

TOBACCO CONTROL

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Editorials

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 in men and women will increase substantially. Given what is known about the disproportionate risk of smoking related diseases among African Americans,⁴ concern 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 young people might be expected to have received more information, about half of 13 year olds today think that smoking a pack of cigarettes a day will not cause them great harm; they also underestimate the risk of becoming addicted to nicotine. Given inadequate knowledge, they face greater obstacles than adults in making informed choices.

One important consideration in the acceptance of and support for national tobacco control programmes is the consequence of reducing tobacco production and consumption for the overall economy. For most African countries, economic consequences would be minimal. Zimbabwe and Malawi are the two exceptions among developing countries in terms of dependence on tobacco exports. Zimbabwe is the sixth largest producer of tobacco in the world and has become one of the world's major tobacco exporters. It exports 99% of the tobacco it produces, and health issues pertaining to tobacco are a low national priority.

There is still an opportunity to change the situation that exists in Africa today by learning from the experiences of other public health interventions, such as those for the HIV epidemic. The prevalence of HIV declined from 23.4% to 20.9% among young people in Uganda between 1990 and 1992. The interventions appear to have reduced risk behaviours by utilising the existing infrastructure, such as antenatal clinics. Applying this model to the current situation, it may be possible to provide public health information on the risks of smoking and exposure to environmental tobacco smoke. In low and middle income countries, it may not be economically feasible to promote the use of relatively expensive cessation strategies such as nicotine replacement therapy.⁵ Non-smoking for women could be reinforced at community health clinics. At that time, children could also be encouraged to remain non-smokers. Additionally, information on health effects could be displayed with messages emphasising quitting.

Tobacco surveillance is an essential component of the assessment of tobacco programmes and should be used as a tool in planning and guiding programme design. An effective global tobacco surveillance system with information on patterns of prevalence, trends in tobacco related morbidity and mortality, and policy and programme interventions will enhance the capacity of countries and governments to assess the relation between tobacco and health status, thereby assisting in setting public health priorities.

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.

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- 1 Lopez AD, Collishaw NE, Pihl T. A descriptive model of the cigarette epidemic in developed countries. *Tobacco Control* 1995;3:242-7.
- 2 Tobacco or health: a global status report. Geneva: World Health Organization, 1997.
- 3 Abedian I, van der Merwe, Wilkins N, *et al*, eds. *The economics of tobacco control-towards an optimal policy mix*. University of Cape Town: Applied Fiscal Research Center, 1998.
- 4 US Department of Health and Human Services. *Tobacco use among US racial/ethnic minority groups: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, Hispanics. A report of the Surgeon General, 1998*. Atlanta, Georgia: Centers for Disease Control and Prevention, Office on Smoking and Health, 1998. (US Government Printing Office Publication No S/N 017-001-00527-4.)
- 5 The World Bank. *Curbing the epidemic: governments and the economics of tobacco control*. Washington DC: International Bank for Reconstruction and Development/The World Bank, 1999.



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.