

Tobacco control in the Eastern Mediterranean Region: overview and way forward

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Introduction

This article is an attempt to highlight the main achievements and the future of tobacco control in the Eastern Mediterranean Region (EMR) Member States.

Tobacco control in the EMR has gone through many important developments during the last 2 decades. In the beginning tobacco control was an individual initiative held/adopted by few Member States. At that time, there were no collective Regional efforts towards controlling tobacco. More organized efforts marked the 90s in the last century: organizations such as the World Health Organization (WHO) and the League of Arab States adopted regional measures for tobacco control. Celebrations marking World No Tobacco Day were among the main characteristics of tobacco control efforts/publicity. However, these celebrations were often criticized for being a 1-day event that lacked continuity and sustainability.

A real turn about in the shape of tobacco control came with the development of the Framework Convention on Tobacco Control (FCTC), the first international treaty to protect public health. The idea of having an international treaty was the dream of Dr Ruth Roemer, an academic who had been working in tobacco legislation for decades.

The then Director-General of WHO, Dr Gro Harlem Brundtland, adopted the idea and turned it into reality [1]. A totally new era for tobacco control came when the World Health Assembly (WHA), through resolutions WHA 49.17 and 52.18, established the working groups for the FCTC in 1999. Moreover; the Director-General turned tobacco control from being one of the WHO units into a cabinet project. Serious efforts in the organization were dedicated to re-shaping tobacco control in-house.

In 1999 the Director-General inaugurated the first working group of the FCTC, which was concluded after 2 working groups and 6 sessions of negotiations; in 2003 the WHA adopted the FCTC by consensus.

The growing momentum created by the FCTC negotiations resulted in the involvement of key national level government and nongovernmental sectors from the EMR Member States. The Region witnessed efforts for developing Regional legislation, with heavy involvement of 3 Regional organizations; the Arab League, the Gulf Cooperation Council (GCC) and WHO Regional Office for the Eastern Mediterranean Region (EMRO). During the same period national efforts focused on strengthening the infrastructure for tobacco control as never before.

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The main characteristics of the FCTC negotiation period at the Regional level were:

- establishment of a Regional and national surveillance system for tobacco control to obtain evidence-based data on prevalence; documenting beliefs related to tobacco use and characteristics of populations at both national and Regional levels;
- well established Regional coordination between WHO, League of Arab States and GCC;
- national and Regional legislation was subject to review and development in a way that reflected the principles and experiences shared during the FCTC negotiations;
- confronting the tobacco industry by governmental and Regional organizations.

Immediately after the WHA resolution of May 1999 on the FCTC, the Eastern Mediterranean Member States Regional Committee adopted, at a Regional level, the first generic plan of action for tobacco control. They also called upon the Tobacco Free Initiative (TFI) to submit an annual progress report on the developments [2].

Following on that, in collaboration with the Centers for Disease Control in Atlanta, tobacco surveillance became an important component for completing a comprehensive profile for tobacco control. The Global Tobacco Surveillance System started in the Region with Jordan implementing the Global Youth Tobacco Survey in 1999 in its pilot phase. Nowadays, the Global Tobacco Surveillance System has 3 more components that are being implemented all over the Region.

WHO/EMRO, the GCC and the League of Arab States joined forces at Regional level to strengthen tobacco control. In 2001, WHO/EMRO released a report on the tobacco industry activities in the Region enti-

tled *Voice of truth* [3]. In the 2 subsequent meetings of the Ministers of Health of the GCC, 2 resolutions were adopted which called upon Member States to monitor and stop any collaboration with The Middle East Tobacco Association. Again, immediately after the *Consultation on litigation and public enquiries as public health tools*, held in Jordan in February 2001, a resolution was adopted at the next meeting of the GCC, held in Saudi Arabia in January 2002 (No. 09/52) calling upon Member States of the GCC to explore litigation possibilities.

From 2002 onwards, the Arab League Ministers of Health council meetings had tobacco control on its agenda. It called upon its Member States to adopt unified legislation, that developed by the technical committee of the League of Arab States on tobacco control. Although the legislation developed was not as affirmative as recommended by WHO policies, especially with regard to 100% tobacco free public places and to the health warning size, it contributed to cultivating the appetite for more work on the legislative front of tobacco control at national level.

The FCTC process was very powerful in that it paved the way for legislative changes that were reflections of the intensively diverse discussions which took place in the negotiation meeting rooms. Some of these legislative attempts were far from being perfect or ideal when it came to the impact on tobacco control. For example, in Qatar the law on tobacco control, adopted in 2002, indicated that the health warning should be 25% of the trademark size, while it was meant at the early drafting stages to be 25% of the pack size. Nonetheless, some major successes were achieved, such as the total ban on advertising, promotion and sponsorship in both Egypt and Qatar.

