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From Inaction to Action: The World Health Organisation and Tobacco Control Policies in Nigeria Since 1970

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Abstract: The need to regulate tobacco usage became internationalized in 1970 following the adoption of a resolution by the World Health Assembly calling on member states to take action in view of its damaging effects. Arising from this, two periods are discernible in the fight against the use of tobacco. The first period is from 1970 to 1995 that was characterized by weak laws which were inconsequential. The second period is from 1996 to date that was marked by multilateral cooperation and effective action at the global level. A glaring manifestation during of the second period is the adoption of the World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC), which has the potential to significantly advance national and international efforts to curb the use of tobacco. This article explores these changing patterns within the context of the Nigerian State. It argues that the progress in tobacco control in Nigeria since the adoption of FCTC has been marred by weak human and institutional capacity in legislation, economics and advocacy, and lack of political will. Although it took Nigeria ten years to domesticate the treaty, only a comprehensive legal framework like the Tobacco Control Act can address the issue of tobacco smoking in Nigeria. There are difficult regulatory and governance challenges ahead but with a sustained political will, adequate resources, and strong institutions, Nigeria will overcome the entirely man-made public health problem.

Keywords: Tobacco, World Health Organisation, Framework Convention on Tobacco Control, Nigeria, Globalization, Policy

Introduction

Since the 1990s, tobacco has been an important subject in academic discourse in terms of its implication for health, environmental, and economic concerns. It was generally agreed that tobacco use is a major public health disasters. There are about 1.3 billion smokers in the world.[1] Tobacco smoking is also the second major cause of death of one in ten adults in the world. It was predicted that if the

[1]J. Baptiste, "Framework Convention on Tobacco Control: A Significant Response to Non Communicable Disease Prevention and Control," *African Health Monitor* (January-June, 2008): 20-23.

smoking patterns continue, they will cause about 10 million deaths each year by 2025.[2] In Africa, available data shows a rising consumption trend. For instance, the total cigarette consumption in Africa rose from 131,181 million sticks in 1995 to 212,788 million in 2000, an increase of 38.4 percent.[3] The Africa Tobacco Situation Analysis report on Nigeria shows that the prevalence rates for cigarette use are greater than 15 percent.[4] About 93 million sticks are produced yearly by two major tobacco companies in Nigeria (the British American Tobacco Nigeria and the International Tobacco Company), and all these cigarettes are consumed in the country. While the potential benefits of WHO resolutions and legal instruments to curb the global tobacco epidemic has been recognized by scholars and policy makers, case studies documenting its impact at the country level remain limited.[5] It is with this rather neglected aspect that this article is chiefly concerned.

Tobacco is a green leafy plant usually grown in warm climates. It is smoked as cigarettes, cigars, or in a pipe, snuffed through the nose or chewed as smokeless tobacco.[6] It is generally believed that tobacco has a stimulating effect. The consumers of tobacco feel energized and the body tends to demand for more to keep the energy high. The stimulation effect has different uses for different groups. For some, it is an effective means to relax the nerves. To others, it is a temporary means to generate happiness to address anxiety and psychological trauma, or as a means of suppressing hunger.[7] Some religious organizations believe that the leaf has the power to take one to the supernatural world through meditation. The tobacco leaf is also considered medicinal for the treatment of certain diseases such as toothache, or for causing witches to confess their diabolical activities to the public.[8]

The economic contributions from the cultivation and sales of tobacco products in tobacco producing economies are well known. Tobacco growing and sales

[2]Ibid.

[3]Nigeria, accessed November 10, 2011, http://www.africatobaccocontrol.org/enfindex.phpresourcelibrary/cou.

[4]Ibid.

[5]See D. Bettcher, D. Yach, and G. Guidon, "Global Trade and Health: Key Linkages and Future Challenges," *Bulletin of the World Health Organisation* 78, 7, (2000): 521-534; A. Taylor and D Bettcher, "WHO Framework Convention on Tobacco Control: A Global Good for Public Health," *Bulletin of the World Health Organisation*, 78, no. 7 (2000): 920-928; D. Yach, "The Origin, Development, Effects, and Future of the WHO Framework Convention on Tobacco Control: A Personal Perspective," Lancet (2014): 1-9; Obijiofor Aginam, "Moving Health Sovereignty: An African Perspective," in *Moving Health Sovereignty in Africa: Disease, Governance and Climate Change*, eds. John Kirton, Andrew Cooper, Franklyn Lisk and Hany Besada (Farnham-Surrey: Ashgate, 2014), 15-26.

[6]E. Brenya, "An Overview of Regionalist Approach to Tobacco Control in Africa," *Africa Development*, xxxvii, no 1 & 2 (2013): 107-132.

[7]Ibid.

