9 of the WHO FCTC requires countries to adopt and implement effective measures for testing, measuring and regulating the contents and emissions of tobacco products. Tobacco product regulation can contribute to reducing tobacco-attributable disease and premature death by reducing the attractiveness of tobacco products, reducing their addictiveness (or dependence liability) or reducing their overall toxicity.

In the African Region, only eight countries[49] reported that they tested and measured the contents of tobacco products, and seven countries[50] reported testing and measuring of emissions. Thirteen countries[51] reported regulating the contents of tobacco products, and nine[52] reported regulations on the emissions of tobacco products (Figure 8). In some countries, the current regulations include disclosure of the amounts of nicotine and tar but not of the other contents; therefore, international guidelines and standards should be followed. In 2014, the Centre for Toxicology, Environmental Control and Public Health at the National Public Health Laboratory in Ouagadougou, Burkina Faso, was designated a WHO collaborating centre for tobacco product testing and research. This is the only government facility in the Region for testing tobacco products.

Figure 8: Status of implementation of key measures under Article 9 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

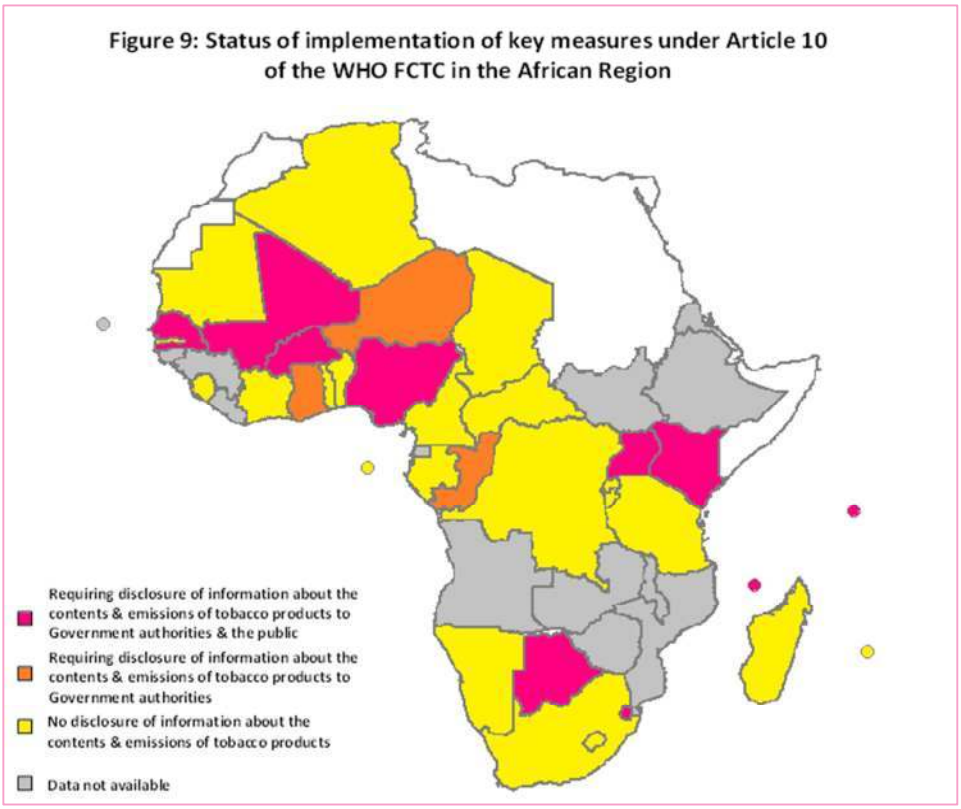
[49] *Algeria, Burkina Faso, Kenya, Namibia, Nigeria, Senegal, Swaziland and Uganda.*
[50] *Burkina Faso, Kenya, Namibia, Nigeria, Senegal, Swaziland and Uganda.*
[51] *Algeria, Benin, Congo, Gabon, Kenya, Mali, Namibia, Niger, Nigeria, Senegal, South Africa, Swaziland and Uganda.*
[52] *Congo, Gabon, Kenya, Namibia, Nigeria, Senegal, South Africa, Swaziland and Uganda.*

4.6 Article 10 on *Regulation of tobacco product disclosures*

Article 10 of the WHO FCTC requires countries to adopt and implement measures to ensure that manufacturers and importers of tobacco products disclose information on the contents and emissions of tobacco products to government authorities and disclose information about the toxic constituents of tobacco products and their emissions to the public. The objective of requiring disclosure by manufacturers and importers to government authorities is to obtain relevant information on the contents, emissions, toxicity and addictiveness of tobacco products; the objective of public disclosure is to inform the public about the health consequences, addictive nature and mortal threat posed by tobacco consumption and exposure to tobacco smoke.

In the African Region, 16 countries[53] require manufacturers or importers of tobacco products to disclose to government authorities information about the contents of tobacco products, while 14 countries[54] require such disclosure about the emissions of tobacco products. Additionally, 14 countries[55] require public disclosure of information about the contents of tobacco products and 11[56] about the emissions (Figure 9). Countries reported that international standards are used to regulate contents and emissions, as most products are imported. Locally produced products that are exported comply with the standards of the country to which they are being exported.

Figure 9: Status of implementation of key measures under Article 10 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[53] Botswana, Burkina Faso, Comoros, Congo, the Democratic Republic of the Congo, Ghana, Kenya, Mali, Namibia, Niger, Nigeria, Senegal, Seychelles, Swaziland, Uganda and the United Republic of Tanzania.

[54] Botswana, Burkina Faso, Comoros, Congo, Ghana, Kenya, Mali, Niger, Nigeria, Senegal, Seychelles, South Africa, Swaziland and Uganda

[55] Botswana, Burkina Faso, Cameroon, Comoros, the Democratic Republic of the Congo, Gabon, Kenya, Mali, Nigeria, Senegal, Seychelles, Swaziland, Uganda and the United Republic of Tanzania

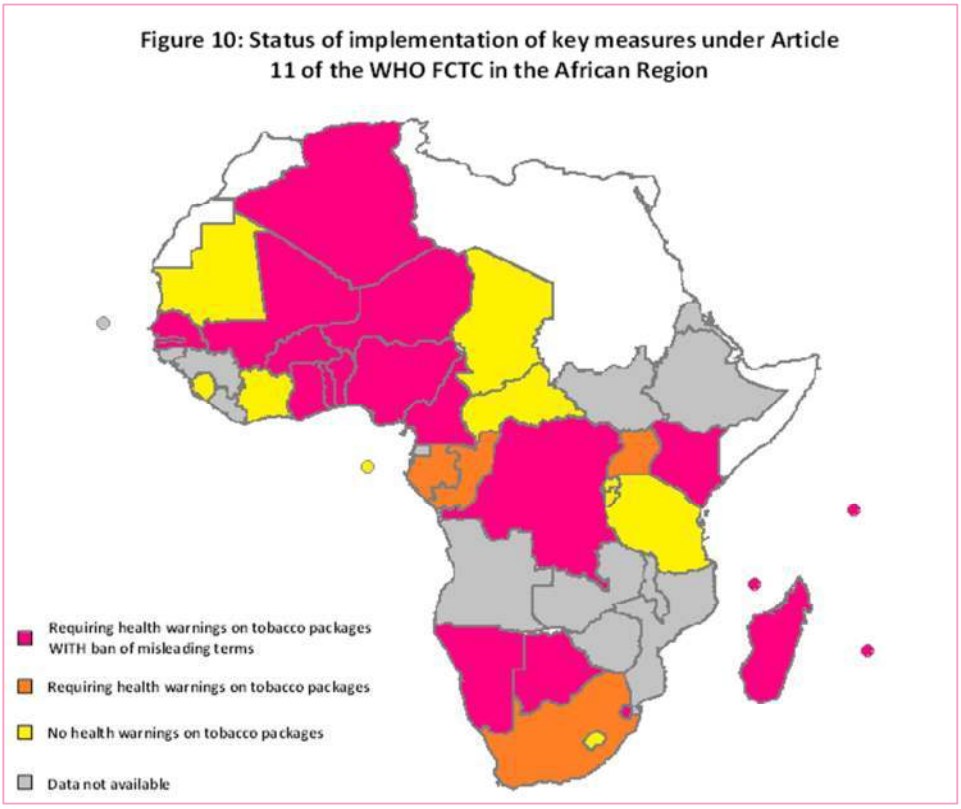
[56] Botswana, Burkina Faso, Comoros, Kenya, Mali, Nigeria, Senegal, Seychelles, South Africa, Swaziland and Uganda

4.7 Article 11 on *Packaging and labelling of tobacco products*

Article 11 of the WHO FCTC requires countries to adopt and implement effective measures to ensure that tobacco product packaging and labelling do not promote the product and that each unit packet and package and any outside packaging and labelling of tobacco products also carry health warnings about the harmful effects of tobacco use. Each Party should adopt and implement effective packaging and labelling measures within 3 years of entry into force of the Convention for that Party.

