TOBACCO CONTROL AND REGULATION IN AFRICA: CONSTRAINTS AND NECESSARY INTERVENTIONS

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I. INTRODUCTION AND PRELIMINARY BACKGROUND

Despite concerted effort to reduce tobacco-related deaths, tobacco use remains the leading cause of preventable death globally, accounting for the loss of nearly six million lives annually, more than 600,000 of them from the effects of second-hand smoke.[1] To put this figure in proper perspective, out

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of every ten deaths around the world, one is caused by tobacco use.[2] This menace is equally responsible for hundreds of billions of dollars of economic damage annually[3] in the form of skyrocketing medical costs and lost productivity——since most deaths associated with tobacco use occur before the age of 60,[4] during the most productive years of the person's life.

Increased health care cost is another concern. In fact, tobacco-related health cost burden exceeds the total tax receipt from tobacco in most countries,[5] seriously undermining efforts at conserving resources needed for health sector funding and contributing to the underperformance of health systems, particularly those in Africa as well as other

[1] WHO (AFRICAN REGION), FACTS ON TOBACCO USE IN THE AFRICAN REGION 1 (2012).
[2] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017: MONITORING TOBACCO USE AND PREVENTION POLICIES 15 (2017).
[3] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2011: WARNING ABOUT THE DANGERS OF TOBACCO 8 (2011)..
[4] WHO, *10 Facts on Noncommunicable Diseases,* Updated March 2013, available at http://www.who.int/features/factfiles/noncommunicable_diseases/facts/en/index2.html (accessed January 23, 2019
[5] WHO, GLOBAL STATUS REPORT ON NONCOMMUNICABLE DISEASES 2014, 53 (2014).

developing countries. Some of the diseases associated with tobacco use include cancer, cardiovascular diseases, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis. Although deaths attributable to tobacco is not geographic-specific, low- and middle-income countries (LMICs) shoulder the highest proportion of these deaths, and unless the current trend is reversed, by 2030 more than eight million people worldwide will die each year from tobacco use, with 80 percent of these premature deaths occurring amongst residents of LMICs, most of them in Africa and other developing nations.[6] Even more disconcerting, it is estimated that tobacco use could result in the death of one billion people or more over the course of the 21st century, unless appropriate interventions are urgently adopted.[7]

At just 14 percent, the current prevalence rate of tobacco smoking in Africa is low——compared, for

[6] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2011, *supra* note 3, at 8.
[7] *Id.*

instance, to the Americas (23 percent) and Eastern Mediterranean (31 percent); yet, the region is on the precipice of experiencing a tobacco smoking epidemic.[8] Recent growth in income, which translates to greater affordability of cigarettes as well as the aggressive marketing strategy increasingly being employed by the tobacco industry have succeeded in pushing the growth rate of tobacco smoking in the region to the highest level globally, with Mozambique, for instance, recording a 220 percent increase in cigarette consumption over the past 16 years[9] and in Nigeria, the figure has surged to 60 percent.[10] Even more alarming, Mauritanian adults smoke about 41 cigarettes each day——the highest in the world.[11] The danger is that if the current trend persists, smoking prevalence in Africa will increase by about 39 percent, which will

[8] Mikolaj Radlicki, *Smoking both down, and shockingly up, in Africa*, MAIL & GUARDIAN AFRICA, June 7, 2015, available at http://mgafrica.com/article/2015-06-03-smoking-prevalence-cultural-acceptance-and-the-big-tobacco (accessed January 3, 2019).
[9] Adele Baleta, *Africa's Struggle to be Smoke Free* 375 (9709) LANCET 107 (2010).
[10] *Id*. at 108.
[11] Radlicki, *supra* note 8.

represent the largest regional increase globally[12] and by 2100, more than a quarter of the world's smokers (26 percent) will live in Africa.[13] For a region already devastated by a wide range of diseases such as HIV/AIDS, tuberculosis, malaria, and a host of others, and which typically ranks at the bottom of most global health indicators, this forecast signals a dismally bleak future. An urgent response is therefore needed on the part of political leadership in the region, backed by the international community, to prevent this looming catastrophe. The good news is that deaths attributable to tobacco use are completely preventable. Evidence-based and scientifically-proven interventions, both preventive and curative, are available and ***harnessable*** to halt the menace in its tracks. Success, however, crucially hinges on whether the political leadership in the region is prepared to operationalize global best

[12] *Id*.
[13] Evan Blecher & Hana Ross/American Cancer Society, *Tobacco Use in Africa: Tobacco Control through Prevention,* 2013, available at https://www.cancer.org/content/dam/cancer-org/cancer-control/en/reports/tobacco-use-in-africa-tobacco-control-through=prevention.pdf (accessed February 6, 2019).

practices regarding tobacco control as contained in the WHO Framework Convention on Tobacco Control (FCTC),[14] WHO Framework Convention on Tobacco Control: Guidelines for Implementation,[15] United Nations (U.N.) Political Declaration on the Prevention and Control of Non-Communicable Diseases, [16] WHO's MPOWER Policy Package and other relevant policy and legal regimes.

Importantly, since its adoption in 2003, the FCTC— the first global evidence-based anti-tobacco global legal instrument and the first international treaty to be negotiated under the auspices of WHO— has become one of the most widely ratified international legal frameworks—in the world—181 Parties as of April 2018, with Mozambique being the most recent Party.[17]

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[14] WHO Framework Convention on Tobacco Control (FCTC), *adopted* May 2003, *entered into force* on 27 February 2005.
[15] WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL: GUIDELINES FOR IMPLEMENTATION (2013).
[16] Muhammad Jami Husaina, Lorna McLeod English & Nivo Ramanandraibeb, *An Overview of Tobacco Control and Prevention Policy Status in Africa*, PREVENTIVE MEDICINE, Suppl: S16–S22. doi:10.1016/j.ypmed.2016.02.017.
[17] WHO, Parties to the WHO Framework Convention on Tobacco Control, 2017, available at http://www.who.int/fctc/signatories_parties/en/ (accessed February 6,

Strikingly, aside from Morocco, Somalia and South Sudan, the rest of the countries in Africa are Parties to the FCTC[18] and are, therefore, subject to its terms and obligations. Nonetheless, a more fundamental concern remains—and that is, the state of implementation in various countries in the region; after all, as affirmed by WHO's Director General, Dr. Jong-wook LEE, "The success of the . . . FCTC as a tool for public health," does not rest on ratification per se but "will depend on the energy and political commitment that [is devoted] to implementing it in countries in the coming years."[19] Therefore, for the expected result to "materialize, the drive and commitment, which was so evident during the negotiations," and which was responsible for the monumental acceptance of the instrument by the global community, implementation "will need to

2019); U.N., Treaty Series, Chapter IX: Health, WHO Framework Convention on Tobacco Control, May 21, 2003, Status as at May 26, 2018, available at https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=_en (accessed February 6, 2019).