[8]Ibid.

provide jobs and income for farmers and other workers. Many governments also obtain tax revenues and foreign earnings from the export and foreign investment in some cases. These social, cultural, and economic benefits have caused the cultivation, sale, and consumption to continue despite its negative effect on human health. For example, smoking has been associated with an increased risk of not only several different cancers, including lung and bladder cancer, but also ischemic heart disease, bronchitis and emphysema, and increased antenatal and perinatal mortality.[9] Moreover, the negative health effects of tobacco consumption have strong public links because forced or passive smoking presents health risks to non-smokers as well.[10]

The issue of tobacco control became internationalized in 1970 following the adoption of a resolution by the WHO Executive Board at its 55th Session regarding the damaging effects of tobacco.[11] Between 1970 and 1996, the WHO in particular worked so hard to get states to control tobacco but outcomes were far from optimal. However, the tide altered when the WHO changed tack in 1996 by resorting to its legal instruments to regulate tobacco.[12] The series of negotiations that began in 2000 eventually culminated in the adoption of the World Health Assembly's (WHA) first ever treaty: The Framework Convention on Tobacco Control (FCTC) in May 2003. The Convention reflects agreements among WHO member states on minimum standards for the regulation of tobacco use and tobacco trade. It is against this background that this paper examines the potential role of WHO/FCTC in halting and reversing the tobacco epidemic, particularly in Nigeria.

Tobacco Control Efforts in Nigeria Before 1970

The origin and spread of tobacco in Africa dates back to the pre-colonial period. John Edward Philips has argued that tobacco was probably introduced to West Africa, including Nigeria, about 1600AD from Eastern North America.[13] In other words, tobacco is known to have been spread by European sailors around the world within a century of the interaction between Europeans and Native Americans. It is widely believed that the aboriginal peoples of the Americas, that is, Native Americans, were the first set of people to cultivate and use tobacco and it was

[9]D. Bettcher, D. Yach, and G. Guidon, "Global Trade and Health: Key Linkages and Future Challenges." *Bulletin of the World Health Organisation* 78, 7, (2000): 521-534.

[10] Ibid.

[11]WHO, *WHO Executive Board Resolution EB45.R9* (Geneva: World Health Organisation, 1970).

[12]The decision to adopt its legal instrument is in line with WHO Constitution. Article 2k of the constitution of WHO provides for three types of legal instruments namely, conventions and agreements, regulations and recommendations. Prior to 1996 the Organisation had addressed the issue of tobacco smoking through its World Health Assembly (WHA) resolutions which were not backed by effective action.

[13]Edward Phillips, "African Smoking and Pipes," *Journal of African History*, 24 (1983): 303-320.

from them that the Portuguese and Spaniards in their worldwide travels in the sixteenth century spread the cultivation and usage of tobacco. The use of tobacco had certainly spread to almost all parts of Africa by the beginning of colonialism on the continent.[14]

The efforts to control tobacco in Nigeria began during the colonial period. However, tobacco control before 1970 was based on cultural, religious and economic grounds.[15] Culturally, tobacco smoking was perceived as an alien behaviour to the practices of many societies in Nigeria and consumers were looked down upon and disrespected. In fact, tobacco smokers and consumers were treated as social deviants and, therefore, ostracized.[16] The story was not different among Christians and Muslims that treated tobacco smokers with disdain. Smoking and chewing of tobacco was seen as a travesty of their religious beliefs and practices. Therefore, tobacco consumers were isolated from society for cultural and religious reasons for a long time. However, tobacco smokers reacted by associating smoking with the movement from primitiveness to modernity and affluence, as a means of offering a different image to smoking. The smokers associated smoking pipes, local cigars and/or chewing tobacco with primitiveness. As a result, smoking was prevalent mostly in cities and urban areas in Nigeria, where people felt they were away from their relatives and the heavy influence of culture often experienced in the rural areas.

There was no conscious attempt by the colonial authorities to control tobacco smoking. Instead, the British colonial government encouraged the production and consumption of tobacco to achieve their colonial economic interest. However, the only form of control on tobacco and its usage was the enactment of the Tobacco (Licences and Returns) Ordinance of 1954.[17] This Ordinance has fourteen sections but was essentially designed to make provisions for the licensing of tobacco and payment of duties on such importation. In other words, the Ordinance only made inferential provisions for tobacco usage by placing restrictions on its importation without license. Therefore, in an economic culture where the colonial state and its successors were supportive of manufactured imported goods, the tobacco smokers emerged victorious.

[14]During the second half of the sixteenth century, the Portuguese and Spaniards shipped tobacco to East Africa from where it spread to Central and West Africa. There was also the use of tobacco in Northern Africa during the same period. The European settlers in South Africa grew tobacco and used it as a form of currency during the last quarter of the seventeenth century.

