Original Investigation

Support for smoke-free public places among adults in four countries in sub-Saharan Africa

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Abstract

Introduction: There is no known safe level of secondhand smoke exposure; yet, less than 30% of the global population is covered by comprehensive smoke-free policies as of 2016 and there are few smoke-free policies in sub-Saharan Africa (SSA). This study examines the support for smoke-free public places in SSA and delineates their correlates.

Methods: Data collected through the Global Adult Tobacco Survey (2012–2017) were analyzed using SAS for descriptive and multivariable analyses, with a significance level set at $p < .05$.

Results: No SSA country had comprehensive smoke-free policies, defined as a prohibition of smoking in eight public places. In the four countries whose Global Adult Tobacco Survey data were analyzed (Nigeria, Cameroon, Kenya, and Uganda), support for the prohibition of smoking in public places was over 90% in all eight public places except bars. Support for smoking prohibition in bars was 65.8%, 81.1%, 81.4%, and 91.0% in Nigeria, Cameroon, Kenya, and Uganda, respectively. Factors associated with support for smoke-free bars differed across the four countries, but in all countries, current smokers had decreased odds of support for smoke-free bars. Knowledge of secondhand smoke harm and living in smoke-free homes were associated with increased odds of support for smoke-free bars in all countries except Kenya.

Conclusion: The high support for smoke-free public places should inform the efforts of the public health community and policymakers in these four SSA countries toward meeting their obligations of Article 8 of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC).

Implications: Much of the population in SSA is not protected by comprehensive smoke-free policies. It was found that the overwhelming majority of adults in four large countries in SSA support the prohibition of smoking in public places and that knowledge of the health dangers of smoking and exposure to secondhand smoke and home smoking rules increased support for the prohibition. High support for the prohibition of smoking in these four SSA countries suggests tobacco control proponents should advocate for comprehensive smoke-free policies.

Introduction

Exposure to secondhand tobacco smoke (SHS) has deleterious health effects on everyone, and there is no known “safe” level of exposure.^{1,2} It accounts for over 890 000 global deaths annually³ and contributes (including direct smoking) to over \$1.4 trillion in direct and indirect economic costs.^{4,5} As such, cost-effective evidence- and population-based smoke-free policies (SFPs) for addressing SHS exposure^{2,6–8} are central to efforts to address the global tobacco epidemic through the World Health Organization Framework Convention on Tobacco Control (WHO FCTC),⁹ Article 8 of which requires Parties to create smoke-free environments. Although the majority of the world’s countries are Parties (181) to the WHO FCTC, comprehensive national smoke-free laws covered less than 30% of the world’s population as of 2017.¹⁰ Although progress has been made in the expansion of the coverage of SFPs because the WHO FCTC became international law in 2005,^{8,10,11} evidence indicates that low- and middle-income countries such as those in Africa continue to lag behind high-income countries.^{3,11–14} For example, as of 2016, only 7 (14.9%) of the 47 countries in the WHO African Region (AFRO) had national tobacco control laws that cover SFPs,^{15,16} although all (except Malawi) have ratified the WHO FCTC. Additionally, only a handful of African countries have comprehensive, or 100%, SFPs covering all public and private places, including restaurants, bars, and night clubs.^{3,11} Compared with other regions in the world, Africa has the weakest and lowest prevalence of SFPs.^{3,13,16} As a region, Africa is projected to have the most rapid growth in tobacco smoking by 2025¹⁷; therefore, adoption and implementation of evidence-based policy initiatives such as SFPs are paramount.

