PDF version

Editorial

Fatimah El-Awa,[1] Prasad Vinayak[2] and Douglas Bettcher[3]

[1]Regional Adviser, Tobacco Free Initiative, World Health Organization Regional Office for the Eastern Mediterranean, Cairo Egypt.

[2]Manager, Tobacco Free Initiative, World Health Organization, Geneva, Switzerland.

[3]Director, Department for Prevention of Noncommunicable Diseases, World Health Organization, Geneva, Switzerland.

We acknowledge the efforts of Anne-Marie Perucic, Luminita Sanda and Alison Commar for their editorial input and for double checking the figures presented.

The year 2015 marked the 10th anniversary of the entry into force of the WHO Framework Convention on Tobacco Control (FCTC). Following this, in the same year, the 18th comprehensive national tobacco control law(s) was adopted in the WHO Eastern Mediterranean Region (EMR) (1).

Member countries of the EMR have come a long way in tobacco control legislation since the entry into force of the WHO FCTC, with 19 of the 22 countries now party to it (except Morocco, Palestine and Somalia). But has this legal movement really succeeded in changing the prevalence of tobacco use in the Region?

The recent tobacco trends report, published by WHO in 2015 (2), clearly indicates that none of the WHO regions will achieve the targeted 30% reduction in tobacco use by 2025 (3). Even worse, two regions are on the contrary expected to witness an increase in tobacco use: the African region and the EMR. In 2015, the prevalence of tobacco use in the EMR was 21.0% and by 2025 it is projected to be 24.5%. The estimated 90 million smokers in the Region in 2015 could grow to 129 million in just 10 years.

The wave of legislation adoption in the Region has not reduced tobacco use in the majority of the countries for many reasons, most importantly because the legislation and policies for the key demand reduction measures have not been adopted at the highest level of achievement. Only six countries have achieved the highest level of protection from second-hand smoke, i.e. a comprehensive ban of smoking in all public places (Lebanon, Libya, Islamic Republic of Iran, Pakistan, Palestine and Saudi Arabia), and only six have completely banned tobacco advertising promotion and sponsorship (Bahrain, Djibouti, Islamic Republic of Iran, Libya, United Arab Emirates and Yemen). Although 12 countries are implementing graphic health warnings (Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Oman, Pakistan, Qatar, Saudi Arabia, United Arab Emirates and Yemen), only three of them have achieved the highest level in the policy (Djibouti, Egypt and Islamic Republic of Iran). As regards taxation, only Jordan and Palestine have implemented a total tax of at least 75% of the retail price of cigarettes (data collection does not cover any other tobacco products) (4). The small number of countries achieving the highest level in the various tobacco control policies has thus resulted in only modest success in reducing tobacco use throughout the Region.

Tobacco use is a risk factor that could impede achievement of the target of a 25% reduction in mortality from NCDs (cardiovascular diseases, cancer, diabetes or chronic respiratory disease) by 2025. However, the recipe for successfully controlling this risk factor is not a mystery. Effective tobacco control policies have been well known since the adoption of the WHO FCTC in 2003, and following WHO’s launch of a set of measures (MPOWER) in 2008 (5) are recognized as part of the best buy measures to prevent and control NCDs. Furthermore, these measures are very affordable for all economic groups of countries (6). This recipe has been implemented nearly in full in only one country in the Region, the Islamic Republic of Iran and, as expected, the country has been able to reduce the prevalence of tobacco use. According to the WHO trend report of 2015, the Islamic Republic of Iran is the one country in the Region that will witness a reduction in tobacco use by the year 2025, although, due to the lack of a good taxation policy, it won’t be able to achieve the target level of reduction in tobacco use (7).

Looking at the key demand reduction measures in the MPOWER and NCD tobacco control best buys, as indicated in the 2015 WHO Report on the Global Tobacco Epidemic (8), there are two features clearly common among the majority of EMR countries. First, most of the countries have only made moderate progress because implementation of tobacco control policies has been at a middle level of achievement, neither the highest nor the lowest, in other words a “comfort zone” level. Thus, some improvement is happening but this is not sufficient to achieve a reduction in the prevalence at the rate agreed by the countries when adopting the NCD Global Action Plan in 2013. The fact that many countries prefer this comfort zone to fighting to achieve the highest level of the policy has two serious impacts. First, it exhausts the legislative system and undermines chances for further legislative change, blocking the way for real change in the future. In addition, it confuses the public on what the real goal of tobacco control is. For example, is it to have designated smoking areas in key public places and ensure the public abides by this, or is it a total ban of tobacco use and hence no designated smoking areas at all, as per the WHO FCTC. In addition, stopping short of the highest level of achievement in the policy allows the tobacco industry to manipulate even these modest targets so they become less effective than the government intended. Thus instead of achieving the modest level of the policy, countries actually achieve even less. Furthermore, whilst working to water down tobacco control efforts and push for non-effective measures, the tobacco industry can then twist logic and argue that such tobacco control measures are not needed since they do not work.