Of the countries that require health warnings on tobacco packages, 20[57] require that the packaging and labelling do not promote the product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions (Figure 10). The guidelines recommend that health warnings occupy 50% or more of the principal display area; 15 countries[58] in the African Region comply with this requirement. Only three countries[59] have so far implemented pictorial health warnings on tobacco packages. Twenty-one countries[60] require that the warnings be in the principal language or languages of the country. Health warnings are most effective when they are large and visible, and pictures send health messages better than words.

Figure 10: Status of implementation of key measures under Article 11 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[57] Algeria, Benin, Botswana, Burkina Faso, Cameroon, Comoros, the Democratic Republic of the Congo, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Senegal, Seychelles, Swaziland and Togo

[58] Botswana, Burkina Faso, Cameroon, Chad, Comoros, Gabon, Ghana, Madagascar, Mauritius, Namibia, Nigeria, Senegal, Seychelles, Swaziland and Togo

[59] Madagascar, Mauritius and Seychelles

[60] Algeria, Benin, Botswana, Burkina Faso, Chad, Comoros, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mauritius, Namibia, Senegal, Seychelles, South Africa, Swaziland, Togo, Uganda and the United Republic of Tanzania

Example of Madagascar

Madagascar implements pictorial warnings labels.

"Tobacco use shortens your life"

Pictorial warning on tobacco package in Madagascar

Madagascar was the fourth country in the African Region to ratify the WHO FCTC, on 22 September 2004, with entry into force for the country on 27 February 2005. Pictorial health warnings on tobacco packages in Madagascar are mandated by Decree No. 2010-1008 of 14 December 2010, which was implemented in October

Large warnings with pictures on tobacco packages are particularly effective in communicating health effects; they provoke a greater emotional response and increase the motivation of tobacco users to quit or to decrease their tobacco consumption.

4.8 Article 12 on *Education, communication, training and public awareness*

Article 12 of the WHO FCTC requires countries to promote and strengthen public awareness of tobacco control issues using all available communication tools and to adopt and implement measures to improve the effectiveness of education, communication and training to raise public awareness of matters related to tobacco control. It is essential to change social, environmental and cultural norms and perceptions about the acceptability of consuming tobacco products, exposure to tobacco smoke and aspects of the growing, manufacture, marketing and sale of tobacco and tobacco products.

In the African Region, educational and public awareness programmes targeting adults or the general public were conducted in 28 countries[61] and targeting children and young people in 31 countries[62]. These programmes cover the health risks of tobacco consumption and exposure to tobacco smoke as reported by 31 countries[63] and the benefits of cessation of tobacco use and tobacco-free lifestyles as reported by 29 countries[64]. Furthermore, 26 countries[65] reported having appropriate special training or sensitization and awareness programmes on tobacco control for health workers (Figure 11); 26 countries[66] reported that such programmes were available for media professionals and 22 countries[67] had programmes for educators.

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[61] Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, the Democratic Republic of the Congo, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo and Uganda

[62] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo and Uganda

[63] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo and Uganda

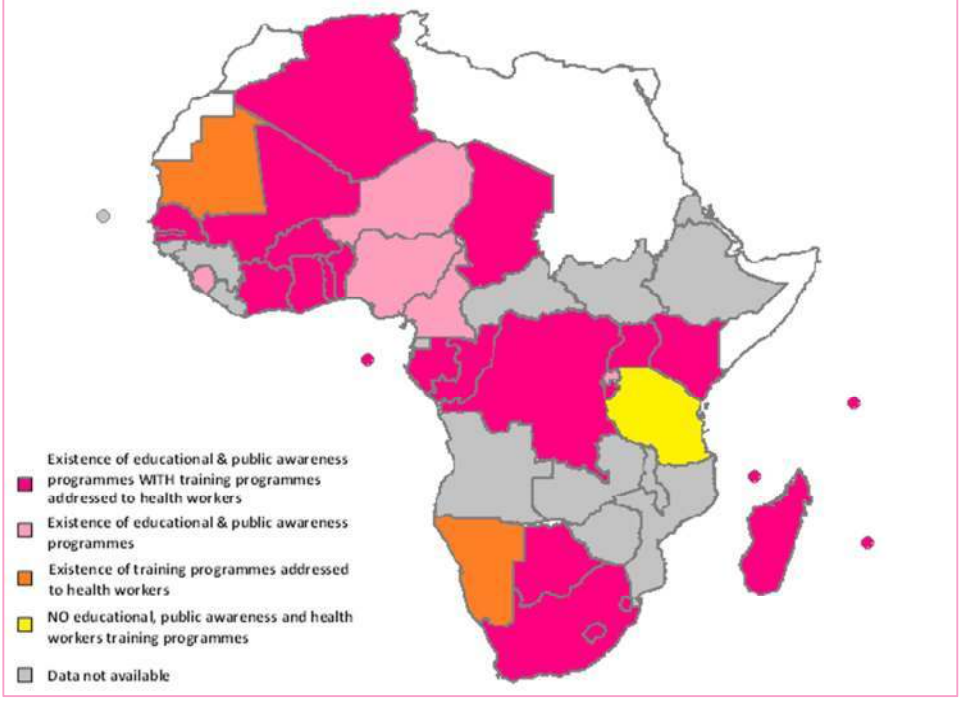
[64] Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo and Uganda

[65] Algeria, Benin, Botswana, Burkina Faso, Burundi, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Togo and Uganda

[66] Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, the Gambia, Ghana, Kenya, Lesotho, Madagascar, Mali, Mauritius, Namibia, Niger, Senegal, Seychelles, South Africa, Swaziland, Togo and Uganda

[67] Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Côte d'Ivoire, the Democratic Republic of the Congo, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Sao Tome and Principe, Seychelles, Swaziland, Togo and Uganda

Figure 11: Status of implementation of key measures under Article 12 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