Several systematic reviews and meta-analyses involving SFPs have shown that extensive research on SFPs has been conducted in high-income countries in North America, Western Europe (mostly United Kingdom¹⁸), Western Pacific countries of Australia and New Zealand,^{19–23} and also in low- and middle-income countries such as India.²⁴ However, a recent systematic review²⁵ shows that research on SFPs to inform policy and advocacy initiatives in Africa is sparse.^{14,26,27} The extant literature focuses on SHS exposure among youths^{1,28–30} and adults,^{31,32} including employees in workplaces.^{33,34} In a study of 25 countries in Africa, Owusu et al. found that the percentage of adolescents exposed to SHS inside the home was ~21% and the percentage of adolescents exposed outside the home was ~39%, with an overall exposure of 45%.³⁵ Similarly, Mamudu et al. found, in a study involving nine West African countries, that SHS exposure among adolescents inside the home ranged from 13.0% to 45.0% and outside the home exposure ranged from 24.7% to 80.1%.³⁶ Consequently, although smoking rates in SSA are generally low,^{18,37,38} substantial numbers of nonsmokers are exposed to SHS. For example, approximately 1 in 20 adults^{38,39} and 1 in 10 adolescents⁴⁰ in Ghana are smokers, but one in three adolescents are exposed to SHS.^{35,36} With respect to public support for SFPs in SSA, only a handful of studies have been conducted in Ghana,²⁶ Kenya,⁴¹ Nigeria,⁴² South Africa,⁴³ and Uganda.^{27,44} This paucity in the research on effective evidence-based SFPs that protect nonsmoking youth and adults from SHS exposure and encourage smokers to cease smoking⁴⁵ warrants further study.

This study’s aim was to examine the level of support for SFPs among adults in four SSA countries (three English-speaking [Kenya, Nigeria, and Uganda] and one English/French-speaking [Cameroon]) and to identify associated factors with SFPs in these countries. The WHO has estimated the adult tobacco smoking prevalence at 9.4% (17.5% male, 1.2% female) in Cameroon, 12.1% (21.4% male, 2.9% female) in Kenya, 4.9% (9.2% male, 0.6% female) in Nigeria,

and 10.3% (16.3% male, 4.3% female) in Uganda in 2017.⁴⁶ Thus, although this study will inform policy and advocacy initiatives to address the tobacco smoking in these countries, it simultaneously has the potential to close a major policy research gap. Curtailing SHS exposure through SFPs means a potential reduction both in the likelihood of smoking initiation/regular smoking and in the incidence of diseases caused by SHS, which supports the 2013 World Health Assembly goal of 30% relative reduction in tobacco smoking by 2025.^{16,17,45} Knowing the level of support for SFPs could motivate policymakers to take such action(s) for the broader public good, as was done in Kenya,⁴¹ without fear of political or social backlash.

Methods

Participants and Procedure

We utilized data from the Global Adult Tobacco Survey (GATS), which used a multistage area clustered probability sampling technique to select a nationally representative sample of civilian noninstitutionalized adults aged 15 years and older, conducted in six sub-Saharan African (SSA) countries: Nigeria (2012), Cameroon (2013), Kenya (2013), Uganda (2013), Senegal (2015), and Ethiopia (2017). Although our aim was to include all six countries, Senegal and Ethiopia were excluded because in Senegal, support for SFPs was assessed only for two places (hospitals and schools), and in Ethiopia, support was not assessed at all. This household survey provided comprehensive information on tobacco use and key tobacco control measures. A standard protocol was used for sampling, data collection and management, and weighting across all countries, which allowed researchers to monitor adult tobacco use and track key tobacco control indicators.⁴⁷ Details of GATS methods have been published elsewhere.⁴⁸ The total sample for the four countries was 27 921 with individual sample sizes and response rates of 5271 and 94.1% (Cameroon), 4408 and 87.1% (Kenya), 9765 and 89.1% (Nigeria), and 8508 and 86.6% (Uganda).

Measures

Support for smoke-free policy (SFP), the *dependent variable*, was assessed as support for the prohibition of smoking in eight public places using the question, “Do you support the law that prohibits smoking inside of [hospitals; workplaces; restaurants; bars; public transportation; school; universities; worship places]?” (yes, no). Support for smoking prohibition in hospitals, workplaces, public transportation vehicles, and schools in Nigeria was assessed by the question, “For each of the following public places, please tell me if you think smoking should or should not be allowed in indoor areas.” Participants who indicated that smoking should not be allowed were deemed to support smoke-free policy in the stated public place.