[15]Brenya.

[16]From personal experience most Nigerians attacked tobacco use as morally irresponsible and a habit of people with base conditions. For further details see J. Best, "Economic Interest and the Vindication of Deviance in Seventeenth Century Europe," *Sociological Quarterly*, 20 (1979): 172-182.

[17]Y. Alli, *Tobacco Usage and Nigerian Laws,* accessed June 2, 2015, http://www.yusufali.net/articles/Tobacco_usage_And_NigerianLaws.pdf.

However, since the tobacco issue was internationalized in the 1970s, tobacco control became a widespread measure adopted in different forms by almost every country, including Nigeria.[18] While the initial effort at controlling tobacco was due to cultural and religious practices and economic interest, the recent attempts at control of the growing, sales, and consumption of tobacco products are motivated by health, environmental, and economic concerns.

Internationalization of Tobacco Control, 1970 – 1996: The Era of Inaction

The origin of the work of WHO with tobacco control as a health issue began with the resolution of the Executive Board at its 55th Session in 1970. The Executive Board's resolution was influenced by the resolutions on the control of cigarette smoking passed by the Directing Council of Pan American Health Organisation (PAHO) and the Regional Committee of Europe at their sessions in 1969. The Executive Board expressed the view that no organization devoted to the promotion of health can be neutral on this matter. In the same year, the World Health Assembly (WHA) also declared itself conscious of the serious effects of smoking on promoting the development of pulmonary and cardiac diseases, including pulmonary cancer, chronic bronchitis, emphysema and ischemic heart disease. This is suggestive that as early as 1970, the world community had reached an agreement on the damaging effects of tobacco smoking to health. Between 1970 and 1995, the WHA adopted several resolutions in favor of tobacco control measures. Perhaps the most significant WHA resolution relating to tobacco smoking was "Tobacco on Health" adopted by 39th WHA in 1986. Section (1) of the resolution affirms "that tobacco smoking and the use of tobacco in all its forms is incompatible with the attainment of health for all the year 2000."[19] In addition, the resolution urged member states to implement smoking control strategies. The WHA also adopted a resolution, which proclaimed April 7, 1988 a world no smoking day. In 1989, the WHA resolved that May 31st of every year should be marked as World No Tobacco Day.[20]

Despite these resolutions and repeated calls on member states to take action, the actions were far from optimal. Available evidence shows that by 2000, about 95 countries including Nigeria had legislations regulating tobacco but most states had weak laws. The measures commonly adopted include ban on sales to minors, vague health warnings on tobacco packs or restriction on smoking in health facilities. For

[18]P. Cairney, Mamudu Hadu, and Donley Studler, *Global Tobacco Control Policy, Power, Policy, Governance and Transfer* (London: Palgrave, 2012), 80.

[19]WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA30.38* (Geneva: World Health Organisation, 1977).

[20]WHO, *Official Records of the World Health Resolutions and Decisions, Geneva Resolution WHA42.19,* World Health Organisation, 1989.

the most part, such laws were inconsequential; they neither seriously threatened the market nor affected the profitability of tobacco. On the contrary, a handful of countries such as Australia, Canada, Norway, and Singapore with comprehensive policies succeeded in reducing tobacco consumption rapidly and significantly. Nevertheless, by 1990 with the rapid and widespread influence of globalization, tobacco became a globalized epidemic. Consequently, the WHO changed tack in 1996 by electing to use its treaty-making process to regulate tobacco.

The Globalization of the Tobacco Epidemic and the Call for Action

Undoubtedly, the tobacco epidemic was spread and reinforced by a complex mix of factors, including trade liberalization, global marketing and communications, and direct foreign investment. A few of many possible examples will suffice to illustrate the globalization of the tobacco epidemic. A distinctive feature of the globalization of the tobacco epidemic is the role of multinational corporations. Since the beginning of the 20th century, a few major corporations took over the control of a larger chunk of the world's cigarette market. The influence of these multinationals largely from America, Britain, and Japan was not only felt in the Western nations but also in the developing world.[21] Powerful and influential tobacco companies targeted growing markets in Latin America in the 1960s, the newly industrializing economies of Asia (Japan, the Republic of Korea, China (Province of Taiwan), and Thailand in the 1980s, and women and young persons in Africa in the 1990s.[22] The successful effort of the tobacco industry to expand their global trade as well as achieve market penetration in developing countries and transitional market economies has been a major contributory factor to the risk of tobacco related diseases worldwide.[23]

This development was further enhanced by the wave of international trade liberalization, which included for the first time the liberalization of unmanufactured tobacco.[24] The Uruguay Round, which was concluded in 1994, gave birth to the World Trade Organisation (WTO). The establishment of WTO brought about the overhaul of the international trade regime culminating in the adoption of an array of multilateral agreements addressing contemporary trade issues including tobacco. These new WTO agreements facilitated the expansion of trade in tobacco products through significant reduction in tariff and non-tariff barriers to trade.