[18] U.N., Treaty Series, Chapter IX: Health, *id*.

[19] WHO, WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL VI (2003).

spread to national and local levels so that the . . . FCTC becomes a concrete reality where it counts most, in countries."[20] So, what is the position in Africa?

Apart from the three nations previously mentioned, the rest of the countries in Africa have adopted legislative and policy frameworks aimed at domesticating the FCTC in their respective jurisdictions.[21] In this sense, the challenge is not a function of deficit of legal regimes; instead, the problem is of a different genre, namely, the dissonance between domestic legal frameworks and practices, on one hand, and the FCTC and global best practices, as stipulated in a number of documents which could be described as "operational guidelines."[22] Consider, for instance, the duty to raise taxes on tobacco—Art. 6 of the FCTC. The vast majority of the countries in the African region (43 of

[20] *Id.*
[21] Campaign for Tobacco-Free Kids, *Tobacco Control Laws: Legislation,* available at https://www.tobaccocontrollaws.org/legislation (accessed January 27, 2019).
[22] Instances include the FCTC Guidelines for Implementation and WHO's MPOWER Policy Package.

47)—have commensurable domestic legal regimes; yet, it is the legal stipulation in only one (Madagascar) that is consistent with global best practices and standards—that is, by imposing 80 percent tax on the retail price of cigarettes.[23] There are several other areas, as will become evident shortly. It is these kinds of dissonance between domestic legal regimes and practices in Africa, on one hand, and global best practices and standards, on the other, as well as the underlying challenges and necessary interventions that shape the thrust of this paper.

Following this introduction, Section II explores the challenges being confronted by countries in Africa in the realm of tobacco use and possible interventions that could yield fruitful dividends. The section analyzes the level of compliance in the region with the FCTC by comparing its attainment against other regions based on WHO's "MPOWER" strategy, which prescribes global best practices

[23] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 138–139.

regarding key provisions of the FCTC. It also identifies gaps and deficiencies, and suggests appropriate remedial measures. The conclusion—Section III—is that robust commitment to the imperatives of the MPOWER package holds the key to protecting Africa from becoming the future epicenter of tobacco epidemic—a conclusion that is based on the experience in Turkey. In addition, whilst urging a full-scale battle against the tobacco industry, for instance, by rejecting its tortured corporate social responsibility (CSR) model, it calls on the international community to step in and assist Africa as envisaged by the various provisions of the FCTC, particularly Art. 22.

II. IMPLEMENTING THE MPOWER STRATEGY IN AFRICA: CHALLENGES AND NECESSARY INTERVENTIONS

This summation by WHO is particularly striking for its relevance to the subject of this section of the paper:

> Tobacco control actions aim to substantially and continually reduce the prevalence of tobacco use and exposure to tobacco smoke. The [FCTC] sets forth different tobacco control measures to be implemented in order to prevent people especially the youth from starting to use tobacco; help current tobacco users to quit and; protect non-smokers from exposure to second-hand smoke.[24]

In other words, a productive starting point in getting a handle on the scourge of tobacco use and associated diseases is to develop a tobacco control regime that is consistent with the vision of the FCTC; that is, one that is predicated on prevention and intervention. WHO was quite explicit, that "[d]eveloping comprehensive tobacco control legislation and building capacity for its effective enforcement" are the keys to success, although it concedes that "[s]trengthening the implementation of the FCTC is one of the big challenges for countries in the African Region."[25] It is this challenge, the

[24] WHO (AFRICAN REGION), *supra* note 1, at 2.
[25] *Id.*

difficulty in calibrating legal and policy regimes in Africa to effectively respond to the obligations imposed by the FCTC and catalyze the measures and interventions of that instrument, that is responsible for the surge in tobacco use and tobacco-attributable diseases in the region. This challenge, though difficult, is not insurmountable and has been rendered even less daunting not only by the coming into force of the FCTC in 2005 and the publication of the Guidelines for its implementation (the first in 2011),[26] but also the unveiling of proven, cost-effective means of combating the deadly menace by WHO in 2008. In that year, WHO released what it describes as "evidence-based tobacco control measures that are the most effective for reducing tobacco use."[27]

Numbering six, these measures are dubbed "MPOWER" policy package (each of the letters representing a distinct strategy) and are based on one

[26] WHO, FRAMEWORK CONVENTION ON TOBACCO CONTROL: GUIDELINES FOR IMPLEMENTATION 2013, *supra* note 15, at V.
[27] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2013: ENFORCING BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP 12 (2013).

or more of the demand reduction stipulations in the FCTC, namely, (a) **M**onitor tobacco use and prevention policies, (b) **P**rotect people from tobacco smoke, (c) **O**ffer help to quit tobacco use, (d) **W**arn people about the dangers of tobacco, (e) **E**nforce bans on tobacco advertising, promotion and sponsorship, and (f) **R**aise taxes on tobacco.[28] Each of these practical, affordable and achievable measures are designed to assist countries in implementing specific provisions of the FCTC. In as much as these six measures are the principal avenues through which reduction in demand for tobacco can be achieved and are consistent with the ultimate goal of the FCTC—that is, expurgating tobacco-related disease, disability, and death[29]— they should be considered indispensable to evaluating the challenges being confronted in translating specific demand-reduction strategies of the FCTC to reality on the ground in Africa.