The *independent variables*, age, sex, education, current smoking status, knowledge of SHS harm, exposure to antismoking messages, seen a health warning label, smoke-free home rules, knowledge of smoking harm, were selected based on the literature.⁴⁹ Age was categorized as 15–24, 25–44, 45–64, and 65+ years old as recommended by the GATS Collaborative Group,⁴⁷ sex was dichotomized as female and male, and education was classified into no formal education, below high school, high school, and above high school. The question “Do you currently smoke tobacco on a daily basis, less than daily, or not at all?” was used to ascertain *current smoking status* with current smokers determined to be smoking daily/less than daily. *Knowledge of SHS harm* was measured with the question, “Based on what you know or believe, does breathing other people’s smoke cause serious illness in non-smokers?” *Exposure to*

anti-smoking media messages was assessed with the question, “In the last 30 days, have you noticed information about the dangers of smoking cigarettes or that encourages quitting in any of the following places?” [Newspapers or magazines, television, radio, and billboards]. Consistent with literature and our previous studies,^{49,50} exposure to antismoking messages was categorized as no exposure, exposure in only one medium, and exposure in more than one medium. Exposure to warning labels was measured by the question, “In the last 30 days, did you notice any health warnings on cigarette packages?” *Smoke-free home rules* were determined using the question, “Which of the following best describes the rules about smoking inside your home: smoking is allowed inside, smoking is generally not allowed inside but there are exceptions, smoking is never allowed inside, or there are no rules about smoking in your home?” We categorized smoke-free home rules into smoking allowed (“no rules/allowed”), smoking restriction (generally not allowed with exceptions), and smoke-free (never allowed). *Knowledge of smoking harm* was assessed by asking, “Based on what you know or believe, does smoking tobacco cause serious illness?”

Analysis

Data analyses were conducted using the SAS (Version 9.4, SAS Institute, Cary, NC) survey procedure to account for the complex survey design. Descriptive analyses were performed to describe study participants’ demographic characteristics and to estimate a weighted prevalence of support for the prohibition of smoking in public places. Weighted multivariable logistic regression analysis was conducted to examine factors associated with support for smoke-free bars in each of the four SSA countries in this study. The logistic regression analysis was limited to factors associated with support for smoke-free bars because in all other public places, only a small fraction of participants indicated opposition to smoking prohibition. In all analyses, variance estimations accounted for the stratified and clustered sampling design. Odds ratios (ORs) and associated 95% confidence intervals (CIs) are reported.

Results

Study Characteristics

Of the 27 952 total participants from the four countries, 50.7% were females, 78.9% were below 45 years old, and 25.7% had

no formal education (Table 1). Support ranged from 65.8% for smoke-free bars in Nigeria to 99.7% for smoke-free worship places in Cameroon. In all countries, more than 90% of participants supported a smoking prohibition in each of the places studied except bars. Support for smoke-free bars was 65.8% in Nigeria, 81.1% in Cameroon, 81.4% in Kenya, and 91.0% in Uganda (Table 2). The proportion of participants indicating support for SFP in all the eight places was 58.2% in Nigeria, 79.6% in Kenya, 80.4% in Cameroon, and 89.5% in Uganda. In each country, less than 1% of the participants did not support an SFP in any of the eight public places (0.2% in Cameroon and Nigeria, 0.6% in Uganda, and 0.75% in Kenya).

Support for Smoke-Free Bars

Cameroon

The odds of support for smoke-free bars were significantly decreased in males (OR = 0.72; 95% CI = 0.59, 0.88), those with formal education, current smokers (OR = 0.35; 95% CI = 0.25, 0.50), and those who know health harm of smoking (OR = 0.64; 95% CI = 0.43, 0.97). Participants with knowledge of SHS harm (OR = 1.91; 95% CI = 1.44, 2.54) and those living in smoke-free homes had increased odds of support for smoke-free bars (OR = 1.7; 95% CI = 1.25, 2.30). The other factors did not show statistically significant association with support for smoke-free bars.

