Tobacco Control in Africa: opportunities for prevention

The Chinese symbol for crisis is composed of two distinct words: “danger” and “opportunity”. The global tobacco epidemic qualifies as a global crisis. The danger is clear, yet there is also opportunity to learn and apply vital lessons from experience gained to date. Only two causes of death are large and growing worldwide: HIV and tobacco. Although most countries have begun to respond to HIV, the response to the global tobacco epidemic is only beginning to emerge.

The findings from the study by Mzileni and colleagues in this issue of Tobacco Control (page 398) provide some compelling information about the spread of the tobacco epidemic and tobacco related diseases in South Africa. The authors found an increased risk of lung cancer for both males and females who smoke. This is not a surprising finding. What is new is: the size of the odds ratios; the increased risk among women, whose smoking prevalence is very low; and the location in which these events occur.

The model of the smoking epidemic,1 based on evidence from countries with the longest history of smoking, describes the typical evolution of cigarette smoking and subsequent mortality in a country. Africa falls into stage 1, where health consequences are not yet apparent on a large scale and fewer women than men have taken up. On the basis of survey information, the World Health Organization estimated smoking prevalence in Africa to be 29% for men and 4% for women.2 Approximately 34% of the South African population smoked in 1995, most of them men.3 If the epidemic continues, more women will smoke in the future, and the incidence of smoking related diseases among African Americans,4 concerning about future smoking related disease in Africa is heightened.

Several questions are raised by this article that one hopes will be addressed in future studies. First, it is not clear why smoking prevalence is low among women and high among men. Presumably some of the risks and protective factors will provide the basis for effective prevention and cessation programmes. Second, the relation between environmental tobacco smoke exposure and increased health risks among men and women is not clear, since this information was not part of this study. Again, this information could be useful for future tobacco control programming. Third, the failure to find increased risks among smokers in occupational exposure groups may be caused by small samples. It should not be concluded that risks are not increased for those smokers who are also exposed to asbestos.

People’s knowledge of the health risks of tobacco use appears to be partial at best, especially in low and middle income countries where information about these hazards is limited. Most tobacco use starts early in life when, apparently, children and teenagers know less about the health effects of tobacco use than adults. Even in the USA, where smoking prevalence is low among women and high among men, most of them men.4 The smoking epidemic qualifies as a global crisis. The danger is clear, yet there is also opportunity to learn and apply vital lessons from experience gained to date. Only two causes of death are large and growing worldwide: HIV and tobacco. Although most countries have begun to respond to HIV, the response to the global tobacco epidemic is only beginning to emerge.

The findings from the study by Mzileni and colleagues in this issue of Tobacco Control (page 398) provide some compelling information about the spread of the tobacco epidemic and tobacco related diseases in South Africa. The authors found an increased risk of lung cancer for both males and females who smoke. This is not a surprising finding. What is new is: the size of the odds ratios; the increased risk among women, whose smoking prevalence is very low; and the location in which these events occur.

The model of the smoking epidemic,1 based on evidence from countries with the longest history of smoking, describes the typical evolution of cigarette smoking and subsequent mortality in a country. Africa falls into stage 1, where health consequences are not yet apparent on a large scale and fewer women than men have taken up. On the basis of survey information, the World Health Organization estimated smoking prevalence in Africa to be 29% for men and 4% for women.2 Approximately 34% of the South African population smoked in 1995, most of them men.3 If the epidemic continues, more women will smoke in the future, and the incidence of smoking related diseases among African Americans,4 concerning about future smoking related disease in Africa is heightened.

Several questions are raised by this article that one hopes will be addressed in future studies. First, it is not clear why smoking prevalence is low among women and high among men. Presumably some of the risks and protective factors will provide the basis for effective prevention and cessation programmes. Second, the relation between environmental tobacco smoke exposure and increased health risks among men and women is not clear, since this information was not part of this study. Again, this information could be useful for future tobacco control programming. Third, the failure to find increased risks among smokers in occupational exposure groups may be caused by small samples. It should not be concluded that risks are not increased for those smokers who are also exposed to asbestos.