[28] *Id.*
[29] *Id.*

Representing global best practices, MPOWER has been at the heart of tobacco reduction strategies throughout the world, including Africa, and is acclaimed for "delivering results," in the sense of creating positive impact "in the places where it is needed the most."[30] At present, nearly two thirds of the world (121 of 194 countries)—comprising 63 percent of the global population—have been able to introduce at least one MPOWER measure at the highest level of achievement.[31] Except for monitoring, which is not considered a prevention or intervention tool, the rest of the package are effective in prevention and/or intervention. Although MPOWER has been particularly useful in pushing Africa forward in the fight against tobacco use and was instrumental to the establishment of the region's first tobacco control center in 2011,[32] factors frustrating implementation are far from being

[30] WHO, *MPOWER in Action: Defeating the Global Tobacco Epidemic*, 4, Dec. 2103, available at http://www.who.int/tobacco/mpower/publications/mpower_2013.pdf?ua=1 (accessed February 6, 2019).
[31] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 18.
[32] WHO, *MPOWER in Action, supra* note 30, at 4.

eviscerated. These factors or challenges will be examined under the six MPOWER rubrics, using principally WHO's latest data on global implementation of the FCTC.

A. Monitor Tobacco Use and Prevention Policies

The duty to monitor tobacco use and prevention policies derives from Art. 20 of the FCTC, which requires, on the part of Parties, *inter alia*, the establishment of surveillance of the magnitude, patterns, determinants, and consequences of tobacco consumption and exposure to tobacco smoke as well as integration of tobacco surveillance programmes into national, regional and global health surveillance programmes so that data are comparable and can be analyzed at regional and international levels.[33] This MPOWER policy package—that is, monitoring of tobacco use and prevention policies—is critical to the success of the entire tobacco control strategy. Unless activities undertaken under the remaining

[33] FCTC, *supra* note 14, Art. 20(2).

five rubrics are informed by credible data obtained from systematic surveys and rigorous monitoring, progress toward combating tobacco use will be quite limited. None of the known preventive strategies or interventions could be effectively employed in absence of accurate data, the kind that would generate knowledge about the nature of the problem, its magnitude, and the right amount or mix of resources to be deployed.

A bastion of essential information could be generated through robust monitoring. Amongst the critical ones are the extent or level of the tobacco epidemic in a country (prevalence); sub-groups (disaggregated according to age, gender, and income) in need of specially tailored policies and programs; level of public knowledge of the epidemic and general attitude towards tobacco control; and, the impact of policy and program implementation on tobacco use.[34] Others include enforcement and public compliance with tobacco control policies,

[34] WHO, *Monitor Tobacco Use and Prevention Policies,* available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_m.pdf?ua=1 (accessed January 23, 2019).

including tax collection and tax evasion, smoke-free places, and ban on advertising and marketing; and, activities of tobacco industry practices that may increase tobacco use or thwart efforts at operationalizing tobacco control policies and programs.[35] The utility of this information is enormous in that the information or data generated serves as a guide to policy makers by assisting in identification of what works or otherwise and tailoring resources and control activities accordingly. Despite these advantages, monitoring systems remain weak in many developing countries, particularly in Africa—quite paradoxically, in the same nations suffering the fastest rise in tobacco use.[36]

Aside from general deficit of actionable monitoring data on the aforementioned areas of need,[37] even when data are available, they are often outdated, fraught with inconsistencies, unrepresentative, or otherwise inadequate to form the

[35] *Id.*
[36] *Id.*
[37] *Id.*

basis for action.[38] This is a big challenge as no country without effective tobacco surveillance system can make meaningful progress in tobacco control activities. Moreover, to be effective, surveys should be conducted at regular intervals to ensure that changes in the epidemic are measured.[39] Obviously, conducting statistically valid surveys does not come cheap, especially when designed to capture the kind of data required by the FCTC.[40] Not only do resource-strapped countries in Africa lack locally grown capacity to embark upon such surveys, they are bereft of resources with which to import foreign expertise. It is no coincidence that only three out of the 47 countries in the African region have attained best practice tobacco use monitoring,[41] compared, for instance, to 39 of the 53 countries in Europe[42] or 14 of the 27 countries in the Western Pacific region.[43] In this scenario, international

[38] *Id.*
[39] *Id.*
[40] *Id.*.
[41] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 138 – 139.
[42] *Id.* at 144 – 145.
[43] *Id.* at 148 – 149.

cooperation becomes essential, to provide needed capacities in these countries including survey administration and data collection, management and analysis as required by Arts. 20 and 22 of the FCTC.

B. Protect People from Tobacco Smoke

The FCTC, in Art. 8, affirms that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability, and, consequently, mandates each Party to adopt and implement measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. This provision is critical for just as tobacco smoking is deadly, so is second-hand exposure, which kills more than 600,000 people each year.[44] It is estimated that second-hand smoke causes more than ten percent of all tobacco-related deaths in some countries.[45] Since

[44]WHO, *Protect People from Tobacco Smoke*, available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_p.pdf?ua=1 (accessed January 23, 2019).
[45] *Id.*

there is a fundamental right to breath clean air,[46] and tobacco use is a major contributor to air pollution, an obligation is imposed upon Parties to the FCTC to ensure 100 percent smoke-free environments to protect health for all people. This goal is only attainable by creating a completely smoke-free indoor environment—with no exceptions whatsoever.[47] Attaining this goal requires the elimination of all smoking and tobacco smoke indoors. Permitting smoking in designated areas or installing ventilation systems does not suffice as an antidote as these measures cannot protect against the health risks of tobacco smoke. Even the tobacco industry data show that allowing exceptions to 100 percent smoke-free environments undermines the impact of such regulations, thereby bolstering support for complete protection from tobacco smoke.[48]

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[46] International Covenant on Economic, Social and Cultural Rights, Art, 12 (2)(b), G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* January 3, 1976.
[47] WHO, *Protect People from Tobacco Smoke*, *supra* note 44..
[48] *Id.*