Kenya

Odds of support for smoke-free bars were increased in participants aged 45–64 and ≥65 years (compared with 15–24 years), those with below high school education (compared with no formal education, OR = 1.68; 95% CI = 1.25, 2.26), those exposed to antismoking messages in more than one media channel (OR = 1.51; 95% CI = 1.01, 2.26), and those living in smoke-free homes (OR = 1.85; 95% CI = 1.32, 2.59). Current smokers had decreased odds of support for smoke-free bars compared with nonsmokers (OR = 0.53; 95% CI = 0.30, 0.93).

Nigeria

Participants who were ≥65 years old (compared with 15–24 years, OR = 1.65, 95% CI = 1.24, 2.19), had received formal education, indicated SHS is harmful (OR = 1.73; 95% CI = 1.47, 2.03), and those living in homes with smoking restriction (OR = 1.64; 95% CI = 1.12, 2.38) or smoke-free rules (OR = 1.35; 95% CI = 1.08, 1.70) showed

Table 1. Participants’ Characteristics (*n* = 27 952)

Variable	Cameroon (<i>n</i> = 5271) (%)	Kenya (<i>n</i> = 4408) (%)	Nigeria (<i>n</i> = 9765) (%)	Uganda (<i>n</i> = 8508) (%)
Age, y				
15–24	36.9	36.1	34.4	35.6
25–44	40.6	41.7	43.8	41.2
45–64	16.3	16.1	16.2	16.5
65+	6.1	6.1	5.6	6.7
Sex				
Female	51.7	51.2	50.0	52.8
Male	48.3	48.8	50.0	47.2
Education				
No formal education	23.1	13.7	31.0	17.0
Below high school	66.1	57.5	30.7	69.0
High school	3.1	19.3	26.6	8.4
Above high school	7.7	9.5	11.8	5.6

Data were obtained from the Global Adult Tobacco Survey, 2011–2017.

Table 2. Prevalence of Support for Smoke-Free Policies in Selected Public Places (*n* = 27 952)

	Cameroon (<i>n</i> = 5271)	Kenya (<i>n</i> = 4408)	Nigeria (<i>n</i> = 9765)	Uganda (<i>n</i> = 8508)
Type of smoke-free places supported	% (95% CI)	% (95% CI)	% (95% CI)	% (95% CI)
Bars				
Yes	81.1 (79.7, 82.5)	81.4 (79.4, 83.5)	65.8 (64.5, 67.1)	91.0 (90.2, 91.8)
Hospital				
Yes	99.4 (99.1, 99.6)	98.5 (98.0, 99.0)	92.3 (91.5, 93.2)	99.1 (98.7, 99.4)
Schools				
Yes	99.6 (99.4, 99.8)	98.8 (98.5, 99.2)	94.1 (93.4, 94.8)	98.9 (98.5, 99.2)
Restaurant				
Yes	97.4 (96.8, 98.0)	97.3 (96.7, 97.9)	91.3 (90.5, 92.0)	97.8 (97.3, 98.2)
Universities				
Yes	99.3 (98.9, 99.6)	96.6 (95.7, 97.5)	91.0 (90.3, 91.7)	96.7 (96.2, 97.2)
Vehicles				
Yes	99.2 (99.0, 99.5)	98.2 (97.8, 98.7)	93.5 (92.8, 94.2)	98.5 (98.1, 98.9)
Workplaces				
Yes	98.6 (98.2, 98.9)	98 (97.5, 98.5)	90.9 (90.0, 91.7)	97.3 (96.8, 97.8)
Worship places				
Yes	99.7 (99.6, 99.9)	98.9 (98.5, 99.2)	98.2 (97.9, 98.6)	99.2 (98.9, 99.5)

CI = confidence interval. Data were obtained from the Global Adult Tobacco Survey, 2011–2017.

increased odds of support for smoke-free bars. In contrast, the odds of support for smoke-free bars were significantly decreased for males (OR = 0.80; 95% CI = 0.70, 0.92), current smokers (OR = 0.35; 95% CI = 0.24, 0.50), those exposed to antismoking messages in one media channel (compared with no exposure OR = 0.82; 95% CI = 0.69, 0.98), and those who indicated they had seen warning labels (OR = 0.72; 95% CI = 0.60, 0.85).