[21] A. Taylor and D. Bettcher. "WHO Framework Convention on Tobacco Control: A Global Good for Public Health." *Bulletin of the World Health Organisation,* 78, no. 7 (2000): 920-928.

[22] G. N. Connoly,"Worldwide Expansion of the Transnational Tobacco Industry," *Journal of the National Cancer Institute Monographs*, 12 (1992): 29-35.

[23] Bettcher, Yach and Guidon, 528.

[24] A. Taylor, "Trade Policy and Tobacco Control," in *Tobacco Control in Developing Countries*, eds. P Jha and F Chaloupka (Oxford: Oxford University Press, 2000), 20-35.

Moreover, the regional trade agreements and associations, such as American Free Trade Agreement, the European Union, the Common Market for East and Southern Africa, and the Common Market for West African States, among others, have acted in concert with the global level by further mandating trade liberalization in goods and services including tobacco at the regional level.

In addition to trade liberalization, the transnational tobacco industry also took advantage of direct forms of market penetration in cash – hungry governments of poor countries via direct foreign investment, by either licensing with a domestic monopoly in joint venture or other strategic partnering with domestic companies.[25] The point being made is that trade liberalization and market penetration contributed largely to a greater risk of increased tobacco consumption, particularly in low and medium income countries. As the challenges of tobacco control transcend national boundaries, stemming the growth of the tobacco pandemic requires global agreements and action. The globalization of the tobacco epidemic restricts the capacity of countries to control tobacco unilaterally within their sovereign borders.[26] All transnational tobacco issues, such as trade, smuggling, advertising and sponsorship, prices and taxes, control of toxic substances, and tobacco package design and labelling require multilateral cooperation and effective action at the global level. Transnational tobacco control gained support of countries such as Australia, Canada, Finland, Norway, and Singapore, with effective policies that recognized that their progress could be undermined by cross border advertising and illicit trade, resulting in the rapid expansion of tobacco use in resource poor countries. This support found expression at the 1993 All Africa Tobacco Conference in Zimbabwe and 1994 World Conference on Tobacco Control in Paris, where calls for action were issued.[27] In addition, the WHO worked assiduously to disengage the sports community from its close relations with the tobacco industry. To this end, it hosted in 2002 a high level meeting that included the Secretary General of the United Nations, Kofi Annan, Archbishop Desmond Tutu, and Gro Harlem Brundtland, WHO Director-General, during the Salt Lake City Winter Olympics in the United States. In the same year, the South Korean government – supported by WHO – declared the FIFA World Cup in South Korea and Japan smoke-free.[28] This ended both tobacco sponsorship and smoking in the stadium. The emergence

[25] World Tobacco File, *World Tobacco File.* (London: London International Trade Publication File, 1998).

[26] Allyn Taylor, "An International Regulatory Strategy to Global Tobacco Control," *Yale Journal of International Law* 21, no. 2 (1996): 257-304.

[27] S. Chapman, D.Yach, Y Saloojee, and D. Simpson, "All African Conference on Tobacco Control." *British Medical Journal,* 308 (1994): 189-191.

[28] WHO, Tobacco Free Initiative, *Tobacco Free Olympics 2002,* accessed on July 30, 2015, www.who.int/tobacco/free_sports/olympics/en/.

of new leaders also gave serious impetus to tobacco control initiatives. Prominent among them was Brundtland who was elected WHO Director-General in 1998. Her commitment to evidence-based policies and awareness of international political strategy played a part in her decision to advance tobacco control within the global health agenda. In this direction, the WHO Framework Convention on Tobacco Control adopted in 2003 provided the platform with the potential to significantly advance national and international efforts to curb the growth of tobacco use.

The WHO and the Framework Convention on Tobacco Control

In accordance with Article 19 of the Constitution, the World Health Assembly has the authority to adopt conventions and agreements with respect to any matter within the competence of the Organisation. Article 19 stipulates that:

> The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the organisation. A two-thirds vote of the Health Assembly shall be required for the adoption such conventions or agreements, which shall come into force for each member when accepted by it in accordance with its constitutional process.[29]

WHO did not adopt any convention from its inception to 2003. The organization has historically neglected international law in its work by underutilising its enormous constitutional powers. Aginam has attributed this neglect to the professional training of bureaucrats in the organization which largely blocks instead of helps the promotion of new norms.[30] However, the World Health Organisation had been granted before then several supervisory and advisory functions under several conventions adopted under the auspices of the United Nations and the International Atomic Energy Agency (IAEA). The World Health Organisation inherited the supervisory role of the League of Nations regarding the 1931 Convention for limiting the manufacture and regulating the distribution of Narcotic Drugs.[31] It was also granted a similar function under the provisions

[29] WHO, *Constitution of the World Health Organisation* (Geneva: WHO, 1948).