There are several challenges to implementing this mandate. Smoke-free laws are often weakly drafted, cover only some indoor spaces, or are poorly enforced.[49] Many contain loopholes which are easily exploited to defeat the intended purpose. To be effective, the law must be drafted in clear and concise language, with appropriately targeted sanctions and not subject to exemptions. Institutional and individual responsibilities, including compulsory posting of clear and conspicuous signage, must be clearly stipulated and primary enforcement responsibility should be vested on administrators, managers, or proprietors of establishments, and penalties for violations should be primarily targeted at them, rather than individual smokers.[50] There is no political downside to enacting such legislation as evidence indicates that such laws are popular, even amongst smokers and have been shown to be successful despite contrary claims by the tobacco industry. [51]

[49] *Id.*
[50] *Id.*
[51] *Id.*

The core advantage of smoke-free laws is that they reduce tobacco use. Data from the United States show five to 20 percent lower per capita tobacco consumption in states with comprehensive smoke-free laws and a decline of average consumption of cigarettes by three and one-tenth cigarettes per day in smoke-free workplaces.[52] Moreover, such laws have no adverse impact on businesses, including bars and restaurants, and protect the health of workers[53] and others whilst also changing social norms by subconsciously making smoking less acceptable.[54] Despite these significant advantages, available data show that 90 percent of Africans are not covered by smoke-free laws[55]—an abysmally poor data considering that best practice regarding protecting people from smoke requires that all public places be completely smoke-free (or at least 90 percent of the population covered by complete smoke-free

[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] Baleta, *supra* note 9, at 107.

legislation).[56] There are only seven (out of 47) countries in the Africa region that met this threshold[57] compared to 13 of the 53 countries in Europe region.[58]

Cognizance must be taken of the fact that the tobacco industry spends an enormous amount of money to frustrate governments' attempt to adopt 100 percent smoke-free policies, and where this fails, they deploy resources toward interfering and misinforming the public at different stages of development and implementation of the regulation.[59] Obstruction, false claims, such as the threat of economic loss, as well as litigation have been employed by the tobacco industry but countries are resisting the onslaught, successfully in most cases.[60] WHO was quite categorical, stressing that any nation, irrespective of resources or level of development can develop and introduce and

[56] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 139.
[57] *Id.* at 138 – 139.
[58] *Id.* at 144 – 145.
[59] WHO, *Protect People from Tobacco Smoke, supra* note 44.
[60] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 49.

effectively implement smoke-free laws by following the Art. 8 Guidelines for implementation of the FCTC.[61]

C. Offer Help to Quit Tobacco Use

The third approach under the MPOWER paradigm, namely, offer help to quit tobacco use, is derived from Art. 14 of the FCTC, which requires each Party to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence. This requirement recognizes that although most people want to quit when informed of the health risks of tobacco, many would not be able to do so without assistance.[62] Various degrees of success that have been recorded in reducing the number of smokers desirous of quitting in countries where cessation support and necessary medical interventions are available attest to the importance of this requirement. The reverse is the

[61] WHO, *Protect People from Tobacco Smoke*, *supra* note 44.
[62] WHO, *Offer Help to Quit Tobacco Use*, available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_o.pdf?ua=1 (accessed February 10, 2019).

case in developing countries, such as those in Africa, where a negligible number of smokers are able to receive the help they need to free themselves from dependence. This is a serious problem given that a high number of smokers in these countries belong to the "socially disadvantaged and vulnerable sub-groups of the population,"[63] individuals who are bereft of the means to cater for themselves and, therefore, stand the risk of being denied access to tobacco cessation interventions.

In what seems like a distillation of the obligations imposed by Art. 14, WHO recommends three approaches to be adopted by countries committed to offering help to quit using tobacco, namely, incorporation of tobacco cessation advice into primary and routine healthcare services, provision of easily accessible and free telephone help lines (known as quit lines) and provision of access to free

[63] Zoe Ferguson, *WHO reveals how tobacco control measures are improving health worldwide,* THE CONVERSATION, July 11, 2013, available at http://theconversation.com/who-reveals-how-tobacco-control-measures-are-improving-health-worldwide-15995 (accessed January 25, 2019).

or low-cost cessation medicines.[64] To these may be added the use of mobile technology (mTobaccoCessation) to provide individually tailored tobacco cessation advice to users.[65] Particularly when coupled with other cessation programs, such as brief counselling sessions and toll-free quit lines, use of text messages can be an efficient and cost-effective way to provide support, as has been recorded in India.[66] Nevertheless, none of these approaches are free of difficulties in implementation in resource-deficit settings such as Africa.

Aside from the cost of mobile phones, the tariffs on usage is not easily affordable as is the case with cessation counselling and nicotine replacement therapy (NRT), even though very effective. Therefore, whether countries are able to integrate these measures into their domestic tobacco control regimes is a function of a number of important

[64] WHO, *Offer Help to Quit Tobacco Use*, *supra* note 62.
[65] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 70.
[66] *Id.*

variables, amongst which are resources and commitment on the part of the government to drive the agenda—two factors that are responsible for lack of uniformity in levels of attainment and epidemic levels in different parts of the world. Best practice is attained by having in place a national quit line, and both NRT and coverage of some cessation services[67]—a level that was attained by just one country (Senegal) out of the 47 nations in the African region[68] *vis*-à-*vis* nine of the 53 countries in the European region.[69] Cost is the most critical challenge, explaining the success recently recorded in El Salvador. The introduction of access to free pharmacological cessation therapy in that country resulted in nearly a 70 percent smoking cessation rate among registered patients one year after the end of the cessation treatment.[70]

Whilst it is the responsibility of the health system in each country to provide tobacco dependence

[67] *Id.* at 139.
[68] *Id.* at 138 – 149.
[69] *Id.* at 144 – 145.
[70] *Id.* at 74.

treatment,[71] the stark reality is that the vast majority of health systems in Africa are underfunded and underperforming, making the provision of even the most rudimentary services difficult, not to talk of adequately responding to the demands presented by increasing tobacco uptake in the region. In other words, despite evidence showing that benefits from tobacco cessation programs are either cost-saving or cost-neutral,[72] many health systems in the region lack capacity to provide desired services and, therefore, cannot attend to most of those in need of assistance. Manpower shortage is a major challenge in the health sector in many parts of Africa. For instance, only 15.9 percent of medical students in the region received formal training in smoking cessation approaches during medical school.[73] The figures range from a high of 46.4 percent in Niger to a low of six and eight-tenths percent in Zambia.[74] This is a challenge that needs to be taken seriously,