Uganda

Participants older than 15–24 years, who had received formal education, who indicated knowledge of SHS harm (OR = 2.75; 95% CI = 2.06, 3.67), those exposed to antismoking messages in one media channel (compared with no exposure, OR = 1.68; 95% CI = 1.26, 2.23), and those living in homes with smoking restriction (OR = 1.96; 95% CI = 1.28, 3.01) or smoke-free rules (OR = 2.31; 95% CI = 1.70, 3.15) had increased odds of support for smoke-free bars. In contrast, the odds of support for smoke-free bars were decreased in current smokers (OR = 0.46; 95% CI = 0.31, 0.66) (Table 3).

Discussion

Research from high-income countries and low- and middle-income countries elsewhere shows SFPs are cost-effective, population-based measures to reduce tobacco smoking while simultaneously protecting nonsmokers and encouraging smokers to quit smoking.^{2,19,20,22} SFPs have several benefits, including a significant reduction in cardiovascular events such as myocardial infarction,^{22,51,52} preterm birth, and asthma.^{53,54} Additionally, research in the hospitality sector indicates SFPs have a neutral economic impact.^{55–57} Generally, the evidence from the existing literature indicates that SFPs are highly supported when implemented in both high-income countries^{58,59} and low- and middle-income countries.^{24,60} The main challenge to achieving the benefits of SFPs, however, has been weak compliance and inefficient implementation.^{61–63} Accordingly, using nationally representative data from the GATS, this study examined the support for SFPs among adults in four large countries in SSA: Cameroon, Kenya, Nigeria, and Uganda.

The support for SFPs ranged from 65.8% for the prohibition of smoking in bars in Nigeria to 99.7% for the prohibition of smoking in worship places in Cameroon. While consistent with the literature^{58–60} but never reported, the almost unanimous support for prohibition of smoking in most public places (except bars and restaurants) in these four SSA countries, demonstrated by this study should serve as a fertile ground for advocates, policy entrepreneurs, policymakers, and international nongovernmental and governmental organizations working to reverse the increasing trend of tobacco smoking. To protect vulnerable children and women from SHS exposure, and to pursue comprehensive SFPs as recommended by the Article 8 of the WHO FCTC,⁹ the pursuit of SFPs in SSA is critical. Research has consistently found no evidence that SFPs reduce sales, revenues, or personnel requirements of bars and restaurants, the main arguments of protagonists of comprehensive SFPs.⁵⁵ In this respect, other countries should emulate Kenya where public opinion about the support for SFP was an integral part of the advocacy campaign for the national tobacco law.⁴¹

To identify factors associated with support for smoke-free bars across these four SSA countries, binary logistic regression analyses were conducted. Knowledge of SHS harm, and smoke-free home rules, were found to be associated with significantly increased odds of support for smoke-free bars. Since the Hirayama studies of the Japanese spousal women in the late 1970s and 1980s,⁶⁴ the linkage between SHS and negative health outcomes is beyond dispute,^{2,6,65} although the tobacco industry and allies attempted to obfuscate such science.⁶⁶ This scientific evidence, that is, the negative effects of SHS on the health outcome of the innocent bystander, has been central to efforts to promulgate and implement SFPs in many places, including the United States.^{2,12} In this study, the results show that knowledge of SHS harm was associated with increased odds of support for prohibition of smoking in bars in Cameroon, Nigeria, and Uganda. The combination of these results with the near-unanimous support for prohibition of smoking in the other public places suggests that to facilitate the adoption and implementation of comprehensive SFPs, advocates, and policy proponents should dedicate resources to engaging in media and educational campaigns to inform the public/population about the health