[30] O. Aginam, "Mission (Im)possible? The WHO as a Norm Entrepreneur in Global Health Governance," in *Law and Global Health: Current Legal Issues*, by M. Freeman, S Hawkes and B Bennett (Oxford: Oxford University Press, 2014), 559 – 573.

[31] WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA7.7* (Geneva: WHO, 1954).

of the 1971 Convention on Psychotropic Substances.[32] In addition, the World Health Assembly in 1988, requested the Director General to make the necessary arrangements for the accession of the WHO to the IAEA convention on Early Notification of a Nuclear Accident and the IAEA Convention on Assistance in the event of a Nuclear Accident or Radiological Emergency.[33] This accession provided a role for the WHO to act as the directing and coordinating authority in health work in matters covered by these conventions. Furthermore, in 1990 the World Health Assembly urged the member states to accede and ratify the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their disposal.[34]

The move towards the negotiation of the WHO Framework Convention on Tobacco Control started in 1996 when the World Health Assembly adopted the resolution for the development of a WHO Framework Convention on Tobacco and Related Protocols.[35] As a follow up, the WHA adopted a resolution in 1999, which established a working group to analyse potential elements to be included in the tobacco treaty and an intergovernmental negotiating body to draft and negotiate a proposed WHO Framework Convention.[36] The Tobacco Free Initiative of the WHO prepared the background documents for the working groups, enumerated possible elements to be covered by the Framework Convention and other elements of subsequent protocols. The negotiation process also galvanized Nongovernmental Organizations (NGOs). Global NGO Coalitions – the Framework Convention Alliance and the Network for Accountability of Tobacco Transnationals – emerged incorporating health, consumer, environmental, and legal groups from north and south. The NGOs provided technical support, supplied detailed analysis of the draft texts, and advocated key policy positions.[37] The Intergovernmental Negotiating Body on WHO finalized its work in February, 2003. The WHO Framework Convention on Tobacco Control (FCTC) was adopted by the 56th World Health Assembly in May, 2003. The Convention entered into force in 2005. This was the first treaty adopted by the WHO.

The adoption of FCTC is significant because it represents the first international legal instrument designed to promote multilateral cooperation and national action

[32]WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA7.7* (Geneva: WHO, 1971).

[33]WHO, *WHO Document WHA 41/1988/REC/1.P.76* (Geneva: WHO, 1988).

[34]WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA43.25* (Geneva: WHO, 1990).

[35]WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA44.26,* (Geneva: WHO, 1996).

[36]WHO, *Official Records of the World Health Resolutions and Decisions. Resolution WHA52.18* (Geneva: WHO, 1999).

[37]Global Health Watch 2, *An Alternative World Health Report* (London: Zed Books, 2008).

to reduce the growth and global use of tobacco. Derek Yach has described it as "a cornerstone of policy development aimed at reducing the burden of disease attributable to tobacco."[38] The policy has been remarkably successful in view of its wide acceptance by WHO member states. The provisions of the Framework Convention on Tobacco Control include measures to encourage state parties to impose bans or restrictions on tobacco advertising, sponsorship and promotion, establish new packaging and labelling of tobacco products, establish indoor air controls, and strengthen legislation to combat tobacco smuggling. [39]

Specifically, the treaty mandated the state parties to undertake a comprehensive ban on tobacco advertising, promotion, and sponsorship as far as their constitutions permit. The treaty also obliges state parties to adopt and implement large clear visible legible and rotating health warnings and messages on tobacco products and its outside packaging occupying at least 30 percent of the principal display areas. The treaty urged the state parties to adopt and implement or promote effective measures providing for protection from exposure of tobacco smoke in indoor workplaces, public transport, indoor public places, and all other public places.

The FCTC also addressed supply reduction measures. It urged the elimination of illicit trade in tobacco products, banning of tobacco sales to and by minors, agricultural diversification, and the promotion of alternatives of livelihood. Furthermore, it urged the state parties to adopt and implement effective measures to eliminate illicit trade, illicit manufacturing, and counterfeiting of tobacco products. The WHO FCTC also states that the state parties must take steps to mark all tobacco packages for tracing purposes and to indicate their country of destination. Finally, it called for enactment and implementation of tax laws and price policies on tobacco products as a way of reducing tobacco consumption, particularly among children.