During that period it was realized that, after the numerous FCTC negotiation rounds, more attention should be given

to disclosing the activities of the tobacco industry and their plans for tobacco trade in the Region, across all 22 countries [4].

Four events marked this era: first, holding the *Consultation on litigation and public enquiries as public health tools*, in Jordan, February 2001 [5]; second, the release of the WHO inquiry *Voice of truth* [6]; third, the release in 2002 of the first version of the practical manual *The tobacco industry papers, what they are, what they tell us, and how to search them* [7]; and finally, a paper on the tobacco industry involvement in illicit tobacco trade in the Region was released [8]. These events, together with the publicity that accompanied the release of the documents and the involvement of high officials in tobacco control activities, led to massive increase in awareness among decision-makers on the tobacco industry's marketing tactics. Moreover, it revealed the truth about the involvement of many high-ranking politicians with the tobacco industry, a heavy association that brought embarrassment to all those involved [9]. These discoveries resulted in a clear separation between the motives of the tobacco industry and tobacco control policies, at least on the surface. As a result, it is very clear now that any moves to undermine tobacco control efforts and measures might be a direct result of tobacco industry influence: this clear revelation resulted in a certain amount of hesitation on the part of those involved.

Why is tobacco control a priority in the Region?

Tobacco control is still a priority in this Region despite all the efforts so far exerted. This is a fact easily realized by looking at the prevalence of tobacco use among youth, adults and women, the price of tobacco,

the rather weak/non-enforced policies of tobacco control, and the up-coming trends in tobacco use.

The initial momentum for tobacco control is already established. Now, all the Regional organizations working in the field of public health have tobacco control on their list of priorities. Surprisingly, however, the trend for tobacco use is not decreasing: on the contrary, it is increasing. The Global Youth Tobacco Survey reveals startling facts about the situation in the Region, especially with regard to prevalence of tobacco use and use of other forms of tobacco such as *shisha* (waterpipe) and more alarmingly with regard to the potential to initiate tobacco use within a year. The reported rate for students who currently smoke is 4.9% for cigarettes and 12.0% for other tobacco products (especially *shisha*), while 17.0% of students who ever smoked were susceptible to initiate smoking in the year following the survey [10].

In addition, the burden of diseases associated with tobacco use is increasing in the Region. In Pakistan, the age standardized mortality rate from noncommunicable diseases among adults is 743 per 100 000 population [11]. In Egypt, the age standardized mortality rate from smoking-related causes (cancer, respiratory and circulatory diseases) among males 35+ years in 2000 was 5665.4 per 100 000 population [12].

Prevalence of tobacco use among adults is very high. The global tobacco control report, released in 2008, indicates that the current male-consumption in the Region is ranging from 24.8% to 61.7% while current female consumption ranges from 1.0% to 7.9% [10].

WHO confirms that less than 5% of the world population is covered by the policies essential to curb the tobacco epidemic. Sadly, none of EMR Member States has applied the recommended best practices

strategies in full compliance with the suggested approaches of WHO [10].

Currently, there is serious concern about the sustainability of tobacco control activities in the Region. These activities depend largely on financial donations, a reliance which throws a shadow on the government resources allocated for tobacco control. An analysis of government expenditure data from the Region indicates that there is a serious need to divert resources to ensure continued sustainability of the policies and to achieve ultimate success in tobacco control.

Nowadays, the Region suffers from a new epidemic which did not exist a few years ago, namely women smoking and high numbers among youth taking up tobacco in all its different forms.

Although the WHO report on women and the tobacco epidemic highlights this new trend, unfortunately, as yet serious efforts are lacking to protect this vulnerable group from being aggressively targeted by the tobacco industry [13].

For example, *shisha* use is spreading rapidly among young women and the Region needs to combat it. Immediate social, economic and legislative measures need to be implemented to control its spread that were also strongly recommended by WHO in its advisory note on *shisha* released 2006 [14].

The Framework Convention on Tobacco Control in the Region

National tobacco control legislation is one of the main tools for bridging the gap between the known facts on consequences of tobacco use and peoples' behaviour [15]. There will be no change in the tobacco epidemic on a national level without strong legislation based on evidence and without applying

the most advanced successful strategies for tobacco control. Regardless of a country's position with regard to the FCTC, national legislation should strengthen public health, and either pave the way for successful adoption of the FCTC, or fulfil national commitments and obligations to implement the FCTC. The FCTC should not be seen as an objective in itself, but rather as a tool to achieve the overall national objective.