[71] WHO, *Offer Help to Quit Tobacco Use*, *supra* note 62.
[72] *Id.*
[73] WHO (AFRICAN REGION), *supra* note 1, at 14.
[74] *Id.*

particularly in respect to highly addicted smokers for whom other measures save access to NRT are unlikely to help to quit smoking.[75]

D. Warn about the Dangers of Tobacco

The fourth MPOWER strategy, duty to warn about the dangers of tobacco, is a derivative of two provisions of the FCTC. Art. 11 prohibits false, misleading, or deceptive packaging or labelling and requires that tobacco products carry health warnings describing the harmful effects of tobacco use. The second— Art. 12—imposes a duty upon Parties to promote and strengthen public awareness of tobacco control issues, using all available communication tools. The significance of these stipulations rests on the fact that there is a high degree of misinformation and ignorance about the dangers of tobacco use, particularly in countries with high illiteracy rate—both of which must be tackled to prevent uptake of smoking and enhance smoking cessation. A critical

[75] Ferguson, *supra* note 63.

challenge is that the warning might not be sufficiently clear (for instance, "smoking kills")—that is, not couched or communicated in such a way as to achieve the desired goal, namely, to prevent tobacco initiation and dissuade smokers from continuing to smoke. This underscores that the warning by WHO about threats posed by smoking has not been adequately explained to the public and the call for public education particularly in developing countries in which there has been a surge in tobacco use and tobacco control is in infantile stages.[76] WHO identifies three major ways of communicating the health risks of tobacco, namely, effective warning labels, anti-tobacco advertising and the proactive use of media platforms to influence the public and policymakers.[77]

To be considered "effective" or "best practice" health warning, the warning labels must describe the harmful effects of tobacco use; be large, clear,

[76]WHO, *Warn about the Dangers of Tobacco,* available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_w.pdf?ua=1 (accessed January 25, 2019).
[77]*Id.*

visible, and legible, covering 50 percent or more of principal pack display areas (both front and back) and in no case less than 30 percent;[78] rotate periodically so that they continue to attract the attention of the public; appear in the country's principal language(s); include graphic pictures; and, receive the approval of the competent national authority.[79] Countries in different regions of the world are in different stages of implementation of these directives, with varying degrees of success. According to WHO, only eight countries in the African region meet the best practice health warning standard[80] compared to 32 countries in the European region[81] and 16 in the Americas.[82] As to the size of the warning, a 2016 report documents that 94 countries now require warnings to cover at least 50

[78] Although the minimum benchmark is warnings to cover at least is 30 percent of the package front and back, to be attain best practice standard, the coverage size must be 50 percent or more.
[79] WHO, *Warn about the Dangers of Tobacco, supra* note 76; WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 139.
[80] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *id.* at 138 – 139.
[81] *Id.* at 144 – 145
[82] *Id.* at 140 – 141

percent of the package front and back, up from 60 in 2014 and 24 in 2008.[83] Of these countries, only eight are from the African region.[84]

Unlike other MPOWER strategies, where domestic funding base is a huge factor in implementation, compliance with this obligation is a question of political commitment by national authorities, whether the country is prepared to impose the mandate on tobacco industries operating within its borders since they (tobacco manufacturers) bear the cost. Mandating pictorial warnings is especially important in places such as Africa, where a large segment of the population is uneducated and, therefore, needs additional assistance in understanding warning labels. Yet, a breakdown of countries with appropriate (large) pictorial warnings show that just eight countries in the African region

[83] Canadian Cancer Society, *Cigarette Package Health Warnings: International Status Report,* Fifth Edition, 2 (2016), available at http://www.tobaccolabels.ca/wp/wp-content/uploads/2016/11/Cigarette-Package-Health-Warnings-International-Status-Report-English-CCS-Oct-2016.pdf (accessed January 27, 2019).
[84] *Id.* at 8 – 9.

are compliant,[85] compared to 16 in the Americas[86] and 32 countries in the European region.[87]

Maximizing the effectiveness of warning labels is very important, and this could be achieved in various ways such as use of pictures with graphic, culturally appropriate depictions of disease, and other negative images in full color.[88] Highly graphic warnings resulted in widespread knowledge of the harmful effects of smoking in Singapore, 71 percent of smokers.[89] This approach is very effective because pictures have greater impact on most smokers than mere words and are easily understood by those who are unable to read. As the Canadian Cancer Society points out, a "picture says a thousand words [and] can convey a message with far more impact than can a text-only message."[90] Other key ways of maximizing the impact of warning labels include use of strong and clear language that are clearly

[85] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 138–139.
[86] *Id.* at 140 – 141.
[87] *Id*. at 144 – 145.
[88] WHO, *Warn about the Dangers of Tobacco, supra* note 76.
[89] *Id.*
[90] Canadian Cancer Society, *supra* note 83, at 2.

descriptive of specific diseases attributable to tobacco use and exposure to second-hand smoke and mandating that other packaging, labelling, or markings should not obstruct warning labels.[91] On the other hand, misleading descriptors such as the term 'low tar', 'light', and 'mild' as well as any packaging that falsely misrepresents the product as being less harmful should be banned as studies show that smokers wrongly assume that products with such designations are less harmful.[92] Enacting legal frameworks banning misleading descriptors presents no real challenge to countries in Africa; instead, the problem lies in implementation. With weak institutions, particularly corrupt politicians and law enforcement agencies and inefficient court system, rigorous implementation can hardly be assured.

Warning about the risk of tobacco use could be accomplished via anti-tobacco advertisements. This is a very efficient and far-reaching way of publicizing the full extent of the dangers of tobacco

[91] WHO, *Warn about the Dangers of Tobacco, supra* note 76.
[92] *Id.*

and has been shown to be effective in making smokers to quit, especially when graphic images are used to drive the message home.[93] Despite these advantages, high quality advertisements are quite expensive, the result being that resources might constitute a barrier to full utilization of the opportunity presented by the media. This might explain why countries in the African region are underperforming. Latest data show that only four countries in Africa meet the best practice anti-tobacco mass media campaign, which includes airing on television and/or radio stations.[94] But, resource challenge is not insurmountable. Experience from Turkey shows that the problem could be surmounted by mandating all television and radio channels to allocate 90 minutes of free airtime every month to tobacco control and addiction broadcast, including 30 minutes of prime time.[95] This action commends itself to other countries, particularly those in Africa.