The development of FCTC led to enhanced national, non-governmental, and political commitment to tobacco control worldwide. For instance, the WHO chaired United Nations Ad Hoc Taskforce on Tobacco Control championed a greater sense of policy coherence among the various sectorial heads that make up the United Nations. The Food and Agriculture Organisation was committed to defining where and when demand reduction will harm populations and develop policies to prevent or reduce the impact. The World Bank and International Monetary Fund worked closely with the WHO to implement excise tax policies. United Nations Children Fund (UNICEF), United Nations Population Fund (UNFPA), United

[38] D. Yach, "The Origin, Development, Effects, and Future of the WHO Framework Convention on Tobacco Control: A Personal Perspective," *Lancet* (2014): 1-9.

[39] WHO, WHO Framawork Convention on Tobacco Control. Adopted by the Fifty Sixth World Health Assembly 21 May, 2003 A56/8.

Nations AIDS Programme (UNAIDS) and the WHO also developed common approaches to working with youth so the complex mix of risk behaviour is dealt with in a comprehensive manner and that healthy alternatives to tobacco, alcohol, illicit drugs, and unsafe sex and violence are developed. The Economic and Social Council (ECOSOC) and United Nations Fund for Women (UNIFEM) also worked with the WHO to ensure that women play a stronger leadership role in tobacco control. The WHO FCTC authorized the Conference of Parties (COP) to adopt protocols to the Convention. After four years of negotiations, the first Protocol to WHO-FCTC – Protocol to Eliminate Illicit Trade in Tobacco Products – was adopted by the parties to the FCTC at the fifth session of the COP on November 12, 2012.

WHO and Tobacco Control Policies in Nigeria

National tobacco control is the foundation for public protection against tobacco. It is an incontrovertible fact that Nigeria's health policies, especially tobacco control policies, had been influenced by various WHO resolutions. Prior to the adoption of the WHO Framework Convention on Tobacco Control in 2003, Nigeria had promulgated laws regulating tobacco smoking. One of such laws was the Tobacco Smoking (Control) Act of 1990.[40] This Act was promulgated during General Babangida's regime and was championed by the former Minister of Health, Professor Olikoye Ransom Kuti. The Tobacco Smoking (Control) Act of 1990 provided for the control of smoking in certain places and advertisement of tobacco in Nigeria. It was introduced as part of the general strategy towards the attainment of Health for All by the year 2000 as well as a faithful commitment to various WHO resolutions, especially the World Health Assembly resolution "Tobacco and Health" in 1986. Other policies influenced by WHO were the Code of Advertising Practice 1993 and the Advertising Practitioners Council of Nigeria (APCON) resolution at its 89th meeting held on July 11, 2001. The APCON gave a directive which banned all sorts of advertisement sponsorship, promotion, testimonial, and brand stretching of tobacco products across the country.[41] The battle between tobacco companies and the tobacco control advocates took two forms. Initially, it started with public enlightenment. Secondly, it took the form of litigations in an effort to checkmate the tobacco industry excesses. Environmental Rights Action/Friends of the Earth Nigeria (ERA/FoEN) with the collaboration of other groups like Nigerian Heart Foundation and Educare Trust, Nigerian Cancer Society (NCS), Journalist Action on Tobacco Health, and All Nigerian Consumer Movement Union (ANCOMU)

[40] Federal Republic of Nigeria, *Tobacco (Smoking) Control Act of 1990, CAP T6, Laws of the Federal Republic of Nigeria Vol 8* (Abuja: Federal Ministry of Justice, 2004).

[41] "The Health, Economic and Social Menace of Smoking: Time for Concerted Action," accessed March 4, 2012, http://www.codewit.com/diet-and-nutrition/131-Nigeria.

formed a formidable opposition against the tobacco companies.

One incident that generated serious criticism was the signing of a memorandum of understanding between Nigeria and the British Tobacco Company (BAT) in London in September 2001 to establish a $150 million modern cigarette manufacturing company. According to the agreement, BAT was expected to source for raw materials in Nigeria, employ Nigerian workers, manufacture, and sell cigarettes to Nigerians and other countries in West Coast of Africa. The agreement also granted the Tobacco Company a high tax concession and waver. BAT had in 2000 taken over the shares in the moribund Nigerian Tobacco Company (NTC) and, as a result, controlled the cigarette market in Nigeria. Other tobacco companies like Phillip Morris from the United States also joined in the scramble for a portion of International Tobacco Company located in Ilorin, Kwara State.