The completion and entry into force of the FCTC is an achievement that no one can undermine in tobacco control: the momentum that was created by the FCTC negotiations and finally its adoption by the WHA in 2003 paved the way for many changes at national level. It augmented the level of political commitment and political awareness for the importance/vitality of tobacco control. Of the 22 countries in the EMR, 17 have become party to the FCTC.

During the negotiations of the FCTC; Member States in the Region realized an important fact owing to their interaction with other nations: that tobacco has become a political priority. It is now considered a global and Regional problem and not merely a national concern. This realization enhanced Regional and sub-regional exchange of information and cooperation, which is now obvious in the meetings of the GCC and the Arab League. This led to Regional unity in negotiating policy changes required at the national level, e.g. the pricing policy of the GCC, although this is not implemented by all Gulf states [16].

The current position proves that there is no fear that the treaty will remain less effective in national tobacco control efforts [17]. Twelve out of the 17 parties to the FCTC in the Region negotiated and were engaged in the process of implementing pictorial health warnings, already agreed to be implemented in 4 out of the 12 countries: Djibouti, Egypt, Islamic Republic of Iran and Jordan. The

remaining 8 are in the final phase of official adoption of the warnings. A similar movement is on-going in regard to a total ban on tobacco advertising. At least 10 countries of the Region have already prohibited sales to minors in their national legislation. It seems that the FCTC is seen to be gradually reaching its full potential.

However, what is alarming and worrying is that the countries are taking a piecemeal approach to the implementation of the treaty rather than following a comprehensive approach in addressing all the legislative needs. This approach delays implementation and increases the difficulty of measuring the effect of FCTC implementation on all aspects of tobacco control. What should also be realized is that internationally evidence-based best practices are being adopted. A clear example of this is the progress on tobacco health warnings. With increasing unfolding evidence, once a strategy for tobacco control is adopted at national level, by the time the next one is due the first one would have already been subject to change at international level. Therefore the development of tobacco control policies should be regarded as a dynamic process. The need for such dynamism exhausts national efforts and divides energy in many battles, rather than unifying them to win all at once. Some voices sympathetic to industry circles claim that a step by step approach would challenge less. However, it should be realized that in a Region as diverse as ours, once the politically right moment is reached, it should be exploited to its full potential. The possibilities that were raised by the FCTC negotiations are still alive, and this is not a continued opportunity. It is rather variable due to changes in the many other relevant factors, time to say the least.

The time has come for a comprehensive change of policy and legislation at national level. The efforts of Regional organiza-

tions should support this approach and push towards its fulfilment. Taking into consideration that many of the FCTC articles are time bounded, they also emphasize the importance of comprehensiveness rather than division of commitments.

The way forward for tobacco control in the Region

Although the evidence that legitimizes policies adopted by the FCTC and the *Global tobacco control report*-recommended policies (MPOWER) are well established at international level, a similar situation does not exist in the Region. There is a serious lack of economic data, reliable adult prevalence data, and tobacco trade data. Comprehensive information is much needed for the multifaceted profile of tobacco, at national level, to develop the solid ground for policy change and development of legislation. A multi-sector approach to tobacco control is not achievable without the completion of such a profile [18].

The completion of a multifaceted tobacco profile does not mean following the EMR Regional profile of 2002 or the global tobacco control report model of collecting available data [10,19], rather it establishes the information by conducting first hand, original studies according to national priorities and needs. Lack of resources is often the excuse for not conducting the required studies and research. Even worse, when resources are available, the preference is to allocate them for activities that result in immediate outcomes, such as national training activities, visits of consultants and media campaigns instead of on-site data collection. Lack of adequate resources prevents the completion of such data. Thus, it is important that international organizations and donors realize that providing adequate

resources for research is the backbone for establishing stronger national policies.

One of the approaches to solving this problem of lack of resources is to adopt an earmarking policy, even with no defined percentage, as in the model implemented by the Gulf States (apart from Yemen), though different from the World Bank definition of earmarking. The GCC adopted a decision to dedicate part of the taxation funds for tobacco control. The implementation of this decision was delegated to each country according to its own system. Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates implemented it with no defined percentage. The allocated percentage changes every year according to the agreement between the Ministry of Health and the Ministry of Finance, but the end result is that funds for tobacco control do exist at the level of the Ministry of Health and this is a major step forward.

Despite the promising developments that the Region has been witnessing since the start of FCTC negotiations, a more planned approach has still to be adopted if rapid and sustained reduction in tobacco consumption is to be achieved. Countries of the Region cannot continue rushing from one suggested international policy to another. In order to achieve the expected outcomes, for each of the internationally recommended policies of the FCTC, the following parameters must be in place:

- clear and achievable objectives of the plan of action
- linkage with a timetable
- combination with a monitoring system
- a built-in upgrading mechanism.