[93] *Id.*
[94] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 138 – 139.
[95] WHO, *Warn about the Dangers of Tobacco, supra* note 76.

Cost of additional broadcast time can be offset through tobacco tax revenue and sundry sources.[96]

CSOs, particularly those whose work on health issues, should partner with the government in creating opportunities for anti-tobacco advertisement. Aside from advertisement, CSOs can also assist in creating public awareness, thereby complimenting the efforts of others such as the school system, which is not doing quite well in terms of educating students about the dangers of smoking. Reports indicate that 49.6 percent of the schools in Africa integrate tobacco use prevention into school curriculum.[97] Whilst some countries in the region have attained high rates of integration—Rwanda (70.6 percent), Togo (65.8 percent), Malawi (64.6 percent), and so forth, others are significantly lagging behind, including Sierra Leone (31.5 percent), Mauritania (25.4 percent) and Guinea Bissau (17.8 percent).[98]

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[96] *Id.*
[97] WHO (AFRICAN REGION), *supra* note 1, at 10.
[98] *Id.*

The mantra "catch them young" should be taken seriously in this context because it makes better socioeconomic sense to equip young ones with the tools to resist taking up smoking than investing in cessation services. Africa occupies a unique position regarding this aspect of MPOWER strategy. This is because although significant variations exist in terms of smoking prevalence between different countries in the region, as documented previously, the aggregate number of smokers in Africa is currently low (at 14 percent)[99] but is expected to rise exponentially in the next few years if nothing is done. Therefore, unlike other parts of the world with higher prevalence rates (and, therefore, in greater need of intervention), the focus in Africa should be on prevention, to curtail uptake of smoking. This is critical given the already detected relatively high rate of new smokers initiation amongst African youth[100] as well as

[99] Radlicki, *supra* note 8.

[100] Note that although smoking prevalence amongst adults in Africa is low vis-à-vis other regions, the pattern is not the same amongst youth in the region. At nine percent, the smoking prevalence amongst boys in African Region is high, exceeding that of other developing regions such as Eastern Mediterranean Region (eight percent), South-East Asia Region (eight percent) but still lower that in European Region

expected growth in population and economic development in the region[101]—all of which point to upward momentum in tobacco purchase and consumption. Moreover, cost effectiveness of prevention is of particular relevance to countries in Africa whose nascent health systems are ill-equipped to provide intervention. Prevention completely shields countries from the social and economic cost of smoking (cost of treatment, effect of second-hand smoke and lost productivity as a consequence of tobacco-attributable disease and illness)—compared to cessation/intervention which only results in cost reduction regarding current and future tobacco consumption.[102]

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and American Region (13 and 15 percent respectively). Noteworthy also is the higher prevalence of smoking amongst girls in Africa compared to women, the implication being that the future is dim for tobacco prevalence amongst women as these girls mature and become women. *See* Blecher & Ross/American Cancer Society, *supra* note 13.

[101] *Id.*

[102] *Id.*

E. Enforce Bans on Tobacco Advertising, Promotion and Sponsorship

Recognizing that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products, Parties to the FCTC agreed to place comprehensive bans on tobacco advertising, promotion and sponsorship (TAPS) within their respective territories as well as cross-border TAPS originating from their territories.[103]Hitherto, just like every other major business enterprise, the tobacco industry spends billions of dollars worldwide each year encouraging the purchase of its products.[104] This takes the form of TAPS, the idea being to position tobacco as any other consumer product, which, in turn, increases its social acceptability and frustrates campaigns targeting the hazards of tobacco use.[105] The rising tobacco epidemic in various regions of the world and billions

[103] FCTC, *supra* note 14, Art. 13.
[104] WHO, *Enforce Bans on Tobacco Advertising, Promotion and Sponsorship*, available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_e.pdf?ua=1 (accessed January 27, 2019).
[105] *Id.*

of dollars in profits reaped by the tobacco industry provide the strongest proof of the success of these strategies by the tobacco industry and, hence, the significance of commitment to comprehensive banning of all the methods employed in encouraging tobacco initiation and resistance to quitting.

Best practice comprehensive bans cover all types of TAPS, direct and indirect, including all types of media such as print, broadcast, billboards and other outdoor advertising (for instance, on transit vehicles and stations) as well as the internet[106] or at least 90 percent of the population covered by a legal regime completely banning TAPS.[107] Very few countries (in Africa and other regions) have attained this best practice standard;[108] yet, leaving no loopholes to be exploited by tobacco manufacturers has been proven to be very effective—quite unlike partial bans.[109] The net drop in consumption level over ten years in

[106] *Id.*
[107] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 139.
[108] *Id.* at 138 – 149.
[109] WHO, *Enforce Bans on Tobacco Advertising, Promotion and Sponsorship*, *supra* note 104.

countries with legal or other regimes comprehensively banning TAPS is high, at——nine percent, compared to those without a comprehensive ban (negative one percent).[110] Countries must recognize that partial bans achieve little or nothing as the industry simply identifies loopholes in the law and channel it's advertising, promotion and sponsorship resources accordingly.[111] It has been shown that independent of other interventions, a comprehensive ban on all TAPS reduces tobacco consumption by about seven percent, and even up to 16 percent in some countries.[112] Countries are urged to adopt legislation banning in-coming and out-going cross-border advertising, such as tobacco advertising on international television and internet sites, and sponsorship of international sporting and cultural events.[113] Promotional strategies such as price

[110] WHO (AFRICAN REGION), *supra* note 1, at 11.
[111] WHO, *Enforce Bans on Tobacco Advertising, Promotion and Sponsorship, supra* note 104.
[112] *Id*.
[113] *Id.*

discounts and free product giveaways should also be banned.[114]