People’s knowledge of the health risks of tobacco use appears to be partial at best, especially in low and middle income countries where information about these hazards is limited. Most tobacco use starts early in life when, apparently, children and teenagers know less about the health effects of tobacco use than adults. Even in the USA, where smoking prevalence is low among women and high among men, most of them men.4 The smoking epidemic qualifies as a global crisis. The danger is clear, yet there is also opportunity to learn and apply vital lessons from experience gained to date. Only two causes of death are large and growing worldwide: HIV and tobacco. Although most countries have begun to respond to HIV, the response to the global tobacco epidemic is only beginning to emerge.

The findings from the study by Mzileni and colleagues in this issue of Tobacco Control (page 398) provide some compelling information about the spread of the tobacco epidemic and tobacco related diseases in South Africa. The authors found an increased risk of lung cancer for both males and females who smoke. This is not a surprising finding. What is new is: the size of the odds ratios; the increased risk among women, whose smoking prevalence is very low; and the location in which these events occur.

The model of the smoking epidemic,1 based on evidence from countries with the longest history of smoking, describes the typical evolution of cigarette smoking and subsequent mortality in a country. Africa falls into stage 1, where health consequences are not yet apparent on a large scale and fewer women than men have taken up. On the basis of survey information, the World Health Organization estimated smoking prevalence in Africa to be 29% for men and 4% for women.2 Approximately 34% of the South African population smoked in 1995, most of them men.3 If the epidemic continues, more women will smoke in the future, and the incidence of smoking related diseases in men and women will increase substantially. Given what is known about the disproportionate risk of smoking related diseases among African Americans,4 concerning about future smoking related disease in Africa is heightened.

Several questions are raised by this article that one hopes will be addressed in future studies. First, it is not clear why smoking prevalence is low among women and high among men. Presumably some of the risks and protective factors will provide the basis for effective prevention and cessation programmes. Second, the relation between environmental tobacco smoke exposure and increased health risks among men and women is not clear, since this information was not part of this study. Again, this information could be useful for future tobacco control programming. Third, the failure to find increased risks among smokers in occupational exposure groups may be caused by small samples. It should not be concluded that risks are not increased for those smokers who are also exposed to asbestos.

People’s knowledge of the health risks of tobacco use appears to be partial at best, especially in low and middle income countries where information about these hazards is limited. Most tobacco use starts early in life when, apparently, children and teenagers know less about the health effects of tobacco use than adults. Even in the USA, where smoking prevalence is low among women and high among men, most of them men.4 The smoking epidemic qualifies as a global crisis. The danger is clear, yet there is also opportunity to learn and apply vital lessons from experience gained to date. Only two causes of death are large and growing worldwide: HIV and tobacco. Although most countries have begun to respond to HIV, the response to the global tobacco epidemic is only beginning to emerge.
The threat to global health posed by tobacco use is unprecedented, but so is the potential for reducing tobacco related mortality and morbidity with cost effective policies. Although it appears to be five minutes to midnight, there are still some ways in which the impending epidemic in the developing world may be arrested.

SAMIRA ASMA
LINDA PEDERSON

Office on Smoking and Health,
Centers for Disease Control and Prevention,
4770 Buford Highway, MS K-50,
Atlanta, GA 30341,
USA


Virtually every sign in this supermarket in Bali, Indonesia was Marlboro branded—from Marlboro sweets to Marlboro babywear, Marlboro breakfast cereal, a Marlboro chemist, Marlboro toys, and even Marlboro chocolate and babyfood. Photo by Trish Cotter, Melbourne, Australia.
Tobacco control in Africa: opportunities for prevention

SAMIRA ASMA and LINDA PEDERSON

Tob Control 1999 8: 353-354
doi: 10.1136/tc.8.4.353

Updated information and services can be found at:
http://tobaccocontrol.bmj.com/content/8/4/353

These include:

References
This article cites 1 articles, 0 of which you can access for free at:
http://tobaccocontrol.bmj.com/content/8/4/353#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/