Table 3. Factors Associated With Support for Smoke-Free Bars in Four African Countries

Variable	Cameroon	Kenya	Nigeria	Uganda
	aOR (95% CI)	aOR (95% CI)	aOR (95% CI)	aOR (95% CI)
Age, y				
15–24	Referent	Referent	Referent	Referent
25–44	1.07 (0.88, 1.30)	1.28 (0.94, 1.73)	0.97 (0.83, 1.14)	1.38 (1.05, 1.83)*
45–64	1.25 (0.89, 1.76)	1.71 (1.06, 2.74)*	1.19 (0.98, 1.45)	1.53 (1.10, 2.14)*
65+	1.65 (0.97, 2.81)	2.01 (1.34, 3.02)***	1.65 (1.24, 2.19)***	1.69 (1.02, 2.82)*
Sex				
Female	Referent	Referent	Referent	Referent
Male	0.72 (0.59, 0.88)**	0.83 (0.59, 1.17)	0.8 (0.70, 0.92)**	0.87 (0.70, 1.08)
Education				
No formal education	Referent	Referent	Referent	Referent
Below high school	0.67 (0.48, 0.94)*	1.68 (1.25, 2.26)***	1.81 (1.51, 2.18)***	1.70 (1.26, 2.30)***
High school	0.47 (0.27, 0.83)**	1.05 (0.64, 1.72)	1.81 (1.46, 2.25)***	2.25 (1.32, 3.85)**
Above high school	0.38 (0.23, 0.63)***	0.98 (0.54, 1.80)	1.75 (1.33, 2.31)***	2.02 (1.22, 3.35)*
Current smoker				
No	Referent	Referent	Referent	Referent
Yes	0.35 (0.25, 0.50)***	0.53 (0.30, 0.93)*	0.35 (0.24, 0.50)***	0.46 (0.31, 0.66)***
Knowledge of SHS harm				
No	Referent	Referent	Referent	Referent
Yes	1.91 (1.44, 2.54)***	1.26 (0.90, 1.75)	1.73 (1.47, 2.03)***	2.75 (2.06, 3.67)***
Exposure to antismoking media message				
No exposure	Referent	Referent	Referent	Referent
Exposure in one channel	0.85 (0.65, 1.12)	1.35 (0.85, 2.13)	0.82 (0.69, 0.98)*	1.68 (1.26, 2.23)***
Exposure in more than one channel	0.92 (0.71, 1.19)	1.51 (1.01, 2.26)*	0.86 (0.69, 1.08)	1.15 (0.83, 1.59)
Seen health warning label				
No	Referent	Referent	Referent	Referent
Yes	0.85 (0.69, 1.04)	1.02 (0.81, 1.29)	0.72 (0.60, 0.85)***	0.90 (0.69, 1.17)
Smoke-free home rules				
Smoking allowed	Referent	Referent	Referent	Referent
Smoking restriction	1.1 (0.72, 1.68)	0.88 (0.50, 1.54)	1.64 (1.12, 2.38)*	1.96 (1.28, 3.01)***
Smoke-free	1.7 (1.25, 2.30)***	1.28 (0.81, 2.03)	1.35 (1.08, 1.70)**	2.31 (1.70, 3.15)***
Knowledge of smoking harm				
No	Referent	Referent	Referent	Referent
Yes	0.64 (0.43, 0.97)*	1.85 (1.32, 2.59)*	1.07 (0.88, 1.30)	1.2 (0.87, 1.65)

aOR = adjusted odds ratio; CI = confidence interval. Results were obtained from multivariable logistic regression. The referent category of the outcome variable was “did not support or opposed ban of smoking in bars.” Data were obtained from the Global Adult Tobacco Survey, 2011–2017.