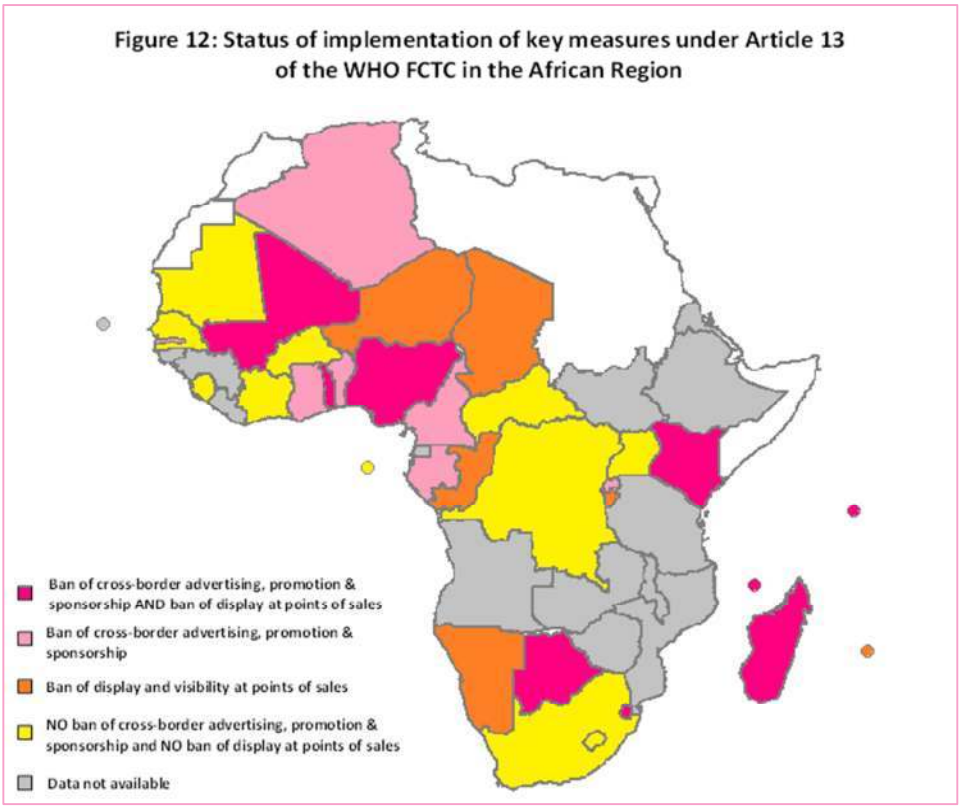
FCTC 10 years 2005–2015

4.9 Article 13 on *Tobacco advertising, promotion and sponsorship*

Article 13 of the WHO FCTC requires countries to legislate a comprehensive ban on all tobacco advertising, promotion and sponsorship, both within the country and that originating from and entering the territory. Each Party should undertake appropriate measures to ban tobacco advertising, promotion and sponsorship within 5 years after entry into force of the Convention for that Party.

Of the countries that ban tobacco advertising, promotion and sponsorship, 15[68] ban the display and visibility of tobacco products at points of sales, while 15 countries[69] ban brand "stretching" and/or "brand sharing". Seventeen countries[70] ban cross-border advertising, promotion and sponsorship originating from their territory, and 18[71] have banned such activities entering their territory (Figure 12). Fourteen countries[72] impose penalties for cross-border advertising equal to those applicable to domestic advertising, promotion and sponsorship. A total ban is effective and should be part of a comprehensive tobacco control law.

Figure 12: Status of implementation of key measures under Article 13 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[68] Botswana, Burundi, Chad, Comoros, Congo, Kenya, Madagascar, Mali, Mauritius, Namibia, Niger, Nigeria, Seychelles, Swaziland and Togo

[69] Botswana, Burkina Faso, Chad, Comoros, Ghana, Kenya, Madagascar, Mali, Mauritius, Niger, Nigeria, Senegal, Seychelles, Swaziland and Togo

[70] Algeria, Benin, Botswana, Burkina Faso, Cameroon, Comoros, Gabon, Gambia, Ghana, Kenya, Madagascar, Mali, Nigeria, Rwanda, Seychelles, Swaziland and Togo

[71] Algeria, Benin, Botswana, Cameroon, Comoros, Gabon, Gambia, Ghana, Kenya, Madagascar, Mali, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland and Togo

[72] Benin, Botswana, Cameroon, Chad, Comoros, Gabon, Gambia, Kenya, Madagascar, Namibia, Nigeria, Seychelles, Swaziland and Togo

Example of Ghana

Ghana bans tobacco advertising, promotion and sponsorship.

Adoption of the Public Health Act by the Parliament in Ghana

Ghana was the fifth country in the African Region to ratify the WHO FCTC, on 29 November 2004, with entry into force for the country on 27 February 2005. A comprehensive ban on tobacco advertising, promotion and sponsorship in Ghana is mandated by the Public Health Act, 2012, adopted on 16 October 2012.

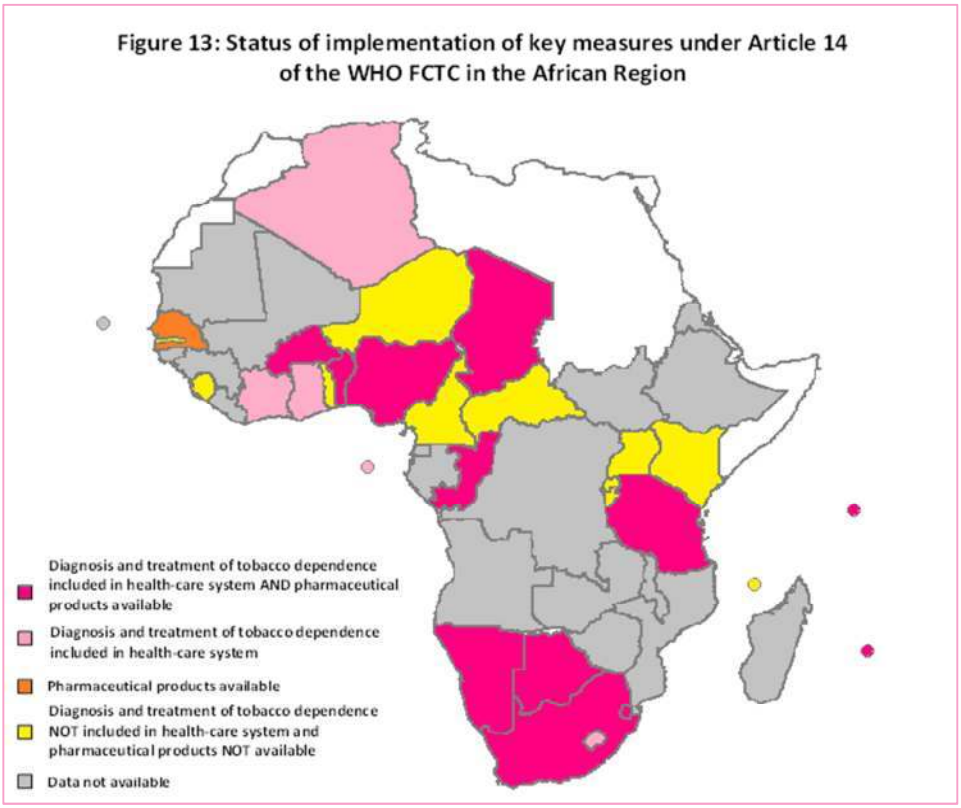
To reduce tobacco consumption effectively, bans on tobacco advertising, promotion and sponsorship must be complete and apply to all types of advertising in all media, all promotion and all sponsorship, both direct and indirect.

4.10 Article 14 on *Demand reduction measures concerning tobacco dependence and cessation*

Article 14 of the WHO FCTC requires countries to develop and disseminate comprehensive, integrated guidelines for cessation of tobacco use based on scientific evidence and best practice, and to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence. Countries should provide cessation support and treatment in all health care settings by all health care providers. Countries should additionally consider providing cessation support and treatment in non-health care settings, by suitably trained non-health care providers.

In the African Region, 17 countries[73] include programmes on the diagnosis and treatment of tobacco dependence in their health care system (Figure 13). Furthermore, 21 countries[74] reported having programmes to promote tobacco cessation, including media campaigns emphasizing the importance of quitting. Nine countries[75] reported programmes for promoting cessation in educational institutions, and eight countries[76] reported similar programmes in workplaces. In 16 countries[77], physicians are involved in programmes offering treatment for tobacco dependence and counselling services. Providing brief advice to tobacco users has been shown significantly to increase the success rates of quitting and should therefore be integrated into the health care system.

Figure 13: Status of implementation of key measures under Article 14 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[73] Algeria, Benin, Botswana, Burkina Faso, Chad, Congo, Côte d'Ivoire, Ghana, Lesotho, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Seychelles, South Africa, Swaziland and the United Republic of Tanzania

[74] Algeria, Benin, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, the Gambia, Ghana, Kenya, Lesotho, Mali, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Swaziland, Togo and Uganda

[75] Botswana, Burundi, Cameroon, Chad, the Gambia, Lesotho, Sao Tome and Principe, Swaziland and the United Republic of Tanzania

[76] Cameroon, Chad, the Gambia, Lesotho, Namibia, Nigeria, Sao Tome and Principe and Swaziland

[77] Algeria, Benin, Burkina Faso, Cameroon, Chad, Congo, Côte d'Ivoire, Ghana, Kenya, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Seychelles, Swaziland and the United Republic of Tanzania

4.11 Article 15 on *Illicit trade in tobacco products*

Article 15 of the WHO FCTC requires countries to adopt and implement measures to ensure that all unit packets and packages of tobacco products and any outside packaging of such products are marked such that countries can determine the origin of the products and any point of diversion and to monitor, document and control the movement of the products and their legal status. Countries should also adopt and implement measures, including licensing, to control or regulate the production and distribution of tobacco products in order to prevent illicit trade. The elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacture and counterfeiting, and the enaction of related national law, in addition to subregional, regional and global agreements, are essential components of tobacco control.

The Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to the WHO FCTC, builds on and complements Article 15, which addresses means of countering illicit trade in tobacco products, a key aspect of a comprehensive tobacco control policy. Illicit trade in tobacco products not only undermines price and tax measures designed to strengthen tobacco control and increase the accessibility and affordability of tobacco products but also undermines health objectives, imposes an additional strain on health systems and causes loss of revenue to governments. Effective action to prevent and combat illicit trade in tobacco products requires a comprehensive international approach to, and close cooperation on, all aspects of illicit trade.

The aim of the Protocol is to secure the supply chain of tobacco products. It requires establishment of a global tracking and tracing regime within 5 years of entry into force of the Protocol, comprising national and/or regional tracking and tracing systems and a global information sharing point located in the Convention Secretariat. Other provisions to ensure control of the supply chain include licensing, due diligence, record-keeping and security and preventive measures, as well as measures to control Internet- and telecommunication-based sales, duty-free sales, duty-free zones and international transit.

The Protocol also covers offences, with provisions on liability, prosecutions and sanctions, seizure payments and special investigative techniques, as well as the disposal and destruction of confiscated products. The Protocol addresses the issue of international cooperation, including measures on information-sharing, technical and law enforcement cooperation, protection of sovereignty, jurisdiction, mutual legal and administrative assistance and extradition.

Any Party to the WHO FCTC may become a Party to the Protocol. The Protocol shall enter into force on the 90th day after deposition of the 40th instrument of ratification, acceptance, approval, formal confirmation or accession.

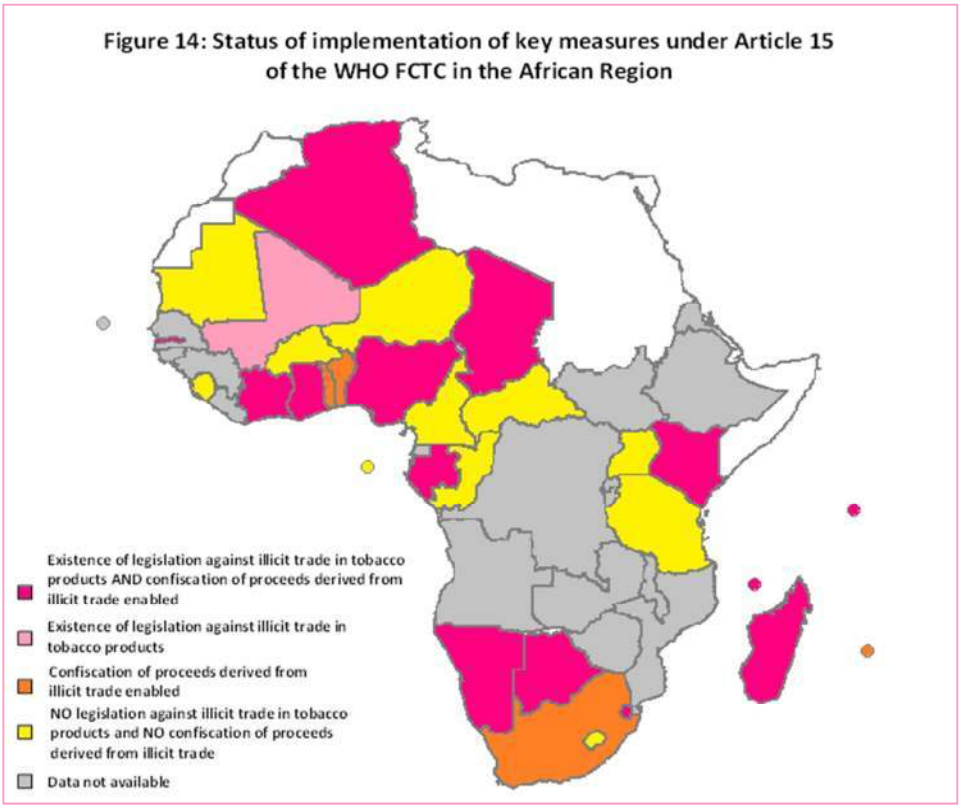
In the African Region, 18 countries[78] require marking of all unit packets and packages of tobacco products and any outside packaging of such products to indicate the origin of the product, while 13 countries[79] require monitoring and collection of data on cross-border trade in tobacco products, including illicit trade (Figure 14). Fifteen countries[80] require that manufacturing equipment, counterfeit and contraband cigarettes and other tobacco products derived from illicit trade be destroyed or disposed of in accordance with national law. Licensing or other action to control or regulate production and distribution in order to prevent illicit trade is required in 19 countries.[81] Ratifying the Protocol is a key commitment in tackling illicit trade in tobacco products, and Parties are urged to ratify and implement the provisions of the Protocol.

[78] Algeria, Benin, Botswana, Chad, Comoros, Côte d'Ivoire, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Nigeria, Senegal, Seychelles and Swaziland

[79] Algeria, Botswana, Chad, Gabon, the Gambia, Ghana, Kenya, Mauritius, Namibia, Nigeria, Senegal, Seychelles and Swaziland

[80] Algeria, Chad, Comoros, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mauritius, Namibia, Nigeria, Senegal, Seychelles, Swaziland and Uganda

[81] Algeria, Botswana, Burkina Faso, Chad, Comoros, Gabon, the Gambia, Ghana, Kenya, Madagascar, Namibia, Niger, Nigeria, Rwanda, Seychelles, South Africa, Swaziland, Togo and Uganda



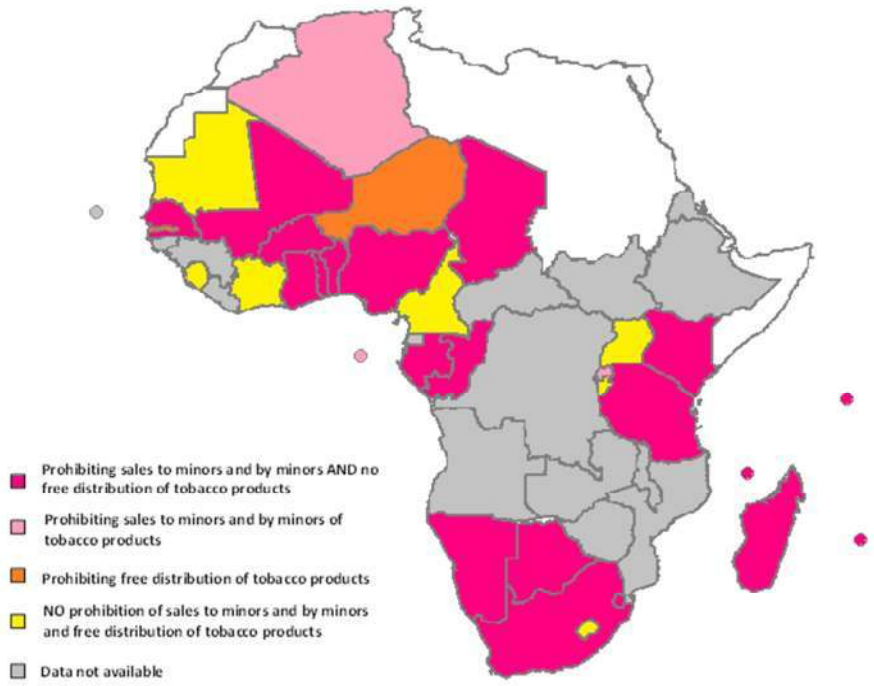
Source: Country reports on implementation of the WHO FCTC

4.12 Article 16 on *Sales to and by minors*

Article 16 of the WHO FCTC requires countries to adopt and implement measures to prohibit the sales of tobacco products to and by persons under the age set by law. Countries should require a clear, prominent sign inside points of sale stating the prohibition of tobacco sales to minors, ban the sale of tobacco products in any manner by which they are directly accessible, prohibit the manufacture and sale of sweets, snacks, toys or any other object in the form of tobacco products, prohibit the distribution of free tobacco products to the public and especially minors and prohibit the sale of cigarettes individually or in small packets.