As an example, increasing tobacco control prices could be an objective: the deadline for achieving it is 6 months and market prices can be monitored through inspectors to ensure control of smuggled tobacco. In

addition, a built-in upgrade mechanism would be to increase taxes every 5 years or to link the increase to the inflation rate.

Creating opportunity for development is vital in the Region. For example, legislation identifying tobacco-free public places cannot leave out restaurants, cafés and bars. It must take into consideration international developments and the difference in the health impact. Nonetheless, the legislation can adopt a gradual mechanism for enforcement. For example, within 5 years all public places shall be tobacco free. The same applies for designated smoking areas; if the modified legislation cannot achieve 100% tobacco free public places, an alternative would be to introduce into the legislation a mechanism to achieve the intended objective gradually, say within 3 years.

The existence of legislation on tobacco control is one thing; however, compliance and enforcement is another. The strongest legislation will have zero health effect if there is no compliance and enforcement. This is a real problem in many countries of our Region. The trend of developing legislation and leaving out its enforcement strategy is a widespread phenomenon in many countries [20].

To delegate the implementation of tobacco control legislation to the interested party is one way of avoiding weak enforcement and compliance, i.e. to the Ministry of Health. This was done in Egypt, although its impact is not yet known. At least, the claim that the Ministry of the Interior has other priorities and gives little attention to health-related legislation is now avoided. Besides, there are other ways to ensure compliance and good enforcement, as indicated in the WHO publication on enforcement and compliance [21].

The influence of the industry, the “underlying cause of the tobacco epidemic”, held back tobacco control efforts for years

in countries of the Region [21]. This was revealed through a series of enquiries and reports released by EMRO. There is no indication that the industry role was minimized or became less friendly towards tobacco control. Despite the diverse exploits of the industry to use the mechanism of “social cooperative responsibility” to be seen as the “vehicle for doing well” [22], countries still have to be mindful of the industry’s ultimate aim, which is not by any means to protect health. To avoid the dilemma that many of our Member States face—being responsible for tobacco control and at the same time being the owner of national tobacco industries—governments have to adopt policies that are in line with the FCTC as follows [23]:

- total separation between the tobacco industry and tobacco control
- declaration of tobacco advertising budgets and plans
- explore possible litigation mechanisms in order to ensure full compliance with legislation
- raise public awareness on tobacco control in general; and in particular on the industry history and activities.

The industry was, and still is, the root cause of all deaths related to tobacco use. This fact should be the foundation for all national policies aiming at controlling the tobacco industry’s influence and activities aimed at undermining tobacco control efforts at national level.

Another tool to protect public health from tobacco industry interference that is still not used to its full potential in the Region is public enquiries and litigation. The potential is worth studying at this stage, not only by governments but also by civil society groups, through using national legislation related to liability, compensation, and violation of law. A comprehensive national

tobacco control scheme requires action and clear vision in dealing with the tobacco industry [24]. To achieve this, understanding the history of the industry and its influence at each national level becomes a necessity.

Way forward and recommendations

The future of tobacco control in the Region is promising. Efforts on all levels should be united in achieving a comprehensive vision on the national level, documented in a national plan of action or strategy that is time bounded and gradual. Any national plan of action should contain a strong research component to build nationally-based evidence for action. Relying on dependable international data is important; however to maintain policy-makers’ consciousness and support to tobacco control, national data will be more reliable and even more credible.

Countries are advised to take a more comprehensive approach in implementing the FCTC rather than a step-by-step approach. In line with this, they need to analyse the current level of compliance and enforcement and to generate new strategies based on each individual national situation in order to strengthen both. Attention should still be given to industry activities in undermining tobacco control efforts. Exploring the possibility of success by using more tools, such as litigation and public enquiries, in combating industry activities is vital.

Securing funds for tobacco control through a sustainable and prolonged uninterrupted system is essential. Earmarking has proven to be a successful method in many countries of the Region; such a system should be considered by the national authorities.

Countries of the Region are now at a historically critical moment. There is strong momentum for tobacco control: the political situation is in favour of tobacco control; the international atmosphere is supportive of

tobacco control; taking this chance at this right moment is vital. Undermining this potential will result in non-reimbursable losses for decades. And our loss of lives will continue due to this destructive epidemic.

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WHO Report on the Global Tobacco Epidemic, 2008 – The MPOWER package

In the 20th century, the tobacco epidemic killed 100 million people worldwide. During the 21st century, it could kill one billion.

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