The second feature that marks the tobacco control movement in the Region is the game of musical chairs in policy adoption. There is no stability in the level of policy achieved; one year country X might be at the highest policy level of achievement, but the following year changes are introduced that result in reducing the policy level. This inconsistency causes significant difficulty, not only in monitoring the impact of the policies over time, but also by confusing the results at the national level.

A further issue is that many countries of the Region are experiencing emergencies and crises which tend to divert attention from tobacco control. These circumstances provide the tobacco industry with the opening to promote its products and undermine any tobacco control opportunities in these countries (9).

Given the situation outlined above, the main concern is that countries will need to report on their success in tobacco control on two dates, the NCD target date of 2025 and the Sustainable Development Goals’ date of 2030. For the countries of the Region to succeed and achieve the targets set by then, a real paradigm shift in tobacco control must be considered with a greater readiness to fight for the highest level of tobacco control best buys.

Fully implementing the WHO FCTC and achieving the highest level in all MPOWER and NCD best buys is a must for moving forward. Research in selected countries of the EMR has shown that if all MPOWER measures are implemented at the highest level, a reduction in tobacco use prevalence ranging from 20% to 35% is likely to occur within 5 years (10). Leadership and political commitment at the national level, serious legislative change, endorsement of a multisectorial approach, and a national partnership based on full technical understanding and commitment are indeed the way forward. This must be combined with implementation of the Article 5.3 guidelines of the WHO FCTC on “Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry” (11). Limiting, if not eliminating, tobacco industry interference and influence in decision making processes is imperative to achieving any progress for tobacco control in the Region.n it will provide, our ability to respond effectively to the virus remains uncertain.

The global fight against the virus will only be a decisive success if a sustained global response is launched; WHO is committed to working with all stakeholders to achieve this.

References

1. Coveting Iran: The infiltration and exploitation of Iran by global cigarette companies (http://applications.emro.who.int/dsaf/EMRPUB_2001_EN_767.pdf?ua=1, accessed 23 March 2015).

2. Maziak W, Nakkash R, Bahelah R, Husseini A, Fanous N, Eissenberg T. Tobacco in the Arab World: old and new epidemics amidst policy paralysis. Health+ Policy Plan. 2014 Sep;29(6):784–94. PMID:23958628 (http://heapol.oxfordjournals.org/content/early/2013/08/19/heapol.czt055.full.html?papetoc#ref-39, accessed 23 March 2015).

3. The cigarette “transit”road to the Islamic Republic of Iran and Iraq. Illicit tobacco trade in the Middle East.Geneva:World Health Organization; 2008, second edition (WHO-EM/TFI/011/E/G; http://applications.emro.who.int/dsaf/dsa908.pdf, accessed 15 May 2015).

4. Protocol to Eliminate Illicit Trade in Tobacco Products, 2012. Preamble paragraphs 5–7 (https://treaties.un.org/doc/source/signature/2012/CTC_ix-4-a.pdf, accessed 15 May 2015).

5. Illicit Trade Report 2013. Brussels: World Customs Organization; 2014.

6. Over 3 tonnes of chewing tobacco confiscated in Abu Dhabi raid. The National. 27 January 2015 (http://www.thenational.ae/over-3-tonnes-of-chewing-tobacco-confiscated-in-abu-dhabi-raid, accessed 23 March 2015).

7. WHO global report on trends in prevalence of tobacco smoking 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/156262/1/9789241564922_eng.pdf?ua=1, accessed 15 May 2015).

8. Smokeless tobacco. In: A review of human carcinogens. Part E: Personal habits and indoor combustions/IARC Working Group on the Evaluation of Carcinogenic Risks to Humans. Lyon: International Agency for Research on Cancer; 2009: 274–275 (IARC monographs on the evaluation of carcinogenic risks to humans). (http://monographs.iarc.fr/ENG/Monographs/vol100E/mono100E-8.pdf, accessed 15 May 2015).

9. Heydari G, Tafti SF, Telischi F, Joossens L, Hosseini M, Masjedi M, et al. Prevalence of smuggled and foreign cigarette use in Tehran, 2009. Tob Control. 2010;19:380–382.

10. Euromonitor International. Passport Tobacco Global. May 2014 (http://www.euromonitor.com/passport-tobacco-global/passport-subscription, accessed 15 May 2015).

Friday 12th of July 2024 04:40:57 AM