This action by the Federal Government was seen as a betrayal of public health in Nigeria. It was totally rejected by the civil society groups, such as the Environmental Rights Action/Friends of the Earth Nigeria (ERA/FoEN). In 2007, the Federal Government in conjunction with the civil society group of Environmental Rights Action/FoEN filed a suit against three major tobacco companies, British American Tobacco Company, Phillip Morris International, and the International Tobacco Company. The suit was for $44 billion in compensatory damages.[42] It also alleged that cigarettes caused more harm to Nigerians. Other states, Lagos, Kano, Gombe, and Oyo also filed suits against tobacco companies. The Lagos State Government in collaboration with ERA/FOEN, on April 30, 2007 sued five tobacco companies (British America Tobacco Limited, International Tobacco Limited, British American Tobacco, Plc, British American Tobacco (investment), and Phillip Morris International). Lagos State, in particular, sued these companies against the backdrop of cases of tobacco related diseases, which stood at 9,000 in its hospitals in 2006. Lagos state also stated that it spent 2.7 million naira in treating these cases for one year only. It filed this suit to recoup its money.

In observance of the WHO-FCTC, the Federal Government instituted an anti-smoking campaign that was featured in the media. Today, cigarette packs in Nigeria contain text-only warnings: "The Federal Ministry of Health warns that smokers are liable to die young," which covers approximately thirty percent of the front and forty percent of the back. This is in line with the belief that domestication of Article 11 of the WHO-FCTC regarding pictorial warning labels may result in a reduced prevalence of youth smoking in Nigeria. Pictorial warnings, when used appropriately, evoke negative emotive feelings of fear and disgust and are readily understood by a diverse audience regardless of age or secular education. Another

[42]"Corrupt Nigerian Government Wants $44 Billion from Multinational Tobacco Companies," *Nigerian Times*, 8, November, 2007.

strategy used for tobacco control is cigarette pricing. In fact, the price of the lowest priced twenty cigarette pack in Nigeria is ₦50 while premium cigarettes were sold for about ₦200. Increasing retail cigarette prices in Nigeria is likely to decrease smoking related disease particularly among youths who are price sensitive. There is clear evidence that among currently known interventions, excise tax increases above inflation have the greatest simple impact on youth smoking, particularly because youth are more price sensitive and less addicted than adults.[43] Bans on all forms of promotion and advertisement and marketing benefit both youth and adults.

Despite all these measures, the tobacco companies continued to explore areas not covered by the APCON directive or existing laws to advertise the products. Those areas include delivery vans, point of sale, traffic signs, and umbrellas. It also continued to associate tobacco with arts, music, and fashion, among others. They also color-coded all their brands in Nigeria. Apparently, these measures were adopted in the absence of a comprehensive law to regulate the manufacturing, distribution, and consumption of tobacco products in Nigeria. The treaty was not domesticated in the country until 2015, ten years after the FCTC entered into force. Nigeria was one of the signatories to the treaty having signed and ratified the treaty in 2004 and 2005 respectively. As a party, Nigeria is obligated to domesticate the treaty and this has come in the form of the Nigerian Tobacco Bill. Nigeria used the Convention as an umbrella to fashion the new Tobacco Bill to bring them into line with the treaty. The Bill was passed by the Senate and the House of Representatives in 2011 but unfortunately was not signed into law by the President. In April 2014, the Bill was repacked by the Federal Ministry of Health and submitted to the Federal Executive Council, which gave its nod to it. The Tobacco Control Act 2015 was finally signed into law by President Goodluck Jonathan on May 27, 2015. The Tobacco Control Act regulates the manufacturing, advertising and distribution of tobacco products in Nigeria. The major provisions include: prohibition of smoking in public places to include bars and restaurants; no smoking on public transportation, in schools and hospitals, among others; a ban on all forms of direct and indirect advertising; prohibition of sales of cigarettes within a 1,000 meter radius of areas designated as non-smoking; mass awareness about the danger of smoking and the formation of a committee that will guide the government on the issue of tobacco control in the country. Prior to 2015, several states had enacted laws prohibiting smoking in public places. They include, Osun, Cross River, and the Federal Capital Territory. It is not surprising that the delay in the passage of the bill suits the tobacco industry, which supports weak legislation or no legislation

[43] D. Yach, "Tobacco Control," in *Critical Issues in Global Health*, eds. E Koop, C Pearson and Scharz (San Francisco: Jossey Bass, 2002), 162-170.

at all. BATN has always argued against increased taxes on tobacco products, a recommendation which the FCTC puts forward as a key to cutting back on the number of people who buy cigarettes.[44]

It has been argued by critics that these measures against the tobacco companies were a breach of the memorandum of understanding between the Federal Government and the tobacco companies, particularly the British American Tobacco Company.[45] They opined that the BATN, for example, contributed to the economic development of the country through sustainable agricultural development projects, sustainable water projects, sustainable environmental projects, and poverty reduction and economic empowerment. In the area of agriculture, the BATN Foundation, conceived and developed agricultural programs to empower subsistence farmers to adopt modern farming techniques. This program involved the establishment of model farms for the cultivation of cassava, maize, watermelon, and rice. To enhance farmers' income, the Foundation built cassava and palm oil processing cottage industries in Nigeria. Some of the communities that benefitted from its Agricultural Development Initiatives were Tede and Ago-Are in Oyo State, Jima in Niger State, Amaokwe-Item in Abia State, Afia-Nsit Uda-Nko in Akwa Ibom State, Odosimadegun in Ogun State, and Akpap-Otoyong in Cross River State. In addition, the BATN foundation embarked on direct empowerment of farmers through establishment of cooperative groups. It assisted the groups with financial take-off to serve as revolving loan.

