Index for Tobacco Control Sustainability

CAMEROON

Vital Strategies

The Union
International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

Background and justification

Cameroon ratified the WHO Framework Convention on Tobacco Control (FCTC) in February 2006, demonstrating the commitment of national authorities to combat tobacco use. The devastating consequences of tobacco consumption and exposure to secondhand smoke have become a harsh reality, affecting health, society, the environment, and the economy. According to the WHO, tobacco use is responsible for the deaths of half of its users and claims the lives of an estimated 7 million people globally each year, with more than 680,000 nonsmokers involuntarily exposed to smoke. Without immediate action, these numbers could rise to more than 8 million deaths annually by 2030. It is concerning that more than 80% of the world's 1 billion smokers reside in low- and middle-income countries, including Cameroon.

In Cameroon, the prevalence of tobacco use has significant impacts on individual and social health. The Global Adult Tobacco Survey (GATS) conducted in 2013 revealed that 13.9% of men, 4.3% of women, or 8.9% of adults overall (equivalent to 1.1 million inhabitants) use tobacco products. Additionally, nearly 7 million individuals are passive smokers due to involuntary exposure to secondhand smoke in public places. Disturbingly, the 2008 WHO Global Youth Tobacco Survey (GYTS) found that 15% of those aged 13 to 15 regularly smoke, with 31% of potential consumers starting before the age of 10. Furthermore, 44% of young people in school have already experimented with cigarettes, and 6.4% have received free cigarettes from tobacco companies. The 2014 GYTS indicates that 10.1% of 13- to 15-year-olds are regular users of tobacco and tobacco products.

In addition to traditional cigarettes, the use of water pipes, commonly known as shisha, is also prevalent, particularly among young people. It is important to note that these products pose similar dangers to those of conventional cigarettes. The burden of tobacco consumption is particularly heavy for low- and middle-income countries, as expenditures related to tobacco account for approximately half of food expenses. Consequently, tobacco use leads to malnutrition, premature death, increased healthcare costs, higher rates of underschooling among youth, and overall economic strain. In Cameroon, according to GATS 2013, each current cigarette smoker spends 4,691 F.CFA per month on manufactured cigarettes, equivalent to 8.9% of the monthly gross domestic product (GDP) per capita. This contributes to increased poverty and hindered development within the country.

Considering that 64.4% of Cameroon's population is under the age of 25, urgent preventive measures are necessary to prevent the tobacco industry from targeting vulnerable groups like women and youth. It is also crucial to protect all citizens from the harmful effects of secondhand smoke in indoor public places, workplaces, and means of public transport. These alarming signs of an emerging tobacco epidemic in Cameroon highlight the need for effective prevention measures.

Because Cameroon requires a healthy and capable population for its development, it is imperative to shield citizens from the dangers of tobacco. This protection can only be achieved through proper implementation of the provisions outlined in the WHO FCTC. Though some progress has been made since the ratification of the FCTC in 2006, significant gaps still hinder the sustainability of tobacco control efforts in Cameroon. To address this, a comprehensive evaluation of the current situation based on clear indicators is necessary. This evaluation, conducted with the technical and financial support of The Union, aims to assess the country's performance, describe the methodology, analyze achievements and shortcomings, and identify emerging priorities.

Presentation of the Focus Group and its process:

Please list the participants and specify the structures they represent in the focus group, also the location of the meeting, date... Please note that the list of participants for the focus group is for internal use only and will not appear in the reports that will be published.