In the African Region, of the countries that prohibit the sales of tobacco products to and by minors, 18[82] require that all sellers of tobacco products place a clear, prominent warning at the point of sale stating the prohibition of tobacco sales to minors. In addition, 18 countries[83] prohibit the manufacture and sale of sweets, snacks, toys or any other object in the form of tobacco products that might appeal to minors (Figure 15). Twelve countries[84] prohibit the sale of cigarettes individually or in small packets, which increase the affordability of such products. Eleven countries[85] ban the sale of tobacco products in any manner in which they are directly accessible, such as open shelves.

Figure 15: Status of implementation of key measures under Article 16 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[82] Botswana, Chad, Comoros, Congo, Gabon, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland and Togo

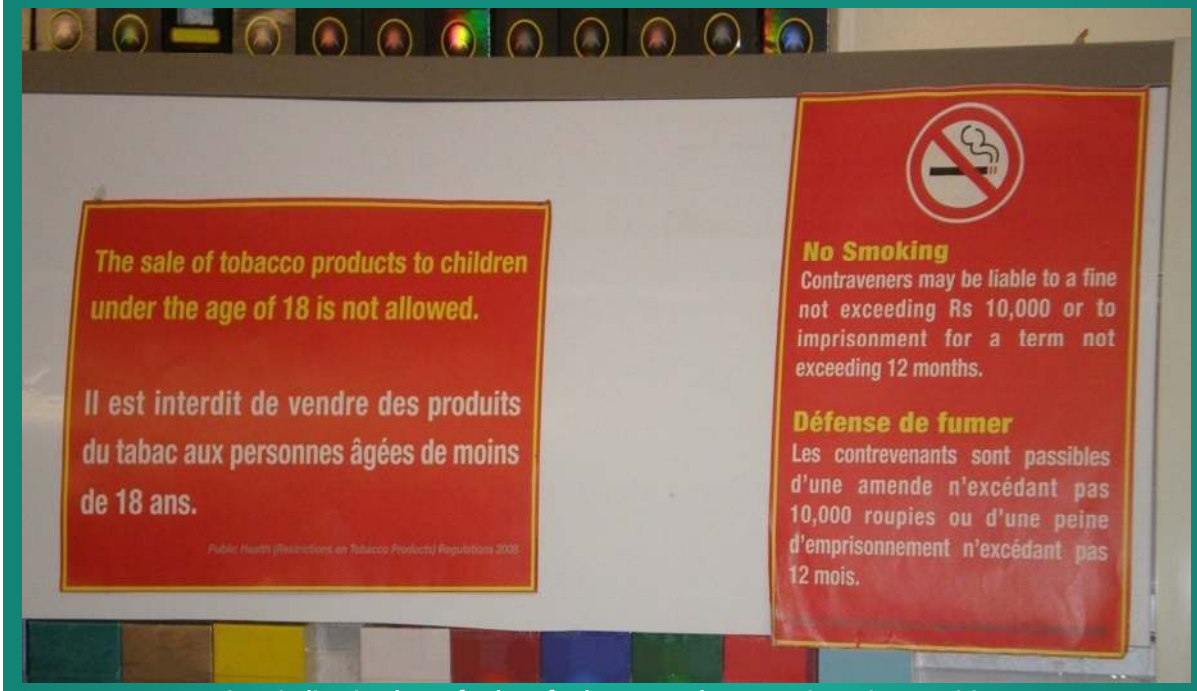
[83] Botswana, Burkina Faso, Chad, Comoros, Congo, Ghana, Kenya, Madagascar, Mali, Mauritius, Namibia, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Swaziland and Togo

[84] Benin, Burkina Faso, Chad, Comoros, Ghana, Kenya, Mali, Mauritius, Namibia, Nigeria, Swaziland and Togo

[85] Botswana, Chad, Comoros, Congo, Kenya, Mali, Mauritius, Namibia, Seychelles, Swaziland and Togo

Example of Mauritius

Mauritius bans the sale of tobacco products to and by minors.



Signs indicating ban of sales of tobacco products to minors in Mauritius

Mauritius was the second country in the African region to ratify the WHO FCTC, on 17 May 2004, with entry into force for the country on 27 February 2005. The ban on sale of tobacco products to and by minors is mandated by the Public Health (Restrictions on Tobacco products) Regulations 2008, adopted on 28 November 2008.

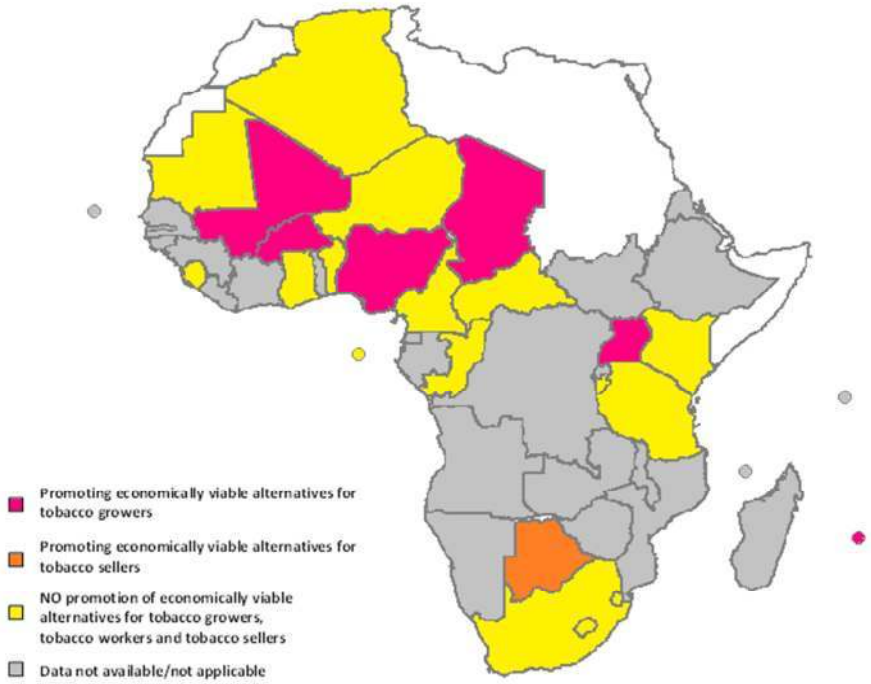
Prohibition of access to tobacco products by minors indicated by clear, prominent signs at points of sale, a ban on vending machines, a ban on free distribution of tobacco products and a ban on sale of cigarettes individually or in small packets are effective in protecting minors from the harm of tobacco.

4.13 Article 17 on *Provision of support for economically viable alternative activities*

Article 17 of the WHO FCTC requires countries to promote economically viable alternatives for tobacco workers, growers and individual sellers. For economically sustainable alternatives to tobacco growing, not only income and crop profitability but all aspects of farmers' livelihoods must be addressed. The alternatives should provide opportunities for tobacco farmers to enhance their health and socioeconomic well-being.

In the African Region, six countries[86] reported promoting economically viable, sustainable alternatives for tobacco growers; only Botswana reported promoting alternatives for individual tobacco sellers (Figure 16). Countries in the Region are not yet promoting alternatives for tobacco workers. A few countries[87] reported that most tobacco is cultivated for personal use and the amount is insignificant, while others[88] reported significant reductions in the demand for locally grown tobacco due to the closure of major manufacturing facilities in the country, followed by a natural transition to growing other crops, such as tomatoes, lettuces, cabbages, potatoes and fruit. Economically viable alternatives to tobacco growing and selling exist and should be promoted to give farmers and workers healthier alternatives.