All these should be understood in the context of the enormous influence of tobacco manufacturers. As Professor of Health Policy, Mike Daube, cautions, "[t]he power of the tobacco industry remains immense. It continues to oppose and delay action in developed countries and to promote its products ruthlessly in developing countries."[115] Whilst Western industrialized countries have been able to rein in the activities of the tobacco industry, developing countries, including those in Africa, have not had commensurable success. For countries in Africa to record significant level of success, strategy must be in place to effectively monitor implementation, for instance, by periodic review of innovations in industry tactics and media technology and adopting appropriate response.[116] The bans should not only be comprehensive but must be

[114] *Id*.
[115] Ferguson, *supra* note 63.
[116] WHO, *Enforce Bans on Tobacco Advertising, Promotion and Sponsorship, supra* note 104.

backed by strong law, with clearly defined terms and couched in plain language, and vigorously enforced against erring individuals and corporations.[117]

The other side of the coin—that is, the challenge—is that the tobacco industry is up in arms against regulation by governments in the region. Parliamentarians in Kenya have been linked to illicit payments by the tobacco industry, a country in which the industry has used the court system to scuttle implementation of tobacco regulation for 15 years.[118] Several other countries in Africa are also implicated. A former executive of British American Tobacco has admitted that the company paid bribes to authorities in Kenya, Burundi, Rwanda and the Comoros Islands to undermine tobacco control regulations.[119]

[117] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 88.
[118] Sarah Boseley, *Threats, Bullying, Lawsuits: Tobacco Industry's Dirty War for the African Market,* THE GUARDIAN, July 12, 2017, available at https://www.theguardian.com/world/2017/jul/12/big-tobacco-dirty-war-africa-market (accessed January 27, 2019).
[119] *Id.*

F. Raise Taxes on Tobacco

The last of the MPOWER strategy, requiring taxes on tobacco to be raised, is a product of two provisions of the FCTC, namely, Art(s). 6 and 15. Art. 6 recognizes price and tax measures as an effective and important means of reducing tobacco consumption and requires Parties to adopt tax policies and price policies on tobacco products, so as to contribute to the health objectives aimed at reducing tobacco consumption. WHO's recommended best practice regarding tobacco taxation is for countries to raise the level to 75 percent or more of the retail price[120] and this has significant implication.

Amongst all tobacco control measures, raising tobacco taxes is the most effective. There is a direct correlation between raising taxes and tobacco consumption in that the addition of tax hikes the price, thereby driving consumption down. Yet, best

[120] WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2015: RAISING TAXES ON TOBACCO 16 (2015); WHO, REPORT ON THE GLOBAL TOBACCO EPIDEMIC, 2017, *supra* note 2, at 139.

practice taxation on tobacco has been very sluggish. There is only one country (Madagascar) in the African region that has attained best practice taxation on tobacco, at 80 percent of the retail price of cigarettes,[121] compared to two countries in the Americas[122] and 26 in the region of Europe.[123]But although very few countries have adopted best practice tobacco taxation, most countries have continued to tax and hike existing taxes imposed on tobacco products, and the result has been quite positive. Reports indicate that smoking rates amongst the poor and the young took a nosedive in South Africa when it raised taxes; yet, tax revenue increased.[124]

Benefits inuring from increase in tobacco prices are many, including steep decline in the number of users; users reduce consumption; former users are less likely to start again; and, the likelihood of young

[121] *Id.* at 138 – 139.
[122] *Id.* at 140 – 141
[123] *Id*. at 144 – 145.
[124] WHO, *Raise Taxes on Tobacco,* available at http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_r.pdf?ua=1 (accessed January 27, 2019).

people starting using tobacco is reduced.[125] There is no downside to increasing taxes on tobacco. The public is generally supportive, even smokers, due to the harmful nature of the habit.[126] Therefore, there is no reason countries committed to improving public health should not consider adopting this approach. In fact, countries are urged to raise tobacco taxes and channel the revenue generated toward reducing smoking, implementing tobacco control policies and funding other public health and social programmes.[127] It has been opined that if in high-income countries, a ten percent increase in the prices of tobacco will reduce use by about four percent, the result in less affluent countries is likely to be greater.[128] The argument is persuasive and deserves consideration by developing countries, particularly those in Africa, as a means of raising money for tobacco control. But there are challenges. Unlike mature economies, tax collection at the retail level is

[125] *Id.*
[126] *Id.*
[127] *Id.*
[128] *Id.*

quite difficult in developing countries, due to the nascent state of the economies and lax tax enforcement regimes. Thus, for these countries, the right path to toe is to levy excise tax at the manufacturer level, as opposed to the distributor or retail level, the benefit being that so doing centralizes revenue collections and minimizes recordkeeping burdens on small businesses, thereby increasing efficiency.[129]

Art. 15 of the FCTC, the other component of the obligation to raise taxes, requires the elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting—all of which are essential components of tobacco control. The overarching idea is for Parties to be proactive in combating smuggling and related illicit activities; that is, to reduce the occurrence to the barest minimum, and this could be accomplished by effective government record keeping; strengthening border security and inspection procedures; improving banking controls

[129] *Id.*

to reduce money laundering; and, ensuring better communication among finance, customs and other agencies involved in tax collection and enforcement.[130] Weak institutions, coupled with rising numbers of organized crime syndicates throughout the world and porous borders across much of the developing world, including Africa, pose a challenge to the implementation of Art. 15.