INDICATORS		Present (P)/ Absent (A)	Weighted Score	Country Score
1	Prerequisite Indicator: ›4 MPOWER policies in place	A	9	0
2	National tobacco control budget (annual)	A	7	0
3	National tobacco control law	A	6	0
4	National budget allocation for tobacco control capacity building	A	6	0
5	Tobacco taxation ›75% of retail sales price	A	6	0
6	Tobacco taxation increases faster than inflation plus gross domestic product growth	A	6	0
7	National tobacco control unit	P	5	5
8	Civil society tobacco control network	P	5	5
9	Civil society representation in national tobacco control advisory committees	P	5	5
10	Health promotion fund for, or including, tobacco control	A	5	0
11	National policy against tobacco industry corporate social responsibility	P	5	5
12	Tobacco-related mortality and morbidity recording system	A	5	0
13	National evaluation framework in place	A	5	0
14	Evaluation built into all major policy implementation plans	A	5	0
15	National tobacco control strategy	A	4	0
16	Tobacco control and non-communicable diseases form part of national health policy	P	4	4
17	Tobacco control forms part of national development plan	P	4	4
18	Human resource for implementation (national)	P	4	4
19	Global Tobacco Surveillance System surveys	P	4	4
20	Intergovernmental coordination mechanism	P	3	3
21	Capacity building plan for tobacco control personnel	A	3	0
22	Developmental assistance funding includes tobacco control	P	3	3
23	Code of conduct for government officials and staff	P	3	3
24	Ministry of health WHO FCTC Article 5.3 policy	A	3	0
25	WHO FCTC Article 5.3 policy across all ministries	A	3	0
26	Economic and social tobacco costs data	A	3	0
27	National focal point post	P	3	3
28	National advisory committee	P	2	2
29	Capacity building plans on research and evaluation	A	2	0
30	Mass media campaigns funded	P	1	0
31	Capacity building plan for non tobacco control specific personnel	P	1	0
Total Score			130	50

Explanation of the scores:

1. According to the WHO Report on the Global Tobacco Epidemic, 2021, Cameroon has only effectively implemented one MPOWER measure, specifically the measure pertaining to Health Warnings. The implementation of Joint Decree N°001/MINSANTE/MINCOMMERCE of January 03, 2018, establishes the guidelines for packaging and labelling of tobacco products sold in Cameroon, mandating the inclusion of graphic and textual health warnings covering up to 70% of the packaging unit's main faces (front and back).
2. Annual Budget. An annual budget of approximately US$60,000 is allocated for sensitization, World No Tobacco Day commemoration, and multisectoral tobacco control commission sessions. This falls well short of the recommended $2.75 million for Cameroon's population of 25 million. Participants disagreed on whether this indicator was present or absent. Some argued scattered funds across departments and grants from the State of Israel for a national drug prevention campaign could meet the indicator's amount. Others contended that no clear, long-term budget line exists for tobacco control.
3. There is no annual national budget allocation for capacity building. To be checked in the MINSANTE PTA.
4. The Finance Law has significantly advanced the ad valorem excise tax in recent years. In 2019, the tax rate stood at 25%, which was subsequently raised to 30% in 2020 and further increased to 50% in 2023. However, that tax rate remains below the recommended threshold of 75% set by WHO.
5. Tobacco taxation does not increase faster than inflation plus GDP growth.
6. The Directorate of Health Promotion has a tobacco control unit that represents the national tobacco control unit/ cell.
7. The Cameroonian Coalition Against Tobacco (C3T) was established in 2006. It is a network of civil society organizations working for a Cameroon free of tobacco-related diseases and deaths. Its website is available at http://c3tcameroun.org/
8. C3T is represented on national tobacco control advisory committees such as the Multisectoral Commission on Tobacco Control and the Technical Committee No. 47 of the Agency for Standards and Quality (ANOR). See Article 3 of Decision No. 3271-D/MINSANTE/CAB of October 12, 2015, on the creation, organization, and operation of the Multisectoral Anti-Tobacco Commission.
9. No health promotion fund is available.
10. A national policy against Tobacco Industry Social Responsibility exists in accordance with Section 39 of the Advertising Act 2006, which prohibits the promotion and sponsorship of activities by the tobacco industry. In practice, the tobacco industry funds holiday championships in the hinterland.
11. No nationwide system is established for recording tobacco related mortality and morbidity. A software project is in process, but staff needs to be trained to make it operational in all hospitals in the country.
12. There is no national evaluation framework.
13. Evaluation is not built into major policy implementation plans.
14. There is no national tobacco control strategy.
15. Tobacco control and NCDs are part of the national health policy, as there is a Sub-directorate for the Control of Chronic NCDs in the Ministry of Public Health. In this sub-directorate, tobacco issues are treated similarly to alcohol issues. See **MINSANTE's organization chart on pages 30 and 43** https://dpml.cm/images/La%20DPML/

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16. Tobacco control is part of the national health policy. This is evidenced by the ***National Development Strategy (NDS 30) page 89*** available at http://cdnss.minsante.cm/sites/default/files/Strat%C3%A9gie%20Nationale%20de%20D%C3%A9veloppement%20SND30_Fench.pdf and the ***Health Sector Strategy (HSS) document Page 36-57*** available at https://www.minsante.cm/site/sites/default/files/SSS_french.pdf

17. The Ministry of Public Health has dedicated human resources to effectively implement tobacco control policies. Specifically, the Directorate of Health Promotion houses a well-staffed Tobacco Control Department. The Technical Secretariat of the Multisectoral Anti-Tobacco Commission, overseen by the National Committee for the Fight against Drugs, further supports these efforts.