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$.

hazards of SHS to the nonsmoker while lobbying policymakers for changes. Such knowledge could provide policymakers with the confidence to reject the tobacco companies’ efforts to dilute SFPs in these countries.

The results of this study show that smoke-free home rules were associated with increased odds of support for SFPs in Cameroon, Nigeria, and Uganda. Studies have found that the prohibition of smoking in public places increases the voluntary adoption of smoke-free home rules,⁶⁷ dispelling the displacement thesis/hypothesis, which asserts that such prohibitions (i.e., SFPs) could increase smoking inside the home. This information can be incorporated into efforts to denormalize smoking and make smoking socially unacceptable, thereby protecting vulnerable children and women from the health dangers of SHS through comprehensive SFPs and voluntary smoking prohibitions at home. Because the majority of people in the four countries in this study and elsewhere in Africa are nonsmokers^{10,17} and probably live in nonsmoking homes, it is important that comprehensive SFPs are adopted and implemented to protect them from the hazards of SHS as they overwhelmingly support such efforts. Whereas lack of formal education was associated with decreased odds of support for smoke-free bars in Nigeria

and Uganda, it was associated with increased odds of support in Cameroon. This study is limited in explaining this difference; hence, further study is required to understand why people with higher education levels are less likely to support smoke-free bars in Cameroon.

Finally, there is an established scientific consensus that the use of tobacco products leads to negative health outcomes, including several diseases and death,^{2,65} although the tobacco industry tried to hide and obfuscate this information from the public.⁶⁸ The results of the multivariable logistic regression analyses show that such knowledge was associated with increased odds of support for smoke-free bars only in Nigeria but decreased odds of support in Cameroon. There may be cultural differences in the perception of bars in these countries, and further studies are needed to understand this finding. However, given that research has shown that SFPs not only protect nonsmokers but also motivate smokers to quit,^{8,10,46} educating people about the harm of smoking has dual benefits: enhancing policymakers’ inclination to support policies to protect nonsmokers and facilitating smoking cessation. Thus, the public health community (domestic and global) should use the results of this study to strengthen efforts to disseminate knowledge about the dangers

of SHS exposure as such efforts heighten public support for SFPs and provide evidence for policymakers that supports policy change as well.

The results of this study should, however, be interpreted against the backdrop of certain limitations. First, this study utilized cross-sectional GATS data, which means that we cannot establish causation. Second, the study outcome, support for the prohibition of smoking (i.e., SFP), is self-reported and subject to social desirability bias, with the risk of inflating the point estimates. Third, the study involved only 4 of the 47 countries in the WHO African region, and although the data are from nationally representative samples, extrapolating the results region-wide may be problematic due to contextual limitations. Nevertheless, this is the largest study on adult support for SFPs in Africa and is critical for informing both domestic policy and advocacy initiatives as well as global tobacco control governance.

Conclusion

The SSA region is expected to experience the most rapid increase in tobacco smoking by 2025,¹⁷ and noncommunicable diseases, for which tobacco use is the leading preventable factor, are predicted to emerge as the leading cause of morbidity and mortality in the region by 2030.⁶⁹ Although tobacco smoking is still generally low,⁴⁶ a substantial proportion of the population, mostly nonsmoking vulnerable children and women, are exposed to the hazards of SHS; yet, SSA has the weakest SFPs^{3,13,16} and lags behind the rest of the world in progress toward policy development.^{12,13,16,45} At the same time, this study of four SSA countries (Cameroon, Kenya, Nigeria, and Uganda) found overwhelmingly high support for the prohibition of smoking in all the public places examined and that the odds of support for smoke-free bars were significantly higher among people with the knowledge of SHS harm and smoke-free home rules. As such, it is vital for the public health community to embark on media and educational campaigns that inform the public and policymakers about the harms of smoking and SHS exposure. At the same time, the adoption of smoke-free homes should be encouraged and the rationale policymakers rely on for not making changes despite the overwhelming support for SFPs should be investigated.

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Declaration of Interests

The authors have nothing to declare.

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