Activating rural voices for effective implementation of tobacco control policies

Just like many other African countries, Malawi, one of the world's top ten exporters of tobacco, is increasingly experiencing the consequences of tobacco-related death and diseases. However, as yet it lacks public health-related control policies. One reason for this is a lack of data, our authors believe. With their action research project, they seek to change this state of affairs – and here, they particularly have the voices of rural communities in mind.

By Mariam Kadzamira, Harriet J. Gausi, Tamara Phiri and Eta Elizabeth Banda

Chronic non-communicable diseases (NCDs) are becoming significant causes of morbidity and mortality in sub-Saharan African countries. But local, high-quality data to inform evidence-based policies are often absent. This also holds true regarding the impacts of tobacco in Malawi. There is little or no evidence of the economic costs of smoking, and the disease burden associated with tobacco usage is difficult to quantify. In order to fill this gap, the social enterprise Youth Enterprise Services (YES) Malawi implemented an action research. Their work also aimed to give a platform for 'hidden rural voices' – those that are often not included in policy formulation processes. In Malawi, according to World Bank estimates, rural communities account for roughly 82 per cent of the population.

"Should the government put in place regulations/laws banning/prohibiting tobacco use in this country? What approaches ought to be followed in order for these laws to be put in place and enforced?" These questions were addressed in the focus group discussions.

Photo: Development Initiative Network (DIN) Malawi

The World Health Organization (WHO) reckons that globally, more than eight million deaths are caused annually by tobacco use. Seven million people die as a result of their tobacco consumption, while 1.2 million non-smokers lose their lives through involuntarily inhaling tobacco smoke from others. Of these deaths, 80 per cent are projected to occur in low- and middle-income countries. Tobacco consumption is on the decline world-wide, but sub-Saharan African countries are witnessing more tobacco use resulting from improved economic conditions, a large and growing young population and the tobacco industry's intensive marketing efforts.

Malawi is one of the world's top ten tobacco producers. Nearly all tobacco leaves are exported, and only a small quantity is processed locally, mainly in cheap low-quality tobacco products. The production, buying and exportation of the tobacco leaf is governed by the Malawi Tobacco Act (1970, last amended in 1990) and the Tobacco Industries Bill (2012). The country is the world's most tobacco-dependent economy, and its government owns a major share of tobacco companies. But Malawi is not a signatory to the WHO's Framework Convention on Tobacco Control (FCTC), the international legal framework developed in response to the global tobacco epidemic which entered into force in 2005. It is thus not surprising that no specific public health-related tobacco control policies exist with restrictions on smoking indoor and/or in public places, tobacco advertising and packaging, and sale restrictions (e.g. minimum age for the purchase).

Reliable data is scarce

Recent official data shows that in Malawi, more than 5,700 people are killed each year by tobacco-related diseases, with over 5,000 children aged 10-14 years and about 920,000 adults using tobacco every day. But this data is most likely an underestimation, one of the reasons for which is how patient data is captured in the public healthcare system. Upon an illness, at facility level, this is done in three ways. Patients' files, with details of their health history, symptoms and their management, remains with the hospital. Health passports, briefs mainly capturing diagnosis, presenting symptoms and treatment/management, are meant to be carried by patients every time they visit a hospital to ensure continuity of care. Finally, there is the web-based District Health Management Information System (HMIS). It can be easily accessed by policy-makers for research, but it only captures a patient's name, age, gender, complaint, diagnosis and treatment. Key information such as a patient's history of smoking or family is only contained in the patient's hospital files.

National population-based data on the prevalence of smoking in Malawi is sparse, too. The most recent statistics come from the 2015-2016 Malawi Demographic and Health Survey which included 26,361 households. The figures indicate that approximately 12.4 per cent of all men aged 15-54 smoke cigarettes, the majority of them on a daily basis, but that a mere one per cent of women aged 15-49 are

smokers. Tobacco usage is prevalent in both rural and urban Malawi. Whereas specific statistics on the type of consumption are hard to find, it can be assumed that tobacco-growing communities tend to 'roll their own' tobacco from their green leaf, while cigarette smoking is more prevalent in urban areas as it requires cash purchases. All in all, smokers are likely to be older, poorer, less educated and living in rural areas of the country.