18. The STEP Global Adult Tobacco Survey and Global Youth Tobacco Survey were conducted in 2013 and 2014 by the National Institute of Statistics and the Ministry of Public Health, respectively. The reports are available in the following links:
GATS 2013: http://slmp-550-104.slc.westdc.net/~stat54/nada/index.php/catalog/54/study-description
GYTS 2014: https://untobaccocontrol.org/impldb/wp-content/uploads/reports/cameroon_2016_annex2_gyts_2014.pdf

    These surveys must be updated to reflect recent developments in tobacco control (modification of the tax structure, specific tax 3500 to 5000 Francs, excise duty from 30% to 50%, the passage of the sanitary textual marking to the sanitary graphic marking, etc.)

19. An intergovernmental coordination mechanism was established by Decision No. 3271-D/MINSANTE/CAB of October 12, 2015, on the creation, organization, and operation of the Multisectoral Tobacco Control Commission.
20.
21. Development assistance funding includes tobacco control. In Cameroon, there is the WHO GATES Project Phase 4. WHO occasionally supports the implementation of government activities, such as the commemoration of the World No Tobacco Day.

22. A Code of Ethics exists for government officials and staff.

    There is no Article 5.3 policy at MOH.

24. There is no Article 5.3 policy across all ministries.

25. Economic and social data on the cost of smoking are absent.

26. Cameroon's national focal point position is housed in the Health Promotion Department of the Ministry of Public Health.

27. The National Committee for the Fight against Drugs (CNLD), an advisory body placed under the MINSANTE, gives its opinion on all questions related to the consumption of psychoactive substances, including tobacco. See the text of the creation of the **CNLD in its Article 1**

28. There are no capacity building plans on research and evaluation.

29. There is no campaign financing in the media. For the commemoration of the WFDW, a week of activities is carried out with the media releasing some reports as well as interviews of media-requested institutional and civil society experts.

30. There is no capacity building plan for staff not specific to tobacco control. Only sporadic activities are organized.

Main conclusions

Cameroon has made some progress in tobacco control through the following achievements:

- The implementation of MPOWER policies has been initiated through the Global Adult Tobacco Use Survey (GATS) in 2013 and the Global Youth Tobacco Use Survey in 2014. However, these surveys are nearly 10 years old, and they have not effectively accelerated public policy on tobacco control. For instance, although GATS reported a significant number of passive smokers compared to active smokers, appropriate measures have not been taken to reduce exposure to tobacco smoke in public places.
- Only a few administrations and territorial authorities have adopted regulations prohibiting smoking in their central and decentralized services. Unfortunately, there is no national governmental text that prohibits smoking in public places, leaving the population vulnerable to secondhand smoke.
- Although the Minister of Health has established 19 national centers for addiction care, support, and prevention, these centers face challenges due to a lack of qualified personnel and adequate resources.
- The implementation of graphic health warnings on tobacco packaging has faced difficulties. The tobacco industry has manipulated the government into extending deadlines for compliance and withdrawing noncompliant packaging. Additionally, no evaluation has been conducted to assess the impact of health warnings on tobacco consumption habits.
- In terms of advertising, the 2006 law governing advertising in Cameroon prohibits the advertising of tobacco and its products in mass media. However, the law lacks specific regulations, allowing the tobacco industry to engage in advertising and sponsorship activities without repercussions.
- Regarding taxation, while there have been some changes to the taxation policy for tobacco products, Cameroon still falls short of the recommended tax rate set by the WHO. The relatively low level of cigarette taxes suggests room for significant increases.
- Despite these challenges, Cameroon has established a tobacco control unit within the Ministry of Public Health and a national focal point for tobacco control. The country also benefits from the presence of the Cameroonian Coalition Against Tobacco, which allows CSOs to participate in consultations and contribute to the fight against tobacco.
- Furthermore, through the 2006 law governing advertising, Cameroon addresses the issue of corporate social responsibility of the tobacco industry by prohibiting promotional and sponsorship activities.