Figure 16: Status of implementation of key measures under Article 17 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

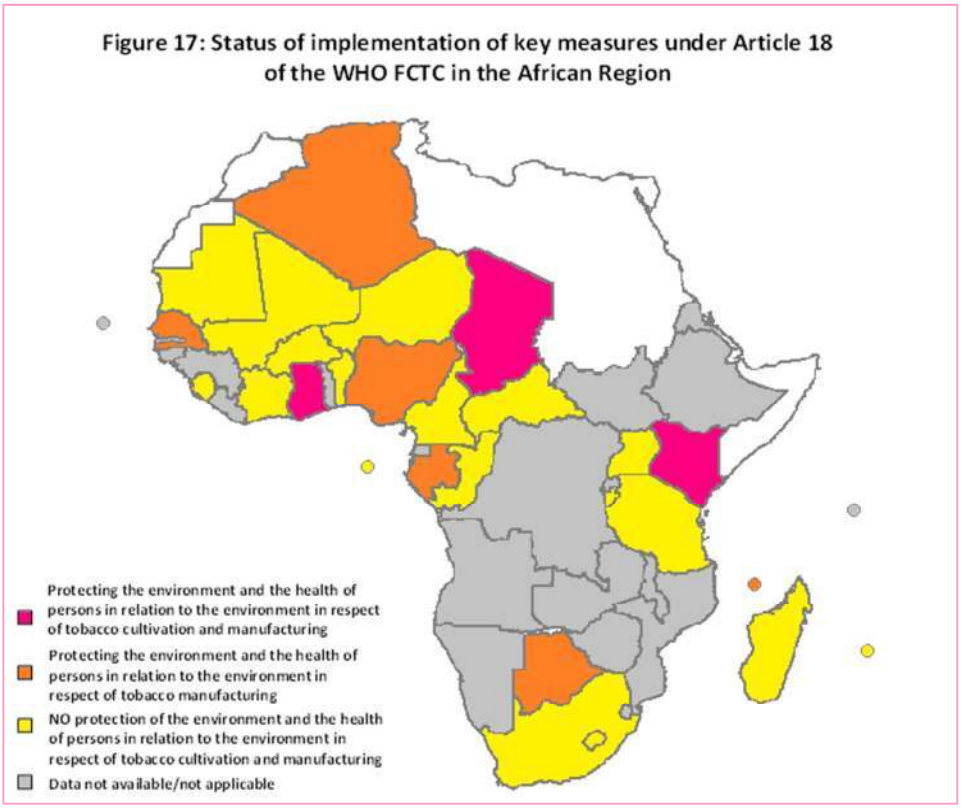
[86] Burkina Faso, Chad, Mali, Mauritius, Nigeria and Uganda
[87] Algeria, Benin, Burundi and Burkina Faso
[88] Mali, Mauritius, Nigeria and Sierra Leone

4.14 Article 18 on *Protection of the environment and the health of persons*

Article 18 of the WHO FCTC requires countries to have due regard to protecting the environment and the health of persons in relation to the environment associated with tobacco cultivation and manufacture. Countries should address concern about the serious risks posed by tobacco growing to human health and to the environment. Well-known occupational risks related to tobacco growing include green tobacco sickness and, as in many other agricultural sectors, pesticide intoxication, respiratory and dermatological disorders and cancers.

In the African Region, 10 countries[89] reported having taken measures in respect of tobacco manufacture that include protection of the environment and of the health of persons in relation to the environment (Figure 17). These countries reported that manufacturing facilities are inspected routinely to ensure that they meet the set standards for protecting the environment and employees, such as requiring protective gear for tobacco farmers and manufacturers. Some countries have agencies to regulate and ensure occupational safety. Four countries[90] reported taking measures in respect of tobacco cultivation to protect the environment and human health. Tobacco growing and manufacture damage the environment, and these effects must be included in the areas of intervention by governments.

Figure 17: Status of implementation of key measures under Article 18 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[89] Algeria, Benin, Botswana, Chad, Comoros, Gabon, Ghana, Kenya, Nigeria and Senegal

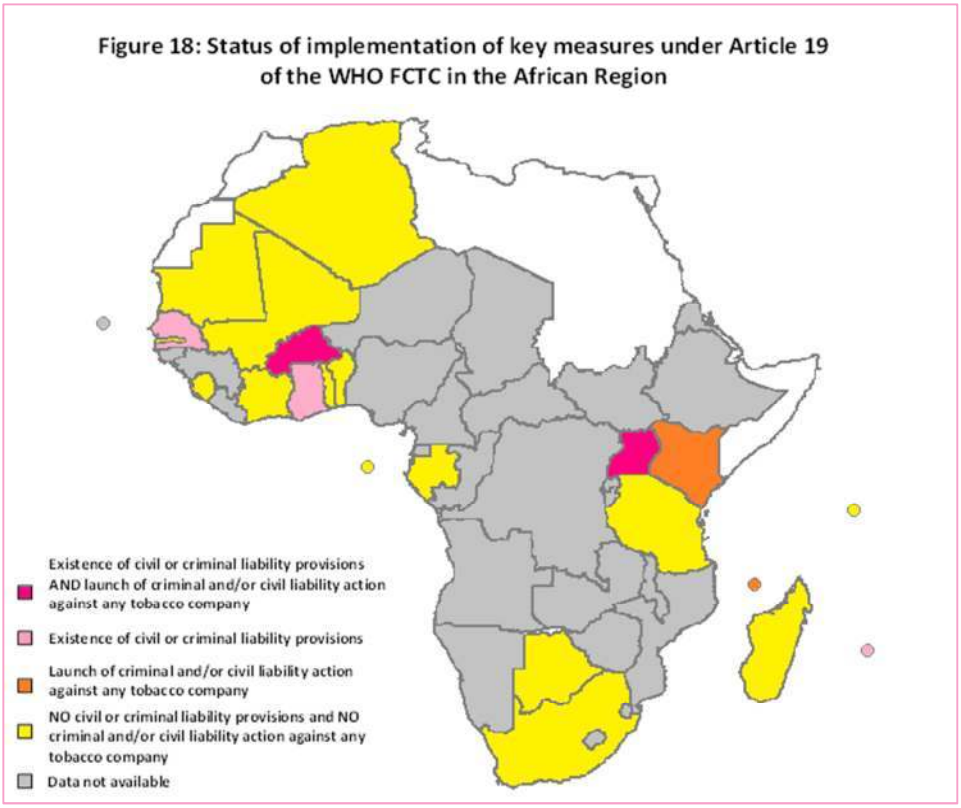
[90] Benin, Chad, Ghana and Kenya

4.15 Article 19 on *Liability*

Article 19 of the WHO FCTC requires that, for the purpose of tobacco control, countries should consider taking legislative action or promoting their existing laws to deal with criminal and civil liability, including compensation. Countries should exchange information and also provide assistance in legal proceedings relating to civil and criminal liability consistent with the Convention.

In the African Region, six countries[91] reported having civil liability measures specific to tobacco control, while five[92] reported having separate criminal liability provisions in relation to tobacco control but separate from tobacco control legislation (Figure 18). Five countries[93] reported having civil or criminal liability provisions that provide for compensation for adverse health effects and/or for reimbursement of medical, social or other relevant costs. Four countries[94] reported that at least one individual in their jurisdiction had launched criminal and/or civil liability action against a tobacco company in relation to adverse health effects due to tobacco use.

Figure 18: Status of implementation of key measures under Article 19 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