The foregoing suggests that the people whose livelihoods depend on tobacco are contributing to the economy. This includes the farmers that grow it, the extension workers that assist the farmers, the tobacco companies that employ thousands of workers, and those who work in factories where machinery for those factories are manufactured. It is also contended that the national revenue is assisted by the various taxes derived from tobacco-related activities. Some even argue that to place restriction on the right of the individual as to what he consumes is an infringement of his fundamental right to the dignity of his person and freedom to choose what he thinks is best for him.[46]

Nevertheless, several studies have examined the potential economic impact of the complete elimination of tobacco use and production.[47] The evidence shows that elimination of tobacco will not affect the economy because tobacco use has

[44]"10 Years of Tobacco Control: Nigeria Fails Domestication Hurdles," *The Nation*, March 8, 2015.

[45]"Corrupt Nigerian Government Wants $44 from Multinational Tobacco Companies," *Nigerian Times*, 8 November, 2007

[46]Y. Alli, *Tobacco Usage and Nigerian Laws.* http://www.yusufali.net/articles/Tobacco_usage_And_NigerianLaws.pdf. Accessed June 2, 2015.

[47]Mayo Clinic. "Economic Impact of Tobacco Use on Employees," accessed August 13, 2011, http://www.mayoclinichealthsolution.com/products/Tobacco-quitline-economicimpact.cf.

many externalized costs not paid for by the smokers or tobacco manufacturers. This involves healthcare costs incurred by government while taking care of smoking-related diseases. When people no longer spend their money on tobacco, they will spend their money on other things.[48] This alternative spending will stimulate other sectors of the economy. Conversely, if the money is saved rather than spent, the increased savings will have stimulatory macroeconomic effects. The World Bank's review of the economics of tobacco use also debunked many of the myths about job and revenue losses that effective tobacco ban was purported to cause.[49] The World Bank demonstrated that policies reducing tobacco demand, such as the increase in tobacco taxes, will neither cause long term job losses nor will it reduce tax revenues. Rather, it will bring unprecedented health benefits without harming economies.

Conclusion

This article has examined the role of the WHO in tobacco control, particularly in Nigeria. The paper further discussed the potential role of WHO-FCTC in halting and reversing the tobacco epidemic in Nigeria. It also argues that although the issue of tobacco control was internationalized in 1970, the period between 1970 and 1996 could be described as the era of inaction as far as the issue of tobacco control was concerned. The period was marked by weak legislations. However, the tide changed following the decision of the WHO in 1996 to make use of one of its legal instruments for tobacco control. This resulted in the adoption of the WHO-FCTC. In Nigeria, progress in tobacco control has been slow for two fundamental reasons: weak human and institutional capacity in legislation economics, and advocacy and lack of political will. Although it took Nigeria ten years to domesticate the treaty, it is only a comprehensive legal framework like the Tobacco Control Act that can address the issue of tobacco smoking in Nigeria. Effective implementation of the Tobacco Law is definitely the way to go and this actually depends on public support. For this reason, media advocacy and communications that frame the tobacco debate in public health terms and encourage vigorous public debate about tobacco control options are essential.

In the light of the availability of verifiable facts against tobacco, governments in the West have adopted strong strategies, which are driving down smoking rates as well as the deaths, diseases, social, and environmental costs linked to tobacco consumption. Nigeria needs to draw lessons from those countries that

[48]Ontario Tobacco Unit, "The Fiscal Impact of a Comprehensive Tobacco Control Programme in Ontario," Ontario Tobacco Research Unit, Department of Public Health Sciences, University of Toronto, 2003.

[49] World Bank, *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (Washington DC: World Bank, 1999).

have recorded positive results in this important public health challenge. But there are considerable challenges ahead. This is because the political economy of tobacco poses difficult regulatory and governance challenges due to several factors notably: the liberalization of global trade rules; the powerful influence of and enormous wealth of tobacco multinationals as shown in their aggressive marketing strategies in developing countries including Nigeria; the economic dependence of some developing world economies on tobacco farming; and the complexity of harmonizing cigarette taxes, policies, and advertisements within domestic jurisdiction and multilaterally.[50] Nevertheless, with sustained political will, adequate resources, and strong institutions, Nigeria will overcome the entirely man-made epidemic.

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[50] Aginam, 559 -573.