In conclusion, while Cameroon has taken some steps in implementing tobacco control measures, many gaps still exist that require concrete actions with clearly defined priorities. It is crucial for the government to address these challenges and prioritize tobacco control in order to protect the population from the harm of tobacco use.

Detailed gap analysis and priorities identified for tobacco control sustainability

One significant gap is the absence of a national strategy and law on tobacco control. While a few regulations are in place that implement some provisions of the FCTC, the draft national anti-smoking law, which was initiated in 2011 by the Ministry of Health after consultation and input from all stakeholders, has yet to be implemented. The tobacco industry has exerted strong interference, impeding the progress of national tobacco control policies, despite numerous pleas from civil society. This interference is evident in the implementation of tax policies and graphic health warnings, with the industry falsely claiming that increased taxes promote illicit trade in tobacco products. Additionally,

the industry is lobbying for extended compliance deadlines for the implementation of tobacco packaging images. This interference, along with corruption, faces few obstacles because an Article 5.3 policy is absent in the Ministry of Health and other relevant ministries. Staff in various jurisdictions lack trainings on the provisions of Article 5.3 of the FCTC, and government agencies hold isolated meetings with tobacco industry stakeholders in violation of Article 5.3.

Cameroon does not allocate sufficient financial resources to tobacco control. According to officials from the Ministry of Public Health, the only dedicated budget for tobacco control is approximately 25 million F.CFA per year, solely for the celebration of World No Tobacco Day and meetings of the multisectoral tobacco control commission. The specific share of the annual budget allocated specifically to tobacco control is opaque, as the fight against tobacco is obscured by efforts against drug abuse conducted by various administrations. Cameroon falls far short of the WHO-recommended rate of $0.11 per capita.

Furthermore, taxation of tobacco products remains low, accounting for about 20% of the retail price, well below the WHO recommendation of 75%. Tobacco taxation is not increasing at a rate higher than inflation and GDP growth, making tobacco products affordable relative to other consumer goods. For instance, with just 25 F.CFA, one can purchase a cigarette stick, whereas a 200g bread stick costs 150 or even 200 F.CFA.

Cameroon lacks a Health Promotion Fund dedicated to tobacco control, and activities in this area are sometimes overly reliant on funding from development partners like the WHO. Civil society organizations also mobilize financial resources from their technical and financial partners, such as CTFK and the Union, to fund certain activities. The creation of the network of parliamentarians and the association of journalists involved in tobacco control, as well as media communication campaigns, have been made possible thanks to the support of CTFK. However, there remains a lack of sustained, large-scale media communication campaigns specifically focused on tobacco control, accompanied by adequate funding. Only a few media campaigns are carried out by civil society within the framework of budgets financed by their partners.

The absence of a national strategy hinders the establishment of a registration system for tobacco-related mortality and morbidity in Cameroon. Currently, obtaining data on tobacco-related mortality and morbidity is challenging. Although a software program has been implemented to record deaths related to chronic noncommunicable diseases, central services and health facilities lack the necessary awareness and training to record tobacco-specific data. This is partly due to the lack of funding and capacity building plans for both specific and non-specific tobacco control staff. The absence of a national evaluation framework and a research and evaluation capacity building plan further exacerbates the issue, limiting the production of data on the economic and social costs of tobacco use in Cameroon. Without such data, guiding national tobacco control policies and priorities remains a major challenge.

In summary, Cameroon faces several gaps, including the absence of a legislative framework and national tobacco control strategy, weak existing regulations, a lack of qualified and trained human resources in tobacco control, the absence of a national policy to combat interference from the tobacco industry, poor coordination, and insufficient funding.

To sustain the progress made in tobacco control, it is imperative to prioritize the following actions:

1. Adopt and implement a national tobacco control law and strategy to consolidate gains and address existing gaps in the implementation of FCTC provisions.
2. Mobilize resources for tobacco control funding.
3. Establish a regulatory framework for the implementation of an Article 5.3 policy in various jurisdictions.

4. Provide training for stakeholders to develop and implement appropriate national tobacco control policies.