

## **INTRODUCTION**

Tobacco is one of the major sources of income to many countries with an annual turnover of almost US\$ 400 billion. However, the globalization of its marketing, trade, research and industrial influence represents a major threat to public health worldwide including economic, environmental and social dangers.

Tobacco use is one of the leading causes of preventable death in world. The World Health Organization (2001) estimates that 11,000 people die daily due to tobacco related diseases. It is also estimated that 4.9 million deaths occur annually from tobacco-related illnesses, a figure expected to rise to 10 million by the year 2030. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. 70% of those deaths will occur in developing countries.

The sheer scale of tobacco's impact on global disease burden, and particularly what is likely to happen without appropriate intervention in developing countries, is often not fully appreciated. The extremely negative impact of tobacco on health now and in the future is the primary reason for giving explicit and strong support to tobacco control on a worldwide basis.

Many of tobacco's future victims are today's children because tobacco use is usually initiated in adolescence and continues through adulthood, sustained by addiction to the nicotine in tobacco. Murray et al (1996) indicate that if the current trends continue, 250 million children alive today will be killed by tobacco. 750 million children are exposed to second-hand smoke. Although it is evident that there are many tobacco related diseases and deaths, tobacco use among young people is increasing as the tobacco industry aggressively promotes its products through media and advertising to a new generation of potential smokers. Therefore, tobacco control is of paramount importance.

### **Tobacco-use in Uganda**

Uganda is on the Eastern Coast of Africa with an area of approximately 236, 040 square kilometers and a population estimated at 23 million people (2002 Census results). The GDP is approximately \$ 6.2 billion per year with per capita of about US\$ 260. Between 1990-1999, Uganda's economy grew at an average of 7.1% per annum.

Tobacco farming was first introduced in Uganda by the British-American Tobacco (B.A.T) Limited in the early 1920's. Currently, it is the second largest cash crop grown in over 16 districts and a major source of revenue for 11 districts. Overall B.A.T contributes approximately 8% (about US\$35

million) of the taxes collected per annum, and over 600,000 people derive a livelihood from the industry hence, contributing to economic development (Karugaba 2001).

### ***Prevalence***

Recent data on prevalence of tobacco-use in Uganda is limited. The Uganda Demographic Health Survey (2001) indicated that cigarette smoking prevalence amongst adults is at 25% for males and 3% for females. Kanyesigye et al (1997) noted that among the youth 19% of the secondary students and about 35% of the students in tertiary institutions including the medical school do smoke. This was attributed to a lot of tobacco products' advertisement in relation to style/fashion; and peer influence. With common advertisement slogans like: **Rex-the test of success; Safari-your best companion; Sportsman-Yee Ssebo; Embassy-smooth all the way.** Advertising increases consumption of tobacco products and this increases the death and disease burden.

Per capita consumption of cigarettes is approximately 150 units (Karugaba 2002). However, with such level of consumption of cigarettes, the health risks seem to be underestimated by many especially within health warning on cigarette packets '*cigarettes smoking can be harmful to your health*' which many may not understand and/or pay attention to. A study carried at Mulago Hospital found that 75% of the patients of oral cancer had a history of smoking with a minimum number of years smoked ranging from 2-38 years (Bataringaya 2001). In addition, 45% of the patients had a history of smoking within the 10-19 year duration. Lukwiya (2000) reported that the mean initiation age for smoking was 13.4 years with a range from 6 to 22 years in Jinja district. Nambi et al (2001) in their study carried out in Arua, Kampala, Lira, Mbale, Mbarara and Masaka districts it was noted that initiation age of underage smokers was below 9 year.

### ***Tobacco control measures***

Despite the damaging effects of tobacco products on human health, many countries, Uganda inclusive, find it difficult to take significant control measures to reduce its toll. This is because of concerns that their interventions might have harmful economic consequences like loss of thousand of jobs and that higher taxes would result in lower government revenues (World Bank Publication 1999).

In Uganda, regulations on tobacco are mainly for promotion of tobacco growing through licensing of green leaf buyer Tobacco (control on marketing) Act 1966. Tobacco control measures in place include the mandatory health warning '**smoking can be harmful to your health**' appearing on cigarette adverts on the electronic media and billboards. In 1995, Government of Uganda banned the advertisement of tobacco products on state media: Radio Uganda and Uganda Television. This ban

however, did not affect popular privately owned radio and television stations. Although, BAT announced withdrawal from electronic media advertisement and pulled down its billboards, point of sale advertising, neon signs for restaurants, bars, shops, and road signs are still up and other ways of promoting tobacco products are used like the street bash. It also carries out theme bars in discotheques like it was the main sponsor of Club Silk's birthday.