III. CONCLUSION: KEYING IN ON WHAT WORKS AND THE WAY FORWARD

This statement, credited to Recep Tayyip Erdoğan, Prime Minister of Turkey, in 2013 powerfully resonates with the overall tone of this paper:

> I love my people and I want them to live their lives in good health. This is my aim. Stealing someone else's right to live in good health is unacceptable. Struggling against the use of tobacco products has become [very] important

[130] *Id.*

> [to us] . . . Tobacco products are literally murdering our future generations. MPOWER not only brought down the consumption rate, but it also changed public opinion. People said it would be protested, but instead it was accepted by everyone and many people started quitting.[131]

Deducible from this statement is a deep-seated commitment to the health of the people of Turkey from the highest level of the country's political leadership. Quite distinct from typical grandstanding and political posturing, practical measures were institutionalized and successfully implemented to realize the goal expressed by the Prime Minister. Recall that in 2008, more than one in three adults in that country used tobacco, the highest rate in Europe; yet, by 2012, smoking prevalence had declined by 13.4 percent and exposure to second-hand smoke dropped too.[132] The catalyst was the MPOWER policy package.[133] The not-long-ago smoke capital

[131] WHO, *MPOWER in Action, supra* note 30, at 8. *Id.*
[132] *Id.*
[133] *Id.*

of Europe became the third country in the region to go 100 percent smoke-free indoors and the first nation to achieve all six MPOWER measures at the highest level.[134] The result of this sustained commitment, not just by the Prime Minister but other actors, including CSOs and multilateral partners, has been nothing short of phenomenal:

> Progress is already evident, with studies showing a 20 [percent] decline in 2012 in the number of citizens admitted to hospital for smoking-related diseases. It's a powerful example of what MPOWER can achieve, and absolute proof that no country needs to remain dependent on tobacco.[135]

This turnaround in Turkey is of tremendous significance because if operationalizing MPOWER could fundamentally alter the tobacco landscape in that country within a relatively short time, there is no reason toeing the same path would not yield

[134] *Id.*
[135] *Id.*

comparable result in other countries. This is a message that should be internalized and acted upon by the political leadership in Africa; meaning that African countries should move beyond ratification and domestication of the FCTC to embrace and fully operationalize the entire MPOWER policy package.

That said, aside from the challenges examined in the previous sections which African countries are facing regarding MPOWER best practices, there are additional issues that need to be addressed. There is a report by *Time Magazine* that as a result of widespread practice of selling cigarettes in single sticks, thereby enhancing affordability, about a quarter of teens—some as young as 13 — in some parts of Nigeria use tobacco, twice the smoking rate of adult men in the country, thus, creating "a demographic powder keg, one that means big trouble if you're a health expert." [136] What this report suggests, considering that Nigeria is, by far, the most

[136] Jeffrey Kluger, *Big Tobacco Sets Its Sights on Africa,* Time, July 24, 2009, available at http://content.time.com/time/health/article/0,8599,1911796,00.html (accessed January 28, 2019).

populous country and the largest economy in Africa, is that the number of years it will take for Africa to become the epicenter of tobacco epidemic may be less than earlier projected. "It's in Africa," argues the reporter, "that the battle for the hearts, minds and lungs of new smokers is being waged most aggressively—and Nigeria offers a telling look at how the fight is unfolding."[137] The battle is being waged through the single stick approach and this presents a very big challenge, especially considering that the people who are likely to patronize single sticks are the poor, the youth or illiterates; paradoxically, the same groups that are less likely to be aware of the dangers of smoking.[138] The sale of single cigarette sticks is not just in Nigeria but occurs throughout the region. It works because "They are extremely affordable," making it possible for "Young teenagers [to be] able to purchase a cigarette."[139]

[137] *Id.*
[138] *Id.*
[139] Boseley, *supra* note 118.

Affordability coupled with ignorance of the deadly consequences of smoking translates to rising volume of sales by the tobacco industry—exactly the scenario intended by big tobacco; yet, the industry denies any responsibility. "If retailers choose to break [packs] up and sell them one at a time—which I believe is very widespread across Africa," a spokesperson for the tobacco industry claims, "that's not something we have any involvement with."[140] Despite this claim, however, the culpability of the industry is not in doubt. The playbook is well-known: "When something gets regulated here [that is, Western countries], we move the risk offshore . . . Africa is in play."[141] And to ensure that Africa remains in play, tobacco industry has morphed into a benefactor, in a warped and twisted display of CSR. Tobacco companies are increasingly exploiting Africa's vulnerabilities to their advantage, and have been very successful. British American has channeled one percent of its local profits to providing

[140] Kluger, *supra* note 136.
[141] *Id*.

drinking water, health care and vaccines.[142] The same company signed an agreement with the Nigerian Customs Service in 2007 to cooperate with the agency on curbing unlicensed tobacco trade and two years earlier sponsored a three-day retreat at a local resort for government officials.[143] Gratitude for this kind of insidious CSR translates to decreased popular support for regulatory activities and lack of serious implementation of anti-smoking policies by the government, both of which portend disaster for public health.

To its credit, Nigeria has borrowed a leaf from the approach of Western countries, commencing legal proceedings seeking $45 billion damages against British American, Philip Morris and the domestic firm International Tobacco, alleging "clear strategy to market their products to young people"—a charge which the tobacco companies vociferously deny.[144] Whatsoever becomes the outcome of the case, one thing is clear, nature abhors vacuum—a

[142] *Id.*
[143] *Id.*
[144] *Id.*

truism also in the realm of global tobacco control. As distorted and self-aggrandizing as the assistance tobacco companies render to governments and the citizens might be, the stark reality is that the help is needed and appreciated by the recipients. Therefore, getting rid of these avenues which provides tangible benefits such as drinking water and health care, as would be the ultimate result of forcing big tobacco out of Africa or seriously eroding their profit base, would create a vacuum which must be plugged immediately to avoid retrogression. This calls into question the international cooperation obligations of Parties to the FCTC, as stipulated in various provisions of the treaty and more elaborately addressed in Art. 22. The duty to assist poorer nations has a long genealogy and is enshrined in core international legal and policy frameworks including, amongst others, the U.N. Charter (Art(s). 1(3), 55, 56)), Universal Declaration of Human Rights (UDHR) (Art(s).22 & 28), International Covenant on Economic, Social and Cultural Rights (Art. 2(1)), Millennium Development Goals (MDG 8) and

Sustainable Development Goals (SDG 17). Serious commitment to this obligation is what is needed to advance African countries and other resource challenged nations toward attaining best practice implementation of the mandates imposed by the FCTC. "Resources should be directed to these countries to ensure they are equipped with the workforce and legislative power to counter the tobacco industry's efforts," says cancer specialist Billie Bonevski, "Tobacco control efforts need to reach the whole of the population, especially people who find it difficult to stop smoking."[145] This very insightful admonition should be taken seriously by the international community if it is really interested in preventing a full blown tobacco epidemic in Africa.

[145] Ferguson, *supra* note 63.