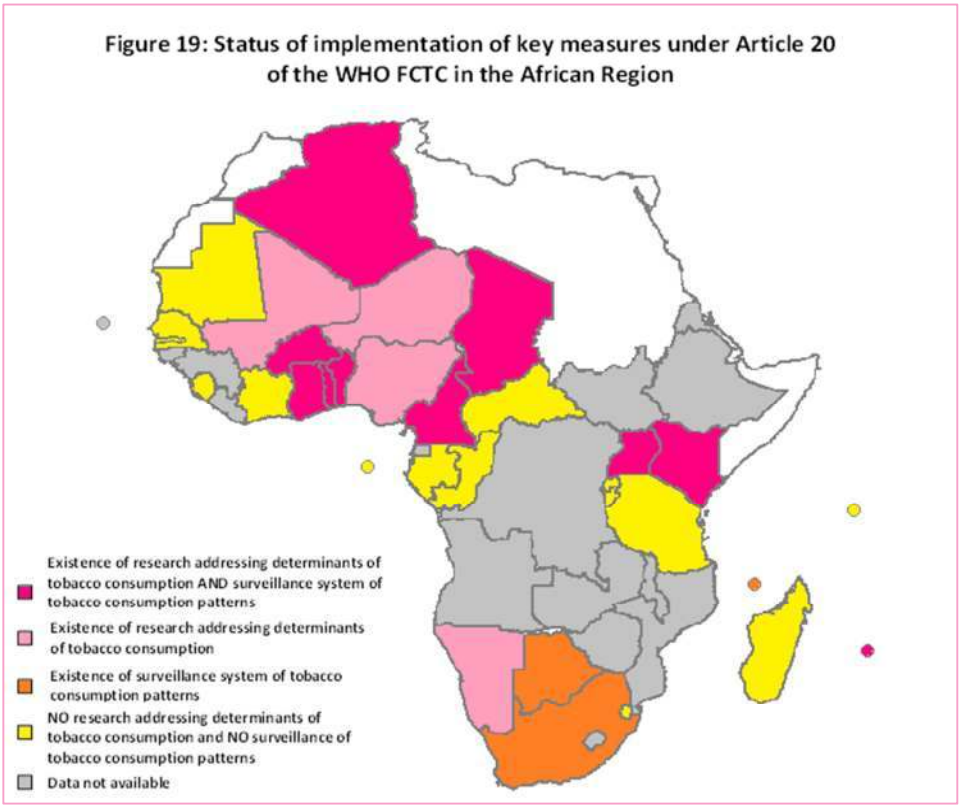
[91] Burkina Faso, the Gambia, Madagascar, Nigeria, Senegal and Uganda
[92] Burkina Faso, the Gambia, Ghana, Nigeria and Senegal
[93] Burkina Faso, Ghana, Mauritius, Senegal and Uganda
[94] Burkina Faso, Comoros, Kenya and Uganda

4.16 Article 20 on *Research, surveillance and exchange of information*

Article 20 of the WHO FCTC requires countries to promote national research in the field of tobacco control and to coordinate research programmes at regional and international levels. Countries are also required to establish programmes for surveillance of the magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke; and integrate tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analysed at regional and international levels.

In the African Region, 17 countries[95] reported promoting research on the determinants and consequences of tobacco consumption (Figure 19). Comparable data for different survey periods are required to monitor and evaluate the impact of tobacco control interventions accurately over time. Four countries[96] in the Region have conducted tobacco-specific household surveys to provide comparable data among adults. Twenty countries[97] have one-time data for young people, 12 countries[98] have two data points from youth surveys, another 12 countries[99] have three data points, and two countries[100] have four data points. Research and surveillance provide evidence for interventions and measure the effects of tobacco control policy.

Figure 19: Status of implementation of key measures under Article 20 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[95] Algeria, Benin, Burkina Faso, Cameroon, Chad, Ghana, Côte d'Ivoire, Kenya, Mali, Mauritius, Namibia, Niger, Nigeria, South Africa, Togo, Uganda and the United Republic of Tanzania

[96] Cameroon, Kenya, Nigeria and Uganda

[97] Angola, Benin, Burundi, Cape Verde, Central African Republic, Chad, Comoros, the Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, the Gambia, Guinea, Guinea-Bissau, Liberia, Madagascar, Rwanda, Sao Tome and Principe and Sierra Leone

[98] Algeria, Botswana, Cameroon, Congo, Côte d'Ivoire, Lesotho, Mali, Mauritius, Namibia, Nigeria, Seychelles and the United Republic of Tanzania

[99] Burkina Faso, Ghana, Kenya, Malawi, Mauritania, Mozambique, Niger, Senegal, Swaziland, Togo, Uganda and Zambia

[100] South Africa and Zimbabwe

Example of Kenya

Kenya conducted its first adult tobacco survey.

Interview for the Global Adult Tobacco Survey with an electronic device in Kenya

Kenya was the third country in the African Region to ratify the WHO FCTC, on 25 June 2004, with entry into force for the country on 27 February 2005. In 2013–2014, the Kenya National Bureau of Statistics conducted a Global Adult Tobacco Survey in collaboration with the Ministry of Health. The results were published on 28 November 2014.

Accurate data and information on consumption of tobacco, the impact of tobacco control interventions and tobacco industry marketing, promotion and lobbying are needed to better inform and monitor implementation of the WHO FCTC.

4.17 Article 21 on *Reporting and exchange of information*

Article 21 of the WHO FCTC requires each Party to the Convention to submit to the Conference of the Parties, through the Convention Secretariat, periodic reports on implementation of the Convention, which should include information:

- on legislative, executive, administrative or other measures taken to implement the Convention;
- on, as appropriate, any constraints or barriers encountered in implementation of the Convention and on the measures taken to overcome them;
- on, as appropriate, financial and technical assistance provided or received for tobacco control activities;
- on surveillance and research as specified in Article 20; and
- as specified in Articles 6.3, 13.2, 13.3, 13.4(d), 15.5 and 19.2.

The objective of reporting is to allow Parties to learn from each other's experience in implementing the WHO FCTC. Parties' reports are also the basis for reviews by the Conference of the Parties of progress in implementing the Convention. The frequency and format of these reports are determined by the Conference of the Parties. Each Party must submit its initial report within 2 years of the entry into force of the Convention for that Party. At the fourth session of the Conference of the Parties, Parties decided that implementation reports should be submitted at regular, 2-year intervals, synchronized with the cycle of the regular sessions of the Conference of the Parties.

Most Parties in the African Region complied with their reporting obligations under the Convention. In the 2014 reporting cycle, nearly 60% of Parties in the Region submitted their report (Table 7).

Parties are required to submit their next implementation report in the 2016 reporting cycle. Parties that did not submit a report during the 2014 reporting period are encouraged to do so as soon as possible.

Reporting requires constant attention to ensure that exchanges of information and monitoring of progress, achievements and challenges, which are key functions and obligations of Parties under the Convention, are fully complied with to the benefit of all Parties.

Table 7. Status of WHO FCTC reporting in the WHO African Region (as of 31 December 2014)

Party	First report submitted	Second report submitted	2012 report submitted	2014 report submitted	2014 additional questions submitted	No. of core reports submitted
Algeria	-	03-Feb-11	30-Apr-12	30-Apr-14		3
Angola	-	-	-	-		0
Benin	-	22-Feb-11	-	20-Mar-14		2
Botswana	21-Dec-07	-	30-Apr-12	-		2
Burkina Faso	23-Feb-09	-	20-Apr-12	27-Mar-14		3
Burundi	27-Jan-09	-	22-Oct-12	-		2
Cameroon	08-Nov-08	-	03-Oct-12	15-Apr-14		3
Cape Verde	-	-	-	-		0
Central African Republic	14-Jan-10	-	01-Jun-12	-		2
Chad	08-Sep-09	-	30-Apr-12	-		2
Comoros	12-May-09	22-Apr-11	31-Mar-12	-		3
Congo	21-May-08	-	27-Apr-12	15-Apr-14		3
Côte d'Ivoire	-	-	16-Aug-12	14-Apr-14		2
Democratic Republic of the Congo	08-Sep-09	-	-	-		1
Equatorial Guinea	-	-	-	-		0
Ethiopia	-	-	-	-		-
Gabon	-	-	22-Apr-12	06-Apr-14	27-Dec-14	2
Gambia	21-Dec-09	-	04-May-12	16-Apr-14		3
Ghana	28-Feb-07	18-Apr-10	04-Jun-12	14-Apr-14	30-Apr-14	4
Guinea	-	-	-	-		0
Guinea-Bissau	-	-	-	-		0
Kenya	04-Apr-07	10-Sep-10	-	15-Apr-14		3
Lesotho	17-Nov-08	13-May-10	03-May-12	04-Jul-14		4
Liberia	-	-	-	-		0
Madagascar	28-Feb-07	19-Jan-12	09-Feb-12	07-Apr-14		4
Mali	17-Mar-09	-	13-Apr-12	01-Apr-14		3
Mauritania	23-Dec-09	-	11-Oct-12	14-Apr-14		3
Mauritius	27-Feb-07	01-Mar-10	23-Aug-13	24-Mar-14		4
Namibia	21-Oct-08	06-Oct-11	-	-		2
Niger	28-Jan-09	-	13-Apr-12	-		2
Nigeria	14-Nov-08	-	-	29-Apr-14		2
Rwanda	01-Sep-09	-	25-Apr-12	-		2
Sao Tome and Principe	-	28-Jul-10	25-May-12	15-Apr-14		3
Senegal	27-Apr-07	-	30-Apr-12	14-Apr-14		3
Seychelles	02-Mar-07	18-May-10	28-Mar-12	15-Apr-14		4
Sierra Leone	-	-	18-Jun-12	07-Apr-14		2
South Africa	18-Jul-08	14-Dec-10	04-May-12	31-Mar-14		4
Swaziland	11-Sep-09	-	12-Mar-12	-		2
Togo	-	24-Feb-11	30-Apr-12	02-Apr-14		3
Uganda	17-Sep-09	-	31-Oct-12	15-Apr-14		3
United Republic of Tanzania	-	-	07-Nov-12	15-Apr-14		2
Zambia	-	-	-	-		0
Zimbabwe	-	-	-	-		-