Socio-economic costs and spill-over effects to family and community members

In the context of our action research, two in-depth case studies were developed, based on the life of two male smokers who had each been smoking for 30 years or more and whose life had been affected by smoking. This helped us to identify and document the direct and indirect socio-economic costs of disease burden associated with smoking. The case studies were augmented with six focus group discussions conducted to determine community knowledge on effects and impacts on smoking, and to gather public perceptions of the enactment of public policies to control smoking in Malawi. Sixty rural communities from various locations (Chikwawa, Salima, Nkhatabay and Kasungu Districts) and two peri-urban areas on the outskirts of the cities of Lilongwe (the capital) and Mzuzu (in the Northern region of Malawi) were engaged, with women making up a third of all participants in each focus group discussion on average. Findings from the case studies and the focus group discussions showed that illness related to smoking results in three impacts for smokers and their families: the smoker's ill health, the economic burden for the smoker, their family and the community, and mental health effects. Resulting from a lifetime of smoking, the smokers had to be hospitalised and stopped bringing income, which led to a loss of economic independence. In the case studies, the affected smokers indicated feeling 'helpless' and depressed, having been the main breadwinner in the family.

When a smoker gets sick in Malawi, the relatives, friends, workmates and other community members step in to provide cash for day-to-day needs. Relatives provide in-hospital support during hospitalisation, meaning that the smoker's close relatives and community members incur losses of income and time. This is true for other diseases as well, but illnesses associated with prolonged smoking are long-term in nature, e.g. hypertension and then a stroke, requiring relatives to give more time and money over a longer period. So costs associated with disease from tobacco usage spill over to an affected person's family and community, often eroding the individual and their family's finances, and pushing them below the poverty threshold – or further down, if they were already poor.

Rural voices as a basis to formulate policies

In our surveys, the rural communities referred to the following aspects alongside health issues as reasons to curb tobacco use in public places, and government enforcement of the same:

- Smoking contributes to air pollution and litters the environment with cigarette stubs.
- Smoking in public violates the human rights of non-smokers and creates conflicts between smokers and non-smokers. Furthermore, it sets youth and children a negative example.
- Public funds must be spent on treating tobacco-related illnesses. Income lost through smokers getting ill results in poverty, while money spent on cigarettes could be used for household needs.

There is much anecdotal evidence that children are often sent to groceries to buy cigarettes for their elders, and also light up the cigarette from the fire. This becomes an unintended initiation. Worse still, children pick up haphazardly discarded stubs and smoke them. Currently, Malawi law does not specify a minimum age for the purchase of tobacco products, which could explain why 3.5 per cent of Malawian youth aged 13–15 smoke cigarettes.

Rural communities consulted also provide insights on specifics that must be included in any policy aimed at curbing public smoking, and they offer insights on how these can be enforced in rural communities. They include the following:

- All businesses and government offices should designate smoking areas. This should go hand-in-hand with the enactment of penalties, stringent monetary fees, for anyone smoking in non-designated areas.
- Sale of tobacco products should be restricted to adults, with businesses selling tobacco products to under-age persons having their business license revoked.
- Government should involve the existing youth groups in communities to engage in advocacy campaigns. Community health talks and the arts could contribute to discouraging tobacco use, encouraging cessation and sharing information on support for quitting.

Our counterparts also called on the government to raise taxes on tobacco and cigarettes, with higher prices then perhaps discouraging people from smoking. These policies must be enacted along with budgetary support for on-going civic education and awareness-raising on the dangers of smoking for the public. The education system should also include anti-smoking messaging as part of the normal curriculum. Finally, the youth must be engaged in public health policy processes to ensure that their voice is heard, and that policies are developed.

The development of tobacco-related diseases shows the need for public policies to control smoking. Incorporating views from traditionally excluded communities – like rural communities – will ensure that their voice is heard, which could be the key to success of policy implementation. In addition, any policy that is formulated will only be effective if it is consistently implemented, has budgetary commitment and is enforced via local stakeholders such as traditional chiefs, who are the gatekeepers of rural communities in Malawi. Furthermore, there is need to put in place nation-wide initiatives aimed at preventing smoking initiation, supporting smoking cessation and sensitising the public on smoking risks. A national databank on smoking statistics has to be set up which includes occurrence of diseases linked to smoking. In addition, medical practitioners should be trained to provide advice on smoking cessation as part of regular health screenings.

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