In addition, Uganda commemorates the World No- Tobacco Day and through Ministry of Health, various NGOs and individuals, public health campaigns on effects of tobacco use have intensified through media, both electronic and print. In schools, for example, smoking is prohibited and any student found is suspended or expelled. This is as a disciplinary measure rather than a health concern. In December 2002, the High Court of Uganda ordered National Environmental Management Authority (NEMA) to make regulations on second-hand smoke exposure in public places. However, there is need to legislate these control measures and protect the population especially the young people who are the window of hope.

## **International Response**

### ***World Health Organization Resolutions***

World Health Organization between 1970-1995 adopted a number of resolutions on the need for both national and international tobacco control policies. Through the resolutions, member states were encouraged to implement comprehensive strategies with the following contents:

- Measures to ensure that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke.
- Measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted.
- Establishment of educational and public information programs on tobacco and health issues, including smoking cessation programs, with active involvement of the health professionals and the media.
- Monitoring of trends in smoking and other forms of tobacco use, tobacco-related diseases, and effectiveness of national smoking control action.

### ***Framework Convention on Tobacco Control (FCTC)***

Arising out of a resolution of the WHO Assembly in 1999, a global/multilateral treaty was initiated aimed at curbing tobacco consumption around the world and reducing the death toll caused by tobacco. This marks the first time that the WHO has used its constitutional mandate to develop a global treaty and the FCTC is to be the world's first treaty in public health.

Negotiations for the FCTC are scheduled to be completed in May 2003, after which it will be open for ratification. The draft treaty covers a wide range of policy measure intended to reduce tobacco-related death and diseases, including measures to:

- Eliminate or restrict tobacco advertising, promotion and sponsorship;
- Protect people from second-hand smoke;
- Require prominent health warning on packages that will occupy a significant portion of the package and could contain pictures or pictograms;
- Ban misleading tobacco descriptors such as '**light**' and '**low tar**' which imply that the products as less hazardous;
- Clamp down on widespread tobacco smuggling; and
- Eliminate duty free tobacco sales.

#### ***United Nations Foundation Project***

The Tobacco Free Initiative (TFI/WHO) recently received a tobacco prevention grant from United Nations Foundation for International Partnerships (UNFIP), to initiate a joint project with UNICEF titled ' Building alliances and taking action to create a generation of tobacco free children and youth.' The aim of the project is to collate evidence, provide technical support, and create strategic alliances necessary to address the negative impact of tobacco, encourage and support children and adolescents in leading healthy and active lives free of tobacco.

The project is conceived as a dynamic and interactive process. The activities and products of each phase will be used to inform and guide subsequent activities. The project consists of three overlapping phases.

Phase I: Focuses on harnessing the evidence from countries, some of which may participate in subsequent phases; undertaking new areas of research to support actions, and establishing a research-based evidence for developing future actions.

Phase II: Activating phase where Country Activating Groups (CAGs) with broad membership, will be formed in each of the participating countries as the coordinating and implementing mechanism to select and develop components of a comprehensive country-based approach in addressing tobacco-use among children and young people. Opportunities to promote exchange of experiences and issues will be developed and strengthened.

Phase III: Involves taking the project to scale, producing and disseminating resources; strengthening regional capacity to sustain activities; integrating the products and results of the project into ongoing tobacco control work at national, regional and global levels; transferring technology and experience between countries and

regions; and strengthening cooperation and collaboration at all levels.

Phase 11, in 1998 WHO/CDC planned for the development and implementation of an initial baseline assessment of tobacco use among young people in each country using a school survey instrument- the Global Youth Tobacco Survey. Presently, several countries have either completed, in the field or planned to implement the GYTS. Among which include: Benin, Botswana, Burkina Faso, Cameroon, Chad, Gambia, Ghana, Kenya, Lesotho, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Poland, Russian Federation, Senegal, South Africa, Sri Lanka Swaziland, Ukraine, United States of America, Venezuela, Zambia and Zimbabwe.