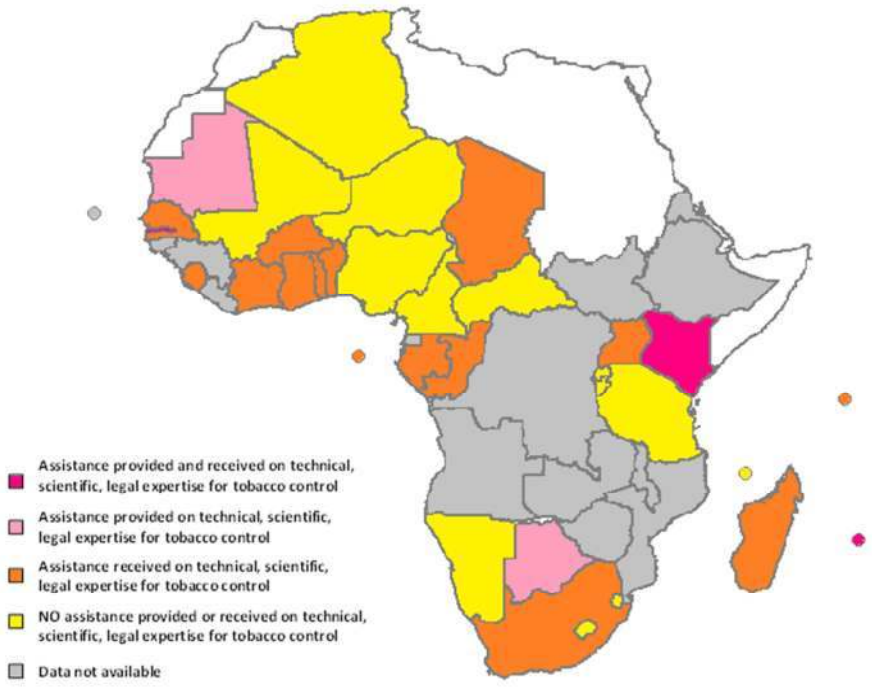
Source: Parties' implementation reports

4.18 Article 22 on *Cooperation in the scientific, technical and legal fields and provision of related expertise*

Article 22 of the WHO FCTC requires countries to cooperate directly or through competent international bodies to strengthen their capacity to fulfil the obligations arising from this Convention, taking into account the needs of developing country Parties and Parties with economies in transition. Such cooperation shall promote the transfer of technical, scientific and legal expertise and technology, as mutually agreed, to establish and strengthen national tobacco control strategies, plans and programmes.

In the African Region, five countries[101] reported having provided technical, scientific, legal and other expertise to establish and strengthen national tobacco control strategies, plans and programmes, while 18 countries[102] reported having received such assistance (Figure 20). Eight countries[103] reported having provided assistance for training or sensitization of appropriate personnel, in accordance with Article 12, and 19 countries[104] reported having received such assistance. The sharing of expertise and capacity within the African Region strengthens South–South cooperation and allows relevant experience to benefit other countries.

Figure 20: Status of implementation of key measures under Article 22 of the WHO FCTC in the African Region



Source: Country reports on implementation of the WHO FCTC

[101] Botswana, the Gambia, Kenya, Mauritania and Mauritius

[102] Benin, Burkina Faso, Chad, Congo, Côte d'Ivoire, Gabon, the Gambia, Ghana, Kenya, Madagascar, Mauritius, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Togo and Uganda

[103] Botswana, Burundi, the Gambia, Mauritius, Namibia, Niger, Rwanda and Swaziland

[104] Burkina Faso, Chad, Côte d'Ivoire, the Gambia, Ghana, Kenya, Madagascar, Mauritius, Namibia, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda and the United Republic of Tanzania

5. CHALLENGES AND BARRIERS TO IMPLEMENTATION

The challenges and barriers that remain, despite the significant progress made in implementing key provisions of the WHO FCTC in the African Region, include:

- **Slow integration of the WHO FCTC into national law:** Not all countries have enacted comprehensive national legislation to implement the WHO FCTC. Some have not yet issued regulations or administrative instructions to enable effective implementation of existing tobacco control laws.
- **Suboptimal enforcement of existing laws:** Inadequate enforcement of existing tobacco control laws has resulted in only a small impact of the Convention at country level.
- **Intensified marketing by the tobacco industry and interference with policy-making:** In response to tobacco control measures by governments, the tobacco industry is aggressively marketing its products, targeting mainly young people and women, and interfering with national policy-making.
- **Inadequate resource allocation for tobacco control:** Inadequate funding for tobacco control has also resulted in slower implementation of the WHO FCTC at country level.
- **Insufficient human capacity:** To fully implement the WHO FCTC, more human resources are required, who are adequately trained to tackle the challenges posed by full implementation of the Convention. Emerging areas of tobacco control, such as tobacco taxation, illicit tobacco trade and alternative livelihoods, are some of the areas that require capacity-building.

6. NEXT STEPS

As the provisions of the WHO FCTC are interrelated and their implementation has synergistic effects, Member States should take the following measures to accelerate implementation:

- **Strengthen national mechanisms**, including comprehensive legislation, a national plan of action and a formal multisectoral steering committee.
- **Prioritize enforcement** of existing laws and regulations.
- **Meet obligations to the time-bound provisions** of the Convention in articles 11 and 13 and the guidelines for Article 8.
- **Involve various national stakeholders**, particularly civil society, in accelerating ratification and implementation of the WHO FCTC.
- **Ratify the Protocol to Eliminate Illicit Trade in Tobacco Products**.
- **Counter interference by the tobacco industry lobby** in the development and implementation of tobacco control policy at country level in order to protect public health policies from the vested interests of the tobacco industry.
- **Identify innovative financing mechanisms** to support and sustain tobacco control activities, particularly at country level.
- **Promote communication and public awareness** in partnership with civil society organizations, including professional health associations, the education sector and the media, in order to encourage behaviour change.
- **Strengthen national surveillance, monitoring and reporting** in order to obtain up-to-date country data and thus determine the resources required for tobacco control.
- **Request intensified technical support** from WHO and other partners.
- **Build capacity** in all relevant areas, including tobacco taxation, elimination of illicit trade and finding alternative livelihoods.
- **Allocate adequate resources** for tobacco control, and intensify South–South collaboration.

7. CONCLUSIONS

Evidence and reports on progress made in implementing the WHO FCTC in the African Region since 2005 show significant improvements overall in the development and enforcement of tobacco control policy and in the development and implementation of national tobacco control programmes. Most countries have adopted and enforced measures to protect their peoples from second-hand tobacco smoke in public places, to require health warnings on packages of tobacco products and to prohibit tobacco advertising, promotion and sponsorship. Countries have also improved their policies with regard to tobacco taxation.

Nevertheless, to accelerate full implementation of the Convention the multisectoral approach must be strengthened. Countries must prioritize comprehensive implementation of the WHO FCTC with the continued support of WHO and other partners and advocates. Tackling emerging areas in tobacco control, such as tobacco taxation, international trade, alternative livelihoods and ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products should be priorities. Governments must continue to counter interference from the tobacco industry and to monitor its activities. They should also identify their needs and allocate the resources required to address those needs adequately in order that they can meet their obligations under the Convention. Mobilizing adequate resources at national level will also advance the agenda of tobacco control.

It is only through full implementation of measures under the WHO FCTC that countries will be able to meet the objectives of the Convention and protect their populations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. They must reduce the prevalence of tobacco use and exposure to tobacco smoke in order